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## **The Challenges of Bilingual Speech-Language Therapy: Perspectives from Speech-Language Pathologists**

Dana Marie Roberts

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## Introduction

In recent years, bilingual speech-language therapy has become an important issue and concern for speech-language pathologists (SLPs) and researchers in the field of communication sciences and disorders, as well as for the bilingual persons who seek services. As the number of people in the United States who speak a language other than or in addition to English continues to grow, it has become evident that SLPs and other bilingual service providers must respond accordingly to accommodate the needs of the nation's changing demographics. While some of the challenges of providing and obtaining bilingual speech-language therapy services have been identified and noted in the literature, not all are known or understood. The purpose of the present study is to explore the challenges faced by bilingual SLPs by conducting in-depth interviews of a small number of SLPs practicing in the Central New York area, and comparing their responses to the information that is currently available in the literature.

According to the most recent data available from the U.S. Census Bureau, more than 15% of the U.S. population aged five years and over speaks a language other than English at home. Of the percentage of people speaking a language other than English, more than 60% report Spanish as that other language. (U.S. Census Bureau, Characteristics, 2006) Indeed, Latinos are a very prominent group in the U.S., and the Latino population has increased greatly over the years, from 4.7% of the total U.S. population in 1970 to 14.7% in 2008 (U.S. Census Bureau 2008; U.S. Census Bureau 2006). Recently released data from the U.S. Census Bureau (2008) indicates that by 2050, nearly 25% of the total population will be

Hispanic (U.S. Census Bureau, 2008). Some believe that percentage may be even higher. According to projections recently released by the non-partisan Pew Research Center reported in USA Today, “The U.S. population will soar to 438 million [currently, the U.S. population is 303 million] by 2050, and the Hispanic population will triple” resulting in a projected Hispanic population of 29% (as cited in El Nassar, 2008). The U.S. Census Bureau (2004) estimates other minority groups will also increase in population, projecting Asians to increase from 3.8% of the population in 2000 to 8% in 2050, and Blacks to increase from 12.7% of the population in 2000 to 14.6% of the population in 2050 (U.S. Census Bureau, 2004). Regardless of the precise numbers, we can be sure that the nation will see an increase in the already growing populations of Latinos and other minorities, such as Asians and African Americans. As a result of this population change, the field of communication disorders has recognized the need to accommodate service provision for this population.

The recent marked increase in not only the Latino population but also many other cultural groups in the U.S. has resulted in SLPs’ caseloads consisting of greater numbers of bilingual and bicultural persons, or the population that is referred to in the field as “culturally and linguistically diverse” (CLD). However, it is not only the increase in the population of CLD individuals that has directly affected clinicians’ caseloads; it is also the fact that these individuals may be more likely to experience communication disorders or at least to be diagnosed with communication disorders. Benson and Marano (1994) said that, “the National Institute of Health Interview Survey indicates that there is a greater

prevalence of communication disorders among racial and ethnic minorities than among white individuals” (as cited in Battle, 2002, p. 21).

Similarly, racial and ethnic minorities have been found to comprise a disproportionate percentage of persons with disabilities and of students enrolled in special education. The Office of Special Education Programs’ *Twenty-Second Annual Report to Congress on the Implementation of IDEA* reported: “Black (non-Hispanic) students account for 14.8% of the general population; however, they represent 20.2% of the children receiving special education in all disabilities” (as cited in Battle, 2002, p. 24). The percentage of certain disabilities in the Latino population was also greater than what was expected, specifically in the categories of learning disabilities, hearing impairment, and orthopedic impairments. (as cited in Battle, 2002, p. 24). A mediating factor that might cause this overrepresentation is inadequate or inferior health care; nevertheless, the overrepresentation is still important.

These data support the fact that the incidence of communication disorders in the CLD population is significant. In fact, Battle (2002) estimated that “6.2 million culturally and linguistically diverse Americans have a communication disorder” (p. 21). This number has climbed since Battle’s book was published in 2002, and demonstrates why CLD individuals are increasingly filling the caseloads of SLPs.

Kritikos (2003) researched the effects of the increasing number of bilingual/bicultural and CLD persons on SLPs. Surveys assessing beliefs about the language assessment of bilingual/bicultural individuals were distributed to

SLPs in five states, representing various regions in the U.S. that were determined to have the highest proportion of individuals who spoke a language other than English in their home. Kritikos found that “most SLPs (95%) worked with at least one client who came from a home where a language other than English was spoken” (2003, p. 84). This illustrates the importance of bilingual and bicultural training and preparation for at least SLPs in those states so that their bilingual clients can be adequately served.

It is important to recognize that even SLPs practicing in areas of the U.S. that have relatively low diversity are likely to encounter clients who speak a language other than English. Diane Scott, a past director of ASHA’s Office of Multicultural Affairs, explained that this is because the cultural, ethnic, and linguistic diversity that was once found in only large cities is now being found in smaller communities across the country (as cited in Coleman & McCabe-Smith, 2000, p. 14). Research by Caesar and Kohler (2007) attests to this. Caesar and Kohler administered surveys to school-based SLPs in Michigan, a state with fairly low diversity, and found that 69% of their respondents had bilingual students on their caseloads. Thus it appears that no SLP is exempt from the possibility of providing services to CLD children, regardless of their location or language spoken.

In the American Speech-Language-Hearing Association [ASHA] survey “ASHA SLP Health Care Survey 2005 ~ Caseload Characteristics Report,” it was found that of certified SLPs employed full-time or part-time as clinical service providers, a mean of 7% of their clients in all types of settings required bilingual

services and/or the use of an interpreter/translator, with the mean percentage being as low as 4.4% for those employed in skilled nursing facilities (SNFs) and as high as 12.4% for those employed in pediatric hospitals (American Speech-Language-Hearing Association, 2005, p. 17). This survey data from ASHA emphasizes that the percentage of clients needing bilingual services varies by setting, but SLPs working in every type of setting indicate that at least some percentage of their clients need bilingual services. Thus, SLPs are held accountable to provide service to culturally and linguistically diverse individuals across the board, in all clinical environments, which creates an essential requirement in the job description for an SLP.

Providing bilingual therapy has proven not only to be an area of considerable significance, but also an aspect of service delivery that requires development of specific skills. Clinicians must understand their role as bilingual service providers in order to be fully equipped and prepared to adequately provide services to clients. As early as 1989, ASHA's Committee on the Status of Racial Minorities drafted a definition of bilingual speech-language pathologists and audiologists that outlined the role, duties, and abilities of such service providers.

This ASHA (1989) definition mandates that:

Speech-language pathologists who present themselves as bilingual must be able to speak their primary language and to speak (or sign) at least one other language with native or near-native proficiency in lexicon (vocabulary), semantics (meaning), phonology (pronunciation), morphology/syntax (grammar), and pragmatics (uses) during clinical management. To provide bilingual assessment and remediation services in the client's language, the bilingual speech-language pathologist or audiologist should possess:

- 1) ability to describe the process of normal speech and language acquisition for both bilingual and monolingual individuals and how those processes are

manifested in oral (or manually coded) and written language;

2) ability to administer and interpret formal and informal assessment procedures to distinguish between communication differences and communication disorders in oral (or manually coded) and written language;

3) ability to apply intervention strategies for treatment of communication disorders in the client's language; and

4) ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to the client's language community. (ASHA, 1989)

It is obvious that bilingual practitioners have a considerable task before them in having to master all domains of not one, but two languages, and have the knowledge base needed to describe, assess, and provide therapy for both bilingual and monolingual individuals. SLPs must also be able to distinguish between a communication disorder and a difference. Cary (1992) reported “Although it is possible for white speech-language pathologists [who make up the majority of the population of practicing SLPs] to be sensitive to the needs of clients from diverse backgrounds, cultural differences between speech-language pathologists and their clients may create barriers to appropriate and effective clinical practice” (as cited in Coleman, 2000, p.xiv). Thus cross-cultural understanding is necessary for all SLPs.

While providing bilingual therapy is possible for clinicians who do not speak the same language as their client, it is important to consider how challenging it is in many ways, a fact that is continually noted by bilingual SLPs and service providers. It has become apparent that in order to maintain bilingual speech-language therapy as a viable, successful branch of communication disorder service provision, the specific challenges faced by bilingual SLPs must be

analyzed and investigated, with the perspectives of currently practicing bilingual SLPs emphasized in the investigation. Therefore, the purpose of this study was to begin to explore the challenges facing bilingual SLPs by obtaining the perspectives of four bilingual English-Spanish SLPs in the Central New York (CNY) area. By analyzing the challenges cited by these bilingual SLPs in addition to the current investigations on bilingual speech-language therapy, it was hoped that possible solutions to these challenges could be posed and insight into the future direction of bilingual speech-language therapy could be gained.

### **Purpose**

This study first aimed to gain a more personal perspective of the issues in bilingual therapy by interviewing four bilingual therapists with language abilities in English and Spanish. This study addressed the following questions:

- What are general therapy practices of four bilingual speech-language pathologists in the CNY area, and what are their perspectives on the challenges in bilingual speech-language therapy today?
- Do the challenges reported by the participants correspond with and/or expand upon the challenges reported in the literature on bilingual speech-language therapy?
- What are some possible solutions and steps that can be taken to address the challenges reported in bilingual speech-language therapy today?



## **Methods**

A literature review was first conducted to gain a general understanding of bilingual speech-language therapy and also to understand the influence of the changing demography of the United States, particularly that of the Latino population, on bilingual speech-language therapy. The Latino population was the focus because of its growing prominence in the nation, and because Spanish is the language that is most widely used after English by clients of SLPs in the U.S.

### *Interview Questions*

Interview questions for the participants in the study were then compiled based in part on the literature review and loosely categorized as 1) questions on their education and background, 2) questions on their clinical experiences with bilingual persons and their typical practices in bilingual service provision, and 3) questions on the challenges they have found in providing bilingual services. Some modifications/additions were made after the questions were reviewed by a professor who teaches a course in cultural and linguistic issues in Communication Sciences and Disorders. (See Appendix A for a complete list of questions.) The same questions were asked of all participants, although not necessarily in the same order. In addition, some questions were eliminated if deemed inapplicable for a particular participant, and some questions were added if a participant introduced a topic that the researcher had not previously brought up.

### *Participants*

Following the compilation of the interview questions, bilingual speech-language pathologists in an urban school district in CNY and other bilingual SLPs

in the area were contacted to participate in the study. Because a complete list of bilingual SLPs in the area was not available, participants were contacted based on suggestions from faculty within the Communication Sciences and Disorders Department of an Upstate NY University and from a local bilingual SLP in the district with whom the researcher was already familiar.

The final group of participants in the study included four Masters level SLPs who practice or work in the CNY area and are all bilingual in English and Spanish: Jane Smith, Beth Miller, and Robin Tate (all SLPs in the same CNY school district), and Diane Cooper, a supervisor at the public speech-language-hearing clinic in a CNY private university. (Note: all names have been changed for confidentiality purposes.)

All four participants had Master's degrees (required by ASHA), and three had already received ASHA's Certificate of Clinical Competence. The fourth, Beth Miller, was completing her Clinical Fellowship Year and anticipated being awarded her certification less than three months after the time of the interview. Three of the participants, Jane Smith, Beth Miller, and Diane Cooper, attended schools in New York State for their Master's programs. One participant, Robin Tate, received her Master's from a school outside of New York State. Three of the participants, Jane Smith, Beth Miller, and Robin Tate, had also received the bilingual extension from NYS and the other SLP, Diane Cooper, was planning on going back to school in the near future to complete that certification, which allows teachers or other individuals in a school setting, such as SLPs, to teach or provide services in a bilingual setting. The extension is only available to those who have

already completed their Masters program; hence it serves as an “extension” of that degree.

All of the participants with the bilingual extension attended schools in New York State for this certification, although the method in which they attained certification varied. Although all the participants reported working in various settings and locations after receiving their degrees, including early intervention centers, schools, and university clinics, they all affirmed that they had at some point worked with bilingual clients or presently had bilingual clients on their caseloads.

In addition, all of the participants indicated that English was their first language (L1) and Spanish their second language (L2). The participants acquired Spanish through sequential acquisition, which means that they learned their second language of Spanish after their first language of English was already either wholly or partly established, compared to simultaneous language acquisition, in which two languages are learned at once. In fact, all participants learned Spanish in school rather than “naturally”, through family or location. Two of the participants, Jane Smith and Robin Tate, also stated that they had been exposed to languages other than Spanish or English growing up (French and Italian), either at home or in school; however, they did not consider themselves fluent in these languages.

Three of the four participants were observed in their current work setting. The only exception to this was Diane Cooper, who could not be observed because she no longer works directly with clients of her own in her current position as a

university clinic supervisor. The researcher conducted the interviews as soon as possible after the observations in a quiet area in the participant's place of work (either a school or clinic). The interviews were recorded on a digital voice recorder. Interviews were then transcribed and the responses were typed into a computer.

After transcriptions were completed, they were reviewed to obtain the educational and background information for each participant. The transcriptions were then thoroughly examined to glean each participant's opinions of the challenges of providing bilingual speech-language therapy through the accounts of their own experiences in the field. Reports of individual participants were then compared and analyzed for similarities. This resulted in the identification of several common themes. Once general themes were identified, they were compared against what has been reported in the literature. Similarly, possible solutions and steps to take in addressing the challenges of bilingual speech-language therapy were identified from the participants' comments and were compared to those recommended in the literature, and were finally supplemented by the researcher's own observations. The themes that emerged from this investigation are presented in the following sections.

## **Results & Discussion**

### *The Challenge of Locating and Receiving a Quality Education in Multicultural/Bilingual Issues*

Early on in the interviews, during the participants' accounts of their educational experiences, the first of a number of challenges of being a bilingual

speech-language therapist was noted: receiving a quality education in bilingual speech-language therapy, and locating adequate and convenient programs to obtain the bilingual extension that is needed to rightfully practice in schools. While the participants did identify positive attributes of their varied educational experiences, the challenge of finding and receiving an exemplary education in bilingual speech-language assessment and remediation, both in a Master's program and an extension program, was noted by all of the participants. This challenge was sometimes stressed more than once during an interview, which attests to its relevance.

#### *Graduate Programs*

When asked about information provided in their Master's programs on bilingual/multilingual populations and their service provision needs, the participants stressed the lack of emphasis given to this topic during their graduate experiences. Robin Tate, a 1981 graduate of a private university in the Midwest, shared that her Master's program exposed her to "only a little bit" of instruction on bilingual education and service provision (interview, March 3, 2008). She wrote a paper on bilingual language development, and she also had experiences talking to and screening bilingual children, but she did not have the opportunity to work with bilingual children in therapy. Similarly, after being asked if she received any instruction on bilingual education or whether it was mentioned in any of her courses during her graduate program, Diane Cooper, a 1991 graduate of a private university in CNY, replied, "definitely not enough...yes, it was addressed in classes. Probably not nearly enough as I would ever want it to be at

that time” (interview, March 3, 2008). Because Cooper received her Master’s 17 years ago, she commented that instruction in bilingual education and therapy has likely changed in the years since she received her degree:

I’m sure it is being addressed even more so now, and a lot of that just has to do with the changing demographics, understanding that we do live in a society where many of the patients that we see, the students that we see in schools, are going to come from homes where more than one language is spoken. And so the need for us to have competencies in terms of working with those families whether or not we speak another language is very important. (interview, March 3, 2008)

Cooper was certainly correct in stressing the importance of SLPs being competent in working with bilingual populations, but was her belief that instruction in bilingual education and service provision is probably a greater focus in today’s programs correct? If the recent graduate experience of another participant, Beth Miller, is used as a comparison, then it seems that instruction in bilingual education is still lacking in Master’s programs, at least at some universities. In response to being asked what she would have wanted her Master’s program to include, Miller, a 2007 graduate of a private college in Upstate NY, immediately stated, “The bilingual [aspect of education]. They don’t even mention it...luckily there was me because I did all my topics on bilingual—like I was the source of knowledge...I gave a presentation to every class on bilingual interventions...” (interview, February 25, 2008). If her experiences are not unique, it is possible that many graduate students today face the same challenge as Miller did: if they want to learn about bilingual populations and service provision for these populations in a detailed and adequate manner, they may find themselves doing so outside of the classroom.

The issue of receiving sufficient instruction in bilingual education in a Master's level program has been cited as a challenge for speech-language therapists in the literature as well. In the introduction to Coleman's (2000) *Clinical Management of Communication Disorders in Culturally Diverse Children*, a student perspective compiled by Hunter (1989) was shared:

One recent graduate of an ASHA-accredited university program reported that she felt "robbed". She commented on the changing demographics of our nation and on projections that may mean that soon one-third or more of our caseloads will consist of individuals from minority populations. She also expressed her concerns about what will happen to the credibility of our profession if we continue to provide services to culturally diverse populations knowing that we do not have the necessary preparation. (as cited in Coleman, 2000, p. xv)

While that perspective dated back almost 20 years ago, the same opinions have been expressed since then. Caesar and Kohler (2007, p. 195) note that of the school-based speech-language pathologists they surveyed on the bilingual training and preparation received in their graduate programs, "Very few respondents agreed that their graduate education was adequate in terms of theoretical knowledge (28%), and fewer still perceived their practical training to be adequate (11.4%)" (Caesar & Kohler, 2007, p. 195). Coleman (2000, p. xv) reports the findings of another survey conducted by Coleman and Lieberman (1995) that addressed graduates' experiences with training programs in communication disorders: "Only 49 percent of survey respondents reported that their programs required students to observe assessment of and intervention practices with clients from culturally diverse populations. Only 30 percent required students to obtain clinical clock hours with clients from diverse populations" (as cited in Coleman, 2000, p. xv). The lack of requirements in observing and working with CLD

populations in graduate programs might be a result of the fact that these programs already have a number of requirements for observation and therapy experiences, and it would be too difficult to include more, or perhaps too few bilingual/bicultural, diverse clients seek services at university clinics. While discussing her educational experience in her Master's program, Diane Cooper, who initially mentioned that she would have appreciated more instruction on bilingual education, then analyzed the situation from her current position as a clinic supervisor now in charge of making sure graduate students receive adequate experiences, and pointed out how difficult it can be to squeeze bilingual education into an already full curriculum. In regards to this issue, she stated:

I think that with everything that needs to be covered in a speech-language pathology program that it is hard to be able to promote the aspects related to bilingual education. We're talking about having to ensure that clinicians are competent with understanding normal processes and disordered processes, and because our field is so varied and there's so much information and so much that's being provided to our knowledge base, it's really hard to include everything. (Cooper, interview, March 3, 2008)

Receiving adequate preparation for bilingual service provision is a challenge not only for students in graduate programs and beginning clinicians, but also for the programs and individuals in charge of planning the curriculum and requirements for the programs as well. ASHA is certainly trying to address the issue through the list of competencies that are required prior to clinician certification. However, this should not diminish the need to address this challenge in graduate programs, especially in a society where changing demography, specifically an increasing Latino population, has resulted in bilingual populations forming a large base of speech-language pathologists' clientele.



### *Bilingual Extension Certificate Programs*

The participants in the study who went on to receive an extension certificate in bilingual education after their Master's program also reported challenges and issues with these programs, not only with instruction and education, but also with simply locating an adequate and convenient program to begin with.

If a student is interested in pursuing a detailed and comprehensive education in communication disorders in CLD populations, he or she may be able to attend a graduate program that has a multicultural/bilingual emphasis. Coursework and instruction varies from program to program, and some programs may focus on a specific population, such as American Indians or Latinos, or a specific language emphasis, such as English/Spanish bilingualism. On the ASHA website, a list of programs nationwide is available for the general public as well as for interested students or clinicians. However, this list is not comprehensive and only reflects institutions with such programs that were known as of September 2006. A full list of academic programs with a bilingual emphasis is available on the site only to members of ASHA or NSSLHA, the National Student Speech Language Hearing Association.

Most of these programs offer clinicians the opportunity to receive the bilingual extension certificate that is usually a requirement for SLPs who serve bilingual populations, especially those working in schools. Interested students can either obtain this certificate during their graduate work if the university they attend has this option, or they can go back after having received their Masters for

a special extension program. In New York State, the bilingual extension certificate consists of three components: academic content, language proficiency, and bilingual field placement (Crowley, 2006).

The difficulty with finding a program with a bilingual emphasis was noted by one of the participants, Robin Tate. Although Tate received her degree in 1981, she was not certified as a bilingual clinician until 2001. In the meantime, her caseload in the schools consisted of a large percentage of bilingual or Spanish-only children beginning in 1989, when administrators were made aware that she spoke Spanish and began to assign her more and more Latino children to evaluate or treat. Tate summarized the reason for the delay in her certification by stating, "...I wasn't certified bilingual for a long time, and I resisted that for a long time because there wasn't any place locally where I could do that, and it was...really inconvenient for me to go and get certification" (interview, March 3, 2008). She eventually enrolled in a bilingual extension program at a university in New York City that ran one weekend a month for six months, although that meant that she had to travel a few hours by train to get to New York City on the weekends that she had classes. She stated that when she did finally enroll, she "really, really enjoyed the program" (interview, March 3, 2008), but the lack of bilingual extension programs in the Central New York area, at least at that time, was the reason she delayed receiving such certification. Another participant, Jane Smith, reflected the same notion of a lack of choices in programs, stating that her choice in pursuing a bilingual extension through a university in another upstate NY city was "her only option" (interview, March 5, 2008) at the time.

The obstacle in finding a conveniently located program is likely a challenge for many students or clinicians across the U.S. On its public website, ASHA lists only 27 programs nationwide with a multicultural/bilingual emphasis. While this list is not comprehensive, as ASHA acknowledges on the site, it does reflect general location patterns that are important and helps to show why it is difficult for many clinicians to receive bilingual certification. The list of programs on the ASHA website represents only 13 states and the District of Columbia, with programs generally being grouped in distinct regions. Of the total programs listed, four are located on the West Coast (in California and Washington), eight are located in the South/Southwest (in New Mexico, Arizona, and Texas), six are located in the Midwest (in Missouri, Kansas, Illinois, Wisconsin, and Minnesota), and eight are located in the Northeast/Mid-Atlantic Region (in New York, Pennsylvania, and Washington, D.C.). Only one program is listed in a Southeastern state, in Florida. Texas alone is listed as having five programs, and another four are located in the New York City area. Although it is not surprising that the majority of the programs are in states or regions that large bilingual populations, it is still alarming that there is such a weak representation of program locations across the U.S., in a greater number of states. The small number of program locations certainly poses an obstacle for students or clinicians in situations similar to that of Robin Tate, who was interested in receiving bilingual certification but did not have a program in her area or did not have a means of attending a program in a different location because it was too inconvenient.

### *Program Quality*

The quality of the education and experience in bilingual emphasis programs, whether pursued through a Master's program or through a bilingual extension program, was also a challenge reported by the participants in the study. Of the three participants in the study who held bilingual extensions, two received their certification through bilingual extension programs, and one received it as part of her graduate program. Educational experiences varied among the participants, but all commented on areas of instruction that could have been expanded upon or that they felt needed improvement, even if they enjoyed their program as a whole. Beth Miller, the single participant who received her bilingual certification during her Master's program, described the bilingual component of her education at a private Upstate NY college and its requirements as follows:

[My] first class was "Foundations of Bilingual Education", which was learning about what bilingual education is and different programs. Then there was "Teaching Spanish to Native Speakers", and then "Teaching English to Second Language Speakers", and then "Spanish Linguistics", and then we had to do a 50-hour placement and take the state test [the Bilingual Education Assessment (BEA), which tests knowledge in two languages]. And that was it. (interview, February 25, 2008)

Miller gained a lot of hands-on bilingual experience in two different CNY school districts, one of which was her clinic fellowship for ASHA. When asked what she would have changed about the classroom component of her education, Miller mentioned that she would have liked the information on bilingualism to be more specific to the field of speech-language pathology. Although her program taught her the steps involved in acquiring a second language and how to identify where children are in their development, she commented that, as a whole, the instruction

was “just generalized...it’s not necessarily specific to speech” (interview, February 25, 2008).

Jane Smith echoed the same concern regarding the generalized nature of the educational instruction in her bilingual certification program, although she completed her certification through an intensive summer extension program at a college in Upstate NY, rather than during her Master’s program. Smith’s bilingual extension program, like many others, also included individuals working in the field of special education or regular education. Because of the varied careers of the enrolled students, the instruction was not oriented towards any specific career track and instead focused on, as Smith said, “theories of bilingual education...and the background...behind that” (interview, March 5, 2008), and did not give any information specific to speech. On a practical basis, this makes sense because of the high expense of creating bilingual programs specific to different careers; yet it still creates the issue of having generalized, broader courses.

While the program at the university Smith attended may have changed, the description under the Childhood with Bilingual Extension (1-6) program listed on the current website for the school reflects this type of instruction and pertains to any teacher or service provider working in the schools. The description states: “programs are suitable for those students who wish to obtain New York State certification to teach bilingual students birth-grade 6, those who already have initial teacher certification before entering the program, and those who aspire to complete both a master's degree in bilingual education and childhood education or early childhood certification requirements” (Childhood Education, 2008). Course

requirements listed for the professional certification also reflect instruction and classes in general concepts of bilingual development and teaching, for example, “Methods in Bilingual Education,” “Foundations of Bilingual Education,” and “Research and Evaluation in Bilingual and L2 Education”. No courses with titles like “Communication Disorders in Bilingual Populations” or “Phonological Disorders in Spanish-speaking Children” are listed, and no course seems to be specifically geared towards speech-language pathology.

For Smith, this was an area that she wished her program had focused on. Like Miller, she wished that her bilingual extension program had been “more bilingual speech-oriented” (interview, March 5, 2008), so that the challenge of having to find information regarding bilingual children’s speech developmental milestones and processes on her own could have been avoided. As Smith stated, in her program “there wasn’t a lot of like, oh, you know, kids by the age of three should have these sounds when they’re Spanish-speaking...things like that I had to look up on my own” (interview, March 5, 2008). Robin Tate reflected a similar sentiment, stating that her program “didn’t adequately deal with ...children with a variety of communication disorders. It focused on language—specific language impairment, learning disabilities, primarily. But we really did not deal a lot with other issues” (interview, March 3, 2008). Tate, like Smith, emphasized one of the challenges speech-language pathologists often face during their bilingual education programs: being adequately informed about not only bilingualism, but how it relates to many different communication disorders.

*The Challenge of Becoming Linguistically and Culturally Competent*

In addition to the challenge of being adequately prepared through their bilingual education experiences, the participants in this study also stressed the challenge of being at a high enough level of linguistic competence in a second language to be able to assess clients and perform therapy. All of the participants learned their second language, Spanish, after they already had a solid foundation in English, with none of the participants beginning their study of Spanish until at least late elementary school age or beyond. For all of the participants, English was the language spoken at home during their youth, so acquisition of Spanish was mainly through academic means, by instruction in the classroom in both middle and high school and again in college, although two of the participants, Beth Miller and Diane Cooper, were also exposed to Spanish through connections with Spanish-speaking family friends during their youth. Only one of the participants, Beth Miller, lived in a Spanish-speaking country, during a semester abroad in Spain, although that was only for several months. None of the participants spoke Spanish in the home or outside of work, with the exception of Jane Smith, who occasionally spoke in Spanish with her Ecuadorian spouse.

Thus the mainly academic way in which the participants acquired Spanish and the limited number of truly authentic experiences in Spanish, such as growing up in a bilingual family or learning the language abroad, in a Spanish-speaking place, contributed to a hesitancy in feeling completely competent in the language for some of the participants, at least in their initial years of practice as bilingual SLPs. When asked what she felt was the greatest challenge of working with

bilingual clients, Jane Smith immediately responded, “I think just getting my Spanish up to speed...For a while, I would listen to Spanish music on the way to work every morning just to get my brain, you know, in the Spanish mode” (interview, March 5, 2008). It wasn’t until after several years of working in a bilingual school and having Spanish-speaking students on her caseload that Smith said she gained a better grasp of the language, although from time to time she still sought help with words or translations she was unsure of.

Seeking assistance became especially important when the participants were working with clients whose dialect of Spanish was different than the one they used. Diane Cooper reported that it was the language differences amongst her Spanish-speaking clients that brought her the greatest challenge in working with bilingual children. She reflected that:

...learning Spanish in school, I was instructed in a different type of dialect of Spanish, and many of the kids that I worked with came from Puerto Rican descent and so sometimes there were semantic differences...the changes were semantic more than anything else...some things I had to relearn in order to be able to shift dialects. (interview, March 3, 2008)

Even after she considered herself fluent Cooper, like Smith, still needed to occasionally confer with a native Spanish-speaking staff member at the school or setting where she worked to help with translations, word meanings, or specific areas of the Spanish language that she had always been weaker in, such as oral, written, or reading skills. Cooper reflected on this, stating that “a lot of the bilingual ed classroom teachers [in the elementary school where she had once worked as a bilingual SLP] were really helpful...helping me with my translation, that kind of thing. My oral language skills in Spanish were much stronger than my



written language skills, and so they [the teachers] were very instrumental in being able to help support me with those other areas” (interview, March 3, 2008).

The issue for bilingual SLPs of being linguistically competent in a second language to the point where they feel comfortable and confident providing services to bilingual children or children who speak a language other than English is reflected in the literature as well. Pioneering research by Vygotsky (1978) demonstrated that “The nature of an individual’s language-learning environment significantly affects the way he or she comes to think about language. Learning a language at home, abroad, or both—rather than at school—would seem to provide the advantage of authenticity” (as cited in Kritikos, 2003, p. 75). This research explains the participants’ feelings of a lack of complete linguistic competence since they counted mainly academic experiences as their foundation in learning Spanish. Kritikos (2003) explained the reasons why a bilingual SLP who learned a second language (or two languages simultaneously) during his/her youth in the home or in a place where they were immersed in the language would be an advantage:

At home, a child often attempts to communicate real messages of the child’s own making. This should promote linguistic proficiency more than the preselected messages provided by school curricula. In addition, social interactions at home provide opportunities for absorbing the values of a culture, such as rules of politeness, story-telling conventions, gender roles, and other pragmatic influences on interaction. Having authentic bicultural experiences as a child may foster an SLP’s understanding of how best to assess bilingual/bicultural clients. (Kritikos, 2003, p. 75)

Kritikos noted that it is having the authentic experience of learning a language at home that further develops linguistic proficiency and offers a more realistic experience of the language and a corresponding culture. Having experienced a

bilingual/bicultural experience of that kind is in turn more beneficial for a bilingual SLP as it further develops their awareness and competency in the language and culture and makes assessment and treatment of clients who speak that language less of a challenge. In a study by Kritikos (2003) in which a survey was administered to monolingual and bilingual SLPs assessing their beliefs about assessment of bilingual individuals, it was found that the group of bilingual SLPs who learned their second language through academic study “reported being only somewhat or not proficient in speaking, listening, reading, and writing their second language. Given this situation, accurate assessment and diagnosis of clients becomes problematic” (Kritikos, 2003, p. 84). Kayser (2002) also makes note of the importance of linguistic competence for accurate assessment. She states that “assessment of competence in the linguistic characteristics of a language cannot be determined unless the speech-language pathologist is knowledgeable of the linguistic features of the language and the normal development of these features in the language” (Kayser, 2002, p. 223).

Although the participants in this study stressed the challenge of becoming linguistically competent in Spanish, they did not express as great an obstacle in becoming culturally competent. Nonetheless, it is important to recognize the value of cultural competence as well, as it is continually stressed in the literature as a vital characteristic of being a capable and competent SLP. Cultural competence is generally defined as “the ability of service providers to recognize, honor, and respect the beliefs, interaction styles, and behaviors of the people we [bilingual service providers] serve” (as cited in Coleman & McCabe-Smith, 2000, p. 3).

Kritikos (2003) emphasized the importance of having bicultural experiences in order to become linguistically competent:

It is assumed that individuals who are bilingual are also bicultural, or at least sensitive to cultural issues. This is not necessarily true. Those who are simply linguistically competent in a second language may not necessarily differ from monolingual SLPs in their confidence about the assessment of a client who speaks another language and is immersed in another culture...Therefore, an SLP who acquires two languages within authentic cultural contexts may be more sensitive to the effects of cultural difference on language use. (Kritikos, 2003, p. 74)

Thus it is important to note that while the participants in this study identified the challenge of linguistic competence, which is certainly reflected in the literature, they did not emphasize the challenge of being culturally competent, which is clearly tied to the issue of being adept as a bilingual SLP overall.

#### *The Challenge of Performing Assessments as a Bilingual SLP*

The challenge of assessing clients who speak a language other than English was briefly touched upon as an issue related to linguistic competence; however, for the participants in this study, assessment proved to be an obstacle far more involved than simply being linguistically and culturally competent enough in Spanish to adequately assess clients. The participants mentioned that a number of issues contributed to the overall challenge of assessing bilingual clients or clients who spoke a language other than English, whether it be Spanish or Urdu, spoken in the home. These issues included: a lack of available diagnostic tests or other formal assessment tools and an inadequacy and unreliability of the standardized, norm-referenced tests that are available, difficulty in deciding how to assess a client who speaks a language that the clinician does not, and a misunderstanding of what constitutes a communication disorder in a bilingual

child on the part of administrators, teachers, or other individuals who recommend a child for assessment by an SLP.

### *Diagnostic Tests*

The availability and adequacy of appropriate diagnostic tests for bilingual populations was one of the chief obstacles mentioned by the participants when discussing the challenge of assessing these individuals. When asked to comment on the availability of diagnostic tests for Spanish speakers, Beth Miller mentioned that although she had several tests available for language assessment, including the CELF [Clinical Evaluation of Language Fundamentals]-Spanish and the Peabody Picture Vocabulary Test in Spanish, she lacked options in diagnostic tests for articulation, stating, “I wish we had the updated artic[ulation] tests but we don’t” (interview, February, 25, 2008). Jane Smith also commented on the lack of availability of diagnostic tests for this population by asserting, “For tests, we only have the CELF. And, whereas in English, you want to give a language test, you can give the CELF or the TOLD [Test of Language Development], you don’t have that option in Spanish” (interview, March 5, 2008). She explained her belief in why this is: “You know, there’s definitely more choices in English, because there are more materials made” (interview, March 5, 2008). Smith also touched upon the inadequacy of many of the diagnostic tests for Spanish speakers, using an articulation test as an example:

...the only articulation test I have in Spanish is...a criterion-referenced test, so you don’t really get a norms score, so you can’t be like, “Oh, you know, he got a standard score of 90, which is, you know, placing him in this percentile.” (interview, March 5, 2008)

Smith mentioned the reason that many diagnostic tests for Spanish-speaking populations are inadequate, which relates to the way the test is structured, either as norm-referenced or criterion-referenced. A norm-referenced test compares a person's score against the scores of a group of people who have already taken the test, otherwise referred to as the "norming group". Criterion-referenced tests do not compare test-takers to each other as normed tests do and instead use a set of criteria which have specific expectations of mastery that compare an individual to themselves and not to a reference group. Norm-referenced tests are particularly important for SLPs and other service providers because they provide a standard score that is used to provide evidence of a disorder or normal development. However, there is an inherent problem in using the standard scores given from diagnostic tests for Spanish speakers or speakers of a language other than English because they are often normed on non-representative populations that do not take into account certain variables, resulting in unreliable, biased scores that SLPs cannot or do not want to use in their assessment. For example, a receptive language test that was normed on a group of English-speaking Caucasian children from the U.S. would be inappropriate to test a bilingual child who recently moved from Mexico and learned English as a second language because of the linguistic, cultural, social, and economic differences that exist between the norm group and the child at hand. These differences could create confounding variables that would make it hard to rely on the scores given from the test. Robin Tate commented on the inadequacy of the one normed test she had available to her for the assessment of Spanish speakers,

the PLS-4 (Preschool Language Scale, Fourth Edition)-Spanish, which is a test that measures young children's receptive and expressive language. She said: "The norms are lousy and I hardly ever use them" (interview, March 3, 2008).

One variable that tests normed for Spanish speakers do not take into account is the variation in dialects. Research by Goldstein and Iglesias (1996) indicated that "the determination of normalcy of the development of phonology in children learning Spanish is difficult because of the number of dialects within the Spanish language and the differences in criteria used to determine the normal developmental stages" (as cited in Myers-Jennings, 2000, p. 176). This can pose a particular problem for diagnostic tests for vocabulary and articulation that assess a certain word or sound. If a Spanish diagnostic test is normed in a particular region where a certain dialect is spoken, vocabulary and pronunciation there may vary from that of another region or dialect, thus making the test inappropriate to use with children who speak various dialects of Spanish. Jane Smith noted how she encountered this challenge with an articulation test she used with the Puerto Rican Spanish-speaking children she evaluated:

...that test was made—I think it was made in California, because a lot of the words the pictures are prompting for are words that you would hear in Mexico. So, my Puerto Rican students see a picture of a tire and they say "goma" whereas the test from Mexico was anticipating to say "llanta". And they're looking for, you know, "dolar" for a picture of a cake. My kids would probably say "bizcocho", and they're prompted for the word "pastel". I would like another articulation test...something that was more designed towards the population I work with... (interview, March 5, 2008)

Thus clinicians are forced to consider how accurate their scores are when the test was created and normed for a different dialect of Spanish. Kim Isaac (2002) discussed the implications for this, for both the client and the clinician:

Tests that are standardized on a narrow population set may restrict performance diversity and result in a limited and possibly biased response pool. Prescribed scoring techniques may not allow for non-standard responses and may result in false negative outcomes for the patient. The responsibility falls on the clinician to interpret test results descriptively and with caution. A patient's poor test performance may be the result of unfamiliarity with testing procedures or items as opposed to speech or language difficulty. (Isaac, 2002, p. 37)

In addition to the problem of diagnostic tests being exclusive to a certain dialect, many tests are simply translated from English to another language, which also creates reliability and accuracy issues. Losardo and Coleman (1996) outlined the problems with this practice in their research:

...problems with these tests include the fact that there is inadequate knowledge of language, learning, and behavior development across and within different ethnic groups. Secondly, test translations are usually based upon a mainstream or Eurocentric view. That view assumes that the language learning and behavioral development of minority children is the same as the development of majority culture children. It does not account for unique multicultural language, learning, and/or behavioral characteristics...Another problem associated with test adaptation is nonspecific multicultural scorings that in some cases may lead to lower standards and expectations...In addition, there are many aspects of language that cannot easily be translated...Also, the content assessed by the test might not be something the child is exposed to on a regular basis, if at all. Items that are considered to be "common objects" within mainstream culture may not be that common in other cultures. (as cited in Wilson, Wilson, & Coleman, 2002, p. 105-106)

Translating a test that was designed in one language creates problems with reliability in part because of the inherent differences between languages. For example, even if a test that was generated in English was translated and normed on a Spanish speaking population, the Spanish translation might not accurately reflect children's development of Spanish. For example, an English word on the original version of the test might be a single syllable word with early-developing phonemes, such as "bed", whereas that same word in Spanish ("cama") on the

translated version of the test might be acquired much later because it is multisyllabic and contains later-developing phonemes.

This problematic nature of diagnostic tests for speakers of languages other than English is continually noted in current literature and research. Caesar and Kohler (2007) stated, “It is generally accepted that static, standardized, quantitative, norm-referenced approaches have proven inadequate for addressing the diagnostic needs of children who are in the process of learning English” (Caesar & Kohler, 2007, p. 191). As a result, SLPs often have to find alternate ways to assess other than using normed tests. For Robin Tate, the best solution to that challenge is relatively simple: “...what I’ve found most useful is to look at language universals and to work by milestones” (interview, March 3, 2008). This is generally acceptable because language development milestones are essentially the same across languages. For example, children across cultures babble, begin to use single words, and then combine words, and similar types of sound errors occur across languages. (Tabors, 2008)

Not being able to rely on tests and particularly the norms or standard scores they provide poses another problem. This is because standard scores not only identify how a child is performing compared to other children, but they can also help determine whether or not a child has a disorder or qualifies to receive services. In addition, they are often used as the basis for qualifying children for school programs that are sustained by grants for children who are bilingual or English language learners. Robin Tate cited her personal experience with an early



reading program for English language learners that required norm-based testing and the problems she encountered with this:

Where I see a real mismatch is that the grant requires testing—what they call scientifically-based assessment of children—and they use the Peabody Picture Vocabulary Test to look at vocabulary growth, and they want us to track standard scores. Now, the standard scores make no sense for English language learners because the entire test was normed on an English language population. And vocabulary may develop according to a really different sequence in second language learners, based on what they already have in their first language. So there, I think, is a real mismatch. (interview, March 3, 2008)

Therefore, the participants' reported challenge of finding adequate diagnostic tests for speakers of languages other than or in addition to English creates a sort of catch-22, especially for school-based bilingual SLPs. School administrators, IEP committees, and grant-funded programs want to see standard scores and data from normed tests before approving services for bilingual students, but few diagnostic tests exist, and those that are normed are often culturally and linguistically biased, and the scores they produce cannot be relied upon. Therefore SLPs are challenged to find alternate ways to assess their clients and to come up with scientifically-based evidence of a communication disorder other than standard scores and data produced through tests.

#### *Assessing Speakers of an Unfamiliar Language*

Another issue that was reported by the participants as a part of the challenge involved in the assessment of bilingual individuals was the difficulty of deciding how to assess a client who speaks a language that the clinician does not speak. While all of the participants were fluent in Spanish and worked with mainly Spanish-speaking bilingual children, they often had to evaluate children who spoke a language other than Spanish or English with which they were not

familiar. Beth Miller noted that she had once done evaluations on Urdu-speaking children and another child from Pakistan. Because the school district did not have a translator who spoke those languages at the time, she had to do the evaluations as best she could by herself in English; she then had to decide where she thought they were in learning English (interview, February 25, 2008), rather than being able to see where the children stood developmentally in both languages.

Robin Tate also spoke of her method of evaluating a child who spoke a language that she did not know:

...I've done a number of evaluations of children whose language I didn't know. And anytime I work with a child whose language I don't know, I learn a little bit of the language first—not that I could use it, but there might be certain things that I could recognize structurally about the language. I want to know what the syntax is like, what the phonological system is like, and I want to know what the semantic system is like, and how I would know whether the child understands concepts, how they're expressed. I would want to know a little about the pragmatic system, about what is considered polite and impolite, things like that. And I would usually spend a few hours in advance studying the language. (interview, March 3, 2008)

Aside from studying the language to gain a general understanding of its properties, Tate also stressed getting the parents of a child involved in the evaluation and working through them, and also observing the child during a natural interaction with his/her parents.

Although Tate had worked with interpreters/translators on evaluations, she noted two reasons why they often seemed to be more of a hindrance than a help:

...number one, interpreters are not readily available here. If I worked in New York City, I think they have a different policy on interpreters and a greater availability...Here we are not always able to...But the other problem of working with interpreters is that when we get an interpreter, we would get that interpreter just for the evaluation. Not for therapy sessions, because they would be ongoing and that would be too expensive. We might get an interpreter only for an evaluation, and if that happens, what we don't get is a chance to talk to

the interpreter ahead of time and to train that interpreter how to give a test. Because they often don't understand a testing environment and will give a child a lot of cues, and then...you don't always get the information you want. (interview, March 3, 2008)

The challenge of using interpreters in assessment has been outlined in the literature as well. In a study by Roseberry-McKibbin and Eicholtz (1994), 39% of the respondents (all of whom were SLPs) encountered problems with interpreter availability (as cited in Kritikos, 2003, p. 74). Additionally, Isaac (2002) noted that there are many issues in interpreting that can create potential barriers for SLPs, including linguistic difficulties, such as paraphrasing, the use of professional jargon, a lack of linguistic equivalents, sentence length, variations in dialect or word meaning, register, and rephrasing/polishing, as well as non-linguistic difficulties, such as dissociation (when the clinician loses his/her ability to assess a patient's emotional state when interacting across cultures), independent intervention (when the interpreter assumes control over the interaction without direction from the clinician or client), and culture differences (Isaac, 2002). Assessment in speech-language pathology is a complex task, and it can be difficult to do when working indirectly through an interpreter, often causing SLPs to find it a less than satisfactory experience. Isaac mentioned many of the reasons why SLPs often feel this way about the experience. These reasons include: an SLP's lack of understanding about the interpreter's role and needs, an interpreter's lack of experience working in speech-language pathology and therefore a lack of understanding about the SLP's role and needs, feelings of anxiety or uncertainty about assessing through an interpreter, the use of an

untrained interpreter, a lack of time to plan and also debrief with the interpreter, and feelings of being out of control or not involved in the session (Isaac, 2002).

For an SLP to find working with an interpreter/translator on an assessment a beneficial experience, spending time beforehand in a comprehensive pre-session briefing seems the best way to make the experience successful. However, as Robin Tate mentioned, she found this to be a challenge in her district because of financial and time constraints. Overall, the participants in this study shared a similar experience with interpreters. There are specific guidelines to working with an interpreter/translator that speech-language pathologists generally follow, and by doing so, it creates a more positive experience for the clinician, the client, and the interpreter.

#### *The Need to Educate Other Professionals*

The final obstacle that the participants found to contribute to the larger challenge of assessing bilingual clients was a general misunderstanding of what constitutes a communication disorder in a bilingual child on the part of administrators, teachers, or other individuals who recommend a child for assessment by an SLP. Many of the SLPs noted that bilingual or Spanish-speaking clients who were recommended to them for assessment did not actually have a communication disorder and might have instead needed English as a Second Language [ESL] or reading support. For example, Beth Miller noted that she had recently been asked to test a fifth-grader who was suspected of needing speech services. After testing him, she realized that he did not need speech services but instead would benefit from ESL. She explained that she found this to

be “a problem sometimes—they [the teachers and administrators] think they [the Spanish-speaking students] don’t know English and they need speech, but you have to look at both languages” (interview, February 25, 2008).

Robin Tate voiced a similar experience that she encountered early on in her career. She shared that:

...one of the funniest experiences I had was that when I walked into [class] at the beginning of the school year...the kindergarten teacher said to me, “I’m so glad you’re here because, you know, all of my Latino children are language-impaired.”...I think that there was a lot of education to be done about what language-impaired meant...because people had this idea that if a child couldn’t speak English, well then, there was no value in anything that he or she could speak...I worked with them to kind of turn around that idea, and found that there were very few children who were really language-impaired in that kindergarten classroom. (interview, March 3, 2008)

Miller’s and Tate’s experiences highlight the participants’ challenge of having to educate other professionals and service providers as to what truly constitutes a communication disorder in Spanish-speaking or other bilingual individuals. This challenge is reflected in the literature as well. Kritikos (2003) mentioned that “bilingual children who have normal language learning ability but who have limited English proficiency (LEP) are sometimes referred for speech-language intervention” (Kritikos, 2003, p. 74). SLPs should avoid being swayed by colleagues’ incorrect assumptions or suggestions for referral because they could “result in inappropriate professional interactions and/or inaccurate interpretation of data/behaviors” (Coleman & McCabe-Smith, 2000, p. 19). Specifically, assumptions or suspicions of a communication disorder by professionals other than a trained SLP could be alarming to a child’s family if prematurely shared, especially if they are unfounded. Occasionally, even

unknowledgeable SLPs form these assumptions. In a review of the research on the clinical implications of bilingualism, Goldstein and Kohnert (2005) reported: “Many SLPs erroneously believe that being bilingual places children at risk for language confusion and ‘delayed’ linguistic development” (Goldstein & Kohnert, 2005, p. 266). Thus SLPs without appropriate education could contribute to the pool of professionals who misunderstand what constitutes a communication disorder amongst bilingual individuals. Chamberlain (2002) recommended that, “for CLD populations, it is best to have qualified bilingual/bicultural professionals who have been trained to conduct the screening” (Chamberlain, 2002, p. 3), rather than relying on untrained individuals to determine who should be evaluated or given services.

#### *The Challenge of Providing Therapy to Bilingual Individuals*

While the participants in this study explained the many challenges faced in the assessment of bilingual individuals, including combating the aforementioned misunderstanding on the part of other service providers who inaccurately recommend an individual for assessment, the participants also noted the challenge of providing effective services or treatment to bilingual individuals. During the interviews, several obstacles were brought up, including the issue of finding available and appropriate Spanish materials, the occasional difficulty of collaborating with parents and other service providers on an individual’s therapy plan, and the difficulty of managing large bilingual caseloads.

*Availability and Affordability of Materials*

A lack of materials was emphasized multiple times by the participants as an obstacle that contributed to providing effective bilingual therapy. During therapy sessions, especially those in schools, clinicians often rely upon published materials, including books, interactive games, and flashcards to make therapy interesting and valuable to clients. However, most materials available to SLPs in the United States are in English, and although materials do exist in Spanish and to a smaller extent in other languages, schools and other facilities are less likely to have them. Beth Miller pointed out that while the bilingual school where she worked offered some Spanish materials to therapists, these materials were tattered and outdated. She estimated that she spent nearly \$1000 her first year as a bilingual therapist creating her own library of materials to use with clients. She purchased a lot of bilingual children's books, which are abundant today, but found that materials for specific disorders were not readily available in Spanish. For example, she said, "I haven't seen anything for bilingual kids who stutter" (interview, February 25, 2008). She also noted that in general, "the bilingual things usually seemed to be priced more."

Jane Smith also found collecting materials to be a problem. In fact, she counted this as one of the greatest challenges of working with bilingual children. She estimated that she spent nearly \$500 on Spanish books during her first year as a bilingual therapist so that she would have something to use with her clients.

Luckily, there are many books for bilingual and Spanish-speaking children that can be used in therapy, although this was not the case in the past. Robin Tate

said that “years ago, it [the lack of materials] was a big problem, because we didn’t have any books” (interview, March 3, 2008), that could be used as materials to engage a client in therapy sessions. Although books or other materials could be translated from English into Spanish, there is an inherent problem in doing this, as Tate explained:

...even though we could translate books as we read, we can’t translate some of the qualities of language that we need for the preschool children to be exposed to, like rhyme, like alliteration. We can’t include the language play by translating a book, because all of that is lost. (interview, March 3, 2008)

Translation of materials such as flashcards or concept cards did not seem to pose the same problem for the participants. The reason that these types of materials can be used with translations is because they do not serve the purpose of demonstrating the specific sound patterns of the language or the deeper qualities of language that books do and instead are often used to work on language, vocabulary, and semantic skills like naming or grouping. Both Tate and Miller attested that they translated English flashcards into Spanish. However, Tate mentioned that if she wanted to use articulation flashcards to elicit certain sounds, she would often put them together herself rather than translating from English to avoid phonetic differences. For example, flashcards in both English and Spanish that depict a dog might prompt for the same object, but in Spanish, the word for dog is “perro” which contains completely different phonemes than the corresponding English term.

Although more materials in Spanish are being developed for therapy sessions, the availability of these materials to clinicians is still problematic because of their expense. Beth Miller previously noted the higher price tag of



Spanish supplies, and it is certainly evident when perusing websites of companies that sell such supplies to speech-language pathologists. On the website for LinguiSystems, which claims to offer the “highest quality materials, unbeatable service, and a lifetime product guarantee,” the 100% Concepts: Intermediate book is listed at \$41.95 and teaches essential concept vocabulary to students.

Meanwhile, Basic Concept Pictures: Spanish and English, a similar product that teaches concept vocabulary for both Spanish and English, is listed at \$89.95, which is almost \$50 greater than the English language product.

The participants noted that the expensive price tag of Spanish materials was also a problem because the budgets allotted to them by the schools were not increased to reflect either the costly nature of Spanish materials or the schools’ deficit of such supplies. Beth Miller stated that she had a budget of \$130 for the year, which was the same for all of the teachers in the school except the art teacher, who had a slightly larger budget. Miller explained the difficulty in working with a budget that small, citing the fact that she wanted to buy bilingual concept cards, but because they cost \$100, they would have eaten up the bulk of her budget. Jane Smith received a slightly larger budget, but the money was allotted to her from three separate budgets and therefore could not be combined. Thus, because of bureaucratic issues, she could not purchase any item that exceeded the amount in any of her separate accounts.

#### *Keeping in Touch with Parents and Teachers*

In addition to the issues of the availability and affordability of materials for bilingual clients, the occasional difficulty of collaborating with parents and

other service providers on an individual's therapy plan also made providing bilingual therapy a challenge for the participants. It was often difficult to explain goals and objectives and even the concepts of bilingualism to parents so that they could understand and support their child's therapy plan. Robin Tate said that for her, the greatest challenge of working with bilingual children was "getting parents to recognize the importance of the home [native] language" (interview, March 3, 2008). Although she worked with a core group of parents who understood the importance of speaking Spanish at home with their children, she noted that:

...sometimes, there are parents who come and say, "No, I don't want anybody to work with my child in Spanish, we want the children to speak English." And they just don't really understand that by working with Spanish, you can promote a more complete learning of English. (interview, March 3, 2008)

Tate stated that this was occasionally an issue with teachers too, especially those who were not bilingual.

Yet despite some parents' and service providers' beliefs, the issue of reinforcing the home language to promote a better success rate for children not only in therapy, but also in learning English, comes up frequently in the literature. Research by Collier (1987) demonstrated that "the bilingual children who do best in school are those who have had a strong grounding in their home language...before being exposed to a second language" (as cited in Tabors, 2008, p. 131). After all, Spanish-speaking children living in the U.S. will without a doubt receive reinforcement in English nearly everywhere outside the home; so continuing to speak in their native language at home is important for a complete mastery of their first language. In addition, "evidence suggests that a strong base in the first language promotes learning a second language" (Thordadottir, 2006, p.

4) Thus encouraging parents of young Spanish-speaking clients to continue speaking the language of the home is justified.

Research has shown that encouraging parents to do otherwise could be detrimental to the child, especially if the parents have not fully developed English themselves. Beth Miller briefly explained that this was the reason she encouraged parents of her bilingual clients to speak in Spanish, “Because sometimes the parents think they should speak English, but their English isn’t very good so they don’t want to model a bad language” (interview, February 25, 2008). Chamberlain (2002) agreed that modeling a bad form of language is problematic and stated that when parents believe English should be spoken at home, even if their models are poor, the result is that “children lose a rich language environment as well as their emotional connection to the language” (Chamberlain, 2002, p. 10). Tabors (2008) expanded on the unfavorable effects this results in for parents and, more importantly, for children:

...their [the parents’] interactions with their child will be less rich in vocabulary and less facile in extended discourse in English than they would be in the home language. In other words, not only are parents who are second-language learners themselves rarely good language models for their children, they may also be less well equipped to help children develop the concepts, vocabulary, and extended discourse skills that are needed in school. (Tabors, 2008, p. 132)

This is especially unfavorable for children who are language impaired. Robin Tate noted this by stating: “...if the family speaks one language and the child has a language impairment and then the school is only in another language and the parent tries to change what they’re doing at home to match what the school is doing...then we see a lot of language loss” (interview, March 3, 2008). Language

loss refers to a gradual loss of the knowledge and use of the native language. Thus a parent switching from the home language to English is actually more harmful than helpful, especially for a child with language impairment.

Although research has shown that overall, “the systematic support of the home language(s) of young children with language impairment (LI) is critical to the long-term success of language intervention” (Kohnert, Yim, Nett, Kan, & Duran, 2005, p. 252), clinicians still encounter difficulties explaining this to parents and other service providers, as Robin Tate noted.

Another aspect of the challenge of working with parents and other service providers on an individual’s therapy plan that was noted by the participants was simply not having the time or opportunity to collaborate. Jane Smith stated: “Normally, I don’t have a lot of parent interaction” (interview, March 5, 2008), and Beth Miller encountered the same issue with parents and teachers alike.

Miller explained the lack of collaboration with teachers as follows:

...we just don’t have a lot of contact with the teachers. Some of the kids are bilingual but they’re misplaced in an English classroom, so they’re not getting the support in Spanish, and then I’m taking them out and trying to work on Spanish and they’re sometimes not interested. It’s very hard, I think, with any therapist, because we have no time to talk to the teachers to carry over anything...I mean, it’s better with email now, but people still don’t check email. (interview, February 25, 2008)

Keeping in touch with parents and teachers is difficult, as Miller explained, but a lack of communication can be detrimental to ensuring that the individuals involved in a client’s life, such as parents and teachers, are informed of the goals of therapy and how the therapy plan can be supported in the home or classroom.

### *Large Caseloads of Bilingual Children*

A final obstacle that the participants cited as contributing to the challenge of performing bilingual therapy was the large caseloads of bilingual children they served, which is probably an effect of the shortage of bilingual SLPs and the increasing population of people who speak a language other than English. Robin Tate remarked that her caseload, which currently consists of 21 bilingual Pre-K children, had been up to 30 earlier in the year. That number of children on a caseload is very high, especially since ASHA recommends that a caseload of preschoolers [even monolingual] should be comprised of no more than 25 children. Jane Smith's and Beth Miller's caseloads of elementary school students currently consist of 40 and 38 children respectively, which fall within ASHA's recommendation of a maximum caseload of 40 for students of these ages. However, Smith estimated about 75% of the students on her caseload to be bilingual, and Miller believed nearly 95% of her students to be bilingual. According to ASHA (1993), special populations, such as bilingual children, might dictate fewer students on an SLP's caseload. Therefore, it can be stated that Smith's and Miller's caseloads of mainly bilingual children are larger than recommended.

Published research reflects that large caseloads are indeed prevalent today, not only for bilingual SLPs, but for monolingual SLPs as well. As Pershey and Rapping (2002) noted: "Large caseloads remain a perennial point of dispute between speech-language organizations and state and/or local education agencies." Robin Tate commented on the difficulties a large caseload poses: "[It]

means more paperwork to do and less time to do it during the day, because there's almost no time for paperwork once you see all those kids, so all of that has to be done at home...time management becomes a real problem" (interview, March 3, 2008). Pershey and Rapping (2002) expounded on the problems a large caseload can cause:

Having larger caseloads may compromise a SLP's effectiveness. Control of session length, session frequency, group size, group composition, program duration, and total time spent with regular education peers may not be possible. It may be difficult to see each student in class at a time when instruction that is conducive to intervention is taking place, or the SLP may not be available to attend grade level or disciplined-based team meetings and thus might not participate in instructional planning and/or design of classroom modifications for caseload students. In order for all students to be serviced, compromises may be made that result in programming where the collaborative element is less than optimal. (Pershey & Rapping, 2002)

While any SLP with a large caseload finds that difficulties abound, the participants in the present study noted that for bilingual SLPs, large caseloads are a greater challenge. Beth Miller cited the longer length of time that is needed for evaluations, because "you have to evaluate two languages, so it takes twice as long" (interview, February 25, 2008). Miller also found that clients remained on her caseload longer, stating, "...my kids just take longer because they're learning two languages" (interview, February 25, 2008). So, bilingual SLPs find themselves spending more time on assessment and therapy for individuals who remain on their caseloads for a longer time.

Robin Tate noted that the challenge of juggling a large caseload could sometimes prove too much for bilingual clinicians, reflecting on an interaction she had with another clinician:

...once there was another [bilingual] therapist who was working with me—I supervised her CFY—she said to me one day, “I don’t know why anybody would let anybody know that they’re bilingual, because all you get is more work.” And it was very discouraging, I think, for her, because for a while...she was getting a lot of work dumped on her because she was bilingual. (interview, March 3, 2008)

However, bilingual individuals still need to be seen, so the caseloads of bilingual SLPs continue to grow. As Beth Miller shared, “...we’ve got kids coming in here every day, coming from another country, that are low. We have a ton. I already have seven more pending coming through. It’s huge” (interview, February 25, 2008). Bilingual SLPs’ caseloads will likely keep increasing as the population of people who speak a language other than English rises and the shortage of bilingual SLPs remains unresolved.

#### *The Challenge of Addressing the Shortage of Bilingual SLPs*

The final challenge that participants in this study found in providing bilingual therapy was one that is directly related to the obstacle of large caseloads: the shortage of bilingual SLPs. The participants expressed that the shortage of bilingual SLPs posed a challenge not only for themselves but also for other bilingual SLPs, as it resulted in larger caseloads and a greater amount of work. While the participants acknowledged the bilingual SLP shortage on a national scale, they also elaborated on the shortage locally, offering their opinions on the current situation in the CNY school district in which most of them are employed as testament to this.

When asked to reflect on the supply of bilingual speech-language pathologists in their district, the three participants who currently work as SLPs in the schools, Jane Smith, Beth Miller, and Robin Tate, immediately said that this

district could benefit from hiring more bilingual SLPs. It should be noted that these three participants constitute the total number of bilingual SLPs currently employed by the district, and can therefore attest to the exigency the bilingual SLP shortage has created for the district. Beth Miller stated: “There’s definitely a big demand. No doubt” (interview, February 25, 2008). Miller elaborated by declaring: “Really, these are the areas where they need bilingual speech people because these kids can’t get stuff in English until they learn Spanish” (interview, February 25, 2008). Robin Tate ventured to guess the exact number of SLPs that would satisfy the demand:

I think they could use probably about a half a dozen more [bilingual SLPs], because there are none at the secondary level at all...and those kids [who received bilingual speech services at the elementary level], when they get to middle school, they don’t receive bilingual therapy, and there are newcomers that arrive also, who don’t receive bilingual therapy” (interview, March 3, 2008).

As Tate mentioned, the district only offers bilingual speech services to children at the elementary level, and of the elementary schools, only two employ bilingual SLPs: the elementary school where Jane Smith works, and the elementary school where both Beth Miller and Robin Tate are employed. The participants expressed two issues of concern with this. The first is that the district does not offer bilingual speech services to middle school students. This is unfortunate because many children could still benefit from bilingual speech services after elementary school, either because they have a significant delay or disorder or because they recently arrived with little knowledge of English and could use support in Spanish from a bilingual SLP. Even students who received therapy in Spanish at the elementary level but have switched over to using English as their dominant



language could still benefit from the support in middle school. As Robin Tate explained, "...I think even when a child's dominant [language] switches, they still benefit from bilingual therapy and they should still get it, because there are still two languages in their environment with which they need to function" (interview, March 3, 2008).

The second issue of concern over the way bilingual speech services are offered in the district is that they are only available in two elementary schools. Robin Tate clarified, "If there is a bilingual child in another school where they [the bilingual SLPs] aren't, then those children receive therapy in English, and often from a therapist who really doesn't know bilingualism at all" (interview, March 3, 2008). While Beth Miller and Jane Smith take turns and evaluate children in schools outside of the ones where they work, they do not go on to provide therapy for these children. These children could therefore be at a disadvantage and might not see the same progress in therapy as they would if they were working with a bilingual SLP.

Beth Miller emphasized the fact that the shortage of therapists is an issue in places outside of her district as well. Before beginning at her school, she was employed in another CNY school district for two years, where she was the only bilingual clinician in the district. She mentioned that she "had to travel within, like, seven schools at one point" (interview, February 25, 2008). Miller also noted that in other districts, "therapists contract themselves out to do bilingual evaluations or Head Start" (interview, February 25, 2008) as a result of the shortage. Miller herself had even been contacted from districts as far away as

Brooklyn with bilingual job offers and opportunities when she began looking for a placement for her Clinical Fellowship Year.

The shortage of bilingual therapists is certainly reflected in the literature. Coleman and McCabe-Smith (2000) emphasized, “While the demographic characteristics of our nation are changing rapidly, the demographic characteristics of ASHA members who provide direct service have remained relatively constant. Individuals from diverse backgrounds comprise only four to five percent of the membership of ASHA” (Coleman & McCabe-Smith, 2000, p. 16). In addition, Langdon and Cheng (2002) noted that “only 2% of certified members of the American-Speech-Language-Hearing Association (ASHA), are able to provide clinical services in languages other than English” (Langdon & Cheng, 2002, as cited in Kohnert, Yim, Nett, Kan, & Duran, 2005, p. 257). Even those SLPs who are bilingual may not be able to provide services if they have not had extensive experience and training in working with clients who speak a language other than their first or second. As Caesar and Kohler (2007) noted:

...merely being proficient in a language other than English may not necessarily create an open communication between the clinician and the bilingual child. It is possible for the L2 of the bilingual clinician to be radically different from that of the bilingual student, and merely being proficient in one L2 may not assure SLPs of competent communication with the wide range of languages that may be represented on their caseloads. (Caesar & Kohler, 2007, p.198)

Thus, with such a small percentage of bilingual SLPs taking on the responsibility of providing services to such a considerable population of linguistically diverse individuals, it is easy to see how large caseloads and heavier workloads have resulted as a challenging situation for bilingual SLPs.

### **Summary and Some Possible Solutions**

The participants in this study cited a number of challenges presented to them as bilingual SLPs, including locating and receiving a quality education in multicultural/bilingual issues, becoming linguistically and culturally competent in Spanish, performing thorough and accurate assessment of bilingual individuals or individuals who speak a language other than English, and providing effective therapy for those individuals. All of the challenges cited by the participants were reflected in the literature as well, which suggests that finding workable solutions is of the utmost importance in maintaining bilingual speech-language pathology as a viable and reputable endeavor. Although the challenges facing bilingual SLPs are complex, there are certainly ways that they can be addressed. Specific solutions targeting each individual challenge are presented here. These solutions combine the participants' opinions and suggestions, the recommendations currently offered in the literature and research, and the researcher's own proposals. It is important to note that these solutions are ideals; in reality they might be difficult to implement because of financial and/or institutional issues.

The first challenge that the participants noted was the concern over both the quantity and quality of current bilingual speech-language pathology programs, whether offered as part of a Master's degree or separately through an extension program. The solution to one part of this challenge is that a greater number of programs need to be created, not only in geographic areas where there is a large population of people who speak a language other than English, but in all areas of the United States. This is important because it has been found that nearly all

clinicians, regardless of location, will at some point work with a client who speaks a language other than English. However, starting a new program is very expensive for a university and also has to be approved at every level, from faculty committees to the administrators to the trustees and the state legislature. This process may take several years of planning and negotiating. To cut down on the high costs of starting a new program, two or three institutions that are in a relatively close area might pool their resources to offer a program that they otherwise could not afford to create on their own. In addition to new programs being created, existing programs that offer Master's degrees in speech-language pathology should seriously consider adding a bilingual certification option for their students. These universities should also seriously consider adding a bilingual extension program for students who have already completed their Master's degree, perhaps with a distance education option that more clinicians could take advantage of.

Universities with existing bilingual certification opportunities at the Master's level or through extension programs should also reevaluate their programs' coursework and requirements. Since many bilingual SLPs have found their formal education to be lacking, both in classroom and clinical experiences, bilingual certification programs should take this into account and modify the curriculum and requirements with the perspective of the speech-language pathologist in mind, while also addressing all of ASHA's required "competencies" which are outlined for students seeking certification in speech-language pathology.

Programs should be designed to provide SLPs with not only more coursework that pertains to bilingualism and communication disorders, but also more opportunities to observe and work with bilingual individuals if such clients are available. This is not to say that those bilingual extension programs that are open to a range of professionals, from SLPs to teachers to other health specialists, should redesign coursework solely for the SLP. Making generalized bilingual extension programs exclusive is not the intent. Instead, specific classes and clinical experiences should be added for SLPs, while coursework that is more generalized or that pertains to individuals with other vocations should also be maintained. Through this sort of restructuring and redesigning, bilingual certification programs can more adequately prepare SLPs to work with bilingual individuals.

The second challenge reported by the participants involved becoming completely fluent and comfortable with Spanish (linguistically competent), as well as culturally competent. Graduate programs and bilingual certification programs for SLPs can help to address this challenge by offering writing, reading, and conversational classes in languages other than English, if they do not already. These programs can also offer courses that impart information on cultural competence and being knowledgeable about and sensitive to unique cultural practices or customs. Such courses should be of interest and relevance to students in a wide range of disciplines, from business to education. However, a part of the solution to the challenge of becoming linguistically and culturally competent falls on the shoulders of the SLP. SLPs should seek out authentic experiences in

another language, whether through studying abroad or living in a country where the language is spoken, if possible, or alternately conversing regularly in the language with individuals who are native speakers. By taking such measures, bilingual clinicians can prepare themselves more adequately as service providers.

Caesar and Kohler (2007) also suggest this:

Ultimately...the mismatch that now exists between actual practice and recommended guidelines will only be corrected when SLPs themselves commit to the responsibility of engaging in ongoing research and information gathering regarding the linguistic attributes of particular languages as a means of further equipping themselves... (Caesar & Kohler, 2007, p. 198)

Therefore, SLPs should acknowledge their own responsibilities in the solution to becoming linguistically and culturally competent by making it a priority to educate themselves in not only their second language, but in any language a client may speak if they are going to be providing ongoing therapy for them. With the support of university coursework and opportunities, motivated bilingual speech-language pathology students can thus ensure their commitment to being linguistically and culturally competent in another language.

The participants in the study also reported a number of challenges in the area of assessing bilingual clients, including issues with diagnostic tests, assessing clients who speak a language they do not speak, and general misconceptions held by teachers and other colleagues as to what constitutes a communication disorder in CLD populations. Solutions to each of these challenges in assessment are possible. To address the issue of the scarcity and unreliability of diagnostic tests for bilingual persons and individuals who speak a language other than English, tests need to be created that are normed on more appropriate and representative

populations, including specific dialects of a language. However, if the psychometric properties for a good test were to be used, creating such a test would not likely be feasible. Even if it could be done, the test would have to be priced very, very high in order for a publisher not to lose money. Therefore, until such tests can be created, bilingual SLPs should be advised to not rely solely on existing tests and to carefully evaluate the results derived from such tests. Isaac (2002) makes a similar recommendation:

The key point to remember is whenever using a standardized test, responses should be interpreted descriptively using modified scoring techniques to highlight what linguistic features the patient has while considering alternate reasons for the patient's poor performance. Even tests which have been translated or designed specifically for bilingual patient populations should be carefully examined regarding validity for individual patients given the diversity within cultural and language groups. (Isaac, 2002, p. 50)

Existing tests therefore can be used, but the SLP should exercise caution and sometimes may want to use modifications. Wilson, Wilson, and Coleman (2000) explain, "Modifications may aid the speech-language pathologist in describing the child's language and communication skills" but they also stress that "...the scores from such testing would be invalid and should not be reported" (Wilson, Wilson, & Coleman, 2000, p. 118).

Bilingual SLPs may also want to rely on alternative types of assessment. As Saenz and Huer (2003) noted: "Given the inherent limitations in the use of standardized procedures, many studies now recommend a variety of alternative procedures for diagnosing language disorders in children who speak a language other than English" (as cited in Caesar & Kohler, 2007, p. 191). Caesar and

Kohler (2007) go on to outline what is considered a method of alternative assessment. They state:

Alternative assessment models include (a) descriptive approaches, including language sampling, interviewing, direct observations, and rating scales; (b) dynamic approaches, which incorporate an instructional component into the assessment process; and (c) curriculum-based language approaches, which are designed to assess language performance using both the context and content of the curriculum. (Caesar & Kohler, 2007, p. 191)

SLPs should also try to use criterion-referenced tests, which translate scores into a general idea of what can be expected from the individual, unlike norm-referenced tests, whose scores tell how the test taker did in comparison with other people who took the test. SLPs should also take advantage of the opportunity to use an interpreter/translator during assessment. Clinicians should be aware of the limitations of using an interpreter, mentioned earlier, and should keep these limitations in mind. When working with an interpreter, they should follow ASHA's guidelines whenever possible. For example, prepare him/her ahead of time and actively include him/her by asking for clarifications, opinions and ideas.

The challenges in therapy reported by the participants in this study, including issues with materials, parent/teacher interactions, and large caseloads, can also be addressed. To address the lack of materials given to school-based bilingual SLPs, school districts should seriously consider expanding the budgets for supplies for these individuals. Bilingual SLPs should be thought of as similar to art teachers, who often receive an increased budget because of the special supplies needed. Like an art teacher, a bilingual SLP also needs special supplies, most of which are considerably more expensive than materials in English. Additionally, SLPs should make as many materials as they can or translate



English materials for use with their bilingual clients when appropriate, at least until the companies that make therapy materials in languages other than English begin to lower the prices on these items. Parents or other community members might be considered to also help make such materials, or local SLP organizations could help advocate with the school board in an effort to raise funds.

To address the issue of interacting with parents and teachers, bilingual SLPs should keep in mind that continuing to encourage the parents' use of the home language is one of the best things they can do for a young student. They can reinforce this by relaying it to teachers as well. While it is difficult for a bilingual SLP to interact with a parent or teacher who is perpetually absent or too time-constrained, the SLP should continue to try to relay important information about the client to the parent or teacher.

The final challenge reported by the participants in the realm of therapy was their large caseloads. This is directly related to the shortage of bilingual therapists; if there were more bilingual SLPs, their caseloads would be smaller. Thus, the concern over the shortage of bilingual clinicians might be arguably the greatest challenge because it creates other concerns, such as large caseloads and overwhelmed clinicians. However, there is hope for a solution. Creating more programs for bilingual certification is one of the solutions to address the shortage of bilingual SLPs. This would give practicing SLPs who are seeking bilingual certification an opportunity to do so. However, as mentioned earlier, creating new bilingual certification programs takes a lot of time and money. Much of the responsibility of addressing the challenge of the shortage of bilingual clinicians

should fall on ASHA and state organizations that could lobby the United States Congress to make sure that bilingualism is supported in programs, rather than ignored. ASHA could also recruit more heavily and offer more scholarships to bilingual students. In addition, creating incentives for bilingual SLPs, such as hiring bonuses or higher salaries would also help to recruit more clinicians into this specialty. Currently, such incentives are being offered to bilingual SLPs by the New York City Department of Education. According to Catherine J. Crowley, a presenter at an ASHA forum on the “Initiatives Developed to Address SLP Shortages in New York State,” “Bilingual SLPs who have been working outside of schools, e.g., as contract consultants or in hospitals, can receive a salary differential of up to 7 1/2 years when they begin working as employees of NYCDOE” (Crowley, 2006). Crowley also mentions another possible solution to the shortage of bilingual SLPs: recruiting SLPs from other countries where a language other than English is spoken. She mentioned that New York State is “currently exploring recruitment in countries where SLP is a profession, such as Argentina and India” (Crowley, 2006). SLPs who know English could thus be recruited from other countries where a language other than English is spoken. Upon arriving in the U.S. they could receive the necessary education and certification to practice with bilingual clients. This would also address the problem of making sure that *qualified* bilingual SLPs are being recruited to lessen the shortage. Unlike some bilingual clinicians who know their second language only through academic study, SLPs recruited from another country would be linguistically and culturally competent in the language, which would be very

beneficial to the client. Care would have to be taken to ensure that the dialect of English spoken by such “imported” clients would be appropriate for the clientele served.

### **Conclusions**

In the United States, the increasing population of people who speak a language other than English, especially the Spanish-speaking population, has resulted in a greater number of linguistically diverse clients appearing on clinicians’ caseloads. Nearly all clinicians across the country will at some point work with an individual who speaks a language other than English, regardless of prior experience, competence, or comfort in working with such individuals. As a result, the American Speech-Language-Hearing Association has recognized the need to improve preparation of clinicians and to adapt to a diversifying client base so that their needs can be adequately addressed. In 1993, Adler stated, “Current demographic trends have made it urgent that we increase our efforts to do something rather than just continue discussions about the need” (as cited in Coleman & McCabe-Smith, 2000, p. 14). However, nearly 15 years after Adler’s statement, there is still much to be done to address the need, and certain issues of concern for bilingual speech-language pathology have remained largely unchanged, such as the shortage of bilingual clinicians available to assist the linguistically diversifying client base.

This study highlighted the challenges faced by bilingual SLPs through analyzing the perspectives of four Spanish-speaking bilingual clinicians in an urban area in Central New York. The challenges reported by the participants in

the study varied from educational obstacles to linguistic and cultural obstacles to obstacles in performing effective diagnosis and treatment. All of the challenges noted by the participants were paralleled in the literature and research, which stresses the legitimacy and urgency of addressing these challenges and implementing solutions. Despite the fact that these challenges were reported through the lens of Spanish-speaking bilingual clinicians in an urban area in CNY, it is important to note that these same challenges can be generalized to any bilingual clinician in the U.S., whether they are fluent in German, Arabic, or Hmong, and live in California, Minnesota, or Maine. This is because it is not the language alone that poses a challenge to a bilingual SLP, it is the issues surrounding language and culture in the context of service provision that create the challenge.

By looking at the issues facing bilingual speech-language pathologists through the personal perspectives of a small number of SLPs, broader solutions, such as those proposed in this study, can be created that can propel the field in the right direction so that it remains viable and effective in the changing world in which we live. In addition, giving bilingual SLPs the opportunity to express the challenges they have faced provides an outlet for them to voice their concerns and reassures them that a path to addressing their concerns is being taken. Although it is the responsibility of the bilingual clinician to provide adequate and effective services to the CLD population, it is essential that ASHA and other professional local and state organizations assist bilingual clinicians by successfully addressing the challenges they face.

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