

Spring 2016

A Thematic Analysis of Bilingual Speech-Language Pathologists in Southern New England

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A Thematic Analysis of Bilingual Speech-Language Pathologists in Southern New England

Subject Categories

Speech Pathology and Audiology

A Thematic Analysis of Bilingual Speech-Language
Pathologists in Southern New England

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Honors Thesis
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Abstract

A bilingual speech-language pathologist (SLP) is a clinician who has the ability to effectively provide services in more than one language. The SLP must be proficient in all aspects of the second language and be able to identify typical versus atypical development. Recognizing cultural diversity and various dialects as well as distinguishing between a language difference and a language disorder are important factors associated with providing bilingual services. The purpose of this project was to find common themes across the field of bilingual speech therapy in southern New England. I interviewed eight bilingual SLPs, focusing on their experiences with assessing and treating the Hispanic population and their knowledge of linguistic diversity. In addition, this study also examined how the SLPs identify a language difference versus a disorder and the therapy procedures that typically follow the diagnosis of a language disorder. Responses were analyzed to find common themes. Results revealed a language difference is most easily recognized in terms of the phonology. Another emerging theme was that the student's age/setting typically determines the language in which the clinician chooses to treat the disorder. In a school setting, the language of the classroom is the focus of therapy, but the first language is still encouraged to be used at home.

Introduction

The American Speech-Language-Hearing Association (ASHA) defines a bilingual speech-language pathologist as a clinician who has the ability to competently provide services in more than one language. This means that the SLP must be proficient enough in all aspects of the second language to be able to identify the typical versus atypical developmental sequence of the phonology, morphology, syntax, semantics and pragmatics of that language. In addition, the bilingual SLP must be able to model these components. Furthermore, the SLP must be aware of the differences in language acquisition for typically developing monolingual children versus bilingual children. Recognizing cultural diversity and various dialects as well as distinguishing between a language difference and a language disorder are also important factors associated with providing bilingual services (Cornish). While ASHA does not provide an official bilingual certification, bilingual SLPs are asked to self-identify based on these criteria (“Demographic Profile”).

Based on data collected by ASHA in 2016, roughly 10,000 SLPs identified themselves as bilingual service providers. This number makes up less than 6% of the total number of ASHA members, including speech-language pathologists and scientists as well as audiologists. The majority of these bilingual SLPs worked with Spanish-speaking populations (“Demographic Profile”).

Another way to look at this discrepancy comes from the 2009 U.S. Department of Education National Center for Education Statistics. It shows a 1 to 360 ratio of speech and language providers to all students but only a 1 to 900 ratio of bilingual speech and language providers to students whose first language is Spanish. This difference in numbers creates

inherent problems, including misidentification of bilingual children with language disorders and less support for the child's primary language while acquiring the second language (Kohnert).

There is little information published in peer-reviewed journals specifically about culturally and linguistically diverse, or CLD, populations (Goldstein). Additionally, the research that does cover bilingual language acquisition has yielded some questionable results, causing concern over its reliability. Some studies in the past, the National Association for Bilingual Education study in 1991 and the Winsler study in 1999 for example, have failed to take into account certain variables that could affect a bilingual child's developing proficiency in the first language (L1) and the second language (L2). These uncontrolled variables include level of cognition, the language learning setting, and the parents' level of education (Stewart 33). The lack of evidence and knowledge about bilingual children makes it difficult for SLPs to rely on evidence-based practice. Without available research on this topic, SLPs might instead base assessment and therapy procedures off what is referred to as practice-based evidence. In other words, the SLP judges each CLD case based on previous CLD clients and the knowledge he or she has gathered through his or her own practices (Goldstein). The limited research available on bilingual speech therapy leaves room for misinterpretation of language skills, which can have many negative consequences. A child with a language difference may be categorized with a language disorder or vice versa. The linguistic variation in the phonology or another aspect of a certain language may not be recognized leading again to the misdiagnosis of a disorder (Centeno, Anderson & Obler).

Minority populations continue to grow in the United States, increasing the demand for bilingual service providers with knowledge of these culturally and linguistically diverse

populations (“Resources”). As there becomes a greater need for bilingual speech-language pathologists, attention is drawn to current bilingual SLPs.

BICS and CALP

Conversational language and academic language differ in acquisition and patterns of development. Children who are dismissed from therapy once they have basic communication skills in English are often not prepared to succeed in the classroom because they have not mastered academic language.

For children learning English as a second language, it is typical that they will acquire conversational language first. However, this is not always the case, and many children do develop academic language before they are able to successfully communicate in social situations.

Basis interpersonal communicative skills, or BICS, and cognitive academic language proficiency, or CALP, are two distinct concepts. BICS depends on extensive exposure to accurate language models in the home setting for example. BICS development usually reaches a plateau, while CALP development continues through education. CALP relies on higher-level thinking, language awareness, and integration of the language into school subjects (Cummins).

Difference vs. Disorder

When assessing a bilingual child’s language abilities in Spanish and English, it is important to be able to distinguish between a language difference and a language disorder. The language difference versus disorder perspective can be seen through dialects as well. A language difference will only be seen in the non-dominant language or dialect. If a language disorder is present, however, it will be seen in both languages or across dialects.

There are many factors to consider when determining if a language disorder is present. Bilingual clinicians look at the influence of learning two languages on the acquisition of each

individual language. They also must look at the fluctuation of dominance based on how often the child uses or is exposed to each language and the settings in which they are spoken (“Bilingual Service Delivery”). They must consider the factors that may be affected by the child’s culturally and linguistically diverse background. For example, eye-gaze, rules of social interaction, and perceptions of health or disability are elements that influence communication and can vary across cultures. A language difference can be defined as an ethnic, regional or social variation in language or any form of communication that follows a rule-governed system (“Cultural Competence”). The variation might be carried over into the child’s second language, presenting as a language difference, and negatively impact his/her educational or social abilities (Reed). All aspects of language, phonology, morphology, syntax, semantics, and pragmatics, of one language can be influenced by the acquisition of a second language (“Bilingual Service Delivery”). A language disorder, on the other hand, is defined as an impairment in language comprehension or production across languages that affects communication (“Cultural Competence”).

Approaches to Intervention

It is important to note again that there is little research on bilingual intervention. The common question that arises is centered around which language should be targeted or if both languages should be treated. Most studies lean towards providing intervention in the dominant language because it is believed that children can generalize the therapy across languages. This perspective, however, does not take into account the issue of cross-language associations. Generalization from one language to the next might not produce the desired results but rather lead to language mixing, code-switching and confusion (Kohnert).

If the child has been diagnosed with a language disorder, then he or she will participate in therapeutic language intervention. Therapeutic language intervention is meant for “children who fail to show competence in any language or dialect” (Reed 385). Therapeutic language intervention targets a language disorder. For example, for the child who presents with a bilingual phonological disorder, the purpose of this type of intervention is to work toward speech intelligibility and comprehensibility in the child’s primary language. The SLP must determine which language to treat the child based on language dominance, the speech community, and the goals of the family. By looking at the strengths and weaknesses in both languages, a dominant language can generally be determined (Reed). Other factors to take into consideration include the frequency and proficiency in each language as well as family input (“Bilingual Service Delivery”). The strengths and weaknesses can be looked at in terms of vocabulary size, length of utterances, comprehension and responsiveness, etc. (Reed). The dominant language is most likely the language primarily spoken at home, which tends to be the language in which the child has the most experience. For example, the child of a Hispanic family with parents who speak Spanish the majority of the time will generally exhibit a dominance in Spanish over English, which he or she uses primarily in a daycare or school setting. However, it may be more difficult to determine the dominant language of a child who lives in a household where both languages are used consistently. The dominant language can also change over time depending on the setting and which language is more functional for the child.

There are many factors that contribute to deciding which language to focus on in treatment of bilingual language disorders in children. For example, if the clinician’s views reflect the idea that the languages are learned separately, he or she might choose to treat the child in English, as that is the language that will lead to educational success in the school and in the

community. If the clinician believes that learning one language facilitates use of the other, then he or she may be more inclined to treat in the child's first language to encourage acquisition in the child's stronger language with the notion that treatment in L1 will facilitate simultaneous or sequential acquisition of L2.

The article "Language Choice in Intervention with Bilingual Children" by Gutierrez-Clellen reviews various approaches to the treatment of bilingual children with language disorders. One approach called subtractive bilingualism focuses on English only in the home and in therapy, often leading to the child becoming monolingual in English. On the other hand, there are a wide variety of bilingual approaches. One approach includes providing therapy in L2 but still encouraging use of L1 in the home. Another bilingual approach works on L1 in therapy as the child learns English in the classroom. Some bilingual approaches even translate between both L1 and L2 to promote dual language learning

The article looks at previous studies discussing input and output in relation to bilingual development as well as education methods and their effect on language transfer. Language transfer is the process in which knowledge of one language interferes with the acquisition of a second language. Intervention that incorporates both L1 and L2 may enable transfers between languages or generalization across languages, which can enhance development of both L1 and L2. By encouraging the use of the child's L1, the motivation and confidence of the child may increase. If the child is being treated in L2 alone, a language he or she is not as comfortable using, the child may become discouraged, which affects his or her ability to learn and execute L2. Continuing use of the child's L1 in the home is also associated with the bilingual approach. By providing rich models in L1, the parents will give the child a solid foundation for language acquisition (Gutierrez-Clellen).

When treating a Spanish-speaking child who is learning English as a second language, the SLP must look at what aspects of the child's target language, or dominant language, are being confused with elements of the second language (Reed). One approach, known as the bilingual approach, does not focus on a specific language at first but instead targets errors seen across both languages ("Bilingual Service Delivery"). When treating children with phonological disorders, for example, a bilingual SLP using this approach would start by looking at the processes that are seen in both the child's use of Spanish and English. In other words, the bilingual SLP would target errors that are seen at similar rates in both languages. Then, the SLP would move on to errors that affect speech intelligibility in both languages but are more prevalent in one language than the other. Finally, the SLP would look at phonological processes that are demonstrated in one language but not the other. There are some processes that would not be exhibited in a monolingual Spanish-speaker, but that a bilingual speaker may use. These errors are the last target in this type of therapy approach (Goldstein & Iglesias).

Research based on bilingual language development in children has also suggested another approach to intervention called the cross-linguistic approach. This approach looks more specifically at one language. It recognizes the different language structures. Instead of starting treatment by looking at the phonological processes seen in both languages like in the bilingual approach, this method of intervention would look at the differences in the languages and pulls out the problems that are specifically influenced by the bilingual factor. For example, final consonant deletion may be a phonological process seen in some monolingual Spanish speakers, but overall, words of the Spanish language end primarily in vowels. Therefore, this phonological process is more commonly seen in bilingual children speaking English because they have a tendency to want to end English words in vowels. Most research suggests that targeting one

language will benefit development in both languages of the bilingual child. However, depending on the setting, providing treatment that focuses on problems seen across both languages has proven to be instrumental to the child's learning ("Bilingual Service Delivery").

In contrast to the bilingual and cross-linguistic approaches, another side of treatment emphasizes an English only approach. Some may argue that the bilingual approach takes more time and effort because it involves a second language, while the English only approach focuses on the language that the child will need to succeed. However, considering the idea of language transfer, using the first language can aid acquisition of the second. Code switching, using more than one language in one utterance, is often seen as problematic. However, code switching is normal in bilingual acquisition (Gutierrez-Clellen).

Aside from the SLP's philosophy, the family's goals for the child are crucial to consider in determining the course of treatment and which language will be targeted. This can present a problem if the parents' perception of how the child should be communicating varies greatly from what the speech pathologist believes is best for the child. The issue of cultural differences comes into play here. In some cases, parent counseling is essential to make sure the child's therapy is carried over at home to whatever extent possible (Reed).

Bilingual vs. Monolingual Language Acquisition

In 2011, the New York Times interviewed Ellen Bialystok, a neuroscientist with a focus on language acquisition, who was involved in research that looked at second language acquisition in school-aged children. She found that language processing was very different in monolingual and bilingual children. The brain of a bilingual child holds the information for both languages and must decide which language is most relevant in each situation. Not only do monolingual and bilingual children process language differently, but they use different parts of

their brain in other activities as well. Neuroimaging technologies show that different areas of the brain are activated when bilingual children are problem solving as compared to monolingual children. Those that are bilingual appear to involve the language center of their brain with problems unrelated to language. This evolved system increases the speed at which they solve problems (Dreifus). The exceptional planning and creative abilities also allow bilingual children to solve more difficult problems and come up with better solutions (Lowry).

The way that bilingual individuals process language also correlates with the executive control system in the brain. This system plays a role in multitasking and staying focused, even when presented with distractions. With bilingual speakers, each situation that provides an opportunity to speak requires the brain to activate one language or the other. This is the executive control system at work. The system becomes more proficient in bilingual speakers through regular use. Some of the research that supports this conclusion came from a simple test between a typically developing combination of monolingual and bilingual five and six year olds. Looking at syntax, they were all asked to identify grammatical accuracy of the sentence, “Apples grow on noses.” Overall, the study showed that the monolingual children were easily distracted and confused by the nonsensicality of the sentence and failed to answer the question of grammar. The bilingual children, on the other hand, were able to recognize that the sentence was illogical but acknowledged that it was indeed grammatically correct. This indicates that the executive control systems are more efficiently at work in bilingual individuals, allowing them to stay more focused on the matter at hand (Dreifus).

The Current Study

The purpose of this project is to get a closer look at bilingual speech therapy by interviewing several bilingual SLPs in the southern New England area. The interview will focus

on the SLPs' experience assessing and treating the Hispanic population and their level of preparation to work with CLD populations. The study will also focus on how they distinguish between a language difference and a language disorder. Finally, I will examine the therapy procedures that typically follow a diagnosis of a language disorder.

Methodology

Participants

This study involved eight bilingual speech-language pathologists.

<i>SLP #</i>	<i>Years of Practice</i>	<i>Spanish Proficiency</i>	<i>Bilingual Focus in Coursework</i>	<i>Experience with Spanish Speakers in Clinical Practicum</i>
1	14	Native	Yes	Yes
2	11	Native	Yes, in grad school	Yes
3	8	Near native	Yes, at least one course	Yes, minimal
4	20	Native	No	Yes, minimal
5	10	Near native	Yes, in grad school	Yes
6	8	Highly proficient	Yes, in grad school	Yes
7	10.5	Conversational in many dialects	Yes, one class	No
8	5	Near fluent	Yes, in grad school	Yes, minimal

Recruitment Procedure

In order to conduct a study involving humans, it was necessary to receive approval from the institutional review board (IRB) at the University of New Hampshire. Once the IRB authorized my project (see appendix A), I started contacting bilingual SLPs.

Using ASHA ProFind, I searched for bilingual (English/Spanish) certified SLPs who work with children. This online resource lists contact information as well as the town or city where each of the SLPs practices, so I was able to locate those who work in the southern New

England area. I sent out my first round of emails to 11 bilingual SLPs. After only receiving a few responses, I returned to the ASHA ProFind website and reached out to 16 more bilingual SLPs, for a total of 27 contacted SLPs. This number was the total number of bilingual SLPs working with school-age children in the southern New England area that I found listed on ASHA. Out of those 27, seven completed my interview questions and one additional bilingual SLP was added through referral by one of the participants.

Data Collection Procedure

Each participant signed a consent form (see appendix B), agreeing to take part in the study. Six of the interviews were completed via email and two interviews were conducted in person. The two interviews conducted in person were transcribed. The interview questions were broken up into three categories (see appendix C). First was background information, second had to do with assessment procedures, and the third was related to therapy or treatment. Once all eight responses to the interview questions were received, they were compared to find commonalities between the bilingual SLPs.

The theoretical framework used to analyze data in this study is a thematic analysis. A thematic analysis is a descriptive qualitative approach to analysis. Thematic analysis is generally used in research related to health professions. It involves the breakdown of data into more specific components and the identification of patterns (Bondas). Through the use of a qualitative analysis, common themes were pulled from the interviews, relative to background information, assessment, and treatment.

Results

Background

The background information focuses on experience and preparation relative to bilingual speech pathology as well as proficiency in Spanish. The number of year practicing in the field ranged from five to 20 years among participants with the average being 11 years of experience. Analysis of the responses to the interview questions revealed that 87.5% of the bilingual SLPs had at least one course with a bilingual or multicultural focus during their college career. The majority of the bilingual SLPs also were able to obtain some practice working with Spanish-speaking children through clinical placements in graduate school. However, out of the seven SLPs that reported clinical experience with Spanish-speaking children in college, three of them classified this experience as minimal. One SLP reflected that she was “fortunate to have some hands-on experience, although limited, the exposure was important.”

With little experience working with bilingual individuals, half of the SLPs reported that they felt fairly unprepared initially to work with Spanish-speaking clients. Only two SLPs out of the eight felt very prepared and confident entering the field to work with culturally and linguistically diverse populations. It is important to note that the clinicians who felt very prepared were both native speakers of Spanish and educated in bilingual practice through coursework and clinical practicum. SLP 6 backed up this finding by stating, “There are a lot of bilingual SLPs out there who have perfect Spanish, beautiful Spanish, but don’t have a lot of the therapy and the background of working with CLD populations or working with bilingual kids. It’s not just applying what you learned in grad school to Spanish-speaking kids. It’s a whole lot more than that.” The clinicians who felt moderately prepared gained more confidence through job experience with support from supervisors and other clinicians in the field. When asked to define their proficiency in Spanish, 62.5% of the interviewees described it as native or near native.

Assessment

When it comes to assessing a bilingual child, the first factor that the SLP might consider is if the child is presenting with a language difference or a language disorder. The SLPs look at what is typical in terms of L1 skills and development, dialects and language variations, and language transfers as a result of dual acquisition. SLP 4 stated, "Once you know the typical, the atypical/delay will be recognized." With a language difference, there is always an explanation as to why the child is producing language a certain way. The language difference can generally be tied to the child transferring skills from the first language to the second language. It could also be that the L2 is not fully developed yet, so the child is compensating through code switching or is in a silent period. Regardless of the development of L2 skills, "children who have typically developing L1 skills are more than likely experiencing a language difference and not a disorder" (SLP 2). Background information, often including a parent interview revealing the child's exposure to both languages and his or her performance relative to what the parents believe is typical for their native language, is crucial to differentiating between a difference and a disorder. With a better understanding of the child's situation and what input he or she has received in both languages, one "can have an appropriate expectation for the output and determine if the output... is expected or unexpected" (SLP 5). It is important to also take note that "milestones in all languages occur at approximately the same time/age; so if a child is missing gestures by 10 months, first words by one year, combining words by two years, it is a red flag for a disorder" (SLP 7). Another prominent response among the SLPs was the need for multiple assessments, such as testing in both languages and dynamic assessments. Overall, the emerging theme in differentially diagnosing a language difference versus a language disorder is recognizing

variations and typical development in both languages as well as being aware of the child's background and history with L1 and L2.

Standardized testing plays a role in the assessment of any child. However, administering a standardized test to a bilingual child can be a difficult task. More than half of the bilingual SLPs agreed that modifications to standardized assessment procedures were necessary when evaluating whether or the child needs speech-language therapy. Some of the SLPs use the standardized test as tool to figure out what type of prompt the child needs in order to produce the correct answer. SLP 3 said, "I administer per protocol and score in response to standardization protocol, but then I prompt and cue to see how much support the student requires in order to obtain a correct response." Other SLPs in the group touched upon the importance of recognizing an accommodation as opposed to a modification. An accommodation is allowed by the test, whereas a modification goes against standardization and can result in inaccurate scores. A couple of the SLPs accept vocabulary that is typical of the child's dialect or native language while testing if it is an appropriate replacement of the desired response. There is some discrepancy over what is and acceptable modification to standardization. SLP 7 argues, "When making modifications, such as repetition of an item in a different language [or] replacing a word to better fit the dialect, standardized scores can no longer be reported, but [it] does provide a valuable narrative with which to write a report and expose strengths and weaknesses of a child's present communication skills." Of the SLPs who did not agree with making any modifications to standardized assessments, they still agreed that the test, although important in the process of assessing a child's abilities, is not always an accurate representation of his or her speech and language. Therefore, it is necessary to include other non-standardized assessments, such as observations and language samples. Even though responses related to assessment procedures

were varied among the bilingual SLPs, they centered around three main points. One, know the test and what is allowed in terms of repetition and translation. Two, recognize the limitations of the standardized test and interpret it accordingly. In other words, do not rely too heavily on one test. Three, without reporting results, use it as tool to find out what works with the child, what initiates a response from him or her.

A language difference may be detected across all languages aspects. Although responses varied with respect to identifying which language aspect it is easiest to detect a language difference, phonology was the most common answer, followed by syntax. SLP 4 stated, “The most obvious and easiest is phonology and then syntax. You hear it immediately.” Syntax was also a common response, and semantics, pragmatics, and morphology were each mentioned once. When asked which language aspect the participants found easiest to identify a language difference, analysis of the responses revealed discrepancy in how they detected a difference.

Therapy

The decision to provide treatment to a bilingual child in English or Spanish depends on many factors. Six out of the eight SLPs agreed that this decision generally depends on the child’s age and the environment, considering the child’s education and the school’s expectations. The other 25% of the bilingual SLPs said that they determine therapy based on the child’s dominant language. In some cases, both languages are used during therapy through code switching, translating vocabulary and concepts to assist the child’s understanding. If the school requires that only English be used in therapy, the SLP still encourages the use of the native language at home “because it is very important in order to have some sort of basis to build on,” according to SLP 6.

In terms of carrying over therapy into the classroom for a bilingual student, the SLPs stressed the importance of informing and involving the classroom teacher. Working as a team

will provide the child with a strong support system. SLPs 5 and 6 talked about role release. As a bilingual clinician, one generally undertakes a very large caseload. Therefore, if the SLP can educate the classroom teacher on the treatment objectives and techniques, the child will ultimately benefit from therapy every day. Overall, the SLPs agreed that additional support is important when carrying over therapy into the classroom. This support may include consulting with the student's teacher, an English as a Second Language (ESL) or English Language Learner (ELL) teacher, a paraprofessional, or a bilingual peer. SLPs 3 and 8 also noted that carrying over therapy into the classroom often depends on the school district and what services are available to the child. Some schools offer curriculum in Spanish up to a certain grade.

The last interview question addressed dismissal from therapy in terms of the child's abilities in L1 and L2. The SLPs responses centered around three main points, the first regarding classroom performance. If the child is proficient enough in terms of CALP in L2 to succeed in the classroom, he or she is most likely ready for dismissal from therapy. SLP 2 reflected that a significant factor in dismissal is "their language ability is no longer inhibiting their success academically or socially." The second main discussion point involved difference versus disorder. If the child is presenting with more of a difference than a delay, the SLP may dismiss the child and the child may continue with the ESL or ELL teacher to work on the language difference. SLP 8 stated, "They only have a true disorder if it is in L1. Therefore, if progress is made in L1 and goals are met and testing demonstrates progress, then they are candidates for dismissal." In other words, if BICS and CALP are fully developed in L1, the child is no longer presenting with a disorder. The third point recognizes that the child may not be performing at the same level as a monolingual age-matched peer. However, if the bilingual child is making significant progress and progressing at a normal rate, he or she is most likely ready for dismissal. Another important

point to note is if the child reaches a plateau based on his or her language abilities or level of motivation, that child will also qualify for dismissal from therapy.

Discussion

Limitations

The questions I prepared to interview the participants proved to be rather open-ended. The wide range of information provided by the SLPs, due to open-ended questions, was beneficial to me in increasing my knowledge and understanding of bilingual practice, but made it difficult at times to find specific themes across responses. On one hand, a less open-ended survey may have lead to a more solid conclusion of how bilingual SLPs practice in this area. On the other hand, the varied results support the idea that bilingual speech pathology is a field that warrants more research. The limited resources available to bilingual SLPs make it difficult for them to all follow the same practices and use the same techniques. In addition, there is no best practice in bilingual speech pathology, or in monolingual speech pathology for that matter. Treatment is individualized for each client depending on his or her needs and goals.

Implications for Future Research

Lack of research in the area of bilingual speech and language intervention as well as the lack of bilingual SLPs presents a problem in a country where the Spanish-population is steadily increasing. More research in this area of study is needed to increase awareness and understanding of the differences in bilingual language acquisition and monolingual language acquisition. An overall increase in knowledge will decrease the chance of misdiagnosis of a language difference as a disorder and will lead to more purposeful intervention for bilingual children.

Conclusion

I interviewed eight bilingual SLPs who have experience ranging from 5 to 20 years. The majority of this group described their Spanish-speaking skills as native or near native. Of those proficient Spanish speakers, the ones who were only exposed to minimal coursework related to bilingual and multicultural populations and limited clinical experience with Spanish-speaking children felt unprepared in the beginning of their career to work with bilingual students. Having a strong background in Spanish is a crucial aspect of pursuing bilingual speech pathology. However, it takes more than knowing Spanish and studying monolingual speech pathology in English to be a bilingual SLP. In order to assess and treat a bilingual client efficiently, the SLP must have a background in all aspects of both languages and also an understanding of bilingual language acquisition and the cultural norms related to both languages.

The SLPs presented a variety of responses in terms of assessment practices. With limited Spanish and bilingual tests available, the SLPs must be creative in their approach to assessing a bilingual child. Through utilizing the resources that are available to them, such as language samples and individualized interpretations of standardized tests, combined with their own knowledge, the assessment process turns into a diagnostic puzzle consisting of a multitude of factors. Due to the complexity involved in assessing a bilingual language disorder, one might argue that being a bilingual clinician requires more work, which also may suggest that the bilingual factor makes for a better clinician.

As far as therapy, the lack of research leads to a difference in approaches, the philosophy of the school regarding ELL, plays a significant role in the type of therapy the clinicians can provide. Bilingual students, especially in school settings, are not always receiving the most beneficial treatment. More research in this field could lead to changes in school policies, for example, allowing the use of Spanish in therapy in schools that use English only.

This project could give the community some insight on the role of bilingual SLPs in southern New England. My goal is to eventually become a bilingual SLP, so this project is beneficial to me. It gave me the opportunity to learn more about current practices in this field and the knowledge and skills needed as a bilingual clinician.

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Appendices

- A. Letter of Approval from the Institutional Review Board
- B. Participant Consent Form
- C. Interview Questions

University of New Hampshire

Research Integrity Services, Service Building
51 College Road, Durham, NH 03824-3585
Fax: 603-862-3564

24-Dec-2015

Collins, Taylor
Communication Sciences & Disorders, Hewitt Hall
21 Madbury Rd N320
Durham, NH 03824

IRB #: 6380

Study: Thematic Analysis of Bilingual Speech-Language Pathologists in Southern New England

Approval Date: 16-Dec-2015

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Exempt as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 101(b). Approval is granted to conduct your study as described in your protocol.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, *Responsibilities of Directors of Research Studies Involving Human Subjects*. (This document is also available at <http://unh.edu/research/irb-application-resources>.) Please read this document carefully before commencing your work involving human subjects.

Upon completion of your study, please complete the enclosed Exempt Study Final Report form and return it to this office along with a report of your findings.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,



Julie F. Simpson
Director

cc: File
Plante, Amy



CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

RESEARCHER AND TITLE OF STUDY

My name is Taylor Collins, and I am an undergraduate student in the Department of Communication Sciences and Disorders at the University of New Hampshire. The title of my study is Thematic Analysis of Bilingual Speech-Language Pathologists in Southern New England.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this research study is to get a closer look at bilingual speech therapy in the southern New England area, focusing on the experiences bilingual SLPs have with assessing and treating the Hispanic population and their knowledge of cultural diversity. The study will focus on how they distinguish between a language difference and a language disorder. It will also look at the therapy procedures that typically follow the diagnosis of a child with a language disorder.

This study will involve approximately 5 to 10 bilingual speech-language pathologists.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

You will be asked to answer several questions regarding your education and experience in bilingual speech pathology. You will have the option of responding to these questions via email or participating in an interview in person. If you choose to answer the questions through email, I may ask you to clarify or elaborate on your responses. If you choose to answer the questions in a standard interview, I will be in contact to set up a time and a date, and I will come to your preferred meeting place. The interview will be audio recorded, and you will then have access to the audio file. If there is a part of the audio recording that you would like to edit or delete, I will honor that request. In the case of a vague or unclear response, you may be contacted via email for further clarification. Whether in person or through email, the interview should take no more than an hour to complete.

WHAT ARE THE POSSIBLE RISKS OF PARTICIPATING IN THIS STUDY?

Participation in this study is expected to present minimal risk to you.

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS STUDY?

There are no direct benefits to participants. However, the overall knowledge gained from this study may be beneficial in identifying commonalities in bilingual practices among bilingual SLPs.

IF YOU CHOOSE TO PARTICIPATE IN THIS STUDY, WILL IT COST YOU ANYTHING?

Participation in this study will not cost you anything other than the time it takes to respond to the questions.

WILL YOU RECEIVE ANY COMPENSATION FOR PARTICIPATING IN THIS STUDY?

You will not receive any compensation for participating in this study.

DO YOU HAVE TO TAKE PART IN THIS STUDY?

Your consent to participate in this research is entirely voluntary. If you refuse to participate, there will be no negative consequences.

CAN YOU WITHDRAW FROM THIS STUDY?

If you consent to participate in this study, you may refuse to answer any question or stop your participation in the study at any time without any penalty or negative consequences.

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

I seek to maintain the confidentiality of all data and records associated with your participation in this research.

There are, however, rare instances when I am required to share personally identifiable information (e.g., according to policy, contract, regulation).

Furthermore, any communication via the Internet poses minimal risk of a breach of confidentiality.

The data collected, including audio recordings, will be stored on my UNH Box account, which is password protected. My faculty advisor Professor Amy Plante and I are the only people who will have access to this data. The results will be reported anonymously through a thematic analysis of the data. Quotations from the responses of the SLPs will be used, but each speech-language pathologist will be referred to by a number, not his/her name or specific location. I will present this project at the Undergraduate Research Conference in spring of 2016, and my thematic analysis will be posted on the UNH Scholars' Repository page. Audio recordings will not be played during the final presentation nor shared with anyone other than my project advisor. These recordings serve the sole purpose of making the interview more time efficient. I will use the recordings to transcribe each SLP's answers after the interview and then store them on my Box account along with the rest of the data. The audio recordings will be deleted at the end of the study, and the transcriptions will be saved in my Box account for my future reference as a bilingual SLP. They will not be used for further research unless given permission to do so at a later time.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have any questions pertaining to the research you can contact Taylor Collins at tag345@wildcats.unh.edu or (401) 632-6369 to discuss them.

If you have questions about your rights as a research subject you can contact Dr. Julie Simpson in UNH Research Integrity Services, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

I, _____ CONSENT/AGREE to participate in this research study

Signature of Subject

Date