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Cultural Competence in Speech-Language Pathology: A Review of Where We Are and Where We Go

Alec R. Perry
Southern Illinois University Carbondale, alecp87@gmail.com

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Alec Perry

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Approved by:

Dr. Valorie Boyer, Chair

Shawna Pope

Graduate School
Southern Illinois University Carbondale
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Speech-language pathologists (SLPs) service a wide range of clients from different cultural and linguistic backgrounds. Therefore, SLPs should be aware of and able to adapt their own personal biases, perceptions, pragmatic behaviors, narrative styles, and teaching methods. Gaps in cultural and linguistic competency may lead to negative perceptions and attitudes towards clients, which may hinder the effectiveness of service delivery. There has been a substantial increase in the amount of cultural diversity in the United States (U.S.) over the years, as a result the population gap between minority and majority groups are decreasing. Thus, it is important for healthcare professionals to acknowledge this change.

Anderson, Fielding, Fullilove, & Scrimshaw (2003) suggested that the growing rate of cultural diversity in the U.S. has caused healthcare leaders in the U.S. to become more concerned due to the increased demand for more culturally competent healthcare providers. For example, in 2000, minorities composed approximately 30% of the population in the United States (US Census Bureau, 2000). A decade later, the U.S. Census Bureau 2010 reported that 36% of the population identified themselves as members of a racial/ethnic group other than "non-Hispanic, White" (Humes, Jones, & Ramirez, 2011). Furthermore, by 2050, it is projected that minority populations will represent approximately 50% of the total U.S. population, meaning ethnically and racially diverse people may no longer be a numerical minority (US Census Bureau 2000).

Unlike the projected rate of cultural diversity in the U.S., the American Speech-Language Hearing Association (ASHA) demographics are relatively homogenous in terms of ethnicity and gender, resulting in a cultural mismatch. According to the 2011

demographic profile of ASHA constituents, its members are comprised of 92.7% White, 4.4% Hispanic or Latino, 3.2% Black or African American, 1.4% Multiracial, 1.7%, Asian, 2.2%, American Indian or Alaskan Native, and 0.3% Native Hawaiian or Other Pacific Islanders. In addition, women represent approximately 94.5% of ASHA's members, while men represent 5.5 %(ASHA, 2011). Furthermore, the communication disorders and sciences (CDS) student population also reflects U.S. demographics, as represented by the small population of ethnic/racial minorities in the field. According to the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) 2000-2001 Survey of Undergraduate and Graduate Programs, ethnic/racial minority students comprised of 9% of the undergraduate student population, 11% of the master's student population, and approximately 12% of the doctoral student population.

Kraemer & Beckstead (2003) stated that not until recently have healthcare professionals in the U.S. begun to acknowledge that they work in a multicultural and multiethnic society. Unfortunately, researchers have also discovered that there has been a limited amount of research conducted in the area of cultural competence among healthcare professionals (Kraemer & Beckstead, 2003). This lack of cultural competence and cross-cultural adaptability has been shown to diminish the effectiveness of patient outcomes and clinical service delivery.

Anderson et al., (2003) took the need for cross-cultural adaptability beyond both service delivery and outcomes, by exposing the lack of access to resources minorities encounter. Ultimately, this lack of resources creates hardships, resulting in higher rates of disease, death, disability, and lower quality healthcare. According to the 1996 National Health Interview Survey, an estimated 6.2 million culturally and linguistically

diverse Americans have a communication disorder, indicating a greater impact of service delivery among culturally diverse populations than among Whites (as cited in Battle, 2002). One report suggested that African Americans and Native Americans have the highest rates of disability totaling or exceeding 20% of their population (U.S. Bureau of the Census, 2000). Moreover, people of color with disabilities have significantly worse outcomes in education, employment, health and social services compared with those who are White (Wilson, Harley, & Alston, 2001). Researchers are convinced that if cultural competence is addressed by training healthcare professionals, then health disparities experienced by racial/ethnic minority groups will improve (Anderson et al., 2003).

Thus, this review will examine the rapid growth of cultural diversity in the U.S. and the cultural mismatch among professionals in the field of speech language pathology, in relation to the clients they serve. Next, this review will address the American Speech Language and Hearing Association's plan of attack for counteracting the lack of cultural competence of its members. Finally, training in cultural competence is a critical skill for students pursuing a degree in speech-language pathology. Therefore, the goal of this review is to provide several training strategies that will facilitate the development of cultural competence among students

Culture and Cultural Competence Defined

Cross, Bazron, Dennis, and Isaacs (1989) defined culture as " the pattern of learned beliefs, values, and behaviors that are shared within a group; it includes language style of communications, practices, customs, and views on roles and relationships" (p.4). Culture refers to the integrated pattern of learned behavior,

including thoughts, communications, knowledge, beliefs, and values of a group, that is passed from one generation to the next (Salzmann, 2007). Culture shapes the way we approach our world and affects the interaction between patients and clinicians. Culture slightly differs from cultural competence in that it deals with the systematic policies in a professional field such as healthcare (Cross et al., 1989).

Cross et al., (1989) defined cultural competence “as a set of congruent behaviors, attitudes, and policies that come together in a system agency or amongst professionals and enables those organizations to work more effectively in cross cultural situations” (p.4). In healthcare, cultural competence entails “understanding the importance of social and cultural influences on patient's health, beliefs, and behaviors, and how these factors interact at multiple levels of the healthcare delivery system, and finally, devising interventions that take these issues into account to insure effective healthcare delivery to diverse patient populations” (Betancourt, Carrillo, Fiempong, Park & Green, 2003 p. 294). Betancourt et al., (2003) said that cross-cultural adaptability relates to cultural competence in that cultural competence is the actual possession of knowledge of appropriate behaviors needed to work with someone from another culture.

SLPs play an integral role in providing services to cultural and linguistically diverse populations in both the medical and education system, as a result, this issue affects the field as a whole. The educational system's demographics also mirror the growing area of diversity in the U.S. According to Roseberry-McKibbin, Brice, and O’Hanlon (2005), the development of the population of English language learners (ELLs) was 105% since 1990. In 2005-2006, there were approximately 5.1 million ELLs in U.S. public schools, representing 10% of the Pre-K through 12th-grade student enrollment

(U.S. Department of Education, 2008). The Department of Education reported that in 2007, of the 6,007,832 students ages six through 21 served under the Individuals with Disabilities Education Improvement Act of 2004, approximately 19% of the students had speech/language impairment. Statistics indicated that of the students receiving services for speech/language impairments, 15.21% were Black (not Hispanic), 19.44% were Hispanic, and 3.2% were Asian/Pacific Islander and 1.3% were American Indian/Alaska Natives (U.S. ED, 2007). In addition, approximately, 5,346, 673 ELLs were enrolled in public schools during the academic year of 2008-2009, depicting nearly 11% of the total enrollment in pre-K through grade 12 (U.S. Department of Education, 2011). The cultural mismatch coupled with a lack of proper training has led some professionals and students to lack confidence in serving clients from culturally and linguistically diverse backgrounds.

Self-Perception to Serve a Diverse Population

The numbers of professionals in the field who feel confident in their abilities to provide service delivery to clients from diverse cultural and linguistic backgrounds are small. In a study on speech-language pathologists' self-perceived competence to serve clients from cultural and linguistic backgrounds, Campbell and Taylor (1992) reported respondents felt most incompetent in evaluating and providing intervention. In addition, Wallace (1997) revealed further that 62% of participants surveyed about clinical practices in adult neurogenics "did not feel competent to provide clinical services to diverse populations, particularly when a language or dialect difference was involved" (p. 116) Harris (2006) reported that 50% of white SLPs felt "somewhat competent" to provide language assessments for children who are bilingual, bidialectal, or bicultural.

Results from a national study conducted by Roseberry-McKibbin and O'Hanlon (2005) implied that public-school SLPS serving ELLs lacked appropriate assessment instruments, knowledge of developmental stages in children's first language, knowledge of second language acquisition, bilingualism, and available interpreters. Responses from ASHA Health Care Conference/Business Institute showed that approximately 73% of respondents reported that they are "very" to "somewhat" qualified to provide services to multicultural populations, these results indicated an approximate 18% increase from the 1994 Omnibus Survey ("Impact of the Future Survey Results", n.d.). The lack of confidence and preparedness of working with clients from diverse cultural and linguistic backgrounds may be a result of the lack of cultural and linguistic diversity training.

Lack of Professional Training in Cultural and Linguistic Diversity

In the 1988 Omnibus survey 17% of the ASHA members reported that they had specific graduate coursework relating to multicultural populations, while 83% stated that they did not receive professional education relating to multicultural issues ("Impact of the Future Survey Results", n.d.). Likewise, Roseberry-McKibbin & Eicholtz. (1994) reported that approximately 40% of public school SLPs provided services to nonnative ELLs and 76% of those participants had no prior coursework that covered ELL students; in addition, 90% could not provide services in another language. Talbot (2006) reported that 31% of a sample of student teachers stated that diversity was not covered in their professional education and 21% rated of the respondents stated that diversity coverage as low to very low. Furthermore, Kohnert, Kennedy, Glaze, Kan, and Carney (2003) conducted a survey that examined the effect of demographic changes on clinical service delivery in Minnesota. A focal point of this survey was to identify challenges that SLPs in

Minnesota experienced related to caseload diversity. Findings from the Kohnert et al. study indicated that only 47% of their SLPs had received any training in working with individuals from diverse backgrounds. In addition, only 27% of respondents had received this training in graduate school. Respondents reported that their inability to speak the language of the client, lack of assessment and treatment materials, and insufficient knowledge of developmental norms in a first language were the most challenging aspects of serving clients from diverse backgrounds.

Several studies suggested that there has been an increase in pre-service training in speech-language pathology related to CLD over the years. Similar surveys completed in 1990 (Roseberry-McKibbin & Eicholtz, 1994) and again in 2001 (Acevedo, 2001) with public school SLPs showed an increase in the amount of education in bilingual services. These studies showed that the percentage of SLPs who had received educational courses regarding the delivery of services to bilingual children increased from 23.6% in 1990 to 73% in 2001. This is further illustrated in a 2004 survey of SLPs in public schools in which approximately 52% of respondents reported having some sort of academic training in CLD as undergraduate or graduate students, whereas 34% reported no course work, and 14% could not recall (Hammer, Detwiler, Blood, & Qualls, 2004). In ASHA's 2010 Health Care Conference/ Business Institute survey, 64% of the respondents reported obtaining their professional education to treat multicultural clients from on-the-job education; followed by continuing education activities 42%, specific graduate coursework 37%, self-study 30%, and no professional education in this area 12%. This same report indicated that in the 1993 Omnibus Survey, 33% of the respondents reported obtaining their professional education to treat multicultural clients

from on-the-job education; while 27% reported no professional education in this area, 22% reported continuing education activities, 21% reported self-study and 19% reported specific graduate coursework (ASHA, 2011). Although there has been a significant increase in professional training and confidence over the years, it is evident that are still issues within the field and ASHA has made a commitment to address the issues.

American Speech-Language and Hearing Association Takes Action

Cultural and linguistic diversity is a very "hot" topic that is being addressed in the field; more specifically as it relates to the recruitment and retention of racial/ethnic minorities, service delivery to culturally and linguistically diverse clients, and multicultural competence throughout the field. In order to address and increase the awareness of cultural and linguistic diversity, ASHA has stressed the significance of SLPs adapting their service delivery to meet the needs of multicultural populations.

Over the past 20 years, ASHA has played an integral role in cultivating more culturally competent speech language pathologists. Stockman, Boult, & Robinson (2004) reported that in 1985, ASHA called for its educators to incorporate multicultural issues within communication disorders curriculum; however, failure to implement content would not negatively affect its members because implementation was on a voluntary basis. ASHA enforced more stringent rules in 1994, requiring programs to include multicultural content in their curricula or face the loss of accreditation. Although ASHA enforced this rule, they failed to provide program guidelines for specifying content that should be incorporated and how to implement multicultural content into the curricula. In addition, it must be noted that the very people responsible for implementing this content were not required to have such knowledge, so it understandable why they would needed

guidance (Stockman, et al., 2004). ASHA's Code of Ethics (2001) provided guidelines that required members to “hold paramount the welfare of persons they serve professionally" and to provide "all services competently" without discrimination "on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability"(as cited in Bolton-Koppenhaver , 2003, para.3). To ensure that members carried out the provided rules, the board stated that "individuals shall continue their professional development throughout their careers” (as cited in Bolton-Koppenhaver, 2003, para.4). It was not until 2005, however, that programs were also required to provide students with supervised practicum experiences with multicultural populations.

Essentially, ASHA stresses the significance of SLPs taking ownership of their learning and the importance of lifelong learning as it relates to serving clients from diverse cultural linguistic backgrounds. Moreover, the current requirements may be a reflection of the change in perception, confidence level, and skill of therapists serving diverse cultural and linguistic populations from 1988 until now. Thus, in order to continue this trend, it is vital that this process begins during the foundational period of SLPs’ careers (i.e. undergraduate and graduate level) and continues throughout their professional development. Therefore, ASHA and others have provided strategies that are conducive to facilitating cultural competence among pre-service professionals.

Developing Culturally Competent Students

Cultural competence can be attained through training at the undergraduate and graduate level or as a part of professional developmental for clinicians already practicing. Battle (2002) suggested that students need to be educated about both the implicit and explicit forms of cultural and linguistic diversity. Explicit forms of diversity

include factors such as race/ethnicity, gender, and age. Implicit forms include sexual orientation and religion. An appreciation of all forms of diversity, including variations within cultures, will help students recognize the potential effects of diversity on communication and encourage their ongoing investment in being culturally competent (Laroache, 2002).

As stated above, in 1994 ASHA required that multicultural content be infused throughout existing courses' curricula. The implementation of cultural infusion fosters a sense of cultural competence as it "relies on the premise that all communication interactions are inherently cultural experiences, and that culture can influence human experience (physical-biological, mental, social, linguistic, emotional, and so on)" (Stockman, Boult, & Robinson, 2004. para. 10). Although educational programs have infused this concept in the curricula, a national survey of CAA-accredited programs discovered an inconsistency in how multicultural instruction was carried out (Stockman et al., 2004).

For example, some researchers suggested that general infusion alone is not adequate. One respondent of the Stockman, Boult, & Robinson, (2008) study stated "it is getting difficult to cover all the core information in a class and all the extra information such as multicultural/multilingual infusion"(p.256). Gay (1997) stated that infusion, although "a powerful idea pedagogically, is a very challenging one operationally"(p. 158). Pope and Mueller (2005) suggested that a more critical analysis of the curricula infusion concept is necessary. Furthermore, survey respondents suggested that multicultural/multilingual infusion is relevant to other groups besides the minority racial or ethnic groups that have been historically defined; they also stated that other issues

were applicable to multicultural/multilingual infusion instruction, in addition to those related to clinical service delivery (Stockman et al., 2008). Revisions of this model would include instruction on how to infuse information about all the different groups and relevant topics into existing courses. Stockman et al. (2008) argues that the push of integral infusion neither adds nor eliminates existing course content; but rather the content is reconstructed in a way that "mitigate[s] known facets, theories, and clinic practices" (p.226). Essentially, infusing multicultural/multilingual education into existing courses may prove to be a more beneficial way of generalizing the content, as oppose to teaching multicultural/multilingual education and existing course content separately.

Another challenge faced by the exclusive introduction of multicultural infusion is not only the culture mismatch of professionals to client but also the limited opportunities of exposure of cultural linguistic diversity. Thus, Stockman et al., (2004) proposed that multicultural/multilingual infusion adapts a pedagogical discourse, providing students with an experiential experience. According to Morey (2000), multicultural education theory emphasizes, “personal development and empowerment, social reform, critical analysis and is fundamentally reconstructive and transformative in purpose” (p. 25).

Horton-Ikard, Munoz, Thomas-Tate, and Keller-Bell, (2009) proposed one pedagogical approach. Horton-Ikard et al. (2009) recommends a pedagogical approach to cultural competence, beginning with instructors providing a teaching philosophy. In this pedagogical approach to cultural competency, instructors assist in teaching students five important components in developing cultural competence. Those five components are as follows:(1) gaining an understanding of the historical and cultural backgrounds of U.S. minority groups to facilitate the understanding of unique and

shared cultural experience; (2) developing culturally sensitive attitudes toward all individuals, gaining theory-based knowledge and a expertise on the impact of sociocultural factors on communication development; (3) becoming experienced with delivering services to individuals who come from a variety of CLD backgrounds; (4) facilitating students' actual application of learned material researchers using literature, case studies, and in-class activities to transfer knowledge to clinical skill; and (5) stressing the significance of assessing cross cultural competence. During the last stage, students rate their perceived competency and complete an open-ended end of the source evaluation (Horton-Ikard et al., 2009).

Bucher (2004) suggested that diversity consciousness is developed through gaining diversity skills, awareness, and understanding. More specifically Bucher states that pre-service clinicians develop these components by way of examining themselves and the world, expanding their knowledge of others and their worlds, stepping outside of themselves, gauging the level of the playing field, checking on themselves, and following through.

Shapiro, Sewell, and DuCette, (1995) applied this concept into real life classroom situations. Shapiro et al., (1995) argued that it is our life experiences that shape the individuals we become. Thus, Shapiro created an autobiographical method in which students and educators share their multi-perspective identity through storytelling. In their narratives, students and educators reflect on the distinctiveness of their identity and how these factors have been created and grown throughout their lives.

Perils (2001) further enhances Shapiro's autobiographic method by adding a reflective component in which students begin by describing their multi-perspective

identity and how it shapes their perspective of the world. Next, students choose the most three significant components that are responsible for shaping their perspectives. This is concluded with both students and instructors sharing their multi-perspective identity and the factors that affect their critical incident stories. The self-reflective component of expression of storytelling allows pre-service clinicians and instructors to comprehend the limitations of their lives and the possible experiences in which they may have felt marginalized or exploited; they in turn foster a sense of open-mindedness in their perspective of others (Peril, 2001). As pre-service clinicians and teachers become more comfortable and skillful with this method, the development of a true understanding of their clients and students is fostered. Ultimately, both partners will have an enhanced appreciation of the cultural perspective (Perils, 2001).

Griffer and Perlis (2007) believe cultural competence is obtained through the development of cultural intelligence. This approach forces students to examine themselves, and acknowledge multi-perspective identity of others. Griffer and Perlis (2007) suggested that people often base their idea racial identity on superficial characteristics and that this "common misperception is where we as faculty begin to educate pre-service clinicians and teachers"(p. 29). Perlis (2001) suggested that instructors first introduce students to the concept of multi-perspective identity which are "characteristics of our identity that enable each individual to view reality through specific perspectives based upon ability, age, ethnicity, gender, race, religion, sexual orientation, and socioeconomic class"(p. 11). At this point, it is suggested students and teachers both gain a sense of cultural intelligence by way of understanding multi-perspective identity and the interrelation between their identities. The development of multi-

perspective identity can be taught by allowing students to participate in discourse, which forces them to recognize their biases, privileged identity, and other factors that contribute to their identity and how these beliefs and experiences shape their developed perspectives (Perlis, 2001). Similarly, Walters and Geller (2002) take this approach a step further by developing a program that infuses a traditional and collaborative learning process. These processes include four underlying constructs: the envisioning of multiple perspectives, participation in collaborative processes, the understanding of developmental processes, and the engagement in reflective processes.

Service learning is a fairly new pedagogical approach to teaching cultural competence. Service learning defined as “experiential (real life) and reflective, problem-based learning in which students enrolled in an academic courses provide a needed service to a community partner” (Strong, Burton, & Bradley, 2004, p. 4) It is implied that through guided reflected practices students acquire knowledge of cultural competence (Strong et al., 2004). In turn, students develop broader perspectives as they begin to think more analytically about challenges, and question traditional beliefs. Essentially, students acquire a sense of civic engagement through service learning. Advocates of service learning claim that this goal of civic engagement is the factor that differentiates service learning from all other forms of experiential learning. Civic engagement is cultivated from students' engagement in the community, their awareness of the power of advocacy, and their realization of the role their chosen profession can play in other lives (Strong et al., 2004). Cultural competence appears to be vital in the facilitation of effective civic engagement. Service learning also appears to be an essential tool in developing students’ critical thinking skills, conflict resolution abilities, and problem

solving skills (Strong et al., 2004).Respondents from the conferences of Huston (2006), Escalera (2006), and Cornell- Swanson (2006) reported that guided reflection and journaling assisted students' transition from feelings of "no accountability" to "expression of concern, openness to listening and acknowledging their role in perpetuating prejudicial thinking"(as cited in Strong, et al., 2004, p. 6).

Another pedagogical approach to cultural competence is through learner-centered education, a model that focuses on enabling students to actively engage in instruction as opposed to traditional instructor focus. According to Mahendra, Bayles, Tomoeda & Kim (2005) "being learner-centered is about promoting a collaborative, supportive classroom culture, not a competitive, individual one"(Diversity and Learner-Centered Education, para. 2).The learner -centered instruction creates an environment in which professors and students "learn together through stimulating, interactive, and thought-provoking experiences"(Diversity and Learner-Centered Education, 2005, para. 2).The learner-centered model for teaching about diversity encompasses five progressive stages.

The focal point of stage one entails learning about the history of culture. During this stage, the instructor must create an environment that fosters a sense of safety in the classroom (i.e., rules, turn taking, prohibiting inappropriate language, preparedness to sum up their cohorts perspectives, and respect and open-mindedness of differing opinions). Adler, (1975), Chan,(1990), and Harry, (1992) stated that during stage two, students are required to define their own culture, which is believed to be a vital step in the process of increasing cultural competence (as cited in Mahendra et al., 2005, para. 11). Martin and Nakayama (2001) suggested that students be "engaged in the practice

of self-reflexivity, a process by which individuals come to understand themselves and their position in a society and learn to recognize the strengths and limitations of their own intercultural experiences" (as cited in Mahendra et al., 2005, para. 11). During stage three, students are taught to recognize the impact of stereotypes and prejudices that influence both their behaviors as well as others'. This stage is facilitated through individual and group activities as students explore the origin and types of stereotypes and discuss personal biases. During stage four, students learn about cultural conflict and how it grows, the origin of intercultural conflict, the elements that cause conflicts, how conflict heightens, and varied types of conflicts (intrapersonal, interpersonal, and intergroup). During the final stage of this model, students engage in class activities that focus on understanding the influence of culture on conflict management strategies to effectively minimize and resolve conflict (Mahendra et al., 2005, para. 11).The various strategies listed above provide a guideline for instructors who lack proper structure in training students to become culturally competent professionals.

Conclusion

Current as well as future changes in U.S. ethnic/racial minority populations have drawn attention to the context in which SLPs approach service delivery for client from ethnic/racial minority backgrounds. For SLPs to provide the most effective services, it is vital for them to communicate effectively with the all patients. A lack in cultural competency may lead a lack of confidence among practicing SLPs, patient dissatisfaction, and ultimately risk less than optimal outcomes in therapy. In order to minimize these risks, ASHA has provided an abundance of recourses for its members.

More importantly, ASHA requires that multicultural content be infused in undergraduate and graduate curricula.

Practicing SLPs have mentioned that teaching a multicultural/multilingual course in communication disorders is meaningful and needed. However, the lack of guidance on what and how to disseminate the content concerns instructors. Nevertheless, several researchers have emphasized the importance of students becoming more competent and have outlined strategies that will assist students with increasing the awareness of clients from diverse cultural and linguistic backgrounds, and societal factors that influence their interactions and opinions of these populations. These proposed techniques should assist students with not only feeling more confident but also more competence in assessing, treating, and managing clients from diverse backgrounds.

One focal point of most of researchers is building open lines of communication among students talking about culture and biases, which is often an uncomfortable conversation that may lead to heated discussions. Academic instruction on cultural knowledge and self-evaluation of biases will help clinicians continue to grow in the professional and personal practice. Another significant factor in developing cultural competence is students' commitment to understanding different perspectives and values and how their own values and biases may influence their behaviors. Through this training, students learn to appreciate and respect others, even if the values conflict. Respect and effective listening provides individuals with the opportunity to gain insight to the speaker’s perspective. Another point stressed by researchers is the importance of instructors engaging in open dialogue with students by sharing their perspectives. A final point in this review addressed the importance of students immersing themselves in

cultural experiences (i.e. service learning) and following through with critical reflection of their progress. These just a few strategies will assist students in growing more culturally competent. However, it may be helpful in future studies to expand the scope of diversity and to including surveys or interviews of faculty members, graduate students, employers, and clients' preparedness in diversity issues. More specifically, intermittently check the effectiveness of cultural competence training of students.

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VITA

Graduate School
Southern Illinois University

Alec Perry

alecp87@gmail.com

Southern Illinois University Carbondale
Bachelor of Science, Communication Disorders and Sciences, May 2012

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