

FOCUS ON SOLUTIONS TO CLIENT-CLINICIAN
MISMATCH: CONVERSATIONS WITH SPEECH-LANGUAGE
PATHOLOGISTS AND PARENTS

By:

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The number of English as a Second Language¹ (ESL) students in US schools is growing rapidly and is currently estimated to be more than 5.2 million. It is estimated that 5 to 10% of these students may need intervention for a communication disorder. Experts in the field of speech-language pathology have determined that assessment and intervention for these students is most effective when it includes intervention in the child's native language; however, most speech-language pathologists (SLPs) speak only English.

The American Speech-Language Hearing Association (ASHA) and universities are making efforts to increase the number of multilingual SLPs entering the field; however, it is unclear if there will ever be enough multilingual SLPs to serve the growing population of ESL students. Even if there were enough bilingual SLPs to work with the Spanish speaking ESL students (75% of the total), the remaining ESL children speak such a variety of languages that it is doubtful that there ever will be enough multilingual SLPs to serve them.

Given the extent of problem, ASHA and experts in the field have suggested a number of possible solutions to clinician/client language mismatch. Some of those solutions involve using bilingual SLPs as consultants, working with interpreters, and providing indirect intervention in the home language through peers or family members. Since implementation of these solutions may require major changes in the relationships

¹ ESL (English as a Second Language), ELL (English Language Learner) and LEP (Limited English Proficient) are all terms used to describe students whose first language (L1) is other than English and are learning English in school. The term ESL will be used in this paper because it best acknowledges the importance of the students' L1.

between SLPs, educational agencies and parents, this project examined the reactions of SLPs and parents to some of these proposed solutions.

This project used focus groups to examine the opinions of two distinct groups of SLPs regarding solutions to clinician/client mismatch. One group consisted of monolingual (English) SLPs, the professionals who are confronted most with the problem. The second focus group consisted of bilingual (Spanish) SLPs, who had extra insight on solutions due to their unique experience.

Since clinician/client language mismatch has a major impact on parents of ESL students with communication disorders, this project included parent interviews. Parents were interviewed regarding their ideas about language mismatch about the problem and possible solutions.

Interview results showed agreement between speech-language pathologists and parents. Both SLPs and parents agreed that clinician/client language mismatch is a major issue for the field of speech-language pathology. However, the bilingual SLPs felt that the field was not sufficiently aware of the long-term effects of providing ESL children with services in English. The consensus of the bilingual SLPs was that if educators fully understood the importance of retaining a student's home language, they would better understand how vital it is for ESL children with communication disorders to receive services in their L1. With this understanding, they reasoned that monolingual SLPs and educators could become advocates for a solution to clinician/client language mismatch.

While the bilingual SLPs were advocating increasing awareness of the issue as a first step, monolingual SLPs were asking for more training on how to better serve their ESL students. The monolingual SLPs felt they did not have the skills and resources to

provide effective services to their ESL students. They felt the time they spent providing direct service to ESL students would be better spent consulting and collaborating with teachers and parents.

Both groups of SLPs supported most of the service delivery models presented to them. When discussing these solutions, the topic of collaboration came up consistently; participants strongly believed that the mostly monolingual field of speech-language pathology will not be able solve the problem without help from others. The fact that both the SLPs and the parents supported the idea of parent-implemented intervention suggests that a paradigm shift towards indirect therapy may be an avenue to a long-term solution to clinician/client language mismatch. It is hoped that this project will be helpful to those who endeavor to solve this problem and most importantly, to ESL students with communication disorders and their families.

Review of the literature

Increase in the Number of ESL Students

There are currently more than 5.2 million ESL students in US schools, an increase of two million (64%) since 1994 (National Center for English Language Acquisition and Language Instruction Education Programs, 2005). ESL students make up more than 10% of the total school population (National Center for English Language Acquisition and Language Instruction Education Programs, 2005) and more than 72% of all ESL students speak Spanish as their primary language (Capps, Fix, Murray, Ost, Passel, & Herwanto, 2005).

It is thought that the overall percentage of ESL children with language disorders is similar to that of the English-only speaking population (5 to 10%), though there are no reliable figures (Kohnert & Derr, 2004). ESL children who have speech and language disorders, like their monolingual English-speaking peers, need intervention to help them to communicate effectively. Intervention from skilled speech-language pathologists (SLPs) can foster development of the language skills needed for successful communication at home and in school. Conversely, lack of adequate intervention can have harmful effects on a child's development of basic cognitive, literacy, and academic skills (Kohnert & Derr, 2004).

With the dramatic increase in the overall population of ESL students, the number of ESL children with speech and/or language disorders has also increased. Indeed, successive national surveys of SLPs done in 2001 (Roseberry-McKibbin, Brice & O'Hanlon, 2005) and 1990 (Roseberry-McKibbin & Eicholtz, 1994) show that the number

of SLPs in the US with 10 or more ESL children on their caseloads increased from 6 to 22%. According to the most recent national survey, the mean percentage of ESL clients on SLP caseloads was 11% (Roseberry-McKibbin et al, 2005). In the Western US, the survey showed that ESL students made up 20% of the caseload of the SLPs who responded. Even in Oregon, a state not traditionally thought of as an area with high linguistic or cultural diversity, the numbers of ESL students on SLP caseloads is increasing. A recent survey of 63 SLPs in Oregon reported that the vast majority (87%) of respondents had at least one client whose native language was Spanish (Koning, 2006). Furthermore, 28% of them reported having between 10 and 20 ESL clients on their caseload.

Client-Clinician Language Mismatch

Unfortunately, there is a large gap between the number of ESL students with communication disorders and the number of SLPs who speak their native languages fluently. Estimates of the number of those SLPs range widely, perhaps due to the definition of “bilingual.” ASHA’s multicultural issues board reports that six percent of its members identify themselves as bilingual or multilingual (ASHA, 2004). Roseberry-McKibbin (2005) noted 12% of the respondents reported sufficient fluency to assess and treat children in a language other than English. However, it is not clear from the survey results how many of the 12% spoke languages (such as Spanish) likely to be spoken by their clients. Koning (2006) found that while 6% of the SLPs in her survey spoke another language, only 6 of those 14 spoke a language (Spanish) that was spoken by their clients, reducing the percentage to 9 percent. If the results of Koning’s (2006) survey of

Oregon SLPs are indicative of national trends, a large percentage of the SLPs who are bilingual may be fluent in languages that are not very useful in their practice.

Although native Spanish speakers make up a large proportion of ESL students, the breadth of language diversity is quite wide (Kohnert, Kennedy, Glaze, Kan & Karney, 2003, Koning, 2006, Kritikos, 2003, Roseberry-McKibbin et al, 2005). For example, in Koning's survey of SLPs in Oregon (2006), over 20% of SLPs worked with native Russian or Vietnamese speakers, and over 5% worked with speakers of Hmong, Ukrainian, Cantonese or Somali. In a large urban school district such as Portland (Oregon) Public Schools, there may be over 100 languages spoken by students. Thus, it is likely that even bilingual Spanish SLPs will not be able to speak all of the languages spoken by their ESL clients (Kohnert et al, 2005).

It is widely acknowledged that the increase in linguistic diversity in the US poses a major challenge for the mostly monolingual profession of speech-language pathology (ASHA, 2004; Goldstein, 2006; Kohnert, et al, 2005, van Tuijl, Lesesman & Rispen, 2001). In fact, SLPs throughout the Western world are seeking an answer to the question of how can the mostly monolingual field of speech-language pathology can provide services to ESL children (Cheng, Battle, Murdoch, & Martin, 2001; Stow & Dodd, 2003).

The purpose of this project was to review proposed solutions to clinician/client language mismatch and to ascertain how SLPs and parents of ESL children with communication disorders perceive the problem. Finally, the project explored parent and SLP opinions regarding solutions proposed by experts in the field of bilingual speech-language pathology.

Assessment

Since assessment of ESL children has been written about rather extensively in comparison to intervention, this project concentrates mainly on solutions to the problem of intervention. Since the two are so intertwined, however, intervention will be discussed briefly.

Assessment of ESL students for communication disorders is particularly challenging for SLPs because they must differentiate language difference from language disorder. Since ESL children are often referred initially based on teacher's perceptions of their English language skills, the SLP must differentiate between a child who is having difficulty communicating because s/he is learning English and a child who is truly disordered. In the Individual with Disabilities Education Act of 2004, the US Congress acknowledged that current practice for assessment of ESL students results in a disproportionate number of these children in special education (IDEA, 2004).

A review of recent research on language choice for assessment with ESL children shows consensus that assessment of bilingual children should take place in the child's home language (L1) and possibly in English (L2) (Goldstein, 2006; Kohnert & Derr, 2004; Ray, 2002). By verifying that the child has language difficulties in his/her L1, SLPs can decrease over-identification. In addition, many experts advocate assessment in English if the student has any degree of fluency to fully understand a child's language abilities.

Intervention

The language mismatch between clients and clinicians poses an even greater challenge for SLPs who are asked to provide effective treatment for bilingual children identified with a communication disorder. According to Kritikos (2003), many ESL students who are identified as students with a communication disorder are receiving services from clinicians who do not speak their primary language. This poses a crucial question for the field of speech-language pathology: Can monolingual SLPs provide effective services to their ESL clients if intervention is done only in English?

Current Research on Intervention

Given the current emphasis on Evidence Based Practice (EBP), one would hope there is clear research evidence to support the use of English for intervention with ESL students. However, there have been no long-term group studies to show that this is effective. Nevertheless, many SLPs believe that English is the best language choice for intervention with ESL children. In Koning's (2006) survey of Oregon SLPs, 27% answered that intervention in English was the best language choice for intervention with ESL students.

While the survey did not explore these responses, it may be that these SLPs believe that intervention in L1 is not necessary, since language gains made in one language would cross over to the other language. At least one treatment study supports these beliefs. Ray (2002) claims that the positive effects of therapy for speech sound disorders in one language will cross over to a child's other language(s), making intervention in L1 unnecessary. Ray, and others with similar beliefs, espouse a Unitary Model of bilingual language development. The Unitary Model holds that as children

learn two languages, they begin with one system for storing and processing language components such as phonology, morpho-syntax, and semantics (Ray, 2002). This implies that therapy effects in one language (English) will cross over to the child's home language.

Research into cross-linguistic transfer of therapy effects is limited to a small amount of single case studies and single-subject experiments involving speech sound disorders. Ray (2002) cites her single-case study of a trilingual (Hindi, Gujarati and English) 5-year-old child as proof that therapy in L1 is unnecessary. The boy participated in cognitive-linguistic speech therapy (in English only), to address six phonological processes. After 5 months of therapy, Ray found that the child's speech errors decreased in all three languages (Ray, 2002). She concluded that multilingual children are likely to have a single phonological system during the early years of language learning. She also used her results to make the claim that it is sufficient to provide therapy in only one of a child's languages.

Since the study's design lacked a control period (during which no therapy was received) it is hard to determine exactly what caused the child's improvement. Other studies done by Holm and colleagues (Holm & Dodd, 1999; Holm, Dodd & Ozanne, 1997), showed only mixed results for cross-linguistic transfer effects of phonological therapy. Holm and Dodd (1999) hypothesized that the type of disorder and the type of therapy might determine whether or not transfer will occur (Holm & Dodd, 1999).

The Interactional Dual Systems Model (IDSM) of bilingual development, in contrast to the Unitary Model, holds that bilingual children have two separate systems for language that have some degree of effect on each other (Goldstein, 2006; Paradis, 2001).

There is evidence showing cross language effects in the areas of phonology and morphology during typical bilingual development (Lopez & Greenfield, 2004; Paradis, 2001).

In Paradis' (2001) study of typically developing 2 year olds, she found evidence that bilingual children have differentiated phonological systems. This study, unlike the case studies mentioned above, involved more than 50 subjects. Monolingual (English or French) and bilingual English/French children took part in a nonsense word repetition task, and Paradis looked for patterns in the ways that they truncated multi-syllabic words. Paradis had hypothesized that truncation would differ depending on the prosodic patterns of the specific language spoken by the child. She found that the bilingual children had mostly separate phonological systems. However, she did conclude that there was a small degree of crossover, since patterns for bilingual children were not the same as patterns for the monolingual children.

Although there does seem to be growing evidence for some degree of language crossover, there is still little evidence that shows intervention in disordered children in one language will generalize to the other language (Goldstein & Fabiano, 2007). Since the degree of interaction is thought to be limited and is yet unknown, adherents to the IDSM do not recommend treatment in English only (Goldstein, 2007; Kohnert & Derr, 2004). To the contrary, they call for assessment and intervention in both languages to address the child's unique needs in each language. Treatment based on the IDSM calls for careful monitoring of progress in both languages so that any interaction effects between languages will be noticed and taken advantage of in therapy.

Children of immigrants often are monolingual speakers of their home language until they are exposed to English in preschool or kindergarten (Capps, et al, 2005). Therefore, children of immigrants who participate in Early Intervention or Early Childhood Special Education often do not share a common language with their SLP.

There have been no studies showing that therapy in English would be effective for a child who does not speak English, and there is no theoretical perspective that gives reason to believe that this might be effective. Gildersleeve-Neumann (2005) hypothesized that such a practice would be essentially meaningless and that it might negatively affect the child's future relationship with education. According to Gildersleeve-Neumann, an SLP who does not share a common language with his/her client may not be the appropriate person to introduce that child to the therapy process.

In addition, several authors (Kohnert, 2005; Restrepo, 2005) suggest that intervention in English only (L2) may have negative social and academic effects. For example, use of English alone as an instructional language, may lead to an erosion of skills in the native language (Kohnert et al, 2005). Erosion of L1 skills can lead to negative social effects related to difficulty in communicating with parents and extended family.

Many studies have shown that ESL students who retain their home language are more likely to succeed academically and to have higher self-esteem than their counterparts who become monolingual English speakers (Feliciano, 2001; Hurtado & Vega; Portes & Hao, 2002). According to Portes and Hao (2002), retention of the home language acts as an "anchor" to their culture, resulting in a high degree of family solidarity and a lower level of conflict. In addition, they found that fluent bilinguals were

more likely to hold higher educational aspirations than monolingual children or limited bilingual children.

Best Practices for Intervention

Treatment of ESL children with communication disorders is even more challenging than assessment. Formal assessments usually take place every three years in a school setting; however, intervention is ongoing and is expected to result in improvement in the child's communication. Due to the ongoing nature of intervention, it is much more staff intensive. While some school districts may have bilingual assessment teams that can identify children with communication disorders, statistics tell us it is unlikely that they will have bilingual SLPs available to provide intervention (Roseberry-McKibbin et al, 2005).

It is unfortunate that there is even less guidance from ASHA regarding intervention for bilingual children than there is for assessment. The practices outlined in 1985 (the last time ASHA addressed this topic extensively) no longer are in accord with current theory and research on bilingual development. ASHA did address the topic tangentially in 2004 when it issued "Knowledge and skills needed by speech-language pathologists to provide culturally and linguistically appropriate services (ASHA, 2004). In it, ASHA simply dictates that SLPs should be familiar with "current research and best practices" for treating disorders in the *language and or dialects* spoken by the client. ASHA also specifies that the SLP be familiar with "delivery models and options for intervention" (pp. 4-5).

Although IDEA (2004) does give fairly specific guidance regarding language choice for assessment, it does not provide the same level of detail for intervention. In the

section regarding consideration of “special factors,” IDEA (2004) simply states that when working with an ESL child the IEP team should “consider the language needs of the child as such needs relate to the child's IEP” (U.S.C. § 614 (2004)). Due to the vague nature of the law, it does not provide practical guidance for SLPs attempting to design intervention for ESL children.

As with assessment, current best practices recommend using all of a child’s languages for intervention (Genesee, Paradis, & Crago, 2006; Goldstein, 2006; Kohnert, 2005). Kohnert and Derr (2004) have outlined two general approaches to dual language intervention. In the bilingual approach, the SLP works to support increases in the cognitive skills underlying language development in general, addresses areas of difficulty that are shared in L1 and L2, and points out similarities between languages to ensure that gains made in one language cross over to the other. In the cross-linguistic approach, the SLP and child work in one language at a time to address areas in which the child’s languages differ. Depending on the child, one or both methods might be necessary at different points during therapy. The results of ongoing assessment (done in both languages) will point the way toward the most appropriate choice for approach and for which language(s) to begin with.

From Current to Best Practices

It is clear from looking at statistics, surveys, and from ASHA’s position papers on the topic (1985, 2004) that the lack of bilingual SLPs makes it difficult to adhere to best practices for assessment and intervention for ESL children. It is crucial for the profession to continue to research both bilingual assessment and intervention (Genesee, et al, 2006). However, since there has been more attention paid to assessment of ESL children, and

because intervention is ongoing and thus more labor intensive, this project will focus on solutions to intervention. As part of the project, SLPs will be asked how current practice for intervention compares to what is considered “best practice.”

There are several avenues for bridging the current language mismatch between clients and clinicians. Some solutions increase the efficiency with which the current number of bilingual professionals is used. Others seek to increase the number of bilingual clinicians available. Other, more radical solutions have been proposed that attempt to solve the problem by using family members or peers who speak the child’s language as the main agents of therapy. The different methods are elaborated below.

Increasing the efficiency of current resources. One way to increase the efficiency with which the current number of bilingual SLPs is employed is to use a coordinated service model (Kayser, 1998). Under this model, the monolingual SLP is responsible for providing service in English to a population (school, for example) and s/he works closely with a bilingual SLP (or SLPs) who provides service in the child’s home language.

Recent bilingual children might begin therapy in their home language, then begin in English once the SLP and school staff believe the child is ready. For others, intervention in both languages would be balanced. According to Kohnert and Derr (2004), such programs can be effective in helping bilingual children to achieve their goals.

In cases where the number of bilingual SLPs is too small to permit use of a coordinated model, bilingual SLPs may act as consultants to monolingual SLPs on an itinerant basis (ASHA, 1985; Goldstein 2000). The bilingual SLP would provide training to monolingual SLPs, bilingual speech-language pathology assistants (SLPAs) and interpreters in his/her district in linguistic and phonetic features of the language(s),

important socio-cultural information, and in effective techniques for bilingual intervention.

Under this model, the bilingual SLP will work with the monolingual SLP (who is the case manager and service provider) to assess the child, set goals, and design intervention strategies for individual clients (Goldstein, 2000). Then, the monolingual SLP will work with an SLPA or trained interpreter to provide ongoing services. The bilingual SLP will consult periodically with the monolingual SLP to monitor progress, answer questions, and occasionally do direct therapy as a team to model discussed techniques. In this way, instead of working with only the 40 clients on his/her own caseload, the bilingual SLP can affect the intervention of many times that number. This model may work for providing services in common languages (such as Spanish); however, it will not work for clients who speak languages that are spoken by very few SLPs, such as Chinese, Russian or Hmong.

ASHA (2004) has also suggested that in geographical areas where there is a dearth of bilingual professionals, regional networks or cooperatives could employ a team of SLPs fluent in the languages most prevalent in the area. This could help smaller districts that cannot attract any bilingual staff. In addition, it could be one way to provide services in less commonly spoken languages (such as Hmong, Chinese, Russian) that are likely to appear on the caseload of SLPs in the area. Team members would work much in the same way as in the itinerant bilingual model outlined above. In the case of Oregon, this could be a role for Educational Service Districts (ESDs) or regional programs, which already employ hearing, vision and autism specialists.

Although this model may represent an even more efficient use of bilingual professionals, it still will not benefit speakers of less commonly spoken languages. Even in a large metropolitan area, it is unlikely that there would be a single SLP who speaks Vietnamese, Russian or Hmong well enough to act as an itinerant SLP.

Another recommendation for increasing efficiency is for SLPs to work in interdisciplinary teams with other, qualified, bilingual professionals (special education teachers, psychologists) to provide services to students who are learning English as a second language (ASHA, 1985). This model might be applicable in cases when an agency does not have any bilingual SLPs, but does have a relative wealth of other professionals who have experience working with ESL students in a non-biased manner. Under this model, those professionals may receive some cross-training in speech-language pathology. The monolingual SLP would still be case manager, and would design and interpret assessment cooperatively with bilingual co-workers. The SLP would develop goals and intervention strategies and would monitor progress. The SLP (as appropriate) might also provide intervention in English as under the coordinated model.

When bilingual SLPs are not available, the bilingual support model can be used to bridge the gap between monolingual SLPs and ESL students (Kayser, 1998). This model makes use of bilingual speech-language pathology assistants (SLPAs) or interpreters. According to ASHA (1985), interpreters should only be used when the models mentioned above are not feasible.

In the bilingual support model, the monolingual SLP works with a bilingual assistant (SLPA or interpreter) to provide service in the home language. The bilingual SLPA should be certified and should have had specific training in working with ESL

children. In some cases, the assistant could act as an interpreter for the ML SLP. In other cases the SLP may design intervention and the bilingual assistant provides treatment in the client's home language (Kayser, 1998). In addition, the SLP may work with the client in English. For this model to be successful, it is crucial that the assistant and SLP both be trained, as outlined below.

Working with interpreters. Best practices have been outlined for working with interpreters (ASHA 1985, 2004; Langdon & Cheng, 2002). SLPs should be involved in the recruitment of their interpreters, and should make sure that they have the necessary language skills and have been trained as interpreters. In addition, the interpreter should be familiar with the terms used by the profession and should be prepared for the tasks that s/he will engage in, preferably by the SLPs with whom s/he will be working. There should be adequate time for the interpreter and SLP to meet before and after assessment, and the interpreter should receive ongoing training along with the SLPs with whom they will be working. Finally, and of equal importance to linguistic skill, the interpreter should be familiar with the culture of the ESL client in addition to that of the majority culture. In this way, the interpreter can serve as a "cultural broker," helping clinicians and clients to better understand each other's culture.

Increasing the number of bilingual SLPs in the field. Although use of the aforementioned models may increase the capacity of schools and agencies to provide intervention in the home language, for best practices, the number of bilingual SLPs needs to be increased. One possibility is to increase the number of bilingual SLP programs. This is definitely an important long-term goal, on which this researcher believes ASHA should increase emphasis.

A shorter-term possibility recommended by ASHA (1985) is for university programs and work settings such as schools work together to provide services to “minority language” students. By providing an opportunity for bilingual graduate students to work in the schools (under the supervision of a trained bilingual speech pathologist) they hope that more children will receive services in their native language, and there will be an increase in the number of trained, bilingual SLPs.

Indirect service delivery. Due to the extent of clinician-client language mismatch and the growing breadth of linguistic diversity among ESL students, the direct service models discussed above will not be sufficient to solve the problem. Therefore, some have suggested indirect service delivery as a possible way to provide service to ESL students in their home language (Kohnert & Derr, 2004; Kohnert, et al 2005). Two promising possibilities are peer-mediated intervention and parent implemented therapy. Andrews and Andrews (2000) suggest that providing service in these “natural” environments is more likely to promote generalization, but there has yet to be a study done to test their hypothesis.

Peer-mediated intervention has been suggested as a possible strategy for monolingual SLPs to use in order to provide intervention for ESL students in their home language. Although the effectiveness of peer-mediated intervention has not been researched with bilingual children, studies done with monolingual children with language impairment indicate that it can be an effective strategy (Kohnert et al, 2005; McGregor, 2000).

In peer-mediated intervention, the SLP sets up structured interactions (socio-dramatic play, storytelling) between a child with a disorder and typically developing

(TD) children so that the disordered child can benefit from the language model of typically developing peers (Kohnert et al, 2005). For example, for a child who has a limited range of vocabulary and play routines, the SLP might set up a situation where the child is encouraged to try a new play routine with peers. It is hoped that the child with a disorder would gain vocabulary and syntax from such ongoing interactions. The SLP would monitor the interactions and modify the tasks as necessary.

With ESL children, a child with a language disorder would be paired with a typically developing (TD) child(ren) who speaks his/her language. If the TD child is fairly fluent in English, the clinician may be able to mediate the use of language more directly. In addition, a bilingual assistant might be able to work with the peers in the home language, and in this way guide and monitor the intervention more closely (Kohnert et al, 2005). However, peer mediated intervention has only been suggested for use with children with language impairment, and may not be suitable for other types of impairments.

Increasing parental/family involvement is another possible method for bridging the gap between the languages of the clinician and the home language of the client (Cheng et al, 2001; Gildersleeve-Neumann, 2005; Kohnert, et al 2005). Kohnert et al (2005) suggest that SLPs train parents to provide direct intervention for their ESL children. Since a recent “meta-analysis” by Law, Garrett, and Nye (2004) showed that trained parents can provide efficacious intervention for their children with developmental speech or language delay, this is an avenue that merits further exploration. While the analysis found parents just as effective as SLPs, it did not include studies that involved ESL children, since they have not yet been conducted. Therefore, this project will take a

closer look at parent implemented therapy as a possible solution to client-clinician language mismatch so that future researchers will have an idea of how parents and SLPs will perceive such programs.

Parent-implemented intervention involves more than just inviting parents to attend sessions and giving them homework. It is a long-term process in which parents or other caregivers are trained in specific techniques that have been shown to facilitate language or speech development.

Under this model, the SLP's would act as a coach; modeling techniques, giving constructive feedback and providing encouragement. Parents would be the experts on their child and culture. The family and the SLP would work together as a team to address the child (and family's) needs.

Law et al (2004) found that parent-implemented programs designed to promote expressive language development were as effective as interventions by SLPs. The researchers also found parent-implemented interventions for speech sound disorders to be as efficacious as intervention led by SLPs. These interventions trained parents to use auditory bombardment techniques, and were more eclectic in their approach than the interventions for language. However, there was greater variation in the efficacy among individual studies that targeted speech sounds than there was among the individual studies designed to promote language development. This suggests that designing and implementing specific programs that target speech sounds may be more challenging than creating successful parent-implemented programs that target language development.

Kohnert et al (2005) describe what parent-implemented intervention would look like for a monolingual SLP working with ESL students. If one of the parents speaks

English fluently, the SLP could train them directly to work with their child in the home language. The SLP would still need to learn more about the linguistic and phonological features of the home language, so s/he could help the parent to modify treatment to match the language. In cases where the parent and SLP don't share a language, a trained bilingual paraprofessional could serve as an intermediary. However, research showing the effectiveness of using a paraprofessional to mediate this type of training of parents has not yet been published (Kohnert, et al, 2005).

Kohnert et al (2005) also recommend the use of a systematic program for parent training that takes place over several months. During the sessions, they suggest that the SLP use a variety of teaching methods designed to ready the parents to become the primary intervention agents for their children. These techniques include “demonstrations, coaching, role-plays, and mediated parent child interactions, videotaped examples and written materials and specific instructive feedback” (p. 258). In addition, videotaping and discussion of parent-child interactions may help some parents to monitor their progress on use of discussed techniques.

A study by Kaiser and Hancock (1996) suggests one model that can be successful in increasing language development. In this model, parents are taught responsive intervention strategies including: following the child's lead, pause, descriptive talk, expansion, and linguistic modeling at the child's target level. In a typical session, parents were taught a specific technique, were videotaped while practicing it with their child, discussed the interaction with the SLP and developed goals for the next session.

The model researched by Kaiser and Hancock has been modified by the Hanen Center for use with groups. The center's “It takes two to talk” program is designed for

groups of parents and children with language delays. This program has already been adapted for use with Spanish-speaking parents. Since one or two SLPs can effectively serve a large amount of clients at a time, this could be an efficient use of bilingual SLPs and/or assistants. Therefore, when parent-implemented intervention is mentioned in this project, this is the type of program to which the researcher is referring.

An additional benefit of involving parents would be increasing the confidence of SLPs in their ability to work with ESL children. By working with interpreters who have been trained to act as cultural brokers, even monolingual SLPs may be able to partner effectively with families. Through increased exposure to the culture and language, SLPs could become even more effective in working with ESL children over time.

For parent intervention to be successful, SLPs would need to change the type of relationships that they have with parents. Cheng (2001) has called for just this type of “paradigm shift” in the way SLPs work with culturally and linguistically diverse families in the US. She advocates a move away from a “medical model” where the SLP tells the family what the problem is and what to do, and towards a model of negotiation.

Under this new paradigm, both SLPs and parents need to understand each other’s perspective to plan and execute an effective intervention. The SLP has important knowledge about child language development to share, and the parents have knowledge of their child, language and culture (Cheng, 2001). What Cheng has suggested is quite similar to the family systems approach advocated by Andrews and Andrews (2000) for use with all clients. Such a family systems approach may be especially effective way to provide intervention for ESL children. However, no published studies exist to show its efficacy with non-English speaking parents (Kohnert et al, 2005).

Since this type of program has not been tried before on a large scale, many questions need to be answered and many details need to be worked out before it can be considered as a medium term solution to client-clinician language mismatch. The proposed change would mean that SLPs would work more closely with parents than is now the case in the public schools. Even for children in the preschool age group, clinicians usually work directly with their clients in a classroom setting.

The central question that SLPs and administrators will ask is “how do we know that this model of treatment will be efficacious?” To answer that question, efficacy studies will need to be conducted. If the model is found to be successful, a change in the service delivery model can be advocated for. However, successful efficacy studies alone may not be enough to cause SLPs and administrators to embrace such a large shift in the service delivery model for working with ESL clients.

It is also important to find out whether the SLPs who are currently working with ESL children are willing to embark on such a change in service delivery paradigm. A second question is whether or not parents of ESL children with communication disorders are interested and have time to participate in this shift in treatment model.

Even though parent-implemented therapy has been successfully used with English-speaking populations in the United States, it is important not to assume that the success will be replicated with non-English speaking parents. Cultural differences with regard to perception of disability, professional competence, and the role of parents in children’s education may require modifications to existing models of parent training or may need to be kept in mind while crafting new ones.

Results of a recent study by Rodriguez and Olswang (2003) show evidence that

parent-implemented programs designed for Mexican-American families may need to be modified to be successful. The researchers surveyed 20 Mexican-American and 20 Anglo-American mothers about their beliefs regarding child rearing and education. They found that the Mexican American mothers had a more traditional authoritarian outlook towards education and child rearing, though more acculturated mothers held a less traditional outlook. The authors' stated that mothers with traditional, authoritarian beliefs are more likely to see child rearing rather than formal education as their domain. They also found that the Mexican-American mothers were more likely to attribute the cause of their child's disorder to extrinsic factors than were the Anglo mothers.

Based on their findings, Rodriguez and Olswang (2003) state that parent training programs might not be appropriate for Mexican American mothers. However, since the number of participants was small and the survey did not directly address opinions of such programs, it would not be wise to abandon the exploration of parent implemented intervention training as a possible solution. Therefore, before embarking on large-scale efficacy studies, it may be helpful to assess the attitudes and opinions of both parents of ESL children and the SLPs who work with them. Since the vast majority of ESL children are native Spanish speakers (Capps et al, 2005), it makes sense to begin a discussion of solutions with parents of Spanish speaking children with communication disorders and the SLPs who serve them.

Focus Groups

This research project utilizes focus groups to explore SLP and parent beliefs about best practices for serving bilingual children with communication disorders. Focus groups and surveys are two common tools used by social scientists to learn more about people's

beliefs and attitudes. SLPs have been surveyed extensively (Kohnert et al, 2003, Koning, 2006; Kritikos, 2003; Roseberry-McKibbin et al 2005) with regard to working with CLD groups. These data have been useful, but the depth of information that can be gained from surveys is limited. On the other hand, focus groups are a type of group interview that is used when the researcher wants to conduct a more detailed analysis of opinions about a topic (Huer & Saenz, 2003). The researcher recruits a group, typically of 6-12 people, that represent a demographic that s/he has chosen to study (Morgan, 1997). Prior to convening the group, the researcher prepares a set of open ended questions that s/he thinks will spark a lively discussion. Once the group is convened, the moderator of the group may decide to deviate from the prepared questions to address opinions that were unanticipated. Finally, the researcher analyzes the data (the participants' discussion) and prepares a summary report of his/her findings.

Focus groups have been used by social scientists since the late 1980s as a tool for conducting qualitative research. (Morgan, 1997) Prior to that, they had been used primarily by business to assess customer attitudes. Currently, they are widely used in the fields of business, politics and the social sciences. Focus groups were chosen for this project because they are the best option when the goal is to come up with new ideas and foster discussion (Huer & Saenz, 2003; Morgan, 1997).

During the past 10 years, Huer and Saenz (2003) have successfully conducted focus groups to learn more about the attitudes and beliefs of CLD populations regarding communication disorders. They have been used to ascertain cultural attitudes towards disability and the provision of professional services (such as speech language therapy). For example, they have been used with Spanish speaking members of Mexican American

families to find more about their attitudes towards use of Alternative and Augmentative Communication (Huer, Parette, & Saenz, 2001).

Summary

It is clear that clinician-client language mismatch has led to poor quality of intervention services for ESL children with communication disorders. ASHA (1985, 2004), IDEA (2004) and researchers (Goldstein, 2000; Kohnert et al, 2005) have proposed possible solutions to the problem. However it is unknown what SLPs in the field and parents of ESL children think of the proposed solutions to clinician-client language mismatch. Since solutions will not work without the participation of SLPs and parents, it is important to explore in detail their thoughts about the current state of services, and what training and resources they believe would improve them. In addition, an exploration of possible solutions to client-clinician language mismatch will be valuable to future researchers. Will SLPs and parents of ESL children regard parent implemented therapy as a possible solution to the problem? The answers to these questions will help future researchers decide if this is an avenue worth further research.

Method

Participants

This project analyzed the opinions of SLPs who serve ESL children who have communication disorders, in order to explore possible solutions to clinician/client language mismatch. The SLPs' ideas about possible solutions to clinician/client language mismatch were explored through the use of focus groups. The project also included two interviews with parents of children with communication disorders to elicit their opinions about the topic of clinician/client mismatch.

SLP Participants

There were two focus groups for SLPs: monolingual English (ML) and bilingual Spanish (BL). ML SLPs were chosen because they make up the vast majority of SLPs working today. However, the project design included a second group of BL SLPs, since the researcher thought they may have valuable insight into the problem of clinician-client mismatch. This project focused on SLPs who work with children whose home language is Spanish, since that is the native language of the majority of ESL children in the US (Capps et al, 2005).

The ML SLP group consisted of 4 SLPs and the BL group consisted of 5 SLPs. Small groups were chosen according to Krueger and Morgan's (1998) criteria for choosing groups size. They suggest that smaller groups be used when the participants have specialized knowledge, since this might cause the discussion to be more heated. Similarly, they suggest smaller groups when the discussion may involve potentially controversial or emotionally charged topics.

The ML SLPs were recruited from a local early intervention program where the researcher had worked, which has a high percentage of ESL clients whose L1 is Spanish. This age group was chosen since preschool children are more likely to be monolingual Spanish speakers than school-age children (Capps et al, 2005). The researcher invited ML SLPs with whom he has worked in the past (and who were interested in finding solutions to clinician/client language mismatch) to participate in the ML focus group. They were also asked to recommend co-workers who had also expressed an interest in the topic.

Since there were so few BL SLPs working in the Portland, Oregon area, BL SLPs who work with elementary age children were also invited to participate. The group of five included 3 SLPs who work with preschool-aged children and 2 who work with elementary-aged children. One of the BL SLPs was bilingual/bicultural. The four other BL SLPs had learned Spanish as a second language. Four of the five BL SLPs were known by the researcher and the remaining one was recommended by a ML SLP co-worker.

Table 1

SLP Participant Description

SLP Group	ML SLPs	BL SLPs
Range of years worked as SLP	3 to 30 years	1 to 33 years
Mean number of years worked as SLP	16 years	14.2 years
% of ESL students (current year)	5%-45%	10-95%
Age of clients	Early Intervention- 3 SLPs	Early Intervention -3 SLPs Elementary- 2 SLPs
Bilingual status of SLP	N/A	4 SLPs learned Spanish as adults 1 SLP was simultaneous bilingual

The researcher contacted potential participants by email and/or by telephone and followed-up by sending them a written informed consent form that explained fully the project.

Parent Participants

Parents of Spanish-speaking preschool children with communication disorders were interviewed for this project. The preschool age group was chosen because many in this age group will not have yet been exposed to English (Capps et al, 2005). Parents were interviewed instead of participating in focus groups since it was felt that they would be more comfortable without the presence of strangers. Also, by doing the interviews it allowed the interviews to be done in the home. This made it more convenient for the participants since the families did not need to arrange for childcare.

Participants in the parent interviews were recruited through contacts at an early intervention agency where some of the SLPs in this study worked. Parents known by the researcher through his previous employment in a local Head Start program were also in the pool of parents from which the families in this study were chosen. The participants were invited to participate in person or by telephone (in Spanish), and received an informed consent form (in Spanish) that explained the project in further detail.

This project originally envisioned six parent interviews. However, after the first two interviews, it was clear to the researcher that the data captured from the interviews was markedly different from the data from the focus groups. With a willing audience, parents seemed to have a need to tell their personal story. The experiences of both families varied, depending on their personal circumstances. While there were some data that was pertinent to this project, most of discussion during these interviews was not

within the scope of this project. However, where there is pertinent data, it will be reported and compared to the results of the SLP focus groups.

Each interview included two adult members of a family. Family A consisted of two sisters who chose to be interviewed together. They and their husbands were born in Mexico and had immigrated to the US. Each family had a child who was currently receiving speech-language services in elementary school from an ML SLP. Both children had been identified as children with communication disorders when they were in Head Start, and received services from an early intervention agency from ML SLPs. Since both sisters had nearly identical views, their comments will not be distinguished from each other.

Both of the children in family A had worked only with ML SLPs and teachers. The children were both born in the United States. The first child, currently 10 years old, received services initially for language, but currently is receiving therapy to remediate speech sound errors in elementary school. He has a sibling who is 5 years old. The other child, currently 6 years old, was identified at 3 years of age and received services during the previous year in kindergarten. At the time of this interview this child had siblings who were 15 and 11 years old.

The second interview was with a husband and a wife. They will be referred to as Family B. The husband was a native of Cuba and the mother was a native of El Salvador. Their son, who was born prematurely, was 2 years 11 months old at the time of the interview. He had received services since birth, initially at a child development center at the hospital in Portland, Oregon where he was born. These services were provided by an ML SLP with a Spanish-speaking interpreter. At the time of the interview, he was

receiving services both from a local early intervention agency and at the hospital. He also received services from the local early intervention agency, from a Spanish speaking (BL) SLP. In addition, his parents were involved in a local Early Head start program.

Moderator/Interviewer

The moderator/interviewer for this project (the researcher) was a second year graduate student in speech language pathology. He was fluent in Spanish, and was a former Spanish teacher. He was not a native speaker, however he lived in Ecuador and Colombia for a year. Though he was not fully bicultural, he had 10 years of experience working with Spanish speaking families.

Focus Group/Interview Questions

Focus Group Questions (For SLPs)

The focus group questions (see Appendix A) were developed to elicit discussion of the current state of services and possible solutions to client-clinician language mismatch. The focus groups followed a moderately structured interview approach. This approach was suggested by Krueger and Morgan (1998) for situations where the researcher wants to explore the participants' view of an issue in addition to getting answers to specific questions. A set of 10 questions was developed. Ten questions were chosen so that each participant would have more than a minute for each one.

The questioning route began with open-ended questions designed to elicit discussion, and ended with more specific questions in order to make sure that key topics were addressed. At the end of the focus group, the moderator summarized the participants' ideas to make sure they were adequately represented. With use of this type

of format, it is not required that all the questions be asked and the moderator is encouraged to ask additional open-ended questions as appropriate (Morgan, 1997; Huer, et al, 2001).

Interview Questions (For Parents)

The interview questions were developed to ascertain the parents' opinions of services their child has received in the past and the current services that they are receiving. In addition, they were designed to find out if parents believe that there is a language mismatch between ML SLPs and ESL children. Finally, the questions were designed to find out how parents' think that services could be improved. Specifically, they were asked their opinions about parent-implemented therapy

The parent interview questions (see Appendix B) began by addressing broad issues and then became more specific. The interview questions differed from the focus group questions, because some of the SLP questions are not pertinent to parents. For example, questions about specific service delivery models (except for parent-implemented therapy) were not included.

Focus Group/Interview Administration

Focus Group Administration

The focus groups were held in a community room in a local library. This location was chosen because it was a neutral location and was accessible for both parents and SLPs. The groups took place in the afternoon, since some of the SLPs were working during the summer. Each group lasted for 90 minutes.

The moderator began each focus group by introducing himself and explaining the purpose of the project. He explained that part of his job is to make sure that everyone

gets a chance to answer each question. The questions were written on a flip chart in order to focus the group on the topic of discussion. Then he asked each of participants to answer the opening question (see Table 1). This question was designed to make the participants feel comfortable, since answers would show participants what they have in common.

Next, participants were asked to answer the Introductory and Transition Questions. These questions were meant to introduce the topic of clinician-client language mismatch without being overly controversial. After addressing these questions, the group moved onto the Key Question. This question was designed to stimulate conversation and create problem solving. Before introducing the Key Question, the researcher asked the participants to read two short paragraphs. (See table 1). The researcher chose to have the participants read the paragraph instead of listen to it, so they wouldn't lose focus while listening to the long statements.

The first paragraph summarized why it is considered best practice for ESL children to receive intervention in both their home language(s) and English. The second one acknowledged the current reality (the lack of bilingual SLPs makes best practice impossible) and at the same time informed the participants that the number of bilingual SLPs is growing. At the bottom of the page is the question: "Given the resources that you expect to be available in five years, what would you like services for ESL students to be like?"

Once each participant had answered, the researcher presented the participants with the second half of the question, which was designed to make sure that the key proposals were addressed. As before, the moderator presented these options in writing,

so that participants would be able to focus on the specifics of the proposal at their own rate. Each proposal was presented separately, on a different colored paper, in order to make sure that only one question was addressed at a time.

In some cases, the moderator decided that a proposal was sufficiently addressed during spontaneous comments, and the group was not specifically asked one of the key questions. This was done in order to make sure that all proposals were addressed. This was done with the BL SLP group, which had discussed extensively the parent-implemented model during previous discussion. Approximately 10 minutes before the group was scheduled to end, the moderator asked the Final Questions, which were designed to summarize the participant's comments and to make sure that the researcher hadn't anything. In the case of the ML SLP focus group, the final question elicited a novel service delivery model that had not been discussed previously. Before the focus group meeting ended, the researcher thanked the participants and reviewed their agreement to keep the information shared confidential.

Interview Administration

Parents were offered the choice to be interviewed in their home or in a convenient, neutral location such as a library. Both families chose to be interviewed in the home. The questioning route was designed in a fashion similar to that of the focus group questions, though the questions that were not pertinent to parents were deleted. Also, a question regarding their opinion of parent training and willingness to participate was added. Each family was asked each question, with the exception of the Family B, which brought up the idea of parent-training. However, most of the time the parents talked about the specifics of their family's history with speech-language pathology. The

interviews lasted more than an hour (the time originally allotted for the interview) and it was clear that the parents had much more to say. The moderator thanked the families for their participation and reminded them that their conversation would remain confidential.

Plan to Avoid Potential Problems

The moderator monitored participant behavior and intervened when necessary in order to keep the discussion on track. The main problems were making sure that all participants got a chance to have input, and keeping the conversation on track. In several cases, the moderator specifically addressed a participant who had not addressed a question, and asked their opinion on the topic. Near the beginning of one focus group, one participant began to talk about the politics of bilingual education. The moderator reminded the group of the question they were asked in order to re-focus the participants' attention.

Data Collection

Data Collection for Focus Groups

The focus groups were recorded with both a digital audio recorder with an external microphone, and with an analog tape recorder as a backup. Audio-taping was chosen because video-taping is more intrusive and may inhibit responses by some participants (Krueger & Casey, 2000). Notes, tapes and digital audio files were labeled and are kept in a secure location.

The researcher used the "tape-based" method of analysis (Krueger & Morgan, 1998) for this project. The researcher prepared an abridged transcript of the participants' discussion that contained points relevant to the topic and the researcher's final summary.

Each transcript was read several times, and pertinent answers were grouped together, regardless of when they came up during the discussion. However, comments that came up spontaneously (rather than being answers to specific questions) were assigned a different font, so that the researcher could make note of the fact for later analysis. This was done for each transcript. Next each groups' answers were combined, again using separate fonts so that researcher could compare each group's comments. Then the researcher noted similarities and differences between the outlook of each group. Finally the researcher re-read the comments and grouped them according to the broad themes. Illustrative quotes were then chosen to express those themes for use in reporting results.

Data Collection for Parent Interviews

The parent interviews were also audio-taped with a digital recorder and external microphone. In addition, they were audio-taped with an analog tape recorder as a backup. The analog tape was used for analysis of the interview of Family B, due to technical difficulty with the digital recording.

Comments pertinent to the research questions were transcribed or summarized. As mentioned earlier, much of the discussion did not relate directly to the research questions. The parent comments were then grouped by the same broad themes as the SLP comments. Finally, the comments of each the parents were compared to those of the SLPs. Illustrative quotes were again chosen to use to express those themes for use in reporting results.

Reporting of Results

The final report used the descriptive model described by Krueger and Morgan (1998). The report was organized by themes, rather than by answers to specific questions. Illustrative quotes were included as appropriate, and specified to which group the participant belonged. The final report addressed the participants' collective opinions regarding the language mismatch between SLPs and ESL children and their opinions about service delivery models that have been proposed. Based on the results of this project and the current literature, the researcher made recommendations for actions that can be made to address clinician/client language mismatch.

Results

Themes

Several themes were evident throughout the focus groups. Some themes were shared across groups, while others were unique to one group or another. The ML SLP group spent a lot of time discussing the challenge of working with ESL students and their lack of preparedness for the task, while the BL group discussed the overall challenge to the profession of speech language pathology. The BL SLP group spent a lot of time discussing the importance of increasing awareness of best practices for working with ESL students. The ML group expressed personal interest in best practices, but did not discuss the issue of increasing overall awareness. The parents who had worked with a BL SLP were aware of the importance of working in the home language, while the parents who worked with ML SLPs were not.

Both the ML and BL SLP groups stated that while they strongly prefer to have enough BL SLPs work directly with all ESL children, they realize that it is not realistic. The parent groups mentioned some challenges that they had encountered that were caused by the mismatch, but neither group addressed the problem on a large scale.

Both SLP groups were also in agreement that collaboration with parents, teachers and other education professionals is the route to better services for ESL children with communication disorders. The ML SLPs expressed that a change in paradigm from direct to indirect service would be necessary in order to meet the needs of ESL children. The BL SLPs did not specifically suggest a paradigm shift, but did endorse service delivery models that would require a shift towards indirect service. The parents who had worked with a BL SLP expressed that collaboration between SLPs and parents was a

crucial component of the therapy process. The parents who had worked only with ML SLPs did not bring up collaboration on their own. However, once the idea was proposed to them, they endorsed it, citing their experience with Head Start's collaborative approach to education.

Meeting the challenge of working with ESL students

All of the SLPs in both focus groups agreed that working with ESL students is very challenging both on a personal and institutional level. They discussed the challenges they faced when they first started working with ESL children, and those that they currently face.

The parents interviewed did not describe the overall challenge of working with ESL students. However, they did discuss personal experiences regarding communication with ML and BL SLPs. Their comments, detailed below, shed additional light on the nuances of working with ESL children.

Initial Preparedness:

Initial Preparedness of ML SLPs. None of the members of the ML group (from the veteran SLP to the most recent graduate) agreed that they felt prepared when first assigned to work with a monolingual Spanish-speaking client. Except for the recent graduate, they had not been trained on what was "best practices" for working with ESL students. Therefore, the participants worked with the ESL students in English. Since the children did not speak much English, the group agreed that they felt more like ESL teachers than SLPs. The group's consensus is well summed-up by statements by two veteran SLPs.

“I think back about some of my first kiddos, we didn’t know anything about how they acquired language... (we) taught them all English norms because we didn’t know any different back then... The resource teacher did their thing in English and I did my thing in English and then sent them back to class and said “good luck”.

“... (we were) the beginning ESL people. I felt like...I don’t know if this is my area, I don’t know if this is ethical, but what do you do?”

Several ML participants mentioned that their experience working with pre-school age children, trainings, and access to research had helped them to better understand how to work with ESL students. They expressed that they now understood that it was important to provide therapy in Spanish and to support the home language. Even though the participants understood better how to serve their ESL students, they indicated that they did not feel that they had the resources to make the improvements.

Veteran members of the ML group mentioned that in recent years they had had training in working with ESL students and that they had increased their awareness of the issues involved. However, they agreed that they would like to have training in the specifics of Spanish language development.

Several group members mentioned that they had either had a Spanish class in the past or that they had learned a little bit of basic vocabulary from students and from co-workers. However, they felt that although knowing a little bit of Spanish had been helpful, the benefit was limited since they knew only basic vocabulary.

The ML group also mentioned that bilingual co-workers had been helpful and one participant mentioned that bilingual teachers had helped them by teaching them specific words and occasionally collaborating to provide service for ESL students.

Initial preparedness of BL SLPs. The BL SLPs fell into two groups when it came to the degree to which they were prepared to work with ESL students. Several of the BL SLPs who were native English speakers stated that they felt scared and unprepared when they first worked with ESL clients. Two felt as if they didn't have enough Spanish skills (though they had more than anyone else in their district). One felt comfortable with the language but didn't feel as though she had enough experience with child-related vocabulary. However, she felt supported by a bilingual teacher and supportive workplace.

Another native English speaker had a great first experience working with ESL students and felt very supported by a group of bilingual SLPs. She was impressed by the degree to which having a Spanish-speaking SLP improved the services that ESL children received.

The one SLP who had grown up as a simultaneous bilingual/bicultural felt that her experience was unique. She had also participated in a graduate program that was specifically designed to train bilingual SLPs. However, she was still worried that she might misdiagnose an ESL student with a language disorder. In addition, she felt unprepared when she had to treat a child from India for a language disorder, because she was unfamiliar with the language. Furthermore, she stated that the lack of standardized tests in the child's language further limited her ability to serve the child. Due to her

training, she was aware of best practices and knew that she should research the language and work with the family to help determine if the child had a communication disorder.

Parent Perception of Initial SLP Preparedness. Family A did not mention any dissatisfaction with the preparedness of the SLPs who initially worked with their children. The family's children received therapy entirely in English, but they did not see this as a problem. These children were already of preschool age, and they felt that they needed to learn English. The parents had the attitude that their child should learn English first, then Spanish later. This attitude was encouraged by ML SLPs, who suggested that they speak primarily English with their children who were language delayed. Both sisters mentioned that their children no longer spoke Spanish, but that they did understand when talked to in Spanish. They did not mention this as a problem; they stated that learning English was necessary for school, and that they still had time to learn Spanish. Thus, they did not look at the mismatch as a challenge, rather as an opportunity to learn more English. Overall, they were happy with services and felt that they had helped their child to talk more. However, one of these parents mentioned later in the interview that it had been hard for her child to adjust to going to Head Start, because of the fact that the class was taught in English. She stated that he cried about going to school when he first started. She did not address this issue with regard to speech-language therapy.

The one area in which Family A did mention a negative effect of the mismatch was communication with the SLP. They stated that they were frustrated when their children began services, because the SLP expected them to work with their child at home, but the "homework" was sent home in English. Even if they had understood the directions, they expressed the fact that their own limited knowledge of English would

have made it difficult to implement them. The family stated that their attempts to do this just confused their children. After initial attempts, they did not attempt to do the homework.

When the SLP recommended that they should try decrease confusion by speaking in English at home, the sisters enrolled in ESL classes. The fathers (who spoke more English) and older siblings talked primarily in English. Family A seemed to fault themselves for the language mismatch, rather than the SLP or intervention agency.

Though Family A was satisfied overall with the initial preparedness of their SLPs to work with their children, they did have two complaints about services in general. They wished that their child had gotten services more than once a week and didn't like the fact that their child's SLP seemed to change multiple times during the school year.

Family B had its first experience with an SLP at the hospital where their son was born. Since he was born prematurely, he was attended to by many specialists. The family worked with a ML SLP through a translator on periodic visits to the hospital. The parents stated that they were satisfied because they were primarily concerned with being able to converse with the SLP. When the family was assigned a Spanish-speaking SLP at the early intervention agency, they were happy.

While the majority of SLPs initially felt unprepared to meet the challenge of working with ESL students, the BL SLPs were more prepared to do so due to the fact that they spoke at least some Spanish. For Family B (which has worked with a BL SLP) the shared language was enough to make them feel comfortable with the SLPs' preparedness. Family A did not directly address this issue. However, given Family A's report, the ML SLP who worked with their children clearly was not prepared to work with a Spanish-

speaking family. The SLP did not speak Spanish and did not seem to be aware of ways that s/he could bridge the language mismatch. The fact that she suggested that the family speak only in English, suggests that she was not aware of the most basic of best practices for working with families of ESL students.

Current Preparedness

Current Preparedness of ML SLPs. The ML group expressed the fact that although they now had a better idea of how to serve ESL children, they do not have the resources that they needed to provide adequate service to them. However, the ML group did mention a few successes. Several members mentioned that improved awareness of bilingual language acquisition issues had led them to successful collaborations with bilingual teachers. Several members of the group mentioned that bilingual practicum students had been the most effective tool for providing services in Spanish. Though they did not mention this, collaboration with the practicum students may have also increased their awareness of best practices.

The ML SLPs also mentioned that their evaluation team was more prepared to differentiate between language disorder and language difference. They agreed that trainings had helped them to better understand what is best practice, but some expressed the fact that they needed more in-depth training. Others mentioned that a lack of Spanish language continues to severely limit their ability to serve ESL children.

Current Preparedness of BL SLPs. Several of the non-native BL SLPs stated that they felt more fluent in Spanish and more aware of cultural differences through their contact with ESL students and their families. Other factors that led them to feel more comfortable with the language were: using a dictionary, listening to interpreters and

collaborating with bilingual teachers. Also, one BL SLP mentioned that parents were very accepting of her because she was trying to speak Spanish. For the non-native Spanish speakers, becoming more fluent was the major ingredient to feeling more prepared. Another mentioned that working with an agency that supported serving children in their L1 had been helpful. The BL SLPs also mentioned that they would still like to have better materials and resources in Spanish, for use during therapy and to give to parents.

The BL participants mentioned several specific successes regarding their work with ESL students. For example, those who work in early intervention all had witnessed their student's language "take off" when they were provided services in Spanish. In addition, members of the BL group mentioned other specific practices that they had found to be successful: the cooperative model, training for parents, and peer-mediated therapy. These practices will be discussed in more detail later in this section.

Overall, it seemed as though the BL SLPs who had initial support and training felt the most prepared. The others had to rely on themselves as they went along. One recent graduate summed up the initial challenge of working with ESL students, even for BL SLPs:

"I can only imagine how much harder it would have been for ML...if I didn't have the preparation or if it wasn't a language (Spanish) I spoke."

While both focus groups discussed the fact that they felt unprepared when they first began to work with ESL children, only the ML group was in agreement that they continued to feel unprepared.

Parent perceptions of current SLP preparedness. Family B shared that their child is about to enter Head Start (preschool) and a ML SLP is soon to be assigned to work with him. They are concerned about the SLP (and teachers) preparedness to work with their son. Specifically they are concerned that being in an English-speaking classroom and working with an SLP in English will slow the progress of his language development.

Increasing Awareness: The Key to Future Preparedness?

When asked what they would like services to be like in 5 years, the BL SLPs overwhelmingly answered that they would like to see an increased awareness among SLPs, educators, union leaders, and parents about bilingual language development and the importance of supporting the home language. Several participants stated that awareness could be raised through mandatory trainings on second language issues for educators. The following quote explains how one BL SLP saw the relationship between increased awareness and improved service:

“I think that trainings for educators about bilingualism...should be mandatory...(then) they (teachers) will understand and do anything to help the parents support their child in their own language.”

The ML SLPs did not specifically discuss increasing awareness on an institutional level. This is not surprising, since they are one of the groups that the BL SLPs felt should be made more aware of bilingual language acquisition issues. However, all the members of the ML group did indicate personal desire to learn more. Specifically, they stated that they would like to have more in-depth training on the specifics of bilingual language

acquisition. They also mentioned that contact with Spanish speaking co-workers had been helpful. The ML SLPs indicated a desire to work more closely with the bilingual/bicultural SLP in their agency. The ML SLPs also stated that new graduates should have more training in that area.

An area of consensus for both the ML and BL SLP groups was the importance of increasing parents' awareness of the importance of maintaining the home language. One BL SLP described the negative effects of abandoning the home language as such:

"I've seen the results of kids who were taught English from day one and...you only have to see a few kids like that and then you realize...what an effect this has...it's just horrific."

Indeed, one of the parents from family A was counseled (by an ML SLP) to avoid use of Spanish with her child because it could create confusion. The parent followed this advice and reports that the child's language is still disordered and he now speaks only English. However, without an awareness of the long-term effects that this might have on her child, she did not express regret at the decision. She felt that the child needed to learn English for school and still had time to learn Spanish.

It is just this situation that the BL SLPs hope to avoid by increasing awareness of both educators and parents. Indeed, Family B's concern suggests that they were aware of the importance of maintaining the home language, which could make it possible for them to advocate on behalf of their child. At the very least, it is clear that they will continue to

speak Spanish. The overall attitude of both the ML and BL SLPs regarding the value of increasing awareness is well summed up by the following quote by a BL participant:

“Increasing awareness of the effects of not supporting the child in the child’s language, what are the effects that could trickle down later on...empowering parents and making them feel confident that its OK, its good to speak Spanish.”

Discussion

The results of the focus groups and interviews suggest that it will be challenging to improve services for ESL students who have communication disorders. On the other hand, the service delivery models designed by researchers to meet this challenge appear to be agreeable to both ML and BL SLPs. Given the urgency of the problem, one would be tempted to attempt to implement these models immediately. It would be wise, however, to heed the consensus of the BL SLPs that the first step in meeting the challenge should be to raise awareness of bilingual language development among educational stakeholders.

It is important for ML SLPs, teachers, administrators, union leaders, and parents to have an awareness of bilingual language development, because all of the service delivery models discussed will require an increase in the level of collaboration. Once these stakeholders understand the gravity of the challenge, there will be more support and resources available to make changes in service delivery to ESL children.

This section will discuss a range of changes that could be implemented. The relatively simple ones could be implemented in the short term and would not involve

changing the paradigm for service delivery to ESL children. There are other suggestions that would take more time and resources to implement, but would not require a paradigm shift. Finally there are some other suggestions that would involve changing the paradigm for service delivery for ESL students from direct service to a consultative model that utilizes trained teachers and parents to implement therapy in the home language.

Short Term Changes

Increasing Awareness

The BL SLPs were in agreement that the first step is to increase the consciousness of educators and parents of the importance of supporting use of L1 at home and providing services in L1. The lack of awareness of the parents who had worked with ML SLPs, compared to the awareness of the parents who had worked with BL SLPs further underscores this point.

This relatively simple step (and unexpected) step makes sense as a starting point, since increased awareness may open the door to further changes. The ML SLPs were somewhat aware of the importance of providing service in the home language, though they may not have understood the full repercussions of not providing services in L1. More in-depth training for ML SLPs could increase awareness, while also giving them new tools for working with ESL students.

The results of a recent survey of school SLPs working in Oregon (Koning, 2006) suggest that there are many SLPs who do not understand the importance of providing service in the students' L1. Twenty-seven percent of SLPs answered that intervention in English was the best way to provide service to ESL students. In addition, 22% of SLPs

responded that standardized testing in English was the best way to assess ESL students suspected of having a communication disorder.

Unfortunately, this lack of understanding of best practices can have negative consequences. In addition, it is not clear from the respondents that they understand the complete extent of the negative repercussions of providing services only in English. With a fuller understanding of the possible linguistic, cultural, academic and social repercussions of not supporting the home language, ML SLPs can be a powerful force for change.

Mandatory trainings should be conducted not only for ML SLPs, but for other educators, including Occupational Therapists, ESL teachers, classroom teachers, assistants, interpreters, union leaders, administrators, and school board members. According to one of the ML SLP participants, trainers who are bilingual/bicultural would have the best chance of convincing trainees of the importance of supporting L1.

The suggested trainings should outline what current practices are and compare them with best practices and IDEA requirements. These trainings would need to acknowledge reasons for the current state of service and the fact that it will take time to make changes. This is important, since the aim is not to make the trainees feel badly about the current state of service, but to increase awareness.

The results of the parent interviews suggest that increased contact with SLPs who can communicate with parents can increase parental awareness. Workshops for parents of ESL children who have communication disorders should be offered. Following the recommendation of the BL SLPs the workshops should include transportation, childcare and food to be the most common barriers for parents. Education should also be done on a

more individual level by BL SLPs and ML SLPs knowledgeable about the subject. The importance of supporting L1 could be encouraged at every point of contact with parents (eligibility meetings, IFSP or IEP meetings). Once awareness is increased among parents, they may be effective advocates for a shift towards services in their child's L1.

Subsequent trainings should lay out some possible options (tailored to the agency) for changes in service delivery. Further focus groups could be held in order to get more buy-in from the other stakeholders. Focus group members mentioned administrators and union leaders as groups that are in need of more information about this subject. These decision makers (along with School Board members) can increase awareness most easily by setting an official policy of support of the home language. In addition, it is hoped that, once they understand the importance of providing service in the home language, they will be willing (and flexible enough) to make further, more difficult changes.

Better Use of Current Resources

Another relatively easy change would be to make better use of current resources. Several of the SLPs mentioned that BL SLPs are often assigned to work with English speaking children. Given the shortage of BL SLPs, it would make sense to create specific positions for them that would be designed to maximize their positive effect on ESL children. A better use of BL SLPs could lead to increased awareness about ESL issues, more effective evaluation, and an increase in direct service in Spanish to ESL students.

A good first step would be to create Bilingual SLP specialist positions at regional agencies, such as Educational Service Districts (ESDs). This would be similar to the autism or hearing specialist positions that exist in the Portland, Oregon metropolitan area.

Such a position could possibly be filled by a bilingual SLP, very knowledgeable bilingual educator, or a monolingual SLP with extensive training in best practices for serving ESL students. It is one way to effectively to increase awareness with relatively few resources, and has the potential to effect services at many school districts in a region.

The first order of business of such a specialist would be to increase awareness at the School Board, administrative and union levels. In this way, the BL SLP specialist could lobby individual districts without having to fear losing his/her position. Once awareness is increased, it could lead to a more robust effort to recruit more BL SLPs, which will make it easier to implement the other options mentioned below. As more BL SLPs are hired, the specialist would spend more time consulting with SLPs, and eventually training BL SLP specialists at the district level.

The second suggestion for increasing efficiency is for school districts to make better use of the BL SLPs on their staff. For example the BL SLPs suggested that they do evaluations of ESL children suspected of having a communication disorder. They indicated that they believe current practice (of testing in English only) is illegal. IDEA (2004) requires testing in L1, and makes clear that testing in English results in over and under identification of ESL students.

While testing in Spanish (and English if warranted) might ensure compliance with IDEA, it would not, by itself, increase the quality of service once a student is identified. A way to stretch the direct service available in Spanish would be to use BL SLPs as itinerants. Rather than assign an SLP to one or two specific sites (where their caseload consists of a mix of ESL and non-ESL students), a BL SLP could be assigned to work with Spanish speaking ESL children at a cluster of schools.

For the BL SLP, this would involve working at various sites and sharing a caseload with multiple ML SLPs. The BL SLP could either work individually with the students or could use the coordinated service model to deliver service in both languages. This arrangement would require a high level of coordination and would take time to implement. According to the ML group, it would be important to keep the staff assignments stable so that the SLPs and teachers could build the relationships necessary for such a high level of coordination. Educational agencies would need to work out the arrangements according to their needs.

A third suggestion, made by both SLP groups and written about in the literature (ASHA, 1985; Goldstein, 2000), is to use BL SLPs as consultants to ML SLPs and teachers. The BL SLP could be assigned to a cluster of schools, in a similar fashion to the itinerant SLPs. In fact, the two roles could be combined. Part of the consultant's role would be to spread awareness of best practices in services to ESL children. In addition, they could consult on specific cases (both new referrals and current clients.) They could be involved in the referral process from the start. The ML SLPs were in agreement that this type of service would be helpful to them and if the BL SLPs were assigned specifically to that task they would feel more comfortable asking the BL SLPs for help.

Medium Term Changes

Increase Training and Recruitment of Bilingual SLPs

Once awareness has increased, there would be support for additional money to increase efforts to recruit (and train) BL SLPs. The ML SLPs were in agreement that a cooperative program that placed bilingual SLP graduate students at their agency was a

success. With more funding, such programs could be expanded. Agencies that host bilingual practicum students could increase efforts to recruit them after graduation.

In fact, schools in Oregon should increase efforts to recruit the limited number of BL SLPs in general. One method would be to increase compensation for BL SLPs. This could be done by creating a new position, such as “bilingual SLP specialist,” which would not have to be tied to the pay scale for teachers, or by offering an extra percentage salary for bilingual employees who use their skills to improve services for ESL children.

Another way would be to show recruits that they are truly interested in improving services and working towards best practices. Districts would have an advantage in recruitment if they had a policy of supporting the home language, involving BL SLPs in decisions regarding provision of service to SLPs and guaranteeing that BL SLPs would be assigned a caseload that includes primarily Spanish speaking children. Districts would need to make sure that they put policies and programs in place that would retain BL SLPs. The participants in the BL SLP group who had the best initial experience working with ESL children were the ones who were well supported (by other bilingual staff) and had received specific training in serving ESL children (in addition to being bilingual).

One way to support new BL SLPs would be to assign them a CFY supervisor or mentor who is an experienced BL SLP. New BL SLPs who did not have a deep background in serving ESL children could be sent to national conferences so that they could provide the best direct and consultative service possible.

Some of these medium term changes would need to also be approved by teacher unions so these changes could appear in contracts. This is an additional reason to include all teachers in trainings regarding this subject.

Increase the Number of Bilingual SLPAs

In addition, districts should try to recruit certified bilingual SLPAs and experiment with using them to provide service in a manner similar to the coordinated service model. However, districts need to proceed cautiously because the BL SLPs had many reservations. To address these concerns, there should be a high level of supervision of the SLPAs by BL SLPs to ensure that the ESL students are receiving quality services. Districts need to work closely with BL SLPs on this option, so that they do not feel that ESL students are being “dumped” on the SLPAs. Districts who do not may risk losing their BL staff to districts that follow best practices in this area.

If bilingual SLPAs are not available in sufficient numbers, a second option is to recruit professional interpreters who would work directly for the district. These interpreters will also need additional training by agency staff, so that they understand their role and have a basic understanding of what the aims of speech-language pathology and ESL issues. Again, the interpreters would need to be closely supervised by BL SLP staff, in addition to the ML SLPs with whom they will work.

Begin Shift from Direct to Indirect Service

In the medium term, districts (especially ones that work with children from birth to age 5) should experiment with decreasing direct service by ML SLPs to ESL students and increasing consultation and collaboration between ML SLPs, BL SLPs and classroom teachers of ESL students.

The ML SLPs mentioned an existing program (Learning Language and Loving It) designed to train early childhood educators to provide intervention to students with communication disorders. The SLPs suggested a similar program, targeted to teachers of

ESL students, could be designed to help them to stimulate language skills for their students with communication disorders.

This might include the utilization of bilingual peers, teacher assistants and parents as models. The SLP (ML or BL) assigned to work with the school would consult with classroom teachers, monitor progress and the team could collaborate and develop goals

This recommendation is based on a consensus of the ML SLP group that their service to ESL students was not effective and that their time would be better spent consulting with teachers. Since less than 30% of respondents to the Koning survey (2006) responded that they felt “competent” or “very competent” to provide services to their ESL clients, it is likely that this belief is widespread.

Since this approach is untested with ESL children (Kohnert, 2005), it would need to be tried on a pilot basis. Ideally, a graduate school with research capability would be available to consult and gather data on the effectiveness of such an arrangement. The experiment could start with a select group of ML SLPs who are already working with bilingual teachers. The ML SLP would be the expert on language and the teacher would know the child and the language. This approach is best suited to the birth to five population, where the teachers are often already cross-trained. Teachers should be invited to collaborate with the design of such programs. It is important to add that teachers would need to be given extra training and time in their schedules to consult with the SLPs.

Long-Term Changes

Parent-implemented therapy was an option that was highly recommended by both groups of SLPs and the parents who had experience with it. However, this model would

be the most difficult to implement. Districts, ML SLPs, and parents would need to change their paradigm for service delivery to ESL students from a direct service model to one that relies on collaboration with parents.

In order for this to happen, awareness of ESL issues (as discussed above) would need to increase. The fact that the ML SLPs and the parents who worked with a BL SLP embraced the parent-implemented model suggests that awareness may lead to a change of attitude. However, the parents who had worked only with ML SLPs had more traditional, authoritarian beliefs with regard to speech pathology. According to Rodriguez and Olswang (2003) this is not unusual for Mexican-American mothers of children with communication disorders. Also, these mothers were not familiar with speech pathology, whereas education was a more familiar process. Therefore, they may have automatically perceived the relationship as a hierarchical one, in which they (or their child) were recipients of specialized knowledge that was only available from the SLP. Without the possibility of communication between the parents and the SLPs, there was no possibility for a change in attitude towards collaboration.

Interestingly, the same participants who thought that speech pathology should be left to the “professionals” also lauded the “parents as teachers” attitude espoused by Head Start. The fact that their Head Start program had bilingual staff may have increased their awareness and made them more comfortable with the idea of family literacy. Indeed, these parents were enthusiastic about parent-training when it was brought up by the interviewer.

It is important to remember that, depending on their personal experience with the education system, parents may have differing attitudes towards collaboration.

Consequently, focus groups or interviews should be conducted with parents and administrators in order to determine their opinions and barriers to implementation. In addition, small-scale experiments with parent-implemented therapy should be conducted in coordination with a research institution. Providing a Hanen-type program for parents of ESL students and comparing results with students not receiving direct therapy would provide legitimacy for the paradigm shift, or lead to further experiments in service delivery. Involving siblings in therapy, in addition to parents, would be a way to involve peers and could further increase the effectiveness of indirect therapy.

Limitations of the Study

This study was conducted by a researcher who had no direct experience with focus groups. Only a few studies that utilize focus groups have been published in the speech-language pathology literature. None of these studies attempted to compare two separate groups with interviews of participants from another culture. A lack of a clear model to emulate made it challenging to conduct and interpret the results of the study. In addition, there is a relative lack of information regarding provision of services to ESL students in general.

Another limitation was the small size of the focus groups. Due to the time of year that the study was conducted (summer) and the very small pool of BL SLPs, the research was only able to recruit 4 ML SLPs and 5 BL SLPs for the groups. Krueger and Casey (2000) suggest a group size of 6 to 8 participants when discussing complex topics. Mini groups of 4 to 6 participants have become more popular, but the researchers say fewer participants reduces the number (and perhaps value) of experiences.

The BL group worked in three different districts. Some worked with school age children and others worked with preschool children. The ML group all worked within the same agency and were working with children from birth to 5 years of age. During the group discussions, it became clear that options that worked for one age group might not work for the other age group. Segregating the SLPs by age of client, in addition to bilingual status would have made it easier to compare and contrast groups.

As discussed earlier, the parent interview portion of the project was not completed. This means that the opinions of this important group need to be further explored. Finally, the changes proposed here do not take into account how a paradigm shift with regard to services to ESL children would affect services to non-ESL children.

Conclusion

There are a growing number of ESL students in our nation's schools and the majority of them speak Spanish (Capps et al, 2005). It is estimated that 5 to 10% of those children may have a communication disorder. The majority of school-based SLPs are monolingual English speakers (Roseberry-McKibbin et al, 2005) and this language mismatch has created a challenge for the profession of speech pathology.

In the short term, there will not be enough bilingual SLPs to provide direct service to all these students. There are numerous options mentioned in the literature for provision of services to ESL students, which might help to improve services in the absence of sufficient numbers of bilingual SLPs. However, the literature does not report on the effectiveness of these measures when used on a large-scale "real world" environment.

This project was designed to find out the opinions of SLPs and parents about how to improve services for ESL students. Two groups of SLPs (monolingual English and bilingual Spanish) were asked what they think could be done to improve services and were asked about specific options mentioned in the literature. In addition, two parent interviews were conducted, in which the parents of ESL students with communication disorders talked about their personal experiences with the services their children received.

A significant finding of the bilingual SLP focus group was the belief that monolingual SLPs and other educators must increase their awareness of bilingual language development. This suggests that researchers should consider taking a step backward (increasing awareness) before trying to implement specific service delivery options.

The overwhelming support of both groups of SLPs and of the families for parent-implemented therapy suggests that there may be support for a paradigm shift towards indirect service. Since both groups of SLPs supported most of the other options presented, it makes sense that, as awareness increases, districts begin to look at their individual needs and resources and then choose the options that best fit their needs. The results of this project may provide helpful information for those wishing to conduct test trials of those options.

Further research is needed in order to determine the attitudes of administrators and parents about the options discussed in this project, as well as towards a paradigm shift toward parent-implemented therapy. If the research supports the creation of parent-implemented intervention programs, it may be useful to conduct focus groups to help

create the large scale, high quality programs necessary to solve the problem of clinician/client language mismatch.

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Appendices

Appendix A Sample Focus Group Questioning Route (for SLPs)

Opening Question: Please give your name, where you work, and percentage of Spanish-speaking clients that you work with.

Introductory Question: Think back to when you first worked with a monolingual Spanish-speaking client. What was it like?

Transition Question: What do you think is going well in your service to Spanish-speaking children?

Introductory Reading before Key Questions

Best Practice for working with ESL children:

Specialists in bilingual speech pathology (such as Brian Goldstein, Kathryn Kohnert and Elizabeth Pena) are in agreement that assessment and intervention for ESL students is most effective when it includes the home language in addition to English. Recent research indicates that a child's language systems are separate enough that we cannot expect that the effects of intervention in English will cross over to the home language. However, research also suggests that the effects of intervention may cross over from the one language to the other, if the target is a shared feature in both languages. The possibility of interaction between languages makes ongoing monitoring of progress in both languages important. It is thought that by bolstering the home language, a foundation is set for future acquisition in English. Also, using the home language in intervention promotes bilingualism, and research has shown that retaining bilingual status has many positive social and academic effects.

The current reality:

With current resources, it's difficult to imagine a way to provide services for ESL children in both languages. However, there is good news; there are more and more bilingual (Spanish) SLPs entering the field. In the past few years, PSU has graduated an average of 5 bilingual SLPs a year. Although it will take some time before most ESL children have access to a bilingual SLP, within 5 years there will be enough to make some changes in the way services are delivered. The ideas of SLPs in the field are important because they can help to ensure that those changes will be of maximal benefit to ESL students.

Key Questions:

Given the resources that you expect to be available in five years, what would you like services for ESL students to be like?

Experts have suggested ways to make use of bilingual staff to improve services to ESL children. I'd like to hear your opinion of each of them:

- **“Coordinated service model”**- English speaking SLP does therapy in English and collaborates with an itinerant Bilingual SLP who does therapy in Spanish. English speaking SLP is case manager.

Cue questions- will there enough bilingual SLPs to make this model feasible?
What to do with students who speak less common languages?

- **Bilingual SLP as consultant**- An itinerant bilingual SLP is available to collaborate on assessment, goal setting, monitoring of progress, and to consult with English speaking case manager/service provider. English speaking SLP works through trained interpreter or SLPA when working with child in home language, and works with alone with child in English.

Cue question: Would this be too hard to coordinate?

- **Trained Interpreter or bilingual SLPA.** SLP works with interpreter (or SLPA) to provide services in Spanish to ESL student. SLP provides services in English and monitors progress in both.

Cue questions: Is this economically feasible? Can an SLPA be enough of an expert?

- **Peer mediated intervention.** Studies have shown setting up, monitoring and manipulating up interactions between a student and a typically developing peer can be an effective method of intervention. With ESL child, English speaking SLP would pair child with a typically developing child (classmate or sibling) who speaks home language, and set up interactions that will be enhance language development. SLP would work with a bilingual SLPA who would assist with setup and monitor progress.

Cue questions: Could this work in a head start classroom? What about ECSE? Would it work for speech goals?

- **Parent implemented intervention:** Research has shown that parents who participate in an intense, long-lasting training program (such as Hanen) can provide effective intervention for their children. Parent would participate in long-term training program (led by bilingual SLP or SLP and interpreter) Parent provides services (in collaboration with SLP) to the child in home language. SLP provides services in English and monitors change across languages.

Cue question: Could this work with speech goals?

Final Questions: If you could make one small change in the way services are provided, where would you start?

Researcher will give a summary of discussion, then ask – Is this an adequate summary of our discussion ?

Is there anything we should have talked about, but didn't?

Reminder Please remember that the information shared today is confidential.

Appendix B Sample Interview Questioning Route For Parents (*Translated from Spanish*)

Opening Question: Please give your name, your child's (who is receiving services) name, age and school. Please tell me a little about your family.

Key Questions: What changes would you like to see that would improve services to Spanish-speaking children?

According to experts, a preschool child should receive therapy in their first language. English speaking children receive services in their first language, but many Spanish speaking children receive services in English. This is because there are few SLPs who speak Spanish.

What do you think about this situation?

What type of skills or training do you think would help your child's SLP to do a better job of providing services to Spanish-speaking children?

What do you think of the idea of your child working with someone who is less experienced than an SLP, but who speaks Spanish?

Would you be willing to go to a parent-training program designed to stimulate your child's language development?

Final Questions: If you could make one small change in the way services are provided, where would you start?

The Researcher gave a summary of discussion, then asked – Is this an adequate summary of our discussion ?

Appendix C Informed Consent form for SLPs

Informed Consent for speech-language pathologists.

You have been invited to participate in a focus group that will meet to discuss ways to improve services for students who are English language learners. You have been selected because you work with Spanish speaking children and you have an interest in better serving that population. The project is being conducted by Monte Bassow, and will fulfill a requirement for the completion of the master's degree program at Portland State University's Department of Speech and Hearing Sciences. Research will be conducted under the supervision of Dr. Gildersleeve-Neumann, Ph.D., CCC-SLP at Portland State University, Department of Speech and Hearing Sciences. Participation in this project is voluntary and can be terminated at any time by the participant.

By participating in this project, you will benefit Spanish-speaking children with Speech and/or language impairments and the speech language pathologists that work with them. The main risk for participants is that criticisms of other speech language pathologists, administrators, or agencies may be overheard. Therefore, the information shared in the groups will be confidential, and the group will be held at a neutral site. In addition, speech language pathologists will not be referred to by name nor by workplace in the final report.

If you decide to take part in the project, you will be asked to attend a focus group that will last approximately 90 minutes. Attendees will be asked to share their experiences working with Spanish speaking clients and to share their ideas about how services could be improved. The focus group will be audio taped by the researcher, so that the ideas of the participants can be accurately transcribed. Your name will not be used in any transcripts of the conversation, and will not be available to anyone except the researcher and the supervisor. It is expected that you will keep confidential the ideas and opinions expressed by other participants in the group. The audio files, tapes and transcripts will be kept in a secure location.

If you have concerns or problems about your participation in this study or your rights as a research subject, please contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 111 Cramer Hall, Portland State University, (503) 725-4288. If you have questions about the study itself, contact Monte Bassow by email at bassow@pdx.edu or by mail at the Speech and Hearing Sciences Department, Portland State University, PO Box 751, Portland, OR 97207.

Your signature indicates that you have read and understand the above information and agree to take part in this study. Please understand that you may withdraw your consent at any time without penalty, and that, by signing, you are not waiving any legal claims, rights or remedies. The researcher should provide you with a copy of this form for your own records.

Signature

Date

Appendix D Informed Consent form for Parents

Formulario de Consentimiento Para Padres

PARTICIPE EN UN PROYECTO IMPORTANTE:

Como mejorar a servicios de hablar y lenguaje para niños que hablen español.

Monte Bassow, estudiante de Maestría en Ciencias del Habla y Audición, de Portland State University, le invita participar en este proyecto porque:

- Usted tiene un niño/a que habla español quien está recibiendo terapia de hablar o lenguaje.
- Usted está interesado/a en mejores servicios para niños quienes reciben terapia de hablar o lenguaje.

El investigador es Monte Bassow, y el proyecto le permitirá completar un requisito de el programa de maestría en el Departamento de Ciencias de Hablar y Oír en Portland State University. La investigación será bajo la supervisión de la Doctora Gildersleeve-Neumann, (Ph.D en terapia de hablar y lenguaje) del Departamento de de Ciencias de Hablar y Audición.

¿Sí Decido Participar en el proyecto, Qué Tengo Que Hacer?

- Usted asistirá a un grupo de discusión que durará aproximadamente una hora. El investigador se va a hacer unas preguntas sobre las experiencias que Usted y su hijo/a han tenido con terapeutas de hablar y lenguaje quienes no hablan español. Se espera que Usted y los demás participantes van a compartir sus experiencias y tal vez hacer sugerencias para mejorar los servicios. Se va a grabar la conversación con cassette-audio, para hacer más fiel la transcripción de sus ideas y los de los otros.
- Es posible que usted o otros miembros del grupo comparte sentimientos fuertes sobre su hijo/a y los servicios que recibe. Por eso, pedimos que todos respetan los sentimientos de los demás y que no comparten los detalles del discusión con personas quienes no asistieron al grupo.
- Habla con el investigador si va a necesitar alguien para cuidar a su niño durante la discusión. El proyecto va a intentar proveer cuidado de niño gratis en el mismo sitio que la discusión.

¿Porque Participar?

- El beneficio más grande de este estudio no es directo. Se espera que el proyecto, va a beneficiar a los niños hispanohablantes quienes tienen impedimentos de hablar o lenguaje, y a los terapeutas quienes trababajen con ellos.

¿Que Hace Ud. Para Proteger Nuestra Privacidad?

Su privacidad es importante para nosotros. Hacemos muchas cosas para proteger su privacidad.

- Para reducir la posibilidad que opiniones críticas sean oídas por personal del programa de temprana intervención, el grupo tomará lugar en un sitio neutro.
- Toda la información que obtengamos de este estudio y que pueda ser conectado a Ud. que puede identificarle será totalmente confidencial.
- Esto quiere decir que los nombres de las personas conectadas con este estudio no serán dadas a ningún otra persona. Nadie más tiene acceso a esta información.
- Todos los videos, audios, y papeles escritos serán guardados en un archivo con seguro en Portland State University. Sólo usaremos la información recibida de participantes para esta investigación y educación.

¿Y Sí Tengo Preguntas?

Si Ud. tiene dudas o problemas sobre su participación en este estudio o sus derechos como una persona que participa en investigaciones, por favor llame: The Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 111 Cramer Hall, Portland State University, (503) 725-4288. Si tiene preguntas sobre el estudio en si, contacte a Monte Bassow, por correo: Speech and Hearing Sciences Department, Portland State University, PO Box 751, Portland, OR 97207, por teléfono: (503) 725-3230, o por correo electrónico: bassow@pdx.edu.

¿Por Qué Tengo Que Firmar Esta Forma?

Esta es una forma de permiso. Su firma a continuación indica que:

- Ud. ha leído esta forma, o alguien se le ha leído a Ud., y que Ud. comprende su contenido.
- Ud. quiere participar en este estudio.
- Ud. sabe que no tiene que participar en este estudio. Y aunque Ud. nos dé permiso hoy, Ud. sabe que puede cambiar su decision de participar en cualquier momento.
- Ud. recibirá una copia de esta forma.

 Firma

 Fecha

 Testigo

 Fecha