AAC *for* ALL

Culturally and Linguistically Responsive Practice

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San Diego, CA 92123

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Website: https://www.pluralpublishing.com

Typeset in 10.5/13 Minion Pro by Flanagan's Publishing Services, Inc.
Printed in the United States of America by Integrated Books International

Library of Congress Cataloging-in-Publication Data:
Names: Mindel, Mollie G., author. | John, Jeeva, author.
Title: AAC for all : culturally and linguistically responsive practice / Mollie G. Mindel, Jeeva John.
Other titles: Augmentative and alternative communication for all
Description: San Diego, CA : Plural Publishing, Inc., [2022] | Includes bibliographical references and index.
Identifiers: LCCN 2021030980 (print) | LCCN 2021030981 (ebook) | ISBN 9781635502855 (paperback) | ISBN 1635502853 (paperback) | ISBN 9781635502930 (ebook)
Subjects: MESH: Nonverbal Communication | Speech-Language Pathology—methods | Communication Methods, Total | Culturally Competent Care
Classification: LCC RC423 (print) | LCC RC423 (ebook) | NLM WM 475 | DDC 616.85/5—dc23
LC record available at https://lccn.loc.gov/2021030980
LC ebook record available at https://lccn.loc.gov/2021030981

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Introduction to *AAC for All*

This country has always been populated by diverse communities, initially (and still) with the various and distinctive nations of Indigenous Native Americans who populated this land, followed by waves of early immigrants wearing the hats of both colonizers and refugees. In modern times, the United States (U.S.) continues to be shaped by waves of diverse international immigrants and regional migrants. This flux of populations can be felt both personally and professionally, with its contribution to the changing demographics of our local communities and schools.

The vast physical size of the U.S. has further contributed to regional differences, creating numerous microcultures through cultural transmission of local congregated groups. The current estimated national population is 328 million (U.S. Census Bureau QuickFacts: United States, 2019), with 8% of all U.S. students identified as having a speech and/or language disorder (American Speech-Language-Hearing Association [ASHA], 2015). As the overall national population increases, along with miraculous advances within the medical field, trends demonstrate exponential growth in members of the population presenting with severe communication disorders (Boyle et al., 2011; McNeilly, 2016). More and more speech-language pathologists' (SLPs) caseloads are bringing them into contact with children with complex communication needs (CCN). There is increased awareness within the field of communication disorders of the necessity to adapt our practices to better serve a diverse population. This perception holds true for children who require augmentative and alternative communication (AAC) tools for functional communication.

AAC is using other means beyond verbal speech in order to communicate. ASHA (n.d.-a) describes AAC as including "all of the ways we share our ideas and feelings without talking." People use AAC as an augmentative tool when they use it to support their existing speech, and as an alternative tool when verbal speech is absent or nonfunctional. AAC is often divided into two broad categories: unaided (gestures, signs, facial expressions, vocalizations, etc.) and aided (systems using objects or photos, communication boards, communication books, text-to-speech or symbol-based voice output systems, etc.). With some debate, aided AAC can be even further divided into the subcategories *no-tech, low-tech, mid-tech, and high-tech*. The majority of students who use AAC, and one could argue all people, are multimodality communicators, using a mix of aided and unaided communication (Table 0–1) (Loncke, Campbell, England, & Haley, 2006). Beukelman and Mirenda (2013) approximate that 1.3% of the population (approximately 4 million people) require AAC tools to communicate for daily functioning for a variety of pragmatic purposes. Additionally, there's a greater prevalence of children under the age of 5 requiring AAC than school-age children (Binger & Light, 2006). The increasing number of children with CNN identified as benefiting

Table 0–1. Categories of AAC

No-Tech AAC	*Low-Tech AAC*	*Mid-/High-Tech AAC*
UNAIDED • Vocalizations • Facial Expression • Body Language • Gestures • Manual Signs • Silence	AIDED • Pictures/Photographs • Objects • Communication Boards/ Books • Printed Visual Scenes • Text/Writing • Braille	AIDED • Single-Message and Sequencing Voice Recorded Devices • Static MultiCell • Tablets With Communication App • Smartphones • SGDs (Speech-Generating Devices) • Computers

from AAC may be a result of increased awareness of AAC interventions, as well as rapidly evolving medical and technological advances.

In this book, the authors consider AAC users to be individuals who use augmented tools of communication as they present with limited or no verbal speech, reduced intelligibility of speech, limited range of communication functions, limited receptive language abilities, echolalia, and/or challenging behaviors secondary to a wide range of congenital or acquired conditions. The AAC users the authors will focus on are those who use AAC to communicate and also have culturally and linguistically diverse backgrounds.

There is also a heightened awareness of the need for culturally responsive practices among SLPs. Through university accreditation, Certificate of Clinical Competence (CCC) maintenance, and adherence to ASHA's Scope of Practice and Code of Ethics, an emphasis has been placed on developing cultural competence and responsiveness to the individual needs of culturally and linguistically diverse (CLD) clients (ASHA, n.d.-b; ASHA, n.d.-c; ASHA, 2016). Although advancements in technology and the corresponding research demonstrating the efficacy of AAC tools for children with CCN have resulted in many more students using AAC, these tools are not adequate to meet all of our students' needs. Students whose cultural and/or linguistic backgrounds do not match those of the majority population (White/Euro-descent, monolingual English-speaking, middle-class, hetero-nuclear family, etc.) have been largely ignored by product developers and researchers. We see that narrow point of view reflected at the institutional level in the U.S. public school system: public schools embrace a culture of English-monolingualism and Eurocentric instruction, despite the presence of numerous students classified as English learners (ELs) and less than half of all students in the United States identified as "non-Hispanic White" (U.S. Census Bureau, 2019).

We see the shifting national demographics reflected in our school caseloads, but not in our profession's membership (Table 0–2). Only 7.5% of ASHA members, associates, and affiliates self-identified as members of

Table 0–2. Detailed Demographics of Students Versus Professionals

Demographics of ASHA Constituents	*White (non-Hispanic)*	*Asian*	*Black/ African American*	*Multi-racial*	*American Indian or Alaska Native*	*Native Hawaiian or Other Pacific Islander*	*Hispanic or Latino*
ASHA Members	91.7%	3.0%	3.5%	1.4%	0.3%	0.2%	5.8%
Student Demographics*	47.1%	5.3%	15.1%	N/A	1.0%	N/A	27.1%
Discrepancy	44.6%	–2.3%	–11.6%	N/A	–0.7%	N/A	–21.3%
Bilingual Provider	79.6%	14.3%	3.0%	2.2%	0.7%	0.2%	43.9%

*Student demographics data taken from 2018 and includes K–12 grades.

Source: ASHA, 2021a, 2021b

a racial minority, and only 8.0% met the ASHA definition of bilingual service providers, with 66.2% of those providers being Spanish speakers (ASHA, 2021a; ASHA, 2021b). Yet nationally, the percentage of White students has steadily decreased to 48.2% (U.S. Census Bureau, 2019). That number fluctuates regionally; for example, looking at the states with the highest levels of CLD populations (i.e., Texas and California student populations are 72.6% and 76.2% CLD, respectively) and those with the middle and lowest levels of CLD populations (Wisconsin and Maine have a CLD student population of 30.7% and 12%, respectively), we see that there is great regional variability (DataQuest, n.d.; Educate Maine, 2020; Texas Education Agency, 2019; Wisconsin Department, n.d.). Looking again at the national numbers, we see that the ratio of SLPs to students who are both CLD is 1:6.5, without even considering that the specific cultural or linguistic characteristic of that dyad's membership may very well differ from each other. This cultural mismatch creates challenges and can lead to miscommunication or disadvantages when the child comes to school (Schachner et al., 2016). As a result, misunderstandings regarding family values, needs, priorities, and resources may occur from the schools' and professionals' perspectives, and misunderstandings regarding school expectations, goals, resources, and obligations may occur from the family's perspective. The negative impact of cultural mismatch between the school and home can be mitigated through active acquisition and ongoing development of cultural competence by the clinician and school stakeholders (i.e., a staff person or a group of staff people who have an active role in the success of the student).

For students with CCN, having access to an AAC system can provide them with improved access to the world they live in, socially, educationally, and vocationally. The processes of identification, assessment, intervention, and engagement for students who use AAC are complex and dynamic. The additional barriers that are in place to support students who are CLD and needing an AAC system are compounded by the lack of supportive research, limited systems designed specifically to support CLD students, a dearth of community outreach and education about AAC, and the minimal diverse representation within the field of communicative disorders. Through training and the dynamic acquisition of cultural competency, clinicians can build a culturally responsive practice. When accessing a dynamic culturally responsive practice, clinicians are better able to support family and community stakeholders in supporting the students' communication through an AAC system by identifying and developing opportunities for authentic communication that can meet both functional and social purposes.

Supporting engagement through social communication across all environments will increase stakeholder buy-in and decrease the potential for device abandonment, particularly as the student matures into adolescence and adulthood. Most families of individuals who use AAC do not feel adequately supported by professionals who are well versed in AAC systems. The cultural barriers that exist between professionals and CLD families make it even more challenging for families to feel adequately supported by SLPs/AAC professionals (Mandak, O'Neill, Light, & Fosco, 2017). Professionals should be aware of the many differences that families from CLD communities present, as compared with the "majority" European American family, especially with regard to how disabilities and interventions of the disabilities are stigmatized and valued in their lives (Pickl, 2011).

Use of Terminology

Writing this book in the midst of a rapidly changing social landscape has posed the challenge of selecting inclusive terminology. This selection process is complicated by regional differences and the lack of homogeneity in preference by the very individuals we are attempting to speak to or highlight. Furthermore, whether certain labels are deemed appropriate and preferable is often determined by who the speaker is and who the listener is. We, the authors, have first-hand experience with these complexities through our own experiences as individuals who are CLD. Selecting the terminology used throughout this book to describe individuals who identify themselves as members of a particular social group was a process that needed to expand beyond our personal experiences. We researched extensively through a process of discussion, literature reviews, ethnographic interviews, and even a deep look at popular culture trends to ultimately settle on the terms used in this book.

One area we looked at extensively was in the use of "person-first" versus "label-first" language. Individuals who prefer a person-first label may wish to have it recognized that they are human beings first and foremost, regardless of their disability or differences, which they feel does not define who they are as individuals. On the other hand, there are plenty of individuals who find using identity-first language as empowering. It is a way of reclaiming a label that may have a negative connotation more generally, and these individuals are declaring that they have nothing to be ashamed of and feel proud of their identity as a person belonging to that particular group. Additionally, for those who wish to highlight their intersectionality, there may be a preference for identity-first language. Our decision to use person-first language rather than identity-first language when referring to students who use AAC is not intended to exclude or deny the preferences of those who prefer the identity-first terms. Rather, as non-members of the social grouping of individuals with complex communication needs who use AAC, we felt it more appropriate to use the person-first labels to describe members of those groups. Therefore, throughout this book, we have selected the terms "student who uses AAC" or "persons who use augmentative and alternative communication (PWUAAC)."

Similar considerations went into selecting cultural and racial terminology. Labels have the ability to include and exclude, empower and disempower. Individuals may identify with one label when they are with others who are a part of their "in-group," and yet choose to use and prefer to use a different term when they are in a mixed group. For example, one of the authors will generally accept and use the term "Jewish American" when in a mixed or public setting, but identifies as an American Jew when just among other Jewish people. That is the author's preference, but as a reflection of the heterogeneous nature of any given ethnic group, there are those who would have a different preference altogether. Similar differences and nuances can be viewed among all cultural and racial groups: African American or Black, First Nation or Native American or Indigenous Persons, Hispanic or Latino or Latinx, and so on. Ultimately, we selected the terminology that was most commonly socially accepted by both those belonging within the social groups and by those outside those social groups. With the fast pace of changing language and terms, we attempted to select the terms that will have positive longevity and reduce confusion among the readers.

A final note on the use of terminology involves the ubiquitousness of the term "culturally and linguistically diverse (CLD)." This term is used throughout this book and is typical in the professional literature and clinical practices of not just speech-language pathologists but also overlapping educational and health professionals. In the U.S., the term is used as a catch-all for individuals who are not Mainstream American English (MAE) speakers, do not identify as White, are not members of the more common Christian faiths, and/or do not identify as cis-gendered or heterosexual. We have embraced this term in the face of a lack of a good alternative, yet those categorized as such find this term highly problematic. Referring to someone as "CLD" prefaces them as the "Other" with a different cultural and/or linguistic experience than the "standard" of White/European American/Christian/Cis-Heterosexual/MAE-speaking population. We question how someone who uses the dialect of MAE is not considered linguistically diverse when compared with someone who uses African American English (AAE) or another dialect of American English. We question how someone who is immersed in the White American cultural experience is not also considered culturally diverse compared with someone who is Asian American or an immigrant from Guatemala with her own cultural centering of Self. This Othering of those from diverse backgrounds who do not reflect the Self of those coining these terms reflects the demographic realities within not just the field of speech-language pathology but also the greater fields of education, medicine, and general academia. The cultural biases of the academics and professionals are reflected in the term "culturally and linguistically diverse" in an unconscious act of in-group/out-group categorization. Alas, though we are uncomfortable with the term "culturally and linguistically diverse," no other appropriate alternative term is as yet readily expressed and easily interpreted by those reading this book.

Moving Through the Chapters

Chapter 1, "Professional and Cultural Competence for the AAC Provider," focuses on the cultural influences, including professional biases, that can affect all clinical activities as they pertain to AAC assessment and use. Clinicians may often find themselves working in communities where a cultural mismatch (i.e., the student and the professionals do not share language or culture) exists. With the understanding that culture is dynamic and that evidence-based practice is ever-evolving, clinicians need to continuously develop and grow their cultural competency as a foundation of professional competency. These are foundational platforms for a culturally responsive practice and are necessary to be effective in clinical application and efforts to facilitate family involvement when working with CLD students. The objective of this chapter is for the reader to gain a deeper understanding of the concepts of culture, cultural dimensions, and cultural responsibility.

Chapter 2, "Differing Perspectives on Disability and ACC," provides an in-depth understanding of culture and its role in the various perceptions of disability. These inherent perceptions of the origins of disability dictate whether the family seeks out interventions and whether they engage in or completely avoid active discussions with AAC professionals. This chapter also discusses the role of religion, socioeconomic status/social class, and generational status in families' views on communication as well as intervention. The use of assistive technology

in the home and the community presents unique challenges for families, depending on their disability perspectives.

Chapter 3, "Language Diversity in Context of AAC," allows the reader to examine the relevant research in the areas of bilingualism, second and multiple language acquisition, as well as code-switching related to communication disorders and its application to students from similar CLD backgrounds who use AAC. This chapter discusses the negative long-term impact of actively promoting subtractive bilingual environments (where the student has an English-only environment at school and exposure to the minority language or dialect only at home, but is not actively supported with his AAC system to maintain and develop both languages) and provides suggested alternatives. We also discuss in some detail the barriers presented in assessment and implementation of AAC due to a lack of multilingual and multicultural AAC materials as well as AAC providers.

The assessment process for selecting an AAC tool is a complex and comprehensive one in which several considerations regarding the skills and abilities of the potential user, the environments in which communication will occur (including the communication partners), the tasks that the user will be engaged in while using an AAC tool, and the many features of the tool are documented. Chapter 4, "Culturally Responsive Assessment for AAC," walks the clinician through the process of an AAC assessment with a heavy focus on additional considerations that need to be made during the assessment process that are specific to potential students using AAC who belong to CLD communities. Clinicians will need to consider the developmental patterns of language in multilingual students and will need to consider how these languages are interwoven into several highly specific contexts of the student's life. This chapter discusses the importance of a comprehensive ethnographic interview process, outlines recommended guidelines for observations across environments and communication partners, and includes suggested assessment tools professionally available and resources for dynamic assessment with the child.

As an integral part of the intervention process, Chapter 5, "Communication Partner Training," discusses the influences of the many communication partners in the lives of students who use AAC, the level of family interdependence, and the values/perceptions about disability of all communication partners. Discussions about the importance of communication partner training and the partner strategies that families of these students will need extensive training in are also included. This chapter reviews considerations that need to be made while designing culturally responsive communication partner training modules in more than one context or environment with professional *tips* for the clinician. Typically, the discussion around communication partner training follows a review of intervention strategies. With the intent to highlight the importance of bringing families into the process right from the beginning when supporting students who are CLD, the authors purposely positioned this chapter before Chapter 6, "Practical Implementation of AAC in CLD Populations." Through this chapter, the authors intend to clearly indicate that training communication partners is one of the most important parts of the early planning process and can essentially guide the success of the overall intervention process.

Chapter 6, "Practical Implementation of AAC in CLD Populations," discusses the need for active collaboration with the various teams that will be creating and learning about communication opportunities for the student using AAC. This chapter identifies

the barriers to culturally sensitive implementation of AAC that have been identified by CLD families. Through personal experiences and perspectives, we explore the many cultural expectations and assumptions we must reevaluate and consider as culturally responsive AAC professionals. This chapter also explores the importance of including culturally responsive materials/curriculum, using collaborative processes and considerations during vocabulary selection for the AAC systems in the CLD populations. Additionally, this chapter reviews a variety of intervention models, such as school-based interventions, home-based interventions, as well as consultation and collaboration.

Chapter 7, "Concluding With a Global Perspective," looks into international perspectives and practices to better explain the experience of cultures outside the U.S., and the immigrant experience within. This chapter explores AAC as a global practice in order to demonstrate that AAC is an internationally used intervention and not unique to the U.S. We provide strategies to support the clinician's development of cultural literacy with practical ideas of engaging within the local immigrant community in which the clinician's students and their families belong, which is best accomplished through engagement with the families and their community. Becoming familiar with the experiences of our students both prior to immigration and in their current communities will assist clinicians in providing culturally responsive services to their students.

Conclusion

Although the changing demographics and increased number of CLD students using AAC on our caseloads can present a challenge for many clinicians, we see this as an opportunity for growth rather than a condition to fear. Clinicians should look to their own cultural perspectives and consider the journey of cultural competence as an additive to their personal culture and worldview, rather than as subtractive. All cultures and languages are dynamic and that includes one's own. Rapid social change necessitates flexibility and a willingness to be open to new encounters, even when it places clinicians outside their comfort zone. This book can be a guide for clinicians, both as a practical roadmap to a culturally responsive AAC practice and as a source of inspiration for continued professional growth.

This book was written in two sections. The first section looks closely at the foundational topics that shape the reader's perspective and understanding of the intersectionality of culture, language, disability, and AAC; the second section provides guidance on the direct application of those concepts. Designed to be read in a linear fashion, each chapter builds upon the foundation of the previous chapter. However, each chapter also functions as stand-alone text that is available to be referenced as needed. Many of the chapters are enhanced with the additions of *Insights* (which are based on the experiences and professional perspective of the author of the chapter as a practicing clinician), *Perspectives* (contributing authors' professional perspectives based on their clinical experiences), *Explorations* (an author's detour to explore an introduced concept in greater depth), and *TIPS* (*To Implement Proper Strategies*, a direct author tip for clinical application of a discussed strategy). Additionally, resources are made available through a companion website, including sample worksheets, resource lists, and templates to support your AAC practice.

This book aims to provide practical resources and references for clinicians who

seek a culturally responsive practice that they can apply to their students who use AAC. With a joint focus on cultural and linguistic access for all of our students who use AAC, grounded in evidence-based research and deeply influenced by our own practice as school-based SLPs working within diverse communities, we have squarely placed our own professional perspectives and hands-on experiences into this text. For some clinicians, this book will be a welcome addition to their robust professional library, whereas for others it may be the sole text that explicitly addresses either CLD or AAC topics. There are many excellent texts and resources available that focus on those two topics individually, which may be an excellent starting point for the newly curious clinician. This book is not intended as an introductory text to either of these topics, but rather as an excellent source of information and insight for clinicians who are looking to deepen their professional practice through an exploration of the intersection of AAC and CLD considerations. We wish you well on your journey to provide "AAC for All."

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1 Professional and Cultural Competence for the AAC Provider

Mollie G. Mindel

Introduction

The professional competence guidelines outlined by the American Speech-Language-Hearing Association (ASHA) require speech-language pathologists (SLPs) to conduct their practice informed by engaged cultural competence (ASHA, 2017). Practitioners are expected to provide culturally responsive services (i.e., identification, assessment, intervention, counseling, advocacy, management) to all their clients, regardless of clients and practitioners' cultural identification. Typically, the cultural identification of the client and practitioner differ from each other, creating a dyadic cultural mismatch. Instances of cultural mismatch can raise tensions within the client-provider relationship, as intercommunication misunderstandings regarding family values, roles, priorities, and resources may occur. These misunderstandings can be exacerbated by hidden professional biases. As Riquelme (2013) describes: "The dynamic between provider and patient often is compromised by various sociocultural mismatches, including the providers' lack of knowledge regarding the patient's health beliefs and life experiences and the provider's unintentional and intentional processes of racism, classism, homophobia, and sexism" (p. 44).

Cultural mismatch is a pervasive demographic arrangement within the field of speech-language pathology (Figure 1–1) (Fannin, 2016; Mindel & John, 2018). The demographic profile of ASHA demonstrates that the majority self-identify their race as White (91.7%), with the next most populous groups self-identifying as Black/African American (3.5%) and Asian/Asian American (2.8%) (ASHA, 2020a). As a whole, 94.7% of ASHA constituents self-identify as "Not Hispanic or Latino," and of the 5.9% of SLPs meeting the ASHA criteria of bilingual service providers, 61.3% are Spanish-language service providers (ASHA, 2019). These demographics are not proportional to the broader demographics of the U.S. Considering the homogeneity of SLPs (i.e., White female), clinicians should consider cultural competence *as* professional competence.

Because SLPs increasingly work with a culturally and linguistically diverse (CLD) population of clients, a professional review of relevant cultural and professional topics is needed. This chapter provides an overview of the concepts of *cultural competency*,

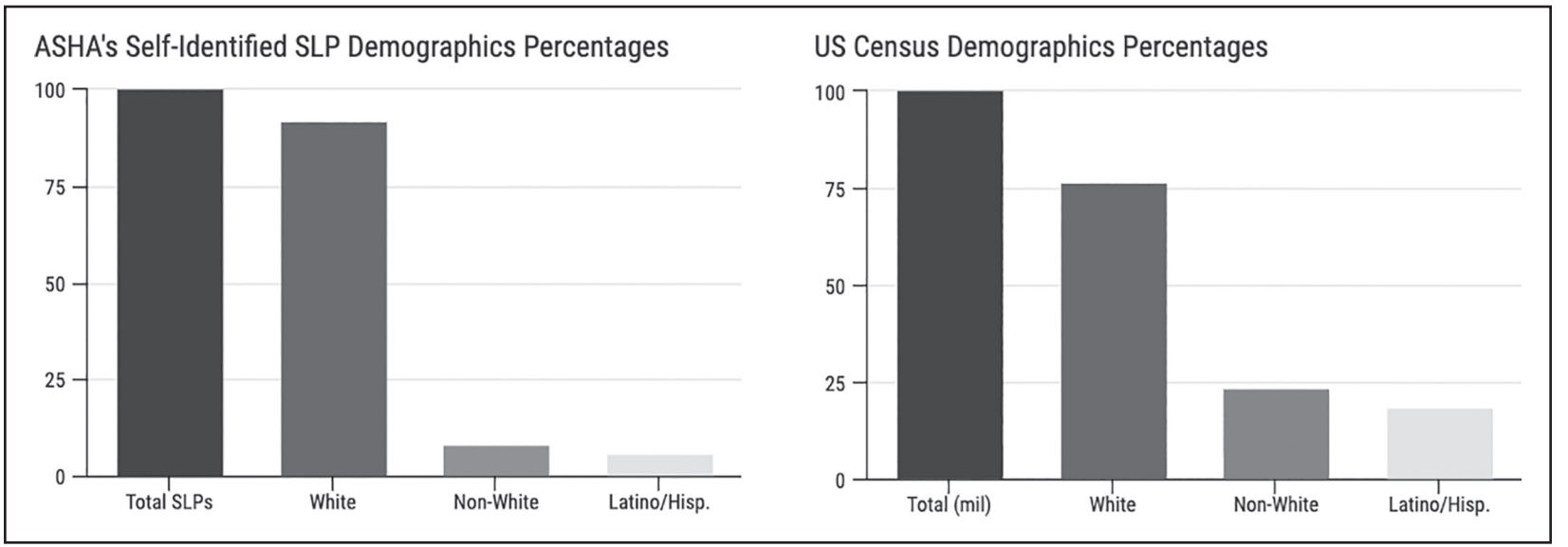

Figure 1–1. Cultural mismatch, a pervasive demographic arrangement within the field of speech-language pathology, is highlighted in the contrasting charts of ASHA SLP demographics and U.S. Census Bureau demographics.

the stepping stones that lead to developing a *culturally responsive practice*. Professional competence through cultural competence is explored and shown as being applicable to supporting all of a clinician's students, regardless of race/ethnicity/linguistic diversity and regardless of the need for augmentative and alternative communication (AAC). The roles and responsibilities of SLPs in delivering culturally responsive practices are discussed within the context of ethics, professional biases, and the dynamic nature of building cultural competence. Frameworks and resources on cultural dimensions are reviewed to assist clinicians in self-developing their own process toward building their cultural responsive capacity.

Professional Roles and Responsibilities to CLD Clients

ASHA provides guidance for SLPs in understanding the role of culture and cultural linguistics within our scope of professional practice. SLPs' goal is to provide evidence-based practices (EBPs) for clients, which involves a dynamic integration of three equally weighted components: (1) research/scientific evidence, (2) clinical experience/opinion, and (3) client/caregiver perspective (ASHA, 2005). The client/caregiver perspective will be influenced by their cultural factors, as is the clinician's, both of which must be taken into consideration in order to maintain the three-pronged EBP model. More specifically, EBPs for CLD populations who use AAC should be framed as incorporating (1) current research on culturally responsive practices in AAC, (2) clinician's experiences when working with a specific population, and (3) family/cultural values and beliefs.

Further guidance is provided by ASHA's Code of Ethics, which outlines the role of cultural competence as a required framework of behaviors, attitudes, and policies for engaging in effective cross-cultural situations (ASHA, 2017). The Code of Ethics specifies that all clinicians must engage in culturally competent practices that are not merely nondiscriminatory but also demonstrate respect and responsiveness to "an individual's values, preferences, and language" (ASHA, 2017). Explicitly it states:

> Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect. (ASHA, 1970)

The Code of Ethics is guided by the framework's ethical principles of professional responsibility toward those we engage with, both as coworkers and clients, in a manner that is nondiscriminatory in assessment, treatment, and advocacy. The Code of Ethics provides the guidelines for ASHA-certified SLPs' work as they engage with others across their professional practice and domains of service delivery (ASHA, 2016).

ASHA's Code of Ethics is also aligned with the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF). The ICF is an internationally recognized disability framework applicable for all global populations by recognizing both the physical element of disability and the context (environmental and personal factors) that impact a person with a disability (ASHA, 2016; WHO 2001, 2014). The ICF is an important guide on international disability and health policy

making. SLPs should be aware of the framework's principles, both for its supporting role in ASHA's outlined Scope of Practice and for the potential influence it may have provided to the experiences of immigrant families prior to their transition to the U.S.

The Cultural Competence Journey

In Hyter and Salas-Provance's excellent textbook, *Culturally Responsive Practices in Speech, Language, and Hearing Sciences* (2019), the authors discuss the process of developing one's cultural competence. They describe cultural competence as the ability to take a client's cultural perspective, including beliefs and values, into consideration throughout the educational and/or therapeutic service. Furthermore, they emphasize that obtaining cultural competence is not a static concept, but that a clinician's cultural competence will change and fluctuate as the clinician encounters new cultures or cultural experiences. They propose that the acquisition of the skills needed to continuously develop cultural competency is required to provide a culturally responsive practice (Figure 1–2).

Cultural competence changes and fluctuates as the clinician encounters new cultures or intercultural experiences and also as

Figure 1–2. These steps underline the development of a culturally responsive practice.

cultures naturally change. Like the concept of cultural competence, culture is a dynamic entity defined by collective characteristics, knowledge, beliefs, and traditions that are socially transmitted and reinforced within a group; but it is also influenced by outside cultures. ASHA (2020b) outlines the steps for developing cultural competence: (1) clinicians' self-assessment, including both personal history and social influences, (2) an understanding of how those factors influence clinicians' perceptions of their clients' communication and abilities, and (3) an understanding of how personal perceptions may lead to biases impacting clinicians' communications and services with their clients. Hyter and Salas-Provance (2019) also provide a roadmap for developing a culturally responsive practice, which the authors describe as "a circular staircase where each step is another stage on the continuum" (p. 26). The imagery of a staircase can imply a beginning and an end, but the image can be expanded to include an infinite number of interconnecting stairways that may take the clinician in different directions of exploration (Figure 1–3). Those steps toward a culturally responsive practice include cultural humility, self-awareness, cultural knowledge, cultural reciprocity, and culturally responsive services. The steps toward a culturally responsive practice do not follow a straight path, but rather one that takes clinicians in many directions and requires a state of self-reflection.

Figure 1–3. The image of a spiraling staircase is used as an analogy of cultural competence.

Perspective—Elizabeth Uduehi, MS, CCC-SLP, MBA

For the first time in 23 years, I was no longer considered a minority in my community. It was my first day of work as a speech-language pathologist during my clinical fellowship (CF) year, and I had just been granted the temporary position of registration clerk for the morning. My CF supervisor used the three minutes it would take to walk from my newly decorated speech room to the front office to explain the basic roles and responsibilities of registering all the new faces. Already overwhelmed from the 1,001 new things I had learned in new hire orientation to setting up beginning-of-the-year paperwork, I was actually relieved to just greet families and hand out paperwork that they needed to fill out.

As family after family stepped into the office, this newly hired CF, who had just graduated from her second predominantly white institution (PWI) and who grew up in a predominantly white Midwestern city, was pleasantly surprised to see a flood of black and brown faces greet me for their first day of school. I remember meeting a very sociable and confident first grader who told me all about her family's move from her last district. When I admitted that "Today is my first day," we instantly related; and she smiled and took her time to reply, "Me too!" through what I instantly observed to be blocking and sound prolongations After receiving her finished paperwork, I soon realized I had just checked in one of the students on my caseload.

For the next four years in that district, I attended campus sites from preschool to the adult transition program, serving students and adults who largely identified with Black and Brown cultures and communities. As time passed, I grew more conscious of how my own identity as a Black, Nigerian American, SLP of color made my ability to relate and create culturally appropriate activities and assessment tools more easily for the students on my caseload who shared similar cultural norms and beliefs. We openly discussed and practiced the benefit and beauty of code-switching between dialects. Before Thanksgiving I sent home communication boards that had sweet potato pie and greens as fringe words, and I used current news articles on topics ranging from recent mass ICE deportations to Black Lives Matter to facilitate their ability to retell story details, infer the definitions of vocabulary new to them, or to answer wh-questions.

In the comfort of those formative years, I grew assured in my ability and identification as a culturally competent SLP. I understood the advantage I had over some of my non-Black and/or persons of color coworkers in my ability to relate more easily with the students and families I sat with in IEP meetings and assessed or for whom I provided training.

When I decided to move to other districts, however, my cultural competence was checked.

In a new environment, geographically, regionally, and culturally I began to reach out to the families of students on my caseload. Although my social and collegiate experiences involved close associations with a variety of cultures and demographics, I soon learned that my personal relationships with those who did not share the same culture as I did

were not enough to help me understand the variety of cultural norms and practices as a whole.

I soon learned this lesson, however, as I eagerly prepared materials for one of my first parent trainings in my new district. I had found a wonderful core vocabulary series that highlighted a different core word through a target theme in each book. As I searched with excitement for the core word that would be the most functional and motivating one to use, I chose the book on "More," which encouraged students to add a variety of pizza toppings throughout the story by expressing "More" on each page as we read. The symbol system matched the one in their AAC communication app, the pictures were salient enough to be easily understood although they were 2D, and I even had access to a color printer so that the pepperoni was the right shade of red and the cheese was the right shade of yellow. It was perfect, so I thought.

I glided through my parent training agenda, highlighting prompting hierarchies and appropriate wait times. I answered questions that the parent had throughout the activity and asked some of my own. After giving what I believed was a very informative training, I began to really observe the student. He hadn't looked particularly excited as I had observed in my former students when we discussed pizza. To reassure myself and the quality of the materials I had nicely prepared, I asked the mother if she thought this book would be useful at home for AAC practice. After a brief silence, I could tell she was looking for the words to politely reply, "To be honest, my son is a poster Asian boy. At home, he mainly eats rice."

I had spent time reading his background concerning his disability; I had double-checked the home language survey to make sure I considered all languages he might use receptively, expressively, or be exposed to; and I had even chosen a motivating activity like food to ensure a "fail-proof" activity that would definitely keep him engaged. But I had not considered how this Filipino American boy, whom I often observed eating breadsticks and burgers at school, would eat something different when he went home and ate around the dinner table with his family.

In that moment and several moments after that training, I realized that even as an SLP of color and a child of immigrants, those cultural identities did not grant me a general license to be culturally competent across different demographics, even if those demographics were similar to mine. I owe each and every student the due diligence to not only be professionally competent in providing evidence-based practices as related to their needs but also provide culturally appropriate services and interventions that best serve them.

It is not enough to understand only the disability, we must also understand the culture to which each of our students relates. Regardless of our cultural identifications, we must make sure that the same level of research we apply on a child's disability is applied in understanding the child's cultural diversity. Both of these variables, culture and disability, will help to drive the AAC interventions we recommend and mold us to be the best AAC team members we can be, regardless of our ethnicity, religion, and gender.