2021

Assessment planning by speech language pathologists: Implicit bias and clinical decision-making

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Assessment Planning by Speech Language Pathologists: Implicit Bias and Clinical Decision-Making

by

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Thesis

Submitted to the Department of Special Education

& Communication Sciences and Disorders

Eastern Michigan University

in partial fulfillment of the requirements

for the degree of

MASTER OF ARTS

in

Communication Sciences & Disorders

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June 9, 2021

Ypsilanti, Michigan

Acknowledgements

To Dr. Ginsberg, there is not enough thanks I could say to express my gratitude. You were a support both academically and emotionally, especially in lieu of the COVID pandemic. You always believed and encouraged me kindly and sincerely any time I doubted or was ready to quit. I hope to be as devoted and passionate as you are to both your students and clients. Your work is not in vain, as you have helped mold me into a better clinician, as many other students before me.

To my committee members, Dr. Sanders and Dr. McGinnis. I have been inspired by your contributions to the greater community. Thank you for the support and interest you have shown in my research from the beginning. Your input has been highly valued throughout this process.

To the Special Education and Communication Sciences & Sciences department. The passion and dedication you have in instilling the foundational knowledge and skills is not futile, nor without recognition. Thank you for the hard work and support you have into helping us succeed in the classroom and beyond.

To Bill and Dee Brehm. Your generosity has impacted me more than just financially. Thank you for creating a support system for students in higher education. The belief you have in us scholars has pushed us toward success, contributing important research to the discipline of special education, ultimately impacting the communities and children we serve.

To my participants, thank you for stepping into this research opportunity. I gleaned so much from each of your assessment processes and thoughts. I strive to be the culturally competent and considerate speech-language pathologist you showed me you were.

To my culturally diverse friends, thank you for offering me a place in your space. In sharing your experiences, you showed great vulnerability and kindness as I reflected on my own

prejudice and misunderstandings. Thank you for the impact you have had on my life in bringing so much joy, hope, and humbleness. I am so thankful I can do life with you. I hope that together we can continue to make the world a space for all.

To my dad and mom, I promise all of you hard work in raising me, providing support in a multitude of ways, will not go without reaping fruit. I literally would not have been able to make it through grad school without you. Thank you for sharing in the excitement and hard work as I hit each milestone.

To Amanda, thanks for always cheering me. You have been my sister, best friend, counselor, and favorite roommate. Even in being a new momma, you made time to listen to my stresses, remind me to be grateful, and most importantly, hopeful in what is to come.

And finally, to God, for your unending forgiveness and grace. Thank you for revealing your Truth to me and making me into a new creation. I pray my love will continue to be refined and ultimately reflect Christ's love.

Abstract

The following thesis is comprised of three research articles focused on the topics of implicit bias, clinical-decision making, and cultural competency in the field of speech-language pathology. The first article is a reflection piece in which I thoughtfully lay out my journey towards cultural humility in addressing my biases through different educational and personal experiences. The second article presents and discusses the results of the qualitative research I conducted on speech-language pathologists looking at the effect of implicit bias on clinical decisions. And finally, the third article discusses the importance of having cultural humility rather than cultural competency, specifically regarding self-reflection and critique in addressing one's bias, two components of cultural humility.

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Article #1: My Journey Towards Cultural Humility

Abstract

My path to becoming culturally humble both personally and professionally as a speech-language pathologist required and continues to require critical reflection of my biases. I began addressing these biases and prejudices in the classroom as an undergraduate student. I was first challenged both through instruction and by listening to my peers' stories. This reflective practice continued by having direct experiences with multicultural people when I studied abroad in undergrad. During my graduate studies, I completed a qualitative study looking at implicit bias in clinical decision-making by speech-language pathologists. Although participants showed emerging cultural humility in their practices, the results of the study suggested a greater need of addressing one's biases and reflective practices by speech-language pathologists. Parallels between my journey toward cultural humility and my participants' may provide insight in ways we can improve in this field in overcoming our biases and becoming culturally humble clinicians.

Introduction

The door opened as the professor walked in: 6 feet tall, spiked hair, and one earring. Immediately he entered the room and shook our hands one by one, introducing himself. He then addressed the class, asking us what our first impressions of him were and what reasons we had for making those assumptions. I believed he was going to be unreasonably tough and unapproachable. However, by the end of the class, I could see how far from the truth that was. It was the start of the semester of learning about my own biases and empathetic understanding of the experiences of those culturally different from me.

In the beginning of my graduate career, if you asked if I had any prejudices, racially or otherwise, I would have exclaimed, "Of course not!" And I most assuredly would have been in the collective of those with a positive self-report rating, but negative implicit associations (Walden et al., 2020; Hall et al, 2015). It was not until I took a class that addressed the diversity of society, intended for teacher education students, that I really began to dissect these implicit attitudes and began this journey. Its impact went beyond those 6 weeks of class, as it was one of three influences that transformed me as a person and as a speech-language pathologist professionally. It was in that classroom that I had to face the hard reality that I did have prejudiced views towards other communities, such as the communities of African Americans and Asian Americans. As a class we analyzed the current societal systems in place and how certain races/ethnicities were more likely to succeed in those systems; however, the most influential component of this class was the opportunity to listen to the experience of my peers, specifically those of color. In actively listening to their stories, I had to humbly compare them to my own realities and beliefs. They challenged me to see outside my circle and to see through their lens,

their skin. Although I wasn't the White antagonist in their stories, I started to see a reflection of my own thoughts and actions embracing those stigmas or behaviors unknowingly, even though I did not explicitly support them.

In addition to this class, I listened to a Christian sermon that addressed the need for racial reconciliation in our nation. As the pastor talked, I saw many parallels in what he spoke and in what I was learning in my class. He stated it was our duty to step outside of ourselves and pursue real relationships with those unlike us. The challenge to overcome bias and move towards empathy and acceptance was now present in an educational setting and in my personal life. The conviction of prejudice and the call for humility were the same, and as a Christian and fellow human being, I wanted to repent and walk in Christ's light, loving not just those who are like me.

As I continued this personal reflection and journey, I began to seek out ways into which I could bridge the gap with peers from diverse backgrounds. I grew up in a predominantly White neighborhood and had a lack of experiences and relationships with people who were outside that suburban bubble. One particular transforming experience I had was when I became interested in Korean culture. Previous to that class, if you had asked, I had never wanted to travel or visit Asian countries. This changed as I began to learn and understand more about the country, its people, culture, and language. This was a step I only took in light of that class and sermon. I reflected on why I had previously felt disdain towards these nations, and realized with shame, it was because I didn't *understand* them. It was uncomfortable, as the differences in our beliefs, history, and customs were so different, they challenged my own ways of life. However, as I pressed on, I could begin to appreciate and celebrate those differences. I recognized the unique beauty and perspectives they contributed to our society.

This change led me to living in South Korea for a year during my undergraduate career. The call for cultural critical reflection (ASHA, n.d.; Tervalon & Murray-Garcia, 1998) was intensified; every day I had to practice humility (Agner, 2020; Tervalon & Murray-Garcia, 1998) in learning their ways of life and the contrast to everything I had known. It was not always easy, but I gained irreplaceable relationships and experiences that impacted me personally and professionally. On a personal level, my relationships with Asian and Asian Americans colleagues and friends grew, and I saw firsthand the racially and culturally driven prejudices toward them. The realities my friends faced were not just facts and stories I was distanced from, now they were personal, as I saw how they affected them. I wanted to continue to address my own biases and help others in my community to do the same.

Upon returning home to finish my final year of undergrad, the influences from the course, experiences in Korea, and my relationships with my friends further motivated me as a future SLP and sparked passion for serving multicultural communities. I decided to complete an undergraduate thesis, which focused on the assessment and treatment of multicultural populations. I wanted to research how to most effectively provide for these clients, as I could not rely on my own cultural instincts and assumptions. This was another important step towards embracing cultural humility as a professional.

In moving forward with my communication sciences and disorders education in graduate school, I continued this research but concentrating on biases, specifically implicit bias, and its effect on clinical decisions in speech-language pathology, as there has been correlational evidence in other health care professions (FitzGerald & Hurst, 2017). Bias is a critical component to address in showing cultural humility (Agner, 2020; Boysen & Vogel, 2008). By understanding bias and how it may manifest, steps could potentially be taken to mitigate its

influences. Therefore, I designed a qualitative study using case vignettes in an attempt to identify patterns of implicit bias during assessment planning by SLPs. Participants had to think aloud as they processed and formed a plan of assessment for each clinical case presented with a child of a different race/ethnicity. As I began analyzing the data, the results I found were unexpected.

In total, I had six participant data to analyze and code. At my first attempt of making sense of the data, I continually tried to pull out evidence of negative implicit bias affecting the behaviors and decisions of the participants. My assumption was that there must be implicit biases manifesting, I am just not recognizing them, which was true. Through triangulation with my committee members, I was then able to see the subtle ways implicit bias was present in the interviews. However, what surprised me was that there was the lack of supporting evidence of negative implicit bias affecting the decisions in assessment planning. Seemingly contradictory, participants who expressed the most knowledge, relative to other participants, of cultural differences, also exhibited more implicit bias in their thoughts and behaviors. This exemplifies the conundrum of cultural competency in which the knowledge one gains on cultural differences in order to become culturally competent, may begin to shift into strong associations with a specific group (Tervalon & Murray-Garcia, 1998). As I explored possible explanations for this, themes emerged regarding the participants' coursework and clinical experiences, like my own journey. They had both the knowledge and understanding of cultural differences and took some opportunities to practice it in their experiences with multicultural populations; however, knowledge and experience are not enough to overcome bias alone, critical self-reflection of one's own bias must be a part of the process as well.

Although the results of my study cannot be largely generalized, it may suggest the need for explicit education on the role of self-reflection in deconstructing one's biases and the need

for opportunities to practice that skill. The results of the study still provide hope, as participants showed a willingness and desire to be culturally humble. Practices in education and clinical settings have continued to be refined in providing awareness of biases and steps toward cultural competency over several decades. The parallels between my journey and the participants in my study may suggest ways in which we can continue to improve in this area in order to keep moving toward progress and cultural humility.

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Article #2: Implicit Bias in Assessment Planning by Speech-language Pathologists

Abstract

When comparing the current demographics of the U.S. and the representation of that cultural diversity in American Speech-Language-Hearing Association-certified speech-language pathologists, there is a clear dissonance, as most clinicians are White. This requires clinicians to practice cultural competence by understanding differences and providing appropriate services. Implicit bias is a component of being culturally competent that is necessary to address. This type of bias can manifest unconsciously and affect a person's thoughts and actions. The current qualitative study used clinical vignettes in an attempt to capture and understand the role of implicit racial bias in the assessment planning of culturally and linguistically diverse populations by speech-language pathologists. There was evidence of implicit bias in participants' "think alouds," but evidence of negative implicit biases impacting decisions in assessment planning was absent; however, using grounded theory, explanations for these results were explored. Themes found among participants included (a) cultural awareness and emerging responsiveness and (b) educational and clinical experience.

Introduction

As of 2019, 91.8% of certified speech-language pathologists (SLPs) in the US are White (American Speech-Language-Hearing Association [ASHA], 2020). In Michigan, the percentage of White, ASHA-certified SLPs is approximately 95% (ASHA, 2020). These numbers are not reflective of the current cultural diversity in America with the United States Census Bureau estimating that in 2019 only about 60.4% of the US population identified as White Non Hispanic or Latinx, 18.3% Hispanic or Latinx alone, 13.4% Black alone, 5.9% Asian alone, 1.3% as American Indian and Alaskan Native alone, and 0.2% Native Hawaiian and Other Pacific Islander alone (United States Census Bureau, 2019). Therefore, it is imperative that one considers the discrepancy of cultural difference between the potential diversity of clients and the servicing SLP, including how this may impact assessment and treatment of these clients. The SLP should accommodate this difference by being culturally competent.

Cultural competence is defined by ASHA as "understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professional and client/patient/family bring to interactions" (ASHA, n.d., para. 1). Although ASHA holds SLPs responsible for being culturally responsive as a standard of certification (*Standard IV-B*; ASHA, n.d.), it is the SLPs ability to recognize a client's diversity, how that impacts the client's performance in the evaluation and diagnostic process, and subsequently adjust assessments and treatment plans as appropriate to provide the best services for the client. Furthermore, it is also a key component of *Principle of Ethics II: Rule D*, stating, "Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills" (ASHA, 2017, Guidance section, para. 13; ASHA, 2016b). Although cultural competence is not

explicitly used in this statement, ASHA (2017) further described this rule as it pertains to serving culturally and linguistically diverse populations, stressing that as professionals, SLPs are to constantly expand their understanding and abilities to provide services competently. In 2016, a survey was conducted in the K-12 schools asking SLPs to rate how qualified they felt they were to serve multicultural populations on a 5-point scale (1 – *not at all qualified*, 5 – very qualified; ASHA, 2016a). Results of the survey showed that only 12% of the participants rated themselves a 4 or 5, with those professionals being more likely to be in urban or city areas. These results suggest that steps must be taken to increase the confidence of SLPs to provide services to multicultural populations.

Being culturally competent requires communication sciences and disorders (CSD) professionals to consider bias. The term *bias* refers to a preconceived attitude toward something or someone, whether positive or negative (APA, n.d.). A person may show bias toward another's gender, religion, ethnicity/race, language, or even weight (FitzGerald & Hurst, 2017; Hall et al., 2018). Bias can be further categorized as explicit or implicit depending on the level of consciousness by the person exhibiting it (FitzGerald & Hurst, 2017; Gawronski & Bodenhausen, 2006). Both explicit and implicit biases affect the thoughts and actions of a person; however, a person exhibiting explicit biases is fully conscious of it. A person exhibiting implicit bias is unaware, as they manifest unknowingly, and may even be considered untrue by the person (FitzGerald & Hurst, 2017; Gawronski & Bodenhausen, 2006; Guedj, 2021). Implicit biases are considered associative processes in which "automatic affective reactions [result] from the particular associations that are activated automatically when one encounters a relevant stimulus" (Gawronski & Bodenhausen, 2006, p. 693). When presented with external stimuli, specific negative or positive associations may be activated. The associations activated depend on

the stimuli presented and the "preexisting structure of associations in memory" (Gawronski & Bodenhausen, 2006, p. 693).

The person exhibiting negative implicit bias may disagree with the allegations themselves (Cunningham et al., 2004, as cited by Gawronski & Bodenhausen, 2006). This can be seen when a person self-reports positive explicit bias but has negative implicit bias, or more negative associations, towards a population. An example of this is seen in assessing explicit and implicit attitudes in SLPs and untrained listeners (non-SLPs) towards stuttering and people who stutter (Walden et al., 2020). Explicit attitudes were assessed through self-report ratings regarding an adult who stutters and one who does not stutter. The clinicians had positive attitudes towards the adult who stuttered and more positive attitudes towards the person who did not stutter. Implicit attitudes towards stuttering were assessed through the Implicit Association Test (IAT) and reported to be negative (Walden et al., 2020). The results of Walden et al.'s (2020) study show the importance of studying both types of biases, especially implicit attitudes as people are unaware of them. A person may consciously want to treat everyone the same, but negative implicit attitudes interfere with their understanding, actions, and behaviors (Hall et al., 2015; FitzGerald & Hurst, 2017; Maina et al., 2018). Clinically, an SLP's own implicit bias may affect the assessment, treatment, and decisions consequently affecting the services the client receives and their treatment outcome.

There is an exiguous amount of research examining implicit bias in CSD. One study was done by Evans et al. (2018) in which they studied the effect of race on the assessment of children's speech, comparing SLPs to clinically untrained listeners. All participants were presented with the children's speech samples; however, they were either presented with no visual stimulus, a picture of an African American child's face to imply the use of African American

English (AAE) dialect, or a European American child's face to suggest the child does not use AAE (Evans et al., 2018). The participants rated the accuracy of the speech and then completed a questionnaire (to assess knowledge of AAE) as well as the IAT. The IAT was conducted to determine if implicit bias would affect speech accuracy ratings. The researchers hypothesized that those with negative implicit and explicit bias towards African Americans and AAE would have stronger penalizing ratings when presented with the African American child's face (Evans et al., 2018). However, they found that these measures were not predictive of speech ratings by either the trained (SLP) or untrained listener (non-SLP). Speaker race did affect the assessment by both trained and untrained listeners, but in an affirmative way. That is, when presented with the African American child's picture, the child's speech was more accurately rated with less penalties (Evans et al., 2018).

Broadening the search regarding implicit bias beyond speech-language pathology to health care in general yields additional relevant literature. In a systematic review of studies on implicit bias within health care professions, almost all of the studies revealed implicit bias in nurses and physicians regarding race/ethnicity, gender, socioeconomic status, age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury, intravenous drug users, disability, and social circumstances (FitzGerald & Hurst, 2017). Correlational evidence also suggested that biases may affect diagnosis, treatment, and amount of care.

A systematic review targeting studies specifically looking at implicit racial/ethnic bias, again in health care professionals consisted of 15 studies; 14 of which revealed health professionals exhibited low to moderate levels of implicit biases toward people of color (Hall et. al, 2015). Thirteen studies found that there were stronger associations between Black Americans

and negative words than White Americans and negative words, meaning there was greater negative implicit bias towards Black Americans. In four studies reviewed, "health care professionals associated Black Americans with being less cooperative, less compliant, and less responsible in a medical context" (Hall et al., 2015, p. 71). These associations could have the potential to affect patient health care outcomes; therefore, further research into the relationship between implicit attitudes and patient health care outcomes is needed (Hall et al., 2015).

Historically, previous studies relied on the IAT as a measure of implicit bias. The IAT calculates the "strength of associations between concepts (e.g., black people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy)" (Project Implicit, n.d., About the IAT section, para. 1). A person who categorizes the majority of negative words with Black people, then they would report with negative implicit bias towards Black people. However, this does not necessarily mean the person's behaviors are predictable; Oswald et al. (2013) found that the IAT had poor predictability for discriminatory behaviors. Although it still provides insight on initial subtle unconscious responses, the IAT may not predict "who will discriminate against whom" (Oswald et al., 2013, p. 188). Therefore, since recent research suggests that it is not a good predictor of behavior (Oswald et al., 2013; Walden et al., 2020), it was not used as a measure of implicit bias in this study.

Research Question

The purpose of this study was to learn about the impact of racial implicit bias specifically during the assessment planning of multicultural clients through the presentation of clinical vignettes. The client population targeted in the case vignettes were young pediatric cases presenting with a language impairment. This research was completed in an effort to contribute to our understanding about how implicit bias might impact the planning of an assessment for

children who presented with similar language disorders but represented different cultural and linguistic backgrounds.

Method

Individual interviews were conducted via Zoom and the case vignettes were presented using the *share screen* feature. Participants were shown the child's presenting language characteristics and a picture of the child that indicated their race; see Table 1 for a synopsis of each child. They were then asked to explain how they would assess the child's language. Analysis of interview transcriptions were approached using grounded theory in an attempt to provide possible explanations regarding the patterns present in the data (Bryant & Charmaz, 2019). More recently, case vignettes have been used to capture implicit bias and may yield higher validity than the IAT (FitzGerald & Hurst, 2017; Maina et al., 2018). Therefore, a qualitative study was designed using clinical cases (Tanner, 2017) and the IAT was not used as a measure of implicit bias.

Table 1

Synopsis of Cases

Clinical Cases		
Jesse	**Xavier**	**David**
European American; 3 years old	African American; 4 years old	Asian American; 2 years 7 months old

Participants

The participants of this study were solicited by email and social media posts following protocols approved by the IRB (see Appendix A for IRB approval letter). A total of six participants were recruited (see Table 2). All participants were women; were ASHA-certified

SLPs in the Midwest, West, and South of the U.S.; and had at least 2 years of experience working with pediatric populations. The current work settings of participants included school-based, private clinic, and hospital settings. The participants represented experiences in a range of geo-spatial areas, including urban, suburban, and rural (Chi, 2012; Hall & Lee, 2010; United States Census Bureau, 2010). Participant ages ranged from 26 to 29 years of age.

Table 2

Participant Demographics

Participant Pseudonym	Age	Race/Ethnicity	Years of Experience in Pediatrics	Experience in Geographical Spaces	Current Setting
Penelope	27	White	2 to 5 years	Urban	School
Kiri	29	White	2 to 5 years	Suburban	Private Clinic
Breanna	27	White	2 to 5 years	Suburban & Urban	School & Private Clinic
Miranda	26	White	2 to 5 years	Suburban & Urban	Private Clinic
Cassidy	26	White	2 to 5 years	Rural & Urban	Hospital
Sandy	27	Asian	2 to 5 years	Suburban	Government-contracted Private Clinic

Data Collection & Analysis

Each vignette was presented with a picture representing the child. Three races were represented: European American, African American, and Asian American (see Appendix B). A small paragraph was provided detailing each child's age, their current language abilities, and who referred them. When needed, the following probes were used: *What are your initial thoughts about the cases? What steps for assessments would you take first? What questions*

would you seek to answer? Are there any specific assessments or protocols you would like to include in the plan of assessment? Based on the information provided, what prognosis would you give each child? Follow-up questions to further understand the participants' thought processes and decisions were used, as necessary.

Data were collected through the "think aloud" (TA) approach (Aitken et al., 2011; Forsberg et al., 2013; Ginsberg et al., 2016) and audio recorded. Research has shown that the TA method may provide better results in capturing data on decisions not easily observed (Aitken et al., 2011). Aitken et al.'s (2011) study of observation and TA as methods for gathering data provided evidence that clinical decisions require an evaluation of options, which results in an action once the clinician chooses an option. These internal evaluations are difficult to observe without the participant thinking aloud, which may provide a better framework in identifying the structure of associations in participants' memory (Gawronski & Bodenhausen, 2006). It provides not just the decision, for example, choosing a standardized assessment, but the reasoning that leads the clinician to that decision. Therefore, the participants were asked to create an evaluation plan out loud and verbally express their thoughts as they processed the vignettes. They had to reason why they asked certain questions and made certain clinical decisions (Lee & Ryan-Wenger, 1997). Audio files were transcribed by a professional transcriptionist. Transcripts were analyzed for repeated patterns and topics, for example, in words or thought processes, and then assigned labels, or codes, to categorize these occurrences (Bogdan & Biklen, 1998). These emerging themes were identified to bring to light discrepancies that occur during assessment planning and the influence of ethnicity in that process regarding implicit bias (Bogdan & Biklen, 1998).

Results

The results of the study showed evidence of implicit bias in participants' thoughts as evidenced by their "think alouds" (TAs). As implicit bias is the activation of associations with a concept or stimuli, as participants began describing certain client populations or factors, associations were made and generalized (Gawronski & Bodenhausen, 2006). Although implicit biases were evident, clinical decisions were not affected by these biases when planning an evaluation for each child.

Implicit Bias in Participant "Think Alouds"

There was evidence of subtle implicit bias in three of the participants' TAs. As some participants began considering cultural factors, they began to use language that indicated strong associations between certain populations and cultural expectations, especially regarding socioeconomic status (SES). One participant, Miranda, who pointed out bias exhibited by a coworker, began to make strong generalizations about the culture of people of lower SES: "If you are thinking about a low SES area, the culture is different. If they were raised a certain way that it's not important to call ahead and cancel. And that's cultural; it's not disrespectful." This was a strong association with lower SES and people of lower SES not calling to cancel an appointment. Another participant, Breanna, when talking about the lack of exposure regarding language, admitted that the population at her urban school affects her assessment: "I try not to let [it affect my assessment] but honestly if I am going to give the expressive vocabulary test, I know they are not going to do very well on it. Because they don't have the vocabulary."

Similarly, Sandy discussed SES and illustrated strong associations with place and the child's language abilities:

> If a child is living in section 8 or in very low-income neighborhoods, then you kind of know that a child may not even recognize what a puzzle is because they've never seen a puzzle. ... a lot of times, in my report, I'll have to write "no opportunity to." So it's almost not a valid item. You can't really test it because a child won't know.

In another instance, Breanna referred to the lack of exposure in the urban city she works in, where many families are of lower SES. She explained there is "exposure to things that we consider normal for kids" and provided an example:

> So like going to the zoo and knowing the names of zoo animals. So I have 4th and 5th graders that are in gen ed and not self-contained classrooms that can't identify a picture of an elephant. And it's purely exposure. If you ask them if they've ever been to a zoo, they haven't.

Miranda talked about how she likes to meet the parents when evaluating a child, as it provides insight into their daily life. Parent interviews can provide critical information; however, the participant made a statement that may allow implicit bias to manifest in clinical decisions later in service delivery:

> Then you can kind of see that, "Oh this parent is pretty involved and I think it's going to go well" or "this parent doesn't necessarily seem to care much about their child," which unfortunately happens and so you will know… like don't make a home exercise program because it won't be carried over.

Clinical Decisions in Assessment Planning

Although there was evidence of implicit biases in participant TAs, there was a lack of evidence of racial implicit bias impacting the decision-making specifically in planning an evaluation. Except for a few guarded prognoses, most participants gave each child a positive

prognosis (see Table 3), with the majority reasoning that the children were at an emerging language age and would respond well to treatment. Xavier, the African American child, was the only clinical case to receive all positive prognoses from the participants. Participants had their own process of forming an evaluation plan and approached each individual case similarly with their unique assessment style. Clinical decisions or thought processes that would suggest discriminatory behaviors in response to the children's race/ethnicity were absent. On the contrary, there were positive decisions as a direct result of knowing the child's race/ethnicity. For example, when forming an evaluation plan for Xavier, the African American child, one participant began addressing the possibility of African American Vernacular English (AAVE; also referred to as African American English [AAE]), a dialect used by many African Americans characterized by unique morphological features and slang terms (Rickford, n.d.). The participant explained how a child speaking AAVE would influence her assessment decisions. Furthermore, the participants also considered other potential cultural factors beyond race/ethnicity that may impact clinical decisions, such as socioeconomic status. Although implicit bias was present in participants, they may not have influenced the final decisions made in forming an assessment. There were several characteristics found among the participants that may have contributed to this result. The following themes were determined: (a) cultural awareness and emerging responsiveness and (b) educational & clinical experience.

Table 3

Prognosis for Each Child by Participants

Participant	Presenting Child		
	Jesse	**Xavier**	**David**
Penelope	"Good prognosis"	"Good prognosis"	"Good prognosis"
Kiri	"Probably pretty good"	"Probably pretty good"	"He would definitely be excellent honestly"
Breanna	"Good prognosis"	"Good prognosis"	"Good prognosis"
Miranda	"Fair-moderately good"	"Pretty good"	"Pretty good"
Cassidy	"Good prognosis"	"Pretty good"	"Good"
Sandy	"Can make progress but..."	"Good prognosis"	"It's going to take a lot of practice. But I think he does have some potential."

Cultural Awareness and Emerging Responsiveness

During assessment planning, three participants were thoughtful about the possible impact of cultural differences regarding the child's exposure to a different language or dialect as well as the impact of SES. They explained why it was important to consider these factors, their influence on assessment planning, and the effect they could have on assessment results and treatment planning. One additional participant mentioned that a child should not be penalized for speaking another language but did not provide practical steps she would make in the assessment to prevent this. The following subthemes were identified: (a) language/dialect, (b) socioeconomic status and exposure.

Language/Dialect. Participants expressed the importance of knowing if a child speaks another language/dialect at home or not. They acknowledged that this information is critical in providing an accurate diagnosis and treatment plan. When provided Xavier's case, Breanna, who works in an urban city, explained how AAVE should be considered:

> You are going to hear a lot of errors which aren't errors because of African American Vernacular English if he uses it. So, I would use a screener to point out the sounds that are missing are not errors. And then you would also have to ask the parents if they use AAE at home or not; if that's the dialect they use. Because not all families do.

She scores and reports on her assessments differently to provide an accurate representation of the child's speech and language since the standardized assessments do not account for this dialectical difference. She reports the actual score and then reports a second score, "recalculate[ing] taking out all of the AAE errors." Breanna continued explaining how previous assessments on her students were not sensitive to this dialectal difference resulting in "so many kids in [urban city] that qualify but should not qualify because that is AAE."

Sandy did not specifically address AAVE; however, she did express that she would ask about languages spoken at home and how this contributes to their diagnosis:

> I'll also ask about language exposure in all three cases. Is there another language in the home? Because oftentimes language delays can… It might seem like a delay but it's not a delay because they are exposed to a second language.

Sandy was mindful of how she prompts a child both when a child may speak a language other than English, but also she was aware of micro differences that occur within regional dialects:

> The other thing too is words are regional - soda, pop, cola, rubbish, garbage, trash. But that's to be mindful too because what words are they using. Because if I prompt a child

> and I say rubbish… "Can you throw it in the rubbish?" It's a very nonchalant thing to say but if it's a family who is military and they just came from Texas, they might not say rubbish. So, I have to be mindful of how I prompt a child.

She continues on how a simple word like "mama" needs consideration:

> So, we have a lot of Asian cultures here and sometimes mama is referred to [as] grandma and not mom. Versus some Hispanic/Latino cultures, mama is their mom- biological birth mom. So, I always have to clarify if a child says mama, who is that in reference to?

Sandy stated how she takes this lingual information from the parent/guardian and tailors her therapy to it. She "[doesn't give] the family the word to say," but rather, she asks what they want their child to say, and works on eliciting those targets, as "there are a lot of different words they might be using." She also described how cultural differences can affect the clinician-client relationship during assessment and treatment. Families are hesitant to ask questions because they "feel like the [clinician] has authority." When asked how she responds to this uneven power dynamic, she explained the importance of rapport, letting them know she "genuinely want[s] to know how [they] are doing."

Miranda, a bilingual SLP, made note of ethical issues in cases where a child speaks a different language at home, relaying a professional experience with a client who had a previous SLP that was uninformed about bilingualism:

> I have this one case and she was 2 and it was truly a bilingual family---like 50 [percent] English and 50 [percent] Spanish---and the mom went to an English-speaking SLP… he evaluated [the child] with the PLS in English and she scored below average, and he still didn't pick her up for services at [that] time because she is "just confused because you won't stop speaking to her in two languages."

She continued to describe how she received this child a year later on her caseload. She chose to do the PLS in Spanish because many parents expose their children in preschool and below more to their native language "because they know that once they get to school, they are going to be exposed to more English." She explained how even in Spanish, the child scored low: "She scored so low that she didn't score. It goes to 55 and then it's like anything lower than that just is a less than sign."

Miranda explained the impact of the SLP's decisions, who was "completely uninformed about bilingualism," on the child's development and how it is unethical to test a child in English when it is not their native language:

> She could have been getting services for a whole year but now she is almost 3 and just started speech therapy a couple years ago because she finally came to me. And so there is a great need in our field for people to at least be aware of if a kid speaks another language… if you can't give an evaluation in the child's native language, you shouldn't give that evaluation or you shouldn't give it unless you have a translator present. It's unethical.

Not only did Miranda consider this at the clinical level, but also thoughtfully evaluated the bias towards bilinguals as a greater issue due to race/ethnicity in the area she works. She explained the area includes a lot of Mexican and Puerto Rican people who speak Spanish, and there is a stigma against bilingual people.

> I don't know if that's systemic racism playing into play because it is a really conservative town- conservative in a way that doesn't support the side of politics that is against people of cultures. Not that all conservatives are like that but it very much leans towards a culture that doesn't support people who aren't White. I don't know if that's because of

> the culture of the area that they just decided that they don't care about bilingual people or what it is but generally, the research is showing that if they are delayed, they are delayed.

Socio-Economic Status & Exposure. Some participants considered other different influences beyond language and dialect. Sandy explained how she caters her assessment plan to children in lower-income areas. She recognized the potential impact SES may have on the child's development and has made her "sensitive to what a child may be exposed to." She will ask certain questions in the assessment, such as what toys they have at home:

> Also when it comes to therapy. It plays a big role in therapy. Not saying that socioeconomic status depicts how much toys or lack thereof you have but it's really thinking about what do they have in their home that you can use. So we don't bring any toys into the home. The only time we bring toys in is when we do our evaluation because it's standardized. So when we are in the home, I always ask, "what kind of toys do they have?"

Breanna reflected on how the results on standardized language assessments are impacted:

> Now that I think about it, it can affect language assessments because there are parts of the CELF [Clinical Evaluation of Language Fundamentals] and stuff... it's identifying some pictures. It's hard! You're saying it's a language impairment based on a lack of exposure? Which honestly, they do because it's impaired vocabulary.

Miranda also recognized the impact of SES and how difficult it is to negate one's biases. She recounted a former co-worker who refused to work with Medicaid patients:

> I feel… it's really hard to get rid of your biases, right, because there was also another SLP that worked at our company who was not white herself but refused to treat Medicaid

> patients because they are unreliable… People on Medicaid are… this, that and the other thing.... They don't show up and they are poor.

Miranda continued to point out how culture is different in low-SES areas and was thoughtful in expressing possible barriers the children may have affecting their ability to fully participate in the therapy process: "Or if they can't afford the gas or if they don't have internet. Like when we shut down for Covid, we were doing online therapy, I lost a lot of kids because they didn't have internet."

Educational & Clinical Experience

As participants made clinical decisions, many of them shared the different facets they would explore and consider. There was a common pattern of exposure in the classroom and experience in clinical settings that guided their thought processes for each client. Subthemes were identified as (a) academic coursework, (b) clinical experience, and (c) geographical space.

Academic Coursework. A few participants noted educational background and resources they received in their coursework that impacted how they plan assessments and make decisions. In particular, the courses included components, whether intentionally or not, that increased the clinicians' knowledge and ability to respond with cultural practices. Breanna referenced a book that may not have been required but possibly an optional reading during her collegiate studies: "Is it called Difference or Disorder?... It's a great resource. I don't know that we even used it in class but it's an awesome resource and it has a ton of different languages."

She explained how it has been a guide in making clinical decisions regarding differences in language and dialect:

> At my school in [the urban city]... we have a couple Arabic speaking families though, so it has that in there also, and it's a really good resource because you can just pull it up and

> it will show you things like [how] final consonant deletion is common with AAE. A /th/ substitution for /f/ in the final position is common.

Sandy, who went into detail about SES, also noted she has an educational background in which she gained knowledge and understanding of the impact of SES:

> So I was a public health major when I was in undergrad so then I get to see families and see how different aspects of their life can affect development and things like that so I kind of have a different lens on seeing development and family dynamics.

She provided an example of a family with a mom and dad who both have to work all the time, leaving grandma to care for the child. The "grandma's main job is to keep the child alive," she states, explaining that priorities are different.

Miranda also took a course during her graduate studies that addressed multicultural studies but did not feel it was necessary. She noted that people in the field "shouldn't need [it]" but should already anticipate these cultural differences going into the field regardless:

> When I was at [my university], we had to take an entire semester of a multicultural class about how to… which I feel like if you are going into this field... You should realize ahead of time you're going to have to serve all populations equally and fairly.

Clinical Experience. Along with coursework in undergrad and graduate school, participants also had clinical experience with multicultural clients. Participant experiences included diverse people regarding race/ethnicity, language, and SES. Penelope and Breanna both worked in an urban city with a large demographic of African Americans. Breanna related how the experience has made her more familiar with AAVE and how she learns from the students:

> I've worked in [urban city] enough now that I kind of just know a lot of them. There are still some, though that I've heard from my students, and I've heard it from multiple students, and I will say, "Oh, is that a characteristic of AAVE?" And sure enough, it is.

In Miranda's case, she has clinical experience with multilingual clients and clients of lower SES. She described her caseload as only being about 60% White. She has received many Spanish-speaking clients since she is bilingual in Spanish herself. However, she noted that her clinic has not only had Spanish speakers, but also Korean and Nepali speakers. Miranda is "more inclined to advocate for bilingual kiddos because of the misconceptions that [she's] seen." Regarding SES, Miranda also had substantial clinical experience with clients from lower SES backgrounds. At the location she worked, demographically, she approximated that "95% of [her] clients are on Medicaid."

She also described how these experiences, in particular, a clinical practicum in an urban city, have challenged her own biases, stating, "You're checking yourself everyday [there] for sure." She has had to evaluate her thoughts and correct herself. When asked how she overcomes her biases, she asserted:

> I think a big thing that helped me is I just tell myself every time I encounter something different than my own life, I just tell myself that my life is different. I can't empathize with that but I can try my best to sympathize. My job is to help that person and their kid and how can I do that to the best of my ability?

Sandy received experience in working with multicultural populations at her current location and where she completed her graduate education, which was in a different state. At her current place of employment, she conveyed that she has worked with "families that were Korean, Japanese, Samoan, Arabic." Her area also holds many military families, deepening the pool of

diversity she comes across. When she compared her current location to her graduate university location, she explained that she experienced greater SES diversity where her graduate school was: "You do get the range of socioeconomic… I think in [a western U.S. state] there was that socioeconomic diversity but I think in terms of ethnicity and language, it wasn't as diverse as here."

Another participant, Cassidy talked about the diversity of clients she has serviced since practicing, especially at her current place of work. She provided a picture of her diverse families and explicitly stated how it has contributed to her cultural competence:

> I have a very diverse caseload. I would say most races, different religions. I have Spanish-speaking families, I have Asian families- they don't speak Chinese or Mandarin or any bilingual- but I just have… all over the place so that kind of gives me a better way to be more culturally competent and also be able to serve many populations.

Kiri also has experience with a diverse caseload, estimating the demographics at her workplace: "I would say we are probably about 60% White and then I have maybe 10% Hispanic, 10% African American, 10% Indian, and then a couple Eastern European."

Geographical Space. Four of the six participants had experience in urban areas. One participant, Miranda, explained her experience in overcoming her personal bias in an urban setting compared to her current suburban area:

> Working in [the urban city]... you are checking yourself every day for sure. That was much more than I've had since I graduated and started my career up here. Being thrown into that environment in downtown [urban city] as a student, you are like checking yourself every time you have a thought.

Like Miranda, Cassidy also noted the difference in caseload in a rural area and urban area, expressing that her current position in an urban setting has provided a "very diverse caseload," which has given her a "better way to be more culturally competent and also be able to serve many populations."

Discussion

The intent of this study was to determine if patterns of implicit bias impacted clinical decisions during assessment planning. There was evidence that showed participants' thoughts and behaviors demonstrate implicit bias, especially towards SES; however, results revealed a lack of evidence suggesting implicit bias affecting final clinical decisions in the case vignettes presented. Participants showed cultural awareness and emerging responsiveness throughout the case vignettes. They contemplated how cultural factors influenced their plan of assessments and adjusted their practices accordingly. They expressed experiences they had both in the classroom and clinically that provided the knowledge and skills to practice cultural competence. Therefore, these emerging themes among participants may provide an explanation for this outcome.

Implicit Bias in TAs

When considering the definition of implicit bias in which "automatic affective reactions [result] from the particular associations that are activated automatically when one encounters a relevant stimulus" (Gawronski & Bodenhausen, 2006, p. 693), it is important to understand how it is being operationalized in participant TAs. For example, in the case of Sandy and her discussion on children from certain neighborhoods, the stimulus was the location a child was living. The association automatically activated is that children in low-income areas do not know what a puzzle is, therefore leading to the automatic assumption that the child she would be providing services to does not know what a puzzle is and that it cannot be tested. Although

Sandy may have experienced this with some clients, it is critical that these assumptions are not placed on every family living in those neighborhoods. Entering a home with these strong associations has the potential to impact the assessment. For example, if it is assumed a child does not know certain vocabulary, the clinician may decide not to test it at all, which would be harmful for children who do know those words even if they live in those neighborhoods.

Another example to look at is in Breanna's TA, in which she refers to normal experiences a child should have. Again, referencing Gawronski and Bodenhausen's (2006) definition of implicit bias in this example, the stimuli resulting in these associations were children who lack these experiences. The affective reaction of the participant was that it must not be "normal." This calls into question the idea of "normal" and what constitutes it. This participant may be drawing strong associations from personal experience and assumptions about childhood that may not be generalizable to all families and all children.

Miranda's approach when meeting parents does not explicitly indicate implicit bias; however, it increases the potential of implicit bias impacting other parts of service delivery, such as treatment interventions. If a family is not given a home exercise program based on initial interactions with the clinician, they are losing an opportunity to further support their child's needs. The participant allows a small first impression to determine treatment decisions. This clinician's mindset may lend itself to implicit biases the clinician has in affecting how she perceives the family.

Possible Correlation Between Cultural Knowledge and Bias

Three participants did not explicitly consider cultural influences nor show explicit patterns of them in planning assessments, rather, their assessments were straightforward, covering the basics (interview, family case history, observation, etc.), similar to other

participants, but lacking discourse about cultural factors. Moreover, compared to other participants, there was less dialogue between themselves and the interviewer. Although the participants lacked evidence of cultural knowledge and consideration of differences when forming an assessment, there was also a lack of evidence of implicit bias in their TAs. For one participant, this result may be because it had "been a while since [she had] thought about the really teeny tiny population," as she worked with school-aged children, with a majority being higher elementary. If provided with case vignettes of older-aged children, her assessment planning may have been expanded and provided more evidence supporting the presence or absence of culturally competent decisions and/or implicit biases. Additionally, this occurrence may also suggest that expanding knowledge about cultural differences with the intent of increasing cultural competency may lead to larger generalizations and stereotyping (Tervalon & Murray-Garcia, 1998), as other participants had revealed. Another explanation is that stimuli that activated stronger associations in the participants who illustrated implicit bias may not have been effective in activating implicit associations in the participants who did not exhibit implicit bias (Gawronski & Bodenhausen, 2006). Under different conditions (e.g., different age or race of clinical case, interview questions), these associations may be stimulated and revealed. Moreover, different conditions may result in implicit bias strong enough to impact clinical decisions in all six participants, especially if information on the children's SES background was provided in the clinical vignettes.

Cultural Awareness and Emerging Responsiveness

When considering the requirements of ASHA regarding cultural competence, the participants in this study were knowledgeable on cultural differences and took beginning steps in the assessment planning to account for the possibility of cultural differences clients may bring;

however, they still exhibited implicit biases towards certain populations. They were aware of the impact of culture and were still expanding their knowledge. This may suggest the participants are moving toward the stage of "cultural pre-competency" on the continuum of cultural competency (Cross et al., 1989, as cited by ASHA, n.d.). For example, Sandy explained how she asks the family what they would like their child to say for certain words, such as "hungry." This practice meets one of the specific responsibilities ASHA (n.d.) defines as attributing to cultural competence, which is "integrating clients'/patients'/families' traditions, customs, values, and beliefs in service delivery" (Key Issues: Roles and Responsibilities section; bullet point 5). Rather than telling the parent what word(s) she wanted the client to use, she has allowed the parents to share what they believe is valuable for the child's language expression. Even so, the same participant still presented with strong assumptions about families from lower SES areas regarding their language exposure and vocabulary. This is an area that needs to be addressed to further her ability to service families ethically.

Another participant, Breanna, recognized the language difference in her African American students who speak AAVE. She stated she does not penalize them for this difference but recalculates the scores to provide a more accurate description of their language and assessment results. This takes into account language differences and shows how the clinician adjusts assessments as appropriate; however, there are other areas that need to be addressed. Specifically, the expectations on what is "normal" for a child and the association of "normal" with specific experiences, without taking into consideration her own background, her strong associations with what experiences children should have and possible barriers in place that prevent children from having those experiences.

ASHA (n.d., 2016) also expects clinicians to critically assess themselves and the potential influence of their own biases. Miranda explicitly stated how she evaluates her biases when providing services, another example of a participant exhibiting cultural competence as a clinician. As she has awareness of bias and does actively check her bias, she is still unconsciously exhibiting bias. This may be because she has taken cultural knowledge and overgeneralized the information. Additionally, this participant equated "helping" a family with overcoming bias. The key to addressing one's bias is through critical reflection, providing services to a family one may have bias towards does not automatically negate the strong associations that have been activated.

Educational & Clinical Experience

Academic Coursework

Some participants in this study expressed how they received knowledge or exposure about different cultures and how to serve them through academic coursework and clinical practice. One participant also used the additional suggested resources not necessarily required in the curriculum of the class itself; however, she continued to reference the source when providing services to linguistically diverse clients. This engages two of the three facets of the model for multicultural counseling competency (Atkins et al., 2017; Arrendondo et al., 1996; Sue et al., 1992). Although Atkins was looking at cultural competency through a counseling perspective, the concepts run parallel to speech-language pathology. The model includes three parts: knowledge, skills, and multicultural awareness (Arrendondo et al., 1996; Sue et al., 1992). In the current study, some of the participants had coursework that provided the foundational knowledge and resources in understanding different cultural factors and servicing them. Breanna explained how she still references a book, although not required, from a class that has guided her clinical

decisions when assessing culturally diverse clients. Similarly, Sandy also noted her educational background: “I was a public health major when I was in undergrad so then I get to see families and see how different aspects of their life can affect development.” She explained how this cognizance has helped her better serve her clients as an SLP, especially regarding SES. This foundational knowledge gave the clinicians insight and understanding into the different perspectives and needs of clients with diverse backgrounds. Additionally, the use of other recommended readings as suggested by one participant’s multicultural course may suggest self-directedness in seeking out information to serve populations on her caseload.

It is also important to note that another participant expressed she thought a multicultural course was unnecessary as people should expect that they will be serving people of cultural and linguistic diversity. This shows different ways clinicians think about the benefit of taking a multicultural course and the content incorporated into the curriculum. Although this study did not look at SLPs’ views on multicultural courses, it is an area necessary for examination.

Considering the role academic courses may play in the development of cultural competency, current curriculum used in multicultural courses should be inspected. Not only should knowledge on different cultures be taught, but more critically, the curriculum should increase awareness on one’s biases. One intervention within the curriculum that may support these outcomes is the integrating of intergroup dialogue (IDG; Schmidt et al., 2020; Gurin, et al., 2013) with critical self-reflective practices (Ip, 2012; Oliver et al., 2021; Johnson & Richard-Eaglin, 2020). Dialogic processes theoretically activated in IDG are the engagement of self and the appreciation of differences (Gurin et al., 2013). The self is engaged through a “focus on personal sharing of experiences and beliefs and on taking risks by disclosing uncertainties and feelings” (Gurin et al., 2013; ch. 4). Differences are then appreciated through active listening and

seeking to understand the perspectives and experiences shared by other members participating in the IDG (Gurin et al., 2013). Regarding the critical processes, critical reflection is employed to evaluate the role of power and privilege in one's life, experiences, and the impact of current social structures (Gurin et al., 2013). Furthermore, alliance building between members is sought through identifying "both commonalities and differences that can be leveraged into collaborative relationships" (Gurin et al., 2013; ch. 4). As this framework already engages reflection, it should extend further by creating opportunities for participants to critically self-reflect on their own bias in light of the new perspectives, knowledge, and relationships gained through the dialogue. Self-reflection is not just examining one's experiences to another but thinking critically and reassessing one's experiences (Boud et al., 1985, as cited by Ip, 2012) and identifying implicit biases through the evaluation of the strong associations activated in the experiences (Gawronski & Bodenhausen, 2006). The integration of IGD and self-reflective practices together may promote cultural competency and decrease implicit bias in recently graduated clinicians, reducing the potential for implicit biases to negatively impact the services rendered in culturally diverse populations (FitzGerald & Hurst, 2017; Maina et al., 2018).

Clinical Experience

Participants were also marked by the clinical experiences they had with culturally diverse clients. The course(s) participants completed provided the basic knowledge in recognizing cultural differences, but these direct clinical experiences with multicultural populations provided the opportunities to refine the skills needed to serve them ethically and effectively (Kwong, 2009; Sue et al., 1992). Breanna used the resources in her course as she began servicing African Americans to help account for linguistic differences in the assessment process affected by AAVE; however, she then explicitly regarded her direct exposure as the

reason for the knowledge she has now: “I’ve worked in [urban city] enough now that I kind of just know a lot of them.” She was able to expand and strengthen the knowledge and abilities to respond to cultural discrepancies through experiences in ways the course was limited in doing so. She has learned directly from the students she has serviced and has modified her assessments accordingly. Cassidy and Miranda also explicitly expressed how clinical experiences with multicultural populations have contributed to their cultural competency and implicit biases. Cassidy stated, “I have a very diverse caseload. I would say most races, different religions… so that kind of gives me a better way to be more culturally competent and also to be able to serve many populations.”

Not only did the clinicians have experience with culturally diverse populations, four of the six participants had experience specifically working in urban settings. This is significant because it supports the findings in the school survey completed by ASHA (2016a), which revealed that SLPs who rated themselves higher in being qualified to serve culturally diverse populations were more likely to be working in urban settings. Therefore, the participants’ experiences in urban areas may explain the results of this study. The experience in urban areas may have provided a wider range of cultures, languages, and in SES than in suburban or rural areas (Hall & Lee, 2010; Kincheloe, 2010), which provided more opportunities to practice the skills of cultural competency (Kwong, 2009; Sue et al., 1992).

Family as an Asset

Participants expressed knowledge of cultural differences and influences of culture as gained from many sources, including coursework, additional readings, and clinical experience. They showed knowledge of cultural differences and began making changes in their clinical practice. However, one important factor absent from the discussion was the family being

serviced themselves. One participant, Sandy, briefly touched on how she has gathered knowledge from understanding family dynamics. Cultural competency is as much about acknowledging what one does not know regarding cultural aspects as it is what they know (ASHA, n.d.). Knowledge on cultures can only take the clinician so far, which is where the family's role is critical. Each family, their own dynamics, although influenced by culture, is still unique with their own lived experiences and cannot fit into cultural expectations by the clinician (Agner, 2020; Foronda, 2016). If participants had recognized the value the families bring themselves, their implicit biases may not have been as present in the interviews nor have the potential to impact service delivery. By maintaining family-centered practices, the families establish what unique cultural differences they bring, as well as their own strengths, and are, therefore, the most valuable partners in identifying what culturally relevant practices will best meet their child's and/or family needs. When clinicians approach service delivery this way, it is less likely that the clinician's biases will extend unwarranted onto families and burdening them with stereotyped expectations.

Age of Participants

It could be hypothesized that the lack of evidence of implicit bias impacting clinical decisions is due to the age of participants. Participant ages ranged from 26 years old to 29 years old. They were all relatively young clinicians, each having between 2 to 5 years of clinical experience. This is significant when considering what year(s) the clinicians completed graduate school. A historical look into the multicultural course requirement by ASHA may provide insight into this.

These clinicians graduated decades after educational programs were first voluntarily suggested in 1985 and then officially required by ASHA in 1994 (Stockman et al., 2004). This

has allowed time for universities and colleges to adapt to these requirements and refine their pedagogy and course structure. Additionally, research into effective educational practices regarding multicultural courses specifically in CSD have been established (Horton-Ikard et al., 2009). Therefore, it is possible these clinicians were exposed to multicultural courses and content that have more effectively addressed cultural competency than in clinicians who have been practicing for substantially longer. Comparatively, this would have given the clinicians a stronger knowledge of cultural influences and foundation for making culturally responsive clinical decisions, decreasing the impact of negative implicit biases.

The generational cohort of this group should also be explored. The participants in this study were born in the millennial generation and were one of the younger generations practicing in CSD, compared to baby boomers (Born around 1945 to 1958; Parment, 2013) or Gen X (Born 1961 to 1980; Gurau, 2012). Therefore, there may be generational differences in political views, education, cultural movements, and lived experiences (Milkman, 2017) that have influenced the participants' knowledge and response to understanding their biases, especially implicit racial biases. Although this study did not address this generational perspective specifically, it is caused to further explore this as a possible explanation.

Limitations

A limitation of this study was the small sample size. Results of this study should not be largely generalized beyond the six SLPs who volunteered to participate; however, it may be used as a basis for further research into implicit bias and contributing factors toward cultural competency. Additionally, four of the participants attended the same university to obtain their master's degree, decreasing the diversity of participant educational backgrounds. A delimitation of the study was the focus of implicit bias specifically in the field of speech-language pathology.

Moreover, as there are many parts involved in servicing clients, only the process of planning an assessment was studied.

Future Research & Conclusion

As the U.S. becomes increasingly diverse, SLPs need to have the cultural competence to respond to cultural differences between themselves and their clients. As implicit bias is an important component of cultural competency to address, this study attempted to capture implicit biases influencing the decisions of the clinicians during assessment planning. Implicit bias was present in participant TAs, especially regarding SES. However, patterns of implicit biases manifesting in the form of discriminatory behaviors and effecting clinical decisions were not found in the clinical vignettes presented. Most participants showed awareness of cultural and linguistic differences and began to incorporate responsive practices in their service delivery. This result may have occurred due to the interconnectedness of the participants' cultural awareness towards differences in language and/or dialect and SES, exposure to cultural differences in the classroom, direct experience with multicultural clients, and the ages of the participants.

Further research of this study looking at implicit bias and culturally competent practices in speech-language pathology is needed to generalize these results. Research should expand to other parts of service delivery, including the conducting of evaluations, treatment interventions, and treatment outcomes, as implicit biases may manifest and affect clinical decisions in these other parts of service the current study could not capture. Providing information on SES in clinical cases and the influence of that knowledge in clinical decision-making should be explored as participants illustrated implicit bias toward SES that could have potentially affected their assessment if SES information was provided in the case vignettes presented. Additionally, in depth exploration of participants' academic and clinical experiences should be examined to

provide clear understanding in their contribution towards cultural competency and impact on implicit bias. SLPs' attitudes toward multicultural courses and research on the self-directedness of SLPs in seeking knowledge and understanding in providing best practices for culturally diverse populations should be investigated. Graduate curriculum should be analyzed and ensure incorporation of relevant content. Furthermore, a comparative study of implicit bias in newer clinicians and experienced clinicians should be established. This would help determine if there is correlational evidence of discriminatory behaviors occurring in clinical decisions regarding generational factors.

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Appendix A: Approved IRB Letter

EASTERN
MICHIGAN UNIVERSITY

Melinda Yax <myax1@emich.edu>

UHSRC-FY20-21-60 - Initial: Initial - Exempt
9 messages

human.subjects@emich.edu <human.subjects@emich.edu> Wed, Dec 2, 2020 at 2:02 PM
To: myax1@emich.edu, sginsberg@emich.edu

EASTERN
MICHIGAN UNIVERSITY
University Human Subjects Review Committee

Dec 2, 2020 2:02:43 PM EST

Melinda Yax
Eastern Michigan University, Special Education

Re: Exempt - Initial - UHSRC-FY20-21-60 Implicit Bias in the Assessment of Multi-Cultural Populations by Speech-Language Pathologists

Dear Melinda Yax:

The Eastern Michigan University Human Subjects Review Committee has rendered the decision below for Implicit Bias in the Assessment of Multi-Cultural Populations by Speech-Language Pathologists. You may begin your research.

Decision: Exempt - Limited IRB

Selected Category: Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Renewals: Exempt studies do not need to be renewed. When the project is completed, please contact human.subjects@emich.edu.

Modifications: Any plan to alter the study design or any study documents must be reviewed to determine if the Exempt decision changes. You must submit a modification request application in Cayuse IRB and await a decision prior to implementation.

Problems: Any deviations from the study protocol, unanticipated problems, adverse events, subject complaints, or other problems that may affect the risk to human subjects must be reported to the UHSRC. Complete an incident report in Cayuse IRB.

Follow-up: Please contact the UHSRC when your project is complete.

Please contact human.subjects@emich.edu with any questions or concerns.

Sincerely,

Eastern Michigan University Human Subjects Review Committee

Appendix B: Case Vignettes

Case Study 1:

Jesse, a 3-year-old, is brought into the clinic by his mother for an evaluation. On the evaluation form, she stated that she is concerned that he doesn't talk, except for a few one-word phrases, such as "please," "no," and "more." He has attempted to put two-word phrases together, but only once or twice. He listens pretty well and likes routines. She noted that he was full-term and nothing significant to report about his birth. He reached all his physical developmental milestones. He has a 3-month-old brother at home. He loves trucks and going to the park with his family. He also likes playing with his dog, Teddy.

Case Study 2:

Xavier, a 4-year-old, was brought into the clinic with his parents. Both his parents and day care teacher expressed concern about his language development. He says one-word phrases and a few two-word phrases (“go outside,” “play me”). The intake form states that the pregnancy and birth were typical. His first word was “mama” at 15 months old. He can follow directions but has difficulty answering WH questions. He lives with his parents and twin sisters, who are 6 months old. Xavier loves playing with trains and building with Magna Tiles. His favorite place to play is the McDonald’s play place.

Case Study 3:

David is a 2-year and 7-month-old boy brought in for an evaluation by his mother. She expressed concern about his language as he doesn't speak very often. He occasionally says "ju" for juice, "mo" for more, and "no." He will shake his head yes/no in response to yes/no questions. He points and grabs his mom's hand to show her what he wants. He is an only child; however, his mother is 7 months pregnant. She also stated on the intake form that his physical development has been typical. He likes to play with balls and going down his slide at home. He sometimes cries and becomes frustrated when his mom or dad don't understand what he is trying to communicate.

Article #3: Embracing Cultural Humility: Self-reflection, Critique, and Bias

Abstract

There is a lack of representation of the diverse populations in the U.S. in the profession of speech-language pathology. This results in many speech-language pathologists (SLPs) providing services to populations culturally different from themselves. Until recently, the skill of providing services to culturally and linguistically diverse clients was defined as cultural competence; however, recently there has been a shift toward the concept of cultural humility. Cultural humility provides more thorough explanation and expectations than cultural competence. One of the key idiosyncrasies of cultural humility is self-reflection and critique. Self-reflection and critique can be used to evaluate and address biases with the potential of negatively impacting client care, evaluation, and treatment outcome in communication sciences and disorders (CSD). Current research into the effect of these skills in addressing speech-language pathologists' biases is lacking; however, evidence in other professions suggest the need to implement such practices into CSD higher education.

Introduction

The United States has been considered the "melting pot" of nations, marked by its diversity in ethnicity, race, culture, and language compared to other nations. According to the United States Census Bureau (2019), about 60.4% of the U.S. population identified as White Non Hispanic or Latinx, 18.3% Hispanic or Latinx alone, 13.4% Black alone, 5.9% Asian alone, 1.3% as American Indian and Alaskan Native alone, and 0.2% Native Hawaiian and Other Pacific Islander alone. And yet, the current demographics of American Speech-Language-Hearing Association-certified speech-language pathologists (SLPs) in the U.S. do not reflect these numbers, where 91.8% are White (American Speech-Language-Hearing Association [ASHA], 2020). Therefore, it is not unlikely that SLPs are servicing clients and families of cultures that are different from their own. These cultural gaps between clinician and client must be thoughtfully considered and appropriately addressed in order to provide both ethical and effective evaluations and treatments. The skill of perceiving these cultural differences and responding appropriately has been referred to as cultural competency (ASHA, n.d.; Agner, 2020; Tervalon, 1998). Although this term is still largely accepted and recognized in speech-language pathology and other disciplines, there has been a shift towards *cultural humility* rather than competency.

Moving Towards Cultural Humility

Although the concepts of cultural humility and cultural competency overlap, in that they both exist to acknowledge and address cultural divergence, there are critical differences (Ginsberg & Mayfield-Clarke, 2021). Cultural competency is the skill of "understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professional and client/patient/family bring to interactions"

(ASHA, n.d., para. 1). The problem with this definition and the use of "competence" is that it implies that it can be mastered; there is a certain point in which one has gained all knowledge and has adopted all appropriate practices to service multicultural populations (Agner, 2020; Ginsberg & Mayfield-Clarke, 2021; Tervalon & Murray-Garcia, 1998). Tervalon (1998), however, argues that in contrast, cultural humility is a "commitment to a lifelong learning process" (p. 119), critical self-reflection and assessment (see also Foronda et al., 2016). There is an ebb and flow of knowledge and practice, continually requiring self-evaluation and appropriate adaptation from the clinician. The clinician recognizes they do not know it all and humbly seeks to learn from the client and families they interact with (Tervalon & Murray-Garcia, 1998; Foronda et al., 2016). Foronda (2016) performed a concept analysis on cultural humility and outlined key attributes of cultural humility: openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. Each of these attributes intersect and are all important for SLPs to practice cultural humility with its fullest impact. The attribute of self-reflection and critique specifically addresses the person's beliefs, attitudes, and feelings and is in relation to one's biases (Agner, 2020; Foronda, 2016). Bias is a preconceived attitude toward something or someone, whether positive or negative (APA, 2020).

Self-Reflection, Critique, and the Relationship to Bias

One danger of cultural competency is that it may lead to increased stereotyping and bias, causing more harm to the client or patient (Tervalon & Murray-Garcia, 1998). When learning about a different culture, it is easy to place general assumptions and expectations on a people as one whole rather than recognizing their unique differences and diversity at the individual level and without consideration of each person's lived experiences (Tervalon & Murray-Garcia; Agner, 2020). Karlsen et al. (2020) conducted a qualitative study on the effects of health care

professionals trying to protect against female genital mutilation (FGM) on people of British Somali heritage in the United Kingdom. Female genital mutilation is the intentional, medically unnecessary, practice of completely or partially removing of the external female genitalia or other genital organs (UNICEF, 2016; World Health Organization, 2020). The government and health care system in the UK intentionally created policies to help health care professionals monitor and prevent FGM to girls and women at risk. It could be argued that these health care professionals who were educated on this cultural practice, regarding those at risk for FGM and how to protect them, were practicing cultural competency as they "understood" the cultural implications and "responded" by adapting certain practices; however, Karlsen (2020) found that the policies and practices in place to help those at risk for FGM were potentially causing more harm than good. Perspectives from the Somali women and men who participated in the study showed how stereotypes led health care professionals to encounter Somali people with suspicion and to misunderstand typical behavior as evidence of risk of FGM (Karlsen, 2020). The FGM-safeguarding practices also negatively impacted the patients' trust in the health care professionals, made them reluctant to pursue care, and looked for treatment in other ways (Karlsen, 2020).

Consider the same situation, but instead, with health care professionals providing care using the attributes associated with cultural humility, specifically self-reflection and critique. The professionals would have reflected on their own thoughts and feelings before, during, and after encountering Somali patients, considering how their basic knowledge of Somali and FGM might overgeneralize to each client and the implications for such occurrences. For example, if a clinician felt mistrust or suspicion upon immediately meeting a Somali patient, it would require digging into those feelings, evaluating the truth of them, and correcting as appropriate.

Additionally, it would call for assessment on how those biases influenced their behavior and interaction with the patients. Instead of solely placing blame or emphasis on the patient's responses, the clinician would take responsibility for their own actions by introspectively investigating how they may have influenced the patient's responses and reactions. If this was done, the Somali patients might not have felt stereotyped and criminalized (Karlsen, 2020) but instead felt mutual trust between themselves and the health care workers, positively influencing their experience in health care and treatment outcome.

Although the previous study was a cultural practice not in the scope of speech-language pathology, it provides an example of how pursuing cultural competence may fall short in providing the best care to culturally diverse clients. Furthermore, culture is not just tied to traditional practices, such as FMG, but involves consideration of the impact of other sociocultural influences and cultural differences, such as ethnicity, socioeconomic status (SES), group membership, language, and identities (Ginsberg & Mayfield-Clarke, 2021; Karlsen, 2020; Schwab & Lew-Williams, 2016), all which are relevant to populations served in communication sciences and disorders (CSD).

A consideration of participant responses in Yax's (2021) qualitative study on implicit bias in assessment planning by SLPs may provide another example specifically in CSD of the limitedness of cultural competency to cultural humility. In the study, Yax found that implicit biases were present in clinicians' "think alouds." Participants showed awareness of cultural decisions and emerging practical changes in service delivery (Yax, 2021). Although implicit bias did not affect the planning of evaluation, there were still areas of concern regarding clinician bias towards populations and a disconnect on how to relearn associations and address one's bias. For example, one participant could easily identify bias in others, recounting one experience with a

previous co-worker, who had refused to treat Medicaid clients because they were unreliable. This co-worker's bias prevented them from providing appropriate services under the assumption all Medicaid clients are "unreliable." The participant detailing this experience discussed how clients in low-SES areas may not have the gas to drive to the clinic or the internet for teletherapy (Yax, 2021). This was a recognition of socio-cultural influences and barriers clients of low-SES face. However, the clinician then continued and began making larger generalizations about the culture of people of lower SES. This illustrates another example, specifically in the field of speech-language pathology, where the knowledge accrued to become culturally competent has led to stereotyping. Moreover, the same participant explicitly described how, in this particular instance, she overcomes her bias by helping those families the best she can. The issue with this is that bias cannot be overcome simply by helping a family in which one has bias towards. Rather, self-reflection of one's assumptions and associations need to be evaluated. If this participant had self-evaluated her thoughts on this population, she would have recognized the bias in herself, evaluated it, and not have expressed those assumptions.

Practice of self-reflection & critique to reduce bias

People who practice reflection can readdress experience, consider the associated feeling, and then reassess the experience (Boud et al., 1985, as cited by Ip, 2012). Those with poor or absent reflective skills may remain static in their thinking and behaviors and may be influenced by preconceived ideas or beliefs without thought into the truth of them (Ip, 2012). This is where explicit, or conscious, and implicit, or unconscious, biases may manifest in one's thinking and clinical decisions if not properly addressed (FitzGerald & Hurst, 2017; Gawronski & Bodenhausen, 2006; Guedj et al., 2021). Consequently, patient care, evaluation, and treatment outcome have the potential to be negatively impacted when these biases are left unchecked

(FitzGerald & Hurst, 2017; Maina et al., 2018). Although intended for teachers, English's (2016) description of self-critique is adequately described as a way of recognizing one's own short-comings and the "ability to seek out and identify those moments in which [one's] thoughts and actions need modification or correction" (p. 164). The integration of both practices allows one to thoroughly evaluate one's experiences by effectively addressing attitudes and resulting mistakes and provides opportunity to correct them.

Literature on the Impact of Self-reflection on Bias

There have been some studies conducted to research the effectiveness of self-reflection on bias. One study by Oliver et al. (2021) explored the impact of self-reflection through journals. An integration of clinical practicum and curriculum on weight sensitivity training required nursing students to execute five reflective journal assignments throughout the practicum. The study found that the reflective journals brought awareness to conscious and unconscious bias to the participants and the impact it had on the care they provided obese patients. Additionally, it encouraged increased empathy in communication. Another study used reflection as part of the Subjective Objective Assessment and Plan (SOAP) notes by nursing students to bring awareness to their biases (Johnson & Richard-Eaglin, 2020). After each SOAP note, students had to reflect on their interaction with the patient and how bias might have influenced the care provided to the patient. Students were introspective in their reflections and some inquired on how they could mitigate their biases (Johnson & Richard-Eaglin, 2020). Although these are not specific to CSD, they may be adapted into CSD programs.

Self-Reflection and Bias in CSD Higher Education

Self-reflection and critique are both skills that require intentional practice both in the classroom and in clinical settings. With this understanding, courses in higher education should

provide opportunities and guidance in refining these skills in CSD students. The participants in Yax's (2021) study were younger clinicians (ages 26-29) and relatively recent graduates. As ASHA has become more specific regarding multicultural course standards in addition to universities building and adjusting their course(s), exhibited by first, a suggestion of a multicultural course(s), and later, a requirement (Stockman et al., 2004), as well as the clarification on standards of multicultural practices (ASHA, 2017). Therefore overtime, more recent graduates may have gleaned the benefits of graduating with a stronger foundation and practice of cultural humility (Yax, 2021). Furthermore, some of the participants expressed a direct connection between clinical experiences and the role of the families being served in refining their ability to serve multicultural populations. Research on the efficacy of self-reflection in reducing bias in SLPs is lacking; however, the above studies provide evidence of practicing self-reflection and critique in understanding and mitigating one's biases. Moreover, the studies show practical ways of incorporating self-reflection in CSD education and practicums. Similar methods, such as reflective journals or SOAP notes, can be adapted into coursework and clinical experiences to practice the skill of introspection. As clinicians build these skills, they can address different types of biases (e.g., race, language, ethnicity, gender), and increase their practice of cultural humility.

Conclusion

In comparison to cultural competency, cultural humility provides more descriptive skills and attributes a clinician must practice to effectively provide services to culturally and linguistically diverse clients. While cultural competency may highlight basic knowledge of cultural differences, it does not completely challenge one to humbly assess one's beliefs and values, which may actually promote stereotyping. Moreover, it suggests that there is a final point

of mastery; however, foundational information of different cultures does not have the capacity to correct all biases in the complex and multitude of ways in which they manifest (e.g., language, SES). This is done through cultural humility, which involves a life-long commitment of self-reflection and critique.

There is evidence that self-reflection has a positive impact on increasing one's awareness of biases and the reduction of them as well as practical ways self-reflection can be implemented in CSD education. Current courses and clinical practicum should be examined to see if practices of self-reflection and critique are being explicitly incorporated. Further adjustment and scaffolding of these skills in higher education may continue to promote increased cultural humility in graduates, reduce clinician bias, and minimize the potential for clinical decisions being negatively impacted by bias, ultimately improving the services culturally diverse populations receive from SLPs.

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