

Student Perceptions of Professional Identity and Cultural Competence

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Dedication

For my girls.

Abstract

By the time they reach their second year of graduate school, students of speech-language pathology are well into the process of developing a professional identity and have been exposed to academic and clinical experiences designed to develop their cultural competence. This grounded theory study was designed to investigate how students perceive their professional identities and how they perceive the concept of cultural competence. The results of this study indicate students are learning the knowledge programs are designed to teach them, but current practices may be limiting. Students understand the importance of culturally competent care, but they tend to narrow their concepts of cultural competence to facts and characteristics of cultural groups they see as other than themselves.

The conclusions from this research encourage the development of cultural competence and professional identity through a process of examining interactive cultural relationships. Within this approach instruction and clinical experiences would involve a consistent recognition that each interaction is a relationship and each interaction involves the coming together of cultures. Helping students recognize the cultural relationship in every interaction allows them to develop their cultural competence and professional identities regardless of the demographics of their geographical placement and will provide them with the skills to adapt and meet the needs of each client and cultural group. Finally, this approach can shift the discourse of the profession away from the concept of how other cultures are different from the norm to one that considers all forms of similarities and differences in the provider-client relationship.

Table of Contents

Acknowledgements	i
Dedication.....	ii
Abstract.....	iii
Chapter 1. Introduction.....	1
Statement of the Research Problem.....	1
Purpose of the Study.....	2
Research Question(s).....	4
Professional Identity and Cultural Competence	4
Context of the Study.....	6
Setting and Participants	8
Significance of the Study.....	10
The Researcher	11
Chapter 2. Literature Review.....	13
Cultural Competence	13
Models of Cultural Competence.....	18
Self-Awareness	25
Identity.....	26
Communities of Practice	31
Summary.....	33
Chapter 3. Methods.....	35
Study Design.....	35

Setting and Participants	35
Data Collection	36
Data Analysis.....	38
Rationale	39
Validity and Reliability	39
Ethical Considerations	41
Chapter 4. Research Findings	43
Participants and Selection Process	43
Results	44
Summary.....	60
Chapter 5. Discussion and Conclusions	61
Discussion.....	61
Educational Implications	67
Limitations.....	71
Recommendations for Future Research.....	72
Conclusions	74
References	76
Appendices	
A. Invitation Letter	86
B. Informed Consent Form.....	88
C. Demographic Questionnaire	93

D. Interview Guide	95
E. Institutional Review Board Approval Letter.....	97

Chapter 1. Introduction

We have not really asked the crucial and difficult questions of relevance of our profession to and with the communities we serve”—M. Iwama (2006, p. 7)

Statement of the Research Problem

Speech-language pathologists (SLPs) and students studying to become SLPs are expected, as stated in standards set by the American Speech-Language Hearing Association (ASHA, 2010c), to be culturally and linguistically competent. The standards set by ASHA are intended to assure students understand the history, theories, and epistemology of what it means to be an SLP by the end of their Master's programs. Currently there is limited published research investigating the relationship between professional identity formation and cultural competence.

Many authors agree a main tenet of cultural competence is self-awareness (Anand & Lahiri, 2009; Bennett, 2009; Campinha-Bacote, 2002; Endicott, Bock, & Narvaes, 2003; Griffer & Perlis, 2007; Kim, 2009; Leininger, 2002; Munoz, 2007; Purnell & Paulanka, 2005; Seligman & Darling, 2007). In the relationship between a health care provider and patient, provider self-awareness means understanding one's identity as a person and a professional. Students in their second year of graduate school are well on their way to becoming professionals, but how do they perceive or define professional identity? Research in several fields supports the idea of professional identity as a critical and formative process that occurs during an educational program and continues throughout a lifetime of practice (Beijaard, Meijer, & Verloop, 2004; Cohen, 2010; Mann, Howard, Nowens, & Martin, 2008; Niemi, 1997; Sutherland, Howard, &

Markauskaite, 2010). If understanding themselves as people and professionals is essential to cultural competence, how do identities in development affect the ability of new professionals to provide culturally competent services?

Purpose of the Study

Cultural competence is the focus of research and conversation in most, if not all, medical and allied health professions. Many authors and researchers cite its importance because of the changing demographics of the U.S. population and the need to serve a more racially and ethnically diverse group of people (ASHA, 2004; Murden et al., 2008; Suarez-Balcazar et al., 2009). Other explanations have included the need to reduce health disparities for minority populations (Goode, Dunne, & Bronheim, 2006), or to improve relationships among professionals in a global work environment (Stimpson & Martin, 2005). Speech-language pathology as a profession is relatively young and the majority of education and research takes place in Western-centric countries like the United Kingdom, U.S., and Australia (Duchan, 2005; McAllister, 2005). As the profession grows and expands across borders, cultural competence becomes essential for client care provision, inter- and multi-disciplinary interactions and collaborations, and meaningful relevant research practices (McAllister, 2005).

Speech-language pathology is based on the medical model in its values, practice, research, and epistemology (McAllister, 2005). This modern paradigm of education has resulted in a similar approach toward cultural competence in curriculum and practice. The result is behaviorist teaching and learning methods composed of categorized facts about culturally and linguistically diverse populations. On the other hand, some believe

cultural competence should not be a destination, it should be a process (Campinha-Bacote, 2002; Munoz, 2007); i.e., students do not *achieve* competence, they develop through every interaction and experience they have with colleagues and clients; and the curriculum for speech pathology programs should reflect that process (Trembath, Wales, & Balandin, 2005).

Self-awareness is a central component in the process of increasing cultural competence. For the health care practitioner and students in the field, self-awareness includes knowing and understanding the history and epistemology of their profession and defining their own professional identity (Iwama, 2007). Speech-language pathology students in their second year of graduate studies are absorbing academic content (knowledge), learning clinical skills (skills), and developing a professional identity (attitudes/awareness). Cultural competence development, much like professional identity development, also includes knowledge, skills, and attitudes/awareness (Bennett, 2009; Campinha-Bacote, 2002; Deardorff, 2004; Gibson & Zhong, 2005) but it has not been shown whether these two constructs are connected (developing in tandem), or if they are unrelated (developing in parallel). Currently in the standards-based speech-language pathology programs accredited by ASHA, cultural competence means students are mindful of the differences and needs of culturally and linguistically diverse populations. The resources ASHA provides to support cultural competence typically include knowledge aspects of clinical competence such as lists of facts about specific races, ethnicities, and other specific social groups. These methods can lead students to believe they have reached a determined endpoint as long as they know some information about

other populations. The question arises about whether this is reasonable or adequate, i.e., should we expect and measure an ill-defined endpoint or should instruction and assessment more closely resemble a continuing conversation about the developmental process of competence in both learning and practice? Is it possible the latter may better serve students and their professional expectations?

Research Question(s)

The purpose of this study was to investigate the development of professional identity and cultural competence through the experiences and perceptions of students in graduate speech-language pathology programs. Specifically, two questions were addressed:

1. How do students at specific developmental levels of cultural competence, as defined by the Intercultural Development Inventory (IDI), identify as professional speech-language pathologists?
2. How do students who have just begun to identify as a speech-language pathologist define cultural competence?

Professional Identity and Cultural Competence

Students working to become SLPs learn large amounts of content across a broad spectrum of topics related to communication and swallowing and they learn the skills to apply their knowledge effectively in myriad settings. At the same time, but perhaps a little less overtly, they are building a professional identity and learning to become SLPs. They are learning the history, the epistemology, philosophy, and culture of the profession. While these areas may not be as directly addressed as content and skills, they

are important to students' development as clinicians and practitioners in a distinct community of practice (CoP).

Professional cultures are as real and significant as cultures defined by ethnicity or gender identity (Endicott et al., 2003). Wenger (1998) provides the characteristics that define a group of people working together as a CoP with constructs reflecting those of professional culture, including one of the main focuses of this project—professional identity. In a CoP participants form an identity that affects how they interpret information and interact with each other. In his discussion about the culture of occupational therapy, Iwama (2006) points out the characteristics of a professional culture affect how practitioners interpret clinical experiences and interactions with clients. In other words, how practitioners identify and define themselves as professionals determines how they interact across situations. Standards-based programs imply a right way to do things; students in the early phase of identity formation may be limited to the right way with less ability for interpretation in any given interaction (Beijaard et al., 2004).

The premise of this research was development and self-definition of identity within a speech-language pathology CoP is interconnected with the level of cultural competence, or “the ability of healthcare providers to apply knowledge and skill appropriately in interactions with clients in cross-cultural situations” (Srivastava, 2007, p. 323). Knowing how students identify with their chosen field may help teachers understand how to approach cultural competence training from a pedagogical and epistemological perspective.

Teaching and learning can be informed by knowing how students perceive their place in the profession they have chosen and their conceptualization of what cultural competence means. Understanding how professional identity and the process of cultural competence are related may enable faculty to create meaningful and effective curricula and experiences for students. As a result students may become more globally effective and empathetic practitioners who will continue to develop competence past their educational programs. The increased focus on internationalization and the growth of the profession into non-Western countries suggest a critical need for students and practitioners who are able to negotiate cross-cultural experiences and move through the process of developing cultural competence regardless of the situation (Kinsella, Bossers, & Ferreira, 2008). In a global society it is not possible to prepare students for every possible cultural situation, but it is the way a modern, fact-based, medical model for education is structured. If students understand cultural competence as a process and have the skills to adapt to all situations, they may leave their programs better prepared.

Context of the Study

Speech-language pathology was born as a profession in the early part of the 20th century and modeled educational, practice, and research methods from medicine and psychology (Duchan, 2005). The earliest reference to cultural competence was the seminal publication by Charles Van Riper (1939) when he emphasized a social view for understanding disability (Duchan, 2005).

As stated earlier, many articles and texts dedicated to cultural competence in health care cite changing demographics of the U.S. population as the reason for teaching

cultural competence (ASHA, 2004; Horton-Ikard, Munoz, Thomas-Tate, & Keller-Bell, 2009; Stockman, Boulton, & Robinson, 2008; Suarez-Balcazar et al., 2009; Sumpter & Carthon, 2011). This reasoning assumes cultural competence exists in the context of race and ethnicity. It could be argued, however, the U.S. population (not to mention the global population) has always been diverse and defining a clinical relationship by race or ethnicity is limiting. Studying cultural competence should focus on the relationship between patient and caregiver and recognize the uniqueness of each participant (Iwama, 2009).

ASHA encourages international experiences for students and expansion of the profession across borders, and it holds multicultural competence as a necessary standard for professional practice. ASHA is not alone among medical and allied health professions in promoting awareness and sensitivity to diversity and cultural competence, but is in the very early stages of defining what it means to educate SLPs in these areas. Likewise, the study of multicultural/multilingual issues (MMI) in speech pathology and other allied health professions is in very early stages (ASHA, 2010b; Munoz, 2007). As a result a clear definition of cultural competence is difficult to find as no consensus has been achieved (Deardorff, 2004). However, according to ASHA, cultural competence is most commonly referred to as the ability to work with culturally and linguistically diverse populations and/or clinicians' ability to recognize their own cultural/linguistic background or life experience and that of their client/patient/student (ASHA, 2004). ASHA's resources and guidelines for working with culturally and linguistically diverse populations are categorized primarily by race, ethnicity, gender orientation, and

socioeconomic status (SES) (ASHA, 2009b; Stockman, Boulton, & Robinson, 2004). It should be noted the resources and guidelines do not include white as a racial category. There is also little discussion of intra-ethnic variation that acknowledges “there is more variation within a cultural group than across cultural groups” (Campinha-Bacote, 2002, p. 182).

Setting and Participants

Modern medical paradigms in which most health professions and certainly speech-language pathology are situated include positivistic approaches to knowledge and practice. Research is empirical, data are absolute, and education is largely behaviorist (Munoz, 2007). This approach applies to all aspects of the programs including cultural competence training. In contrast, postmodern paradigms hold a more relative approach to knowledge and practice—that is, the scientific method is still relevant, but the data are presented in context often with qualitative explanations. Education programs based on postmodern constructivist patterns invite a range of perspectives with the “central assumption that learners structure and restructure their theories of the way the world works in order to make their theories congruent with observed situations and experiments” (Endicott et al., 2003, p. 408). A postmodern lens on cultural competence offers a relative view more favorable to cultural competence as a process. The difference is described simply by Campinha-Bacote (2002) who suggested health care providers must see themselves as *becoming* culturally competent rather than *being* culturally competent.

Despite subtle differences in definitions, much of the literature on cultural competence uses terms like *multiculturalism*, *internationalization*, *diversity*, *intercultural*, and *transcultural* interchangeably (Beach et al., 2005; Deardorff, 2004; Gibson & Zhong, 2005; Hammer, Bennett, & Wiseman, 2003; Purnell & Paulanka, 2005; Sumpter & Carthon, 2011). Cultural competence from a modernist perspective is defined in terms of race, gender, ethnicity, and sexual orientation and compares and contrasts characteristics against the norm—typically middle class white America (Iwama, 2007; Vandenberg, 2010). Postmodern theory has cultural relativity at the core, not defining by labels or demographic data, but through descriptions of lived experience and situation. Bronfenbrenner (2005) indicates categorical terms like sex and race are class-theoretical concepts which have no explanatory power, suggesting the current models of addressing cultural competence are based on concepts that hold less potential for understanding one another. This leads to the question, how can an explanation of human beings based on class-theoretical characteristics that hold no power, lead to cultural competency? Could there be better ways to help students move through the process of developing cultural competence?

Multicultural competence is mandated by ASHA and most other allied health professions, and is often defined in modernist and positivistic terms directed at how others are different from the majority population (Munoz, 2007; Preis, 2008; Vandenberg, 2010). For example, the ASHA Cultural Competence Awareness Assessment Pretest, created to provide clinicians with the ability to self-assess, defines culture as “the customary beliefs, social forms, and material traits of a racial, religious or

social group” (ASHA, 2009b, n.p.). In contrast, the postmodern view of Iwama (2006) defines culture as “a dynamic social phenomenon that changes depending on location and time” (p. 9). This perspective, which encourages cultural relativism and holding a mirror up to ourselves (as individuals within a profession), may be a more appropriate approach to cultural competence and understanding across and within cultures and as a framework in the dissemination of knowledge, education of students, and expansion of the speech-language pathology field.

Significance of the Study

Speech-language pathology is a relatively young profession with a Western-centric background and an evidence-based medical model approach to client care. Like many allied health professions, the training program is standards-based and the majority of research is quantitative, relying primarily on control-group design. Iwama (2006), in reference to occupational therapy programs, proposes “our theoretical materials and epistemology have yet to move through the postmodern and post-structural bumps and grinds that will take us from the rational and universal towards the culturally relative and culturally safe” (p. xvi).

Curriculum, pedagogy, and licensure regulations have resulted in collaborations between Australia, the United Kingdom, and the U.S. However, other countries hoping to develop academic programs and provide services to their communicatively impaired citizens are forced to adopt the Western habits, data, values, practices, and language which may or may not apply to their culture and needs. Cultural competence is often stressed because the population of the U.S. is continuously increasing in cultural and

ethnic diversity. When culture is considered beyond categorized definitions like race and gender and focuses on culture in a more postmodern way, the need for intercultural competence increases exponentially.

Speech pathologists are almost exclusively focused on communication and all it entails (Walsh, 2005). Communication itself is a major part of intercultural competence (Gibson & Zhong, 2005; Kim, 2009; Spitzberg & Changnon, 2009); it is only natural the practitioners specifically identified as the experts in communication should have a strong grasp of the importance of intercultural relationships.

Identifying and understanding how students identify with their profession and whether there is a connection to their levels of cultural competence can provide significant information for pedagogy, curriculum, and educators in speech pathology programs. Deardorff (2004) supports this idea in her identification of the perceptions of college students and experts in fields like health care as important next steps in intercultural competence research. Learning how students perceive these two elements, identity and cultural competence, may provide the information needed to develop a deeper understanding about a possible connection between the two leading to teaching and learning approaches that could advance students' understanding as well as the profession itself.

The Researcher

Qualitative research, such as this grounded theory study, involves creating meaning through ongoing dialogue and makes it necessary to describe the researcher (Gibson, Dollarhide, & Moss, 2010). The researcher is a 36-year-old woman who has

been an SLP since 1999, working with adults and children in outpatient, school, and medical settings. She is an instructor in a Communication Sciences and Disorders Program and is seeking ways to more effectively teach cultural responsiveness to undergraduate and graduate students of speech-language pathology by studying the education of SLPs for her dissertation in a Teaching and Learning Doctor of Education program. Her training and practice has occurred in geographical areas considered to be lacking in diversity if definitions of diversity are defined by race and ethnicity. It is her assumption that everyone—students, practitioners, and clients—will benefit from broader definitions of diversity and cultural competence, including positive effects on treatment efficacy and expansion of the profession on a global scale.

Chapter 2. Literature Review

Theorizing about a possible connection between two concepts requires an understanding of the target concepts and a review of the current literature and research. This chapter includes definitions of the key constructs that make up cultural competence and professional identity, a review of the current literature on both, and the framework behind the proposed interconnection between the two concepts.

Cultural Competence

Studying cultural competence is challenging due to a lack of consensus on its actual meaning and the variety of terms used to convey the concept. Terminology used in current research includes cultural awareness, cultural sensitivity, transcultural, cultural diversity, multicultural, cross-cultural competence, intercultural competence, global competence, and intercultural effectiveness (Beach et al., 2005; Deardorff, 2004; Gibson & Zhong, 2005; Hammer et al., 2003; Purnell & Paulanka, 2005). Determining an operational definition of cultural competence in the context of health care, and more specifically speech-language pathology, is essential for any research on the topic. Achieving an operational understanding requires a comprehensive view of the ways culture and cultural competence can be interpreted, the general models of cultural competence and those in health care professions, and ways to assess it.

Culture. Purnell and Paulanka (2005) define culture as “the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs and lifeways and all other products of human work and thought characteristics of a population of people that guide

their worldview and decision making” (p. xvii). Some authors refer to constructs of culture that can include categorical identities like age, gender, race, etc. (Mahendra et al., 2005; Stockman et al., 2004). Hofstede and Hofstede (2005) use dimensions of culture that include power distance, individualism, masculinity, uncertainty avoidance, and long-term orientation. Still other authors use domains or parameters that characterize culture by explaining, for example, views of time and space, overview/heritage, communications, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and the childbearing family, death rituals, spirituality, health-care practices, and health care practitioners (Mahendra et al., 2005; Purnell & Paulanka, 2005). Culture can also be more broadly defined as “any framework of expectations and values” (Endicott et al., 2003, p. 404), which goes beyond geography, race, and ethnicity and leads us to considering the culture of professions or organizations like education and health care (Munoz, 2007; Purnell & Paulanka, 2005). Bickenbach (2009) offers a general definition when he states “A prominent theoretical notion [of culture is] that of ‘worldview’—that fundamental set of cultural beliefs that shape people’s understanding of themselves, their relation to others, to nature and to ways of explaining the world” (p 1116).

Competence. A simple dictionary definition of competence is “the quality or state of being competent” (“Competence,” n.d., n.p.) and competent means “having requisite or adequate ability or qualities” (“Competence,” n.d., n.p.). Bronfenbrenner (2005) explains competence requires context and mastery within a specific environment and is achieved by meeting the requirements of that setting. This explanation of competence

implies a static state, and students may find it difficult to develop knowledge or skills beyond those of their teachers or profession. Mann et al. (2008) add dimension to the definition when they state, “mastery is the product of a complex system of education affected by the outcomes of the program of study, the work environment and personal factors” (p. 2). Professions that define cultural competence by characteristics of race, ethnicity, and gender limit students’ abilities by neglecting to incorporate continued flexibility or cultural responsiveness (Iwama, 2009; Munoz, 2007).

Cultural competence: General definition. In the context of internationalization of higher education and study abroad experiences, Deardorff (2004) attempted to achieve a consensus on a definition of cultural competence through a Delphi study. She concluded, “Intercultural experts and higher education administrators did not define intercultural competence in relation to specific components (i.e., what specifically constitutes intercultural knowledge, skills, and attitudes). Instead, both groups preferred definitions that were broader in nature” (p. 191). The only item that received 100% consensus in defining cultural competence was “understanding others’ world views” (Deardorff, 2004, p. 169).

Characteristics. Beach et al. (2005) discuss cultural competence as the ability to develop relationships that supersede cultural differences, and Kim (2009) states intercultural competence is about fostering cooperative relationships. Most definitions of cultural competence include some form of knowledge, skills, and attitudes at their core (Bennett, 2009; Campinha-Bacote, 2002; Deardorff, 2004, Gibson & Zhong, 2005; Mahendra et al., 2005). These elements and others are delineated below.

Knowledge. Cultural knowledge involves having and seeking a foundation of information about cultural and ethnic groups, but knowledge alone is not enough to be culturally competent (Bennett, 2009; Campinha-Bacote, 2002; Deardorff, 2004).

Skills and behaviors. Cultural skills are the ability to collect relevant cultural data, engage in cross-cultural interactions, and interact and communicate appropriately and effectively (Bennett 2009; Campinha-Bacote, 2002; Deardorff, 2004).

Attitudes. Cultural attitudes are the affective aspects of competence that include empathy, humility, motivation, cognitive flexibility, curiosity, suspension of judgment, tolerance of ambiguity, and a desire to seek, experience, and understand relationships with people who have cultures other than our own (Bennett, 2009; Deardorff, 2004).

Awareness. Deardorff (2004) identified three common elements of awareness—valuing and understanding differences, experiencing other cultures, and self-awareness.

Structures. Professional, workplace, and societal structures are those policies and procedures outside the control of an individual. Individual cultural competence can be limited by policies and structures that do not promote its development (Goode et al., 2006).

Definition in health care. In a health care context cultural competence is equally difficult to define and currently is at the top of the list of discussions for medical and allied health professionals. Much of the research and literature begins by citing the changing demographics of the U.S. and justification for teaching cultural competence in health care programs (ASHA, 2004; Suarez-Balcazar et al., 2009; Sumpter & Carthon, 2011).

Specific to health care, cultural competence encompasses values, principles, knowledge, behaviors, skills, attitudes, policies, and structures that enable health care providers to provide care to people from diverse cultural backgrounds (National Center for Cultural Competence, n.d.; Srivastava, 2007). Srivastava (2007) offers this definition: “the ability of healthcare providers to apply knowledge and skill appropriately in interactions with clients in cross-cultural situations” (p. 323). Campinha-Bacote (2002) developed a commonly agreed upon definition which views cultural competence as “the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)” (p. 181). This definition holds a postmodern view of cultural competence as a process that “involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire” (Campinha-Bacote, 2002, p. 181).

Anand and Lahiri (2009) suggest cultural competence in health care is especially challenging because of the “intensely personal nature of the services offered, which often touch the core of patients’ and providers’ culturally influenced values, beliefs, and attitudes” (p. 387). Definitions of cultural competence in a health care context share several characteristics including terms like *competence*, *awareness*, and *sensitivity*, which are often used within the same definition but can hold different meanings. Cultural sensitivity means being aware of values, beliefs, life ways, and practices. Cultural responsiveness means integrating these cultural aspects into effective and acceptable treatment (Anand & Lahiri, 2009) or, as Munoz (2007) found, “Culturally responsive caring is [a process] of actively developing a synergistic relationship grounded in

mutuality and an intentional respect for a person's cultures" (p. 256). In his report on cultural competence in medical education, Hamilton (2009) supports the notion of cultural competence as an intricate process that should be cyclical, experiential, and reflective.

Models of Cultural Competence

Several models have been created to encourage development of cultural competence in a wide variety of fields. Spitzberg and Changnon (2009) identify five types of theoretical models for intercultural competence found in the literature that spans across health care and non-health fields: compositional, co-orientation, developmental, adaptational, and casual process. Compositional models identify the hypothesized components of competence without specifying the relationships among those components and provide "... 'lists' of relevant or probable traits, characteristics, and skills supposed to be productive or constitutive of competent interaction" (Spitzberg & Changnon, 2009, p. 10). Co-orientation models are "focused on a particular criterion of communicative mutuality and shared meanings" (Spitzberg & Changnon, 2009, p. 10). Developmental models emphasize the evolution of competence through stages of progression. Adaptational models share two characteristics: multiple interactants in the process and interdependence of these interactants as they move toward mutual adjustment. In these models, "competence is manifest in mutual alteration of actions, attitudes, and understandings based on interaction with members of another culture" (Spitzberg & Changnon, 2009, p. 10). The most testable models, casual process models, often have

fairly specified and identifiable concepts that lead to outcomes to represent a “criterion of competence” (Spitzberg & Changnon, 2009, p. 10).

General models. Some of the models discussed by Spitzberg and Changnon (2009) are intended for use in teaching and assessing cultural competence across professions and experiences in preparation for existing in a global society. Hofstede and Hofstede (2005) provide an example for achieving cultural competence and/or improving cross-cultural interactions by understanding dimensions of culture organized within geographical borders. A developmental example of a generally applicable model is The Developmental Model of Intercultural Sensitivity (DMIS), which is a theoretical framework consisting of six orientations used to conceptualize levels in intercultural sensitivity and ultimately cultural competence (Hammer et al., 2003).

Cultural competence models in health care. There are several models and practice frameworks specific to application in health care professions and health care education; the majority come from nursing, but examples are growing in the medical and rehabilitation fields (Hamilton, 2009; Munoz, 2007).

Leininger (1999) was one of the first people in health care to consider culture within practice when she developed the Theory of Culture Care Diversity and Universality. This theory includes the Sunrise Model that guides nurses to provide culturally congruent care that is meaningful, holistic, and beneficial. In her words, “it refers to the *emic* (local cultural knowledge and lifeways) in meaningful and tailored ways that fit with *etic* (largely professional outsider’s knowledge)” (Leininger, 1999, p. 1999) to provide appropriate care.

Campinha-Bacote (2002) shares Leininger's belief that cultural competence is critical for meaningful and effective service delivery. Her model contains five constructs, takes into account variation within ethnic groups, and holds the assumptions that "cultural competence is a process, not an event" (Campinha-Bacote, 2002, p. 181). She also believes there is a direct relationship between cultural competence and ability to provide care. The constructs of The Process of Cultural Competence in the Delivery of Healthcare Services include variations of knowledge, skills, and attitudes as many other models do:

- Cultural awareness: the self-examination and in-depth exploration of one's own cultural and professional background
- Cultural knowledge: the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups
- Cultural skill: the ability to collect relevant cultural data regarding the client's presenting problem and accurately performing a culturally based assessment
- Cultural encounters: the process that encourages the health care provider to directly engage in cross-cultural interactions with others from culturally diverse backgrounds
- Cultural desire: the motivation of the health care provider to *want* to, rather than *have* to, engage in the process of becoming culturally aware, knowledgeable, skillful and familiar with cultural encounters. (Campinha-Bacote, 2002, p. 182)

Purnell and Paulanka (2005) provide a model for culturally competent care (also from nursing although less of a process-oriented model than Campinha-Bacote's) with an accompanying framework intended for guiding patient assessments. These authors identify twelve domains or constructs: (a) overview/heritage, (b) communications, (c) family roles and organization, (d) workforce issues, (e) bio-cultural ecology, (f) high-risk health behaviors, (g) nutrition, (h) pregnancy and the childbearing family, (i) death rituals, (j) spirituality, (k) health care practices, and (l) health care practitioners, and provide explanations for each of these domains within specific cultures categorized and defined by race and ethnicity.

Iwama (2006) has created one of the first truly postmodern models for culturally sensitive practice for occupational therapists centered around understanding each person and therapeutic relationship in a socio-cultural context. As Iwama (2009) describes it, "rather than focusing primarily on the individual client, the Kawa model focuses on 'contexts' that shape and influence the realities and challenges of peoples' day-to-day lives" (p. 1125).

Communication and cultural competence. Cultural competence models in health care are intended to improve relationships between providers and patients. This makes the models relevant to speech-language pathology as well, but it is necessary to know what the relationship is supposed to be about. Leininger (2002) puts *care* at the center of cultural competence for nursing, and Iwama (2006) says *human occupation* defines the profession of occupational therapy, guides the philosophy, and clarifies professional identity. Speech-language pathology does not have a well-defined construct

to define the core of the profession and practice. ASHA (2010a) states SLPs work with the full range of human communication and its disorders and specifically lists cognition, speech, language, and swallowing. Walsh (2005) points out there is a great deal of misunderstanding inherent in the terminology of speech pathology, but there is evidence *communication* may be the best construct to define and guide speech-language pathology philosophy, identity, and practice.

Cultural competence in health care has been a focus in nursing for quite a while, beginning with Leininger in the 1950s (Leininger, 1999). Medical, dental, pharmacy, and other allied health programs are in the early stages of research on how cultural competence manifests itself in these professions. Most of the focus of this research is how cultural competence, or cultural competence trainings, impact the results specific to those fields such as measureable health outcomes. It is noteworthy in each of these fields, communication is listed as a primary component of cultural competence but has not been a direct focus of the research (Gibson & Zhong, 2005)—evidence it may be up to those who concentrate on communication to conduct the research on cultural competence and communication. Iwama (2006), developer of the culturally relative Kawa Model for Occupational Therapists, supports this idea:

Although the work began in the field of occupational therapy, as word about this work gets around people in other allied health professions appear to be taking an interest. And amongst the rehabilitation sciences, SLP leads the field. Perhaps this is because so much of communication and human relations can be seen to have a fundamental connection with matters of culture. More and more, SLP pathologists

are taking greater interest in social context as an enabling factor in the processes of communicating. (Iwama, personal communication, January 4, 2010)

Additional evidence in support of a communication lens for research in cultural competence is provided by Gibson and Zhong (2005) when they state, “Within this increasingly multicultural society there is a need for competent communication between all cultures in every aspect of our lives” (p. 622). Srivastava (2007) identifies communication as the “main tool that healthcare providers use to supply healthcare services” (p. 101) and, “communication and cultural competence go hand in hand” (p. 102). Empathy and experience create more effective communication, and appropriate and effective communication can result in greater health outcomes and better satisfaction for patients—and therefore less anxiety and better job satisfaction for health care providers (Gibson & Zhong, 2005). SLPs are health care providers primarily focused on communication and are supposed to be “well aware of the role of the cultural context in discourse” (p. 104), according to Ferguson (2009). SLPs are therefore a natural group of professionals to bridge the connection and advance the study of cultural competence and health care.

Assessing cultural competence. In addition to understanding what cultural competence is and how it fits into speech-language pathology, it is important to know what cultural competence looks like in the practice of professionals and students. In other words, we need to know how to assess levels of cultural competence to determine a connection to practice and outcomes.

Deardorff (2004) concluded, according to the opinions of higher education administrators and intercultural experts, cultural competence can be measured with certain stipulations. First it should be measured over time as opposed to one point in time, and multiple methods of measurement should be used. As in all good assessment, “it is vital for the assessment method to match the definition devised for intercultural competence” (Deardorff, 2004, p. 200). Hamilton (2009) provided a health care example of this premise when he stated assessment of cultural competence should be embedded later in an educational program and should involve experience and reflection.

Many of the models used in nursing are suggested as frameworks for assessment of professional cultural competence in other health care venues. For example, Purnell (2002) indicated the domain related to workforce issues like autonomy, “ethnic communication styles, individualism and health care practices from the country of origin” (p. 195) make the Purnell Model of Cultural Competence appropriate for assessing organizational cultural and “cultural issues among staff” (p. 196). Stimpson and Martin (2005) used Leininger’s Sunrise Model and its seven key components (technological; religious and philosophical; cultural values, beliefs, and life-styles; kinship and social; political and legal; economic; and educational) as a measure of intra-professional cultural competence to determine the Finnish nursing students’ perceptions of nurses in the U.S. They “expected that responses obtained within the structural dimensions provided by Leininger’s (1991) model would accurately illuminate key components of Finnish cultural perspectives” (Stimpson & Martin, 2005, p. 65) and concluded the students held stereotypical views of U.S. nurses. They suggested studying these intra-professional

cultural understandings and misunderstandings could lead to more effective cross-cultural working relationships.

The IDI is a reliable and validated measure of intercultural sensitivity based on Bennett's theoretical framework, the DMIS (Hammer et al., 2003). Bennett's DMIS framework is intended "for conceptualizing intercultural sensitivity and competence" (Hammer et al., 2003, p. 422). While the DMIS has six levels of cultural sensitivity orientation—denial, defense, minimization, acceptance, adaptation, and integration—there are five levels of orientation on the IDI. Psychometric analysis to assess the internal validity and reliability of the IDI did "show it to be a reasonable approximation of the theoretical model of intercultural development" (Paige, Jacobs-Cassuto, Yershova, & Dejaeghere, 2003, p. 483). This measure, while not complete on its own, provides a quantified and validated look at levels of cultural competence development.

Self-Awareness

Self-awareness, a critical component of cultural competence in health care, is often placed in the attitude or awareness categories of cultural competence (Munoz, 2007). Self-awareness is a "deliberate and conscious cognitive and emotional process" (Purnell & Paulanka, 2005, p. 3) where health care professionals think about themselves and their own existence and reflect and appreciate how their own heritage and experiences make them culturally similar (universality) or different (diversity) from people they are encountering (Leininger, 2002; Munoz, 2007).

In health care relationships, self-awareness goes beyond the provider's own personal culture and experience to include the cultural history, values, practices, and

epistemology of their profession. Professions are cultural, and “In the USA the traditional, biomedical perspectives on care, including the definition and categorization of illness and the various systems developed for providing and paying for care, represent a broader cultural context” (Munoz, 2007, p. 256). SLPs must consider who they are in the context of their profession and practice, which is firmly situated in the Western biomedical perspective as demonstrated in Ferguson’s (2009) challenge to SLPs “to consider their own culture of speech-language pathology and its assumptions in relation to clients’ difficulties” (p. 105). A profession, in this case speech pathology, is a specific social context in which students must go through the process of understanding and developing their own professional identities. And as Kim (2009) points out, the ability to foster intercultural relationships is dependent on understanding one’s own identity orientation within a given situation.

Identity

Identity and self-awareness are interconnected components central to developing cultural competence (Anand & Lahiri, 2009; Bennett, 2009; Endicott et al., 2003; Kim, 2009; Purnell, 2002; Seligman & Darling, 2007); and like cultural competence, professional identity requires definition. In their review of research involving professional identity in teacher education, Beijaard et al. (2004) found a clearly defined operational definition of professional identity is absent but they did identify four essential features including (a) process, (b) self and context, (c) sub-identities, and (d) agency. These features are also supported in research outside of teaching in management, medical, engineering, and allied health fields (Chreim, Williams, & Hinings, 2007;

Edwards & Dirette, 2010; Fagermoen, 1997; Griffer & Perlis, 2007; Niemi, 1997; Ohlen & Segesten, 1998).

Professional identity. Each of us has our own personal identity or identities based on our experiences in varying social contexts. Connected to but different from our personal identities are our professional identities or who we are as practitioners within a profession. Understanding this professional identity is part of the self-awareness needed for cultural competence. The following sections mirror the way current research on professional identity is often organized or categorized.

Process. Like cultural competence, professional identity is a process rather than a destination (Beijaard et al., 2004; Cohen, 2010; Mann et al., 2008; Niemi, 1997; Sutherland et al., 2010). In her research on teacher identity development, Cohen (2010) states “there is general agreement that professional identity itself is an ongoing, dynamic process in which individuals negotiate external and internal expectations as they work to make sense of themselves and their work” (p. 473). Fagermoen (1997) studied professional identity formation in nursing and determined it is a process involving social interaction and self-reflection, a premise supported by Niemi (1997) in medicine; Beijaard et al. (2004), Cohen (2010), and Sutherland et al. (2010) in teaching; and Wenger (1998) in several fields including business, education, and government. Rummens (2003) also acknowledges the process dynamic, and identifies three processes at work to determine one’s self, personal, and social identities: (a) identity development/formation, (b) identity construction, and (c) identity negotiation.

Self and context. Identity is a partial result of self-awareness as we develop our own self-concepts within specific contexts (Rummens, 2003). Self-awareness in a health care cultural context has both cognitive and behavioral characteristics. Health care practitioners must recognize their own cultural norms—including existence, sensations, thoughts and environment, professional and personal cultural positions, cultural patterns (professional and personal), the cultural positions of others—in interactions with others (Anand & Lahiri, 2009; Bennett, 2009). They must also suspend assumptions, adjust their behaviors to maximize care, and integrate their values, beliefs, and behaviors to create effective interactions (Anand & Lahiri, 2009; Bennett, 2009). Iwama (2006) explains identity as part of social structure when he says, “...if identity and definition of ‘self’ are strongly tied to collective, or frames, one’s allocated role has an extraordinary effect upon one’s sense of identity and construction of ‘self’”(pp. 88-89). In considering the development of a professional self, the social structure is based primarily on educational and professional practices in the field.

Practice. Who we believe we are as health care providers affects and is affected by how we practice (Beijaard et al., 2004; Cohen, 2010). In standards-based educational programs, identity tends to be prescribed through the attributes and competencies are measured and determined to be necessary for successful practice (Mann et al., 2008), a rather modernist view antithetical to identity as process. Consistent with this concept, Niemi (1997) investigated medical students’ reflective skills and the connection to professional identity in an attempt to determine a constructivist (postmodern) framework for advancing curricula. She found students who were “committed reflectors” or able to

take multiple perspectives had a stronger connection to their professional choices and identity.

Students new to a profession must undergo these processes throughout their education. They will need to examine their history to determine where they are similar or different from their fellow students, future colleagues, and clients. As they are constructing their identities they are learning about a professional community and how they will participate. As they negotiate identity, students begin to understand their experience and their identity within a socially constructed profession.

Role. Identity in context, specifically a professional context, involves ideas of role—the “goals, values, beliefs, norms, interaction styles and time horizons typically associated with a [profession]” (Chreim et al., 2007, p. 1515). The ways professionals view their role identity is central in how they interpret and act in work situations (Chreim et al., 2007). Even though professional role is considered more superficial than professional identity (Ohlen & Segesten, 1998), a conflict between actual role and role expectations can compromise interactions and identity (Edwards & Dierette, 2010). Role ambiguity has been an issue in speech-language pathology for years and continues to be an issue, but the impact of this ambiguity on students has not been investigated (ASHA, 2009a).

Sub-identities. Beijaard et al. (2004) state, “professional identity consists of sub-identities that more or less harmonize” (p. 122). Gee (2001) provides a framework for the role of identity in education by explaining definitions and connections between four types of identity that help to define what it means to be a “certain kind of person” (p. 100): (a)

nature-identity, (b) institution-identity, (c) discourse-identity, and (d) affinity-identity. These sub-identities are described as “ways to view identity” (Gee, 2001, p. 100) that come from different perspectives and manifest themselves in different ways depending on context and interactions.

“In most professional fields, strongly institutionalized beliefs and values define professionalism” (Chreim et al., 2007, p. 1517). In speech-language pathology, Ferguson (2009) conducted a postmodern deconstruction of professional discourse and warns of the need to pay attention to the assumptions and attitudes communicated within that discourse. Knowing our own identity and culture as a person and professional, and being able to self-assess how we will react and respond in situations with a client, patient, or student as a result of that orientation is important to ensuring equitable treatment. Our identity comes from our background and experience, and it also forms within our professional training and practice. Who we know we are is important, but so is knowing who we *think we are*.

Wenger (1998) uses the term identity as a central concept to social learning theory and participation in a CoP. He explains, “participation is a source of identity” (Wenger, 1998, p. 56) and the communities of practice we participate in define a big part of who we are. As students enter into the speech pathology CoP, they are developing identity as individuals and within a social context. Social and personal identities focus on social comparisons and positioning of individuals; as students learn and develop, they negotiate and renegotiate their place within the professional community along their learning trajectory (Rummens, 2003; Wenger, 1998).

Communities of Practice

Many of the constructs of cultural competence and professional identity are similar, if not related to one another. A theory that includes both constructs could provide a framework for determining if professional identity and cultural competence are somehow connected. The theory of Communities of Practice shares these constructs.

Wenger (1998), a researcher on CoPs in professional settings, describes CoPs as a “social theory of learning” (p. 3) that involves participation in social community and negotiation of identity within the community. A community is defined by three dimensions: (a) mutual engagement, (b) joint enterprise, and (c) shared repertoire. Learning occurs through participation centered on those dimensions and as learners define and negotiate their identity through their experiences and observations.

In Wenger’s (1998) paradigm, mutual engagement involves the negotiated actions and meanings of a group of people. In other words, it is what matters to a specific group and how they work to get it done. In speech-language pathology, practitioners are mutually engaged in helping people who have difficulty communicating. SLP students are mutually engaged in achieving personal skills and knowledge in relationships with peers, and academic and clinical educators. There is a distinct focus on self during the education of an SLP; and then an important shift of focus on the client or patient happens when SLPs enter their careers. Somewhere in between there is an overlap or shared focus where students are learning about themselves while serving others. This is the point in their education when they are assessed for cultural competence. Since cultural

competence requires an awareness of self and understanding of others, this overlap is a critical point in an SLP's education.

Joint enterprise, Wenger's (1998) second characteristic, is the process of negotiation among members of a CoP resulting in accountability and meaning that exists in spite of extrinsic influences. Through joint enterprise members interpret information through a lens of participation that keeps the goal(s) of the community in mind. When cultural competence is defined as characteristics of race, ethnicity, or gender there is no room for interpretation. Views of culture from the lens of the medical model prevalent in SLP programs limit the negotiation important to a CoP. A postmodern view, however, sees culture as social phenomena that change with time and context. It allows students to gain the flexibility to appraise and re-appraise the meaning of culture with each new experience.

Wenger's third characteristic of a CoP is shared repertoire, the discourse of practice. It includes the "routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions or concepts the community has produced or adopted" (Wenger, 1998, p. 83). In other words, what students see, hear, or experience is what they will recreate in their own practice. If they experience cultural competence as a skill instead of a process, it may limit their ability to continue to grow. Skills can be (and often are) assessed as either present or absent (e.g., a student is able to write a measurable goal or she is not). A process on the other hand is developmental and capable of constant change. The way educators of SLP students present cultural competence within their discourse could impact whether students continue to develop cultural competence as practitioners.

Wenger (1998) states, “what we think about learning influences where we recognize learning” (p. 9), suggesting the epistemology and ontology of a professional practice will greatly influence how students interpret information and apply it to practice. Cultural competence as a process is a personal, developmental, and ongoing transformation resulting in increased awareness, sensitivity, and communication skills best experienced within a CoP (Wenger, 1998).

Summary

It is difficult to find a clear definition of cultural competence and professional identity, but the two concepts do share several constructs. Both are considered developmental processes that involve self-awareness, behaviors, skills, attitudes, and perspectives determined within context and through interactions with others. A systematic look at how students near the end of their academic career interpret cultural competence and professional identity may provide new understanding and insight about these two concepts and a framework for future research, curriculum design, and pedagogy.

Grounded theory methodology is intended to move beyond description of an experience to generate theory that may explain practice or provide a framework for future research (Creswell, 2007). Charmaz (2006) explains, “grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories ‘grounded’ in the data themselves” (p. 2). As a result, grounded theory methodology allows for further development of the literature review following the

collection and analysis of data. As potentially new theory emerges from the data, a further review may be needed to anchor the findings in additional literature.

Speech-language pathology programs are focused on preparing students to work in a variety of settings and communities to improve the lives of people with communication and swallowing impairments. Effective interactions with clients, patients, and/or students require cultural competence and self-awareness. A self-aware practitioner understands their own personal culture and the culture of their profession and how it can impact interactions with those they are serving. Wenger's (1998) theory of Communities of Practice provides a framework for investigating the connection between the process of professional identity formation and the self-awareness aspect of cultural competence.

As this literature review demonstrates, a significant amount of research has been conducted on professional identity development and cultural competence in and out of health care settings, but there is a lack of research on a possible connection between the two concepts. Graduate students studying to become SLPs are in the middle of both processes—a critical point in their education and a logical point for researching a possible connection.

Understanding how students perceive their own developmental levels of cultural competence and professional identity and how these concepts fit within their education programs can inform curriculum and pedagogy. The following chapter will provide an explanation of the specific methods used to achieve the purpose of this research.

Chapter 3. Methods

This study investigated a connection between developmental levels of cultural competence and speech-language pathology graduate students' perceptions of professional identity. The participants in this study were students in their second year of graduate programs in speech-language pathology. The intended audience of the study is faculty and administrators in speech-language pathology programs and practitioners supervising students and fellows in the field.

Study Design

Grounded theory methods provide “systematic, yet flexible guidelines for collecting and analyzing data” (Charmaz, 2006, p. 2). The original method was “developed by Glaser and Strauss (1967) for the purpose of building theory from data” (Corbin & Strauss, 2008, p. 1). Because there is limited literature connecting professional identity and cultural competence, it was considered necessary to construct a theory from the data or experiences and perspectives of students themselves.

Setting and Participants

SLPs typically must hold a Master's degree to be licensed to practice. Most graduate programs in speech-language pathology involve two years of study which include coursework, internship, and externship experiences across the nine categories of communication and swallowing disorders in a variety of settings. Students in their first year of graduate school typically attend courses full-time while beginning their clinical experiences on campus. In the second year of graduate study students attend class and participate in part-time and full-time externships in settings off campus. Second-year graduate students are in a transition phase of education as they move from student to

practitioner under the guidance of licensed clinicians in the field. Students in this study were recruited from ASHA accredited graduate programs on both U.S. coasts and in the Midwest.

Participants in this study represent a criterion sample defined by enrollment in the second year of a speech-language pathology Master's program. Gall, Gall, and Borg (2003) explain stratified sampling "involves selecting a sample so that certain subgroups in the population are adequately represented in the sample" (p. 173). In this study, *stratified purposeful sampling* was used to ensure each developmental orientation of cultural competence within the distribution of scores was represented. To obtain this sample, participants completed the IDI ($n=18$) and participated in a one-hour interview if they were available ($n=14$). The IDI results were initially interpreted by a third party qualified administrator (QA), and a distribution of the scores from the sample was determined. Six interviews were chosen for analysis: the top, middle, and bottom two scores within the distribution.

Data Collection

Students enrolled in their second year of a speech-language pathology program were interviewed regarding their perspectives on professional identity, their identity as SLPs in the context of interactions with clients, who and what they are representing to clients as professionals, and their perspectives on and definitions of culture and cultural competence. The data collection process included the following steps:

All students enrolled in their second year of graduate school at six universities were invited to participate through an invitation letter describing the study (see Appendix

A). Following provision of written consent to participate (see Appendix B), each participant completed a demographic questionnaire and electronically completed the IDI. The demographic questionnaire was used to gather general data regarding gender, age, educational data, and geographic and international experience (see Appendix C). The IDI is a valid and reliable tool designed to “index intercultural sensitivity” (Paige et al., 2003, p. 468) based on the DMIS. Participants completed the online IDI two weeks to ten days before their scheduled interview. The IDI results place individuals within one of five intercultural orientations: (a) denial, (b) polarization, (c) minimization, (d) acceptance, and (e) adaptation. Results were interpreted by a third-party QA and placed in a distribution of scores. The highest, middle, and lowest two scores were chosen for analysis without researcher knowledge of individuals’ specific orientations.

An interview guide (see Appendix D) was developed based on the literature on professional identity and cultural competence. These questions served as conversation starters in the face to face interviews, evolved, and expanded based on the experiences and discussions during the interview process. The professional identity questions were derived from constructs of Wenger’s (1998) CoP, a social theory of learning, which provides a framework for defining a community or profession. Wenger (1998) suggests most transformative learning happens when the learner is a member of a community, understands the nature of the practice, and develops an identity within that community. Interviews were recorded using a Sony digital voice recorder, iPod, and Voice Memos recording application. Each interview was transcribed verbatim.

An additional source of data came from the researcher's memos. "Memo-writing constitutes a crucial method in grounded theory because it prompts you to analyze your data and codes early in the research process" (Charmaz, 2006, p. 72). Memos are personal notes from the researcher which include recorded thoughts, comments, questions, and connections that emerge throughout the coding and data collection process. Memos were kept by the researcher throughout the IDI administration, interview, and coding process and were used in the construction of themes and theory. All notes and comments regarding participants were recorded using pseudonyms.

Data Analysis

Charmaz (2006) describes grounded theory data analysis as *constant comparison analysis* which involves three phases of coding: (a) initial/open, (b) focused, and (c) axial or theoretical coding. Glesne (2006) describes *thematic coding* for qualitative data analysis as "a process that involves coding and then segregating the data by codes into data clumps for further analysis and description" (p. 147). With each of the methods data analysis involves organizing to make sense of the information, describing, creating, and developing theories and connections, and searching for patterns and categories for interpretation (Charmaz, 2006; Glesne, 2006). Concepts and steps from both methods were used in this study, and at each stage themes and categories that emerged from the data were compared to researcher-created memos and field notes.

Initial coding provided names and general schemas for the data and an opportunity to sort, synthesize, integrate, and organize (Charmaz, 2006; Glesne, 2006). Focused coding integrated researcher memos and information from field notes to further

synthesize and explain the data, create categories, and formulate a theory. Theory connecting constructs of professional identity and developmental orientations of cultural competence was developed based on the information that emerged during the coding process.

Rationale

Speech-language pathology students in their second year of graduate studies are at a point in their education where they are developing both professional identity and cultural competence. The participants in this study represented a convenience and criterion sample recruited from a pool of approximately 150 students enrolled in speech-language pathology programs at universities located in the U.S.

Charmaz (2006) states grounded theory sampling is aimed toward theory construction, not for population representativeness; therefore a random sample of students was not considered necessary. Stratified sampling ensured representation within the distribution of scores representing developmental orientations of cultural competence.

Validity and Reliability

Creswell (2007) identifies the 13 criteria (seven for process and six for empirical grounding) developed by Strauss and Corbin (1990) as the “benchmarks for assessing the quality of a study” (p. 217). These include:

Process.

1. How was the original sample selected?
2. What major categories emerged?

3. What were some of the events, incidents, actions, and so on that pointed to some of these major categories?

4. On the bases of what categories did theoretical sampling proceed? Guide data collection? Was it representative of the categories?

5. What were some of the hypotheses pertaining to conceptual relations and on what grounds were they formulated and tested?

6. Were there instances when hypotheses did not hold up against what was actually seen? How were these discrepancies accounted for? How did they affect the hypotheses?

7. How and why was the core category selected? On what grounds?

As will be shown in the following chapters the categories and themes that emerged from these data were provided by second-year graduate students enrolled in speech-language pathology programs across the U.S.—a population at the point of transition from student to professional. Discussion was guided by ten original questions centered on the two main constructs of this study, professional identity and cultural competence. Participants provided answers and stories that came from their personal and academic experiences (which included course and clinical experiences). These experiences represented situations in their lives that contributed to development of their professional identity and cultural competence.

Empirical grounding.

1. Are concepts generated?

2. Are the concepts systematically related?

3. Are there many conceptual linkages, and are the categories well developed?

With density?

4. Is much variation built into the theory?

5. Are the broader conditions built into its explanation?

6. Has process been taken into account? (Creswell, 2007, p. 216)

All of these criteria were addressed during analysis and interpretation of the data.

Glesne (2006) indicates qualitative research and analysis can be validated by a constant process of looking for new and representative data sources, reflecting on researcher bias, spending an adequate amount of time observing and engaging with the data, and enlisting feedback on the interpretation of data. In this study the researcher recruited a representative data source by analyzing data from participants in each orientation of cultural sensitivity represented in the distribution of scores. Research memos included reflections on bias and were used in data analysis and interpretation; and time was spent coding, categorizing, recoding, analyzing and interpreting data.

Ethical Considerations

This study was reviewed by the University of Minnesota Internal Review Board and given written approval. Participants were all adults who were not considered protected subjects. The researcher notified each participant of the risks and benefits of the study. All data were stored on a secured University of Minnesota Duluth server and pseudonyms were used on all research materials.

Chapter 4. Research Findings

This study was designed to discover second-year speech-language pathology graduate students' perspectives on professional identity and cultural competence.

Specifically, it was intended to answer two questions:

1. How do students at specific developmental levels of cultural competence, as defined by the Intercultural Development Inventory (IDI), identify as professional SLPs?
2. How do students who have just begun to identify as speech-language pathologists define cultural competence?

Participants and Selection Process

Volunteers were recruited from six speech-language pathology graduate programs from east coast, west coast and Midwest states. Twenty students responded to the request for participation, 18 completed the IDI, 17 completed the Demographic Questionnaire, 14 were interviewed, and six interviews were used for analysis. All of the participants were students in the second year of their graduate program.

Results of the 18 completed IDIs were interpreted by a third party IDI QA. The scores of the 18 participants who completed the IDI represented two orientations, polarization ($n=6$) and minimization ($n=12$). According to the IDI V.3 (Hammer, 2009), people in the polarization orientation tend to view cultural difference in terms of *us and them* in one of two ways: (a) *defense*, demonstrated by an uncritical view toward one's own culture and an overly critical view toward others' views and practices; or (b) *reversal*, an overly critical view of one's own values and practices and uncritical view

of others. People in the minimization orientation highlight commonalities and universal values but may fail to recognize and appreciate cultural differences (Hammer, 2009).

Fourteen subjects were interviewed and a representative sample selected from the population was determined on the bases of median representative scores across the distribution. The participant interviews chosen for analysis in this study represent the highest two (minimization), median two (also in the minimization category), and lowest two (polarization) scores in the distribution of the group. Each interviewee was given a pseudonym; the six interviews chosen for analysis are called Cameron, Danny, Drew, Kyle, Randy, and Sam (five women and one man). All participants were between 22 and 30 years old at the time of the interview and all reported they have interacted with both child and adult clients in clinical settings.

Results

All participants were interviewed using the Interview Guide (see Appendix D). Following initial and focused coding of the six interviews, six themes and 21 categories or subthemes emerged around the main constructs of professional identity and cultural competence. All of the themes and categories were represented in statements made by all participants—no response differences were noted based on participants' IDI scores.

Professional identity. Themes of professional identity and what it means to be an SLP were elicited through questions and inquiries about meaning, what matters most, role, and unique aspects of the profession. Overall, the participants shared a positive opinion of the profession and indicated being an SLP means helping, serving, and changing clients' lives through improved communication. The clients and their

communication needs took precedent and should be treated “with dignity and respect so that [speech-language pathologists] can serve them well and so that their communication environment can be as enhanced as possible” (Drew).

Making meaning of the profession. A unique and singular focus on communication as the center of the profession was demonstrated in statements by Cameron and Kyle who said, “I really didn’t know until I got in this program, how important communication was;” and “I mean, we solely focus on all aspects of communication and all other professions may work in aspects of it.” In the service of improving communication were several additional subthemes.

Helping. Sam said, “Being a speech pathologist means that you want to help people with difficulties communicating, whether it’s speech related or language related.” The theme of helping, or giving assistance, to others was also supported by Cameron who said, “being a speech pathologist I think is really helping to help those who have difficulties with just the talking part, become better talkers so that they can be better communicators.”

Service. Service, which differs from helping in that it suggests performing a service to or for others as opposed to assisting them, recurred in several statements including this one by Kyle: “I think we really know how to help them communicate more just using their own voice and giving them the tools that they need.” Drew suggested a belief that speech-language pathology service is the right thing by stating, “That’s a cultural perspective that we have is that speech pathology is good and useful and so if you need it you should be receiving the services.”

Changing lives. A desire or belief that an SLP makes an impact on the lives of others was demonstrated in statements by Sam and Randy who said respectively, “For me, I know it’s going to be most important that I feel like I’m making a difference,” and “I really like the fact that you have...an actual impact and you can see an impact in somebody’s life. It makes it so much more rewarding to actually see that they are learning.”

Defining the work. Separate from attempts to find meaning, participants often tried to define the work or actions that go into everyday speech-language pathology practice.

Work. Participants used the term *work* to describe what they do as practitioners, e.g., “we were working on behavior management” (Sam). They also used the term to describe what their clients do as demonstrated in these examples by Randy and Danny: “Because sound work is difficult,” and “Allowing someone to be able to communicate in whatever way they can and whatever their goal is, whatever they want to work on, [we] try and somehow find a strategy to help them with that.”

Evidence-based practice. When asked what matters most in speech-language pathology practice, Drew responded, “I would say providing evidenced-based treatment. I’m kinda [*sic*] big on that.” Sam’s statement, “It’s so important that you are able to...do the research in the field and what you’re working with and making sure that what you’re doing is proven to be effective,” represents the importance of conducting research. Sam also explained, “I think more what I take away from research is the importance of

keeping up on the research in the field and knowing how to read the studies...learning how to analyze it and see whether it's reliable.”

Methods of practice. The meaning of the profession is centered on communication. Similarly, statements about diagnostic and treatment activities were concentrated on increasing or improving communication. For example, Kyle connected the subthemes of helping, service, and methods of treatment with this response to a question about role: “Helping people to communicate their thoughts. Whether it's...by speech, by gesture, by AAC devices...and just kind of providing the best services you can to them.” Danny used an almost identical description of the work of the profession by saying, “I would say we just help people to communicate in whatever way they can, whether it's verbally, or sign, or AAC or compensatory strategies or use whatever we can to help people communicate.” Drew's statement, “I'm studying speech pathology and pretty much I'm going to get paid to play with kids all day,” demonstrated a less technical view of treatment methods.

The breadth of the speech-language pathology scope of practice emerged several times. Danny explained, “We do a huge range of everything...I think it's pretty unique.” This large scope practice can make developing into a professional difficult as suggested when Cameron said, “I've had a hard time making the connections between everything because I feel like speech pathology is such a broad field.”

Skills. When asked about interactions with clients, many participants spoke of skills they have learned such as responding, adjusting, adapting, guiding, counseling, and making decisions. Drew explained, “Clinically, I gained a lot of skills in observation and

responding to clients on the fly...,” and provided a connection between skills and evidence-based practice by stating, “I think I’ve also learned how to look into research and evidence-based practice to know what are the best clinical approaches for the kinds of populations that I was working with at the time.” Cameron told a story of a clinical experience that involved “trying to adjust what’s practical and what you can do with the individual and with their expectations and what’s important for them.”

Drew defined responsiveness in various contexts by explaining the need to “be responsive to [client] communication needs,” as well as “being responsive to [colleagues’] differing ideas on what constitutes communication effectiveness, health, well-being, etcetera.” Sam recognized the patience, time, and “everything that goes into a research study” through laboratory experience. Sam discussed skills yet to develop by looking forward to “knowing how to interact with our colleagues in a very comfortable way,” and “a lot of creativity that I’d like to develop.”

Community. Participants almost exclusively assumed fellow SLPs when asked to speak about colleagues. One participant, Sam (without prompting), identified colleagues as a treatment team that included parents and other professionals. When asked questions about interactions with colleagues and how colleagues perceive the role of an SLP, participants indicated professionalism, communication, collaboration, sharing information, and a common goal were most important.

Perspective. A unidirectional perspective emerged in professional identity and cultural constructs. When describing interactions with teachers, Randy indicated needing to “just be direct that they know exactly what I expect of the client and what I expect of

my therapy with them.” Examples from clinical interactions were provided by Drew who said, “We provide building blocks,” and Danny who referenced “working on behavior”. When participants mentioned working with someone it was to identify a population, as in “I worked with an autism group” (Drew) rather than to describe a mutual exchange with clients.

Negotiating roles. Participants identified several roles for SLPs including “providing diagnosis, assessment, counseling, [and] referral to other professionals” (Drew). They overwhelmingly demonstrated a belief that other professionals do not understand the role of an SLP in statements like:

I don’t think people actually understand what goes into it and that...everything is interrelated. I think others think a lot of what we do is very simple and very contrived and that anybody can do it. I don’t think there is much of a respect for speech pathologists. (Randy)

Despite feeling disrespected and treated like a “teacher’s aide” in the school setting, Drew indicated SLPs are recognized for a unique perspective on “illness and symptoms...and therefore [are] clinically useful” in medical settings.

Teaching. Teaching or educating appeared as a theme in reference to how SLPs fit into the educational system, act as teachers for clients, and educate families. “We aren’t teachers in the sense that we are teaching curriculum; however, we are teachers in the sense that we provide building blocks upon which curriculum can be taught” (Drew). Randy made a similar statement, “I feel like an educator...I don’t feel like I’m doing

therapy I feel like I'm teaching...skills," and also referred to "having to educate the parents."

At times, it appeared participants were struggling to understand their place within educational structures. Randy explained supplementing rather than providing instruction because, "I find it really difficult to turn the water cycle into a speech and language game...but then maybe it's just because I don't have much experience with turning class curriculum into speech and language lessons." Cameron connected teaching in higher education to clinical practice by saying, "I really would like to teach...and I also love speech-language pathology...I just think that's such an important thing so combining the two of them is something that I think would be just thrilling."

Advocacy. Participants identified the role of advocate for the profession and clients. Danny provided an example of having to advocate for the usefulness of the profession by referring to other professionals who may have a limited view of the role of an SLP: "I think a lot of it is advocating, and I'm always having to tell people [speech pathology is not just articulation] I also work with people who have had strokes, I also work with young, young babies." And in reference to clients, Danny said, "I think a lot of it is advocating...for the populations that we work with." Drew agreed by saying, "I see my role as a speech pathologist to be an advocate for the communication needs of my client."

Counseling. Randy used the term confidant to identify a role in speech-language pathology, explaining it is most important with "older kids 'cause they're going to tell you how they're feeling about their speech and...I need to be trustworthy enough to be

able to, one, take that information, and two, figure out how to make that situation better.” Cameron attempted to draw a line between counselor and SLP by saying, “I do a little bit of the counseling role as a speech-language pathologist, but I’m not going to turn into the counselor.”

Compartmentalizing. When discussing experiences and interactions with clients, participants provided information typical to that seen in a medical model. Cameron provided this theme’s title in the statement:

I guess I kind of compartmentalize speech in some ways. I see the school aspect of speech whereas the professors and the student going to school almost a smaller branch of that. I almost see research as being separate.... I see therapy in a hospital setting be it acute care or rehabilitation and I see the schools.

Participants used dichotomies like adult vs. child or medical vs. school in response to a variety of questions including those about the meaning of the profession, what represents the profession, and interactions with clients. Sam provided a compartmentalizing statement summarizing those typically used by participants to explain the profession by saying,

It’ll be good, whether it’s children or adults, all those areas that we’re qualified to help with, whether it’s language or voice...it almost seems like there’s kind of two sides. There’s the medical and there is also the more language-based side of it.

Clients, activities, and interactions were described using categories of age, setting, and diagnosis. When asked what represents speech pathology, Danny used diagnostic

categories to respond: “I think about young kids with speech and language. I think about fluency. I think about aphasia,” and continued to use age categories to describe future plans with, “It’s been nice working with adults, but I feel like that’s not where I’ll head.” When asked to describe interactions with clients, common responses included, “A fifteen-year-old with sounds. Seventeen-year-old fluency...elderly man with aphasia” (Randy). Some provided more detail like, “A very affluent former medical researcher [who] had a stroke ten years ago and was beginning to show signs of dementia and possible Parkinson Disease and was concerned about language comprehension” (Drew); but responses were limited to characteristics of the client, not descriptions of the actual interactions.

Participants also used compartmentalizing statements about themselves, e.g., “I do research” (Drew), and other professionals they may encounter in the field. For example, Kyle stated, “PTs look at the physical...OT works on stuff like eating, and teachers look at the whole educational experience, and doctors look at more their health in general.” They also had difficulty explaining speech pathology unless they referenced a specific setting (school vs. medical) and failed to recognize professors as SLPs.

Participant views of what SLPs do from day to day were very consistent. Each category and theme contained statements from every participant, regardless of where they were on the developmental continuum of cultural sensitivity. And despite differences in clinical and academic experiences, participants had a homogenous view of speech-language pathology in general. Although the collective identity of SLP was emergent in

their statements, it is noted in the next section on cultural competence, participants stated they did not yet feel part of the profession.

Cultural Competence. To capture their perspectives on this topic, participants were asked to explain the culture of speech-language pathology, describe their own personal cultural background, define cultural competence, and provide perceptions of their own cultural competence.

Culture. Participants used the constructs of ethnicity, nationality, geography/community, race, SES, occupation, religion, skin color, sexual orientation, and gender when speaking of culture in general. Cultural parameters used in conversations included music, holiday celebrations, family priorities, goals, values, and beliefs. One participant used the construct of “good solid working” to describe culture, a theme that emerged in two contexts of professional identity as well—professional work and work of the client.

Cultural self-awareness. Participants were asked to elaborate on constructs they used to define culture but were unable to provide responses. When asked to describe or define American or define personal culture, Kyle responded, “I don’t know...we had to do this in class too at one point and...I didn’t know what to say,” and “I feel like it might be easier if I was Hispanic or something, I don’t know.” Similarly participants used ethnicity as a cultural construct but indicated, “We don’t really hold on to any customs at all” (Randy), and “I am Irish/Polish, but it’s not something that I’m...gung ho about” (Sam).

Cultural interactions. It was common for participants to state they had little experience with what they referred to as diversity or other cultures. Sam explained a

move from a suburban high school in one state that was “stereotypical white, middle-class,” to a suburban high school in another state that was “split into white, middle-class and more inner city,” as “[my] first experience of people of different cultures.”

A lack of cultural self-awareness was demonstrated in several examples of cultural interactions where participants described negative experiences or constructs within other cultures they believed did not exist in their own cultures. Danny, who grew up in a suburban setting, told a story of working in an urban school district and said, “It’s always the kids that need the most help that you want to talk to their parents so badly. Those are the ones that you can’t get a hold of and I feel like that’s very different than suburban.” After describing experiences with clients who lived in their car and missed 70 days of school, Danny stated, “I don’t feel like you see that in suburban or rural schools.” Similarly, Kyle, who grew up in the suburb of a major metropolitan area, said, “When I hear things about things in the south like racism and all that stuff, it’s just, I wasn’t exposed to that so to me it’s just, what?”

A cultural experience in a professional school setting resulted in Randy being “far less tolerant of some things.” But Cameron was able to identify personal cultural differences and provided an example of feeling like a cultural outsider in a professional setting by describing an experience in an unfamiliar setting: “I don’t know how these rules go. I don’t know how it works.” Cameron also described an example of connecting with a client by “being able to figure out something that was important to her.” Kyle was able to recognize a missed opportunity to increase cultural experience by stating, “My roommates are Jewish but...I don’t know if I know them as in depth as I should.”

Conversely, despite receiving dirty looks for being American and being spit at, Danny described a study abroad experience as “awesome, for sure.”

Professional culture. When discussing professional culture, participants identified a language specific to speech-language pathology (both jargon and use of the International Phonetic Alphabet) and a group that is typically white and female. The most common statements about a speech-pathology culture are best represented by Randy and Danny when they state, “I would say we’re all out of our minds, insane and organized, and overachievers, and very type A. I think you have to be a certain kind of person to be in this,” and “A lot of them tend to be type A, perfectionist. Maybe a little high strung. Not all of them, but a lot...[and]... in my experience, mostly female.”

Statements like Drew’s, “We have a high sense of self efficacy,” and “[speech-language pathologists] believe, whether rightly or wrongly that individuals will benefit from speech pathology no matter what,” suggest a collective belief speech-language pathology practice is the correct or right thing to do. This theme was also present when Drew described interactions with clients by saying, “I see that this is difficult for you and this is where you’re at [but] it’s also my job to say this is where I think we go to improve your communication needs.”

Participants provided descriptions of professional culture but indicated they felt disconnected from it in the same way they indicated they felt disconnected from their personal cultural constructs. In reference to a typical mold of an SLP, Randy stated, “I don’t want to put myself in the mold. I would like to think that I’m one of the special ones that are outside of it,” and when asked about connection to fellow classmates, Drew

stated, “So I would have to say that there are times in which maybe I’m a cultural outsider in that way.” Sam indicated, “Speech pathology could become a much stronger field if there was more diversity in it,” which suggested a belief speech-language pathology is a homogenous culture.

Unidirectional perspective on client interactions. Similar to the perspective noted in the professional identity construct, several statements in the cultural construct represented a unidirectional perspective, meaning the participants saw themselves as standard and clients as other. Sam referred to “doing your best to, not in a stereotypical way, learn about their culture, so that you can make them comfortable.”

Defining Cultural Competence. Participants’ statements about cultural competence represented knowledge, skill, and attitude constructs of cultural competence but suggested a struggle to conceptualize cultural competence beyond those constructs. Sam’s statement illustrates this:

Cultural competence, I would say, is having knowledge that there are other cultures and knowledge of the difference among those cultures. And I think cultural competence is something that you’re always going to be striving for because you are in your own culture so to be able to completely understand what a different culture is like is impossible unless you’re in it. So you’re always striving to be able to take that other perspective. So maybe cultural competence just doesn’t exist. But it’s something that is important to always have in mind, especially in a field like speech.

Knowledge. Participants often saw cultural competence as regionally, geographically, or setting specific and referred to needing to learn about the other cultures based in the areas they will work in. The specific knowledge areas mentioned included dialects, pragmatics (eye contact, etc.), common sound errors, food preferences, beliefs, values, styles of communication, “approach to health, well-being, treatment and assessment” (Drew). Danny represented a feeling common to participants by saying, “I guess I could look [information] up on my own but it’s hard because there’s a thousand different cultures so where would you start?”

It was common for participants to make statements about cultural competence that represented knowledge and awareness. For example, Danny defined cultural competence as “at least a small amount of understanding about other cultures and what their customs are, what their traditions are and what is respectful to them.” When asked what being respectful looked like, Danny responded, “I guess having an understanding that what is different is ok.”

Skills. Drew believed cultural competence was having knowledge of other cultures and “being able to also apply your knowledge of those beliefs in practice, clinically.” Kyle noted awareness of difference is important but “I don’t think I would act that much differently.” Cameron did not reference specific skills in cultural interaction but explained, “It’s pretty much getting into a situation with someone from a different culture and saying ok, I know nothing about this situation right now, let’s see if I can try to avoid making as many faux pas as possible.” Sam connected knowledge and

skills and provided a point of interaction between practice and culture by saying, “In order to really help them you have to have some degree of cultural competence.”

Awareness. Concepts of awareness were varied among the participants. Randy referred to sensitivities as “being aware that...a lot of people are not as white as I am...and with other cultures comes dialect differences...what’s appropriate eye contact [and] appropriate volume [and] appropriate rate.” Cameron referred to “making sure that I’m aware of family backgrounds,” and Drew explained the importance of “recognizing that your clients may or may not fall within strictly the kind of cultural understanding that you have formulated as a result of your knowledge of that culture.”

Self-awareness. There was no consistency in how the participants responded to the question, Do you believe you are culturally competent? Sam responded with, “I believe that it is a really important thing, but no.” Danny stated, “I’m respectful of other cultures. I definitely can’t say that I know a lot about other cultures and their traditions.” Cameron self-defined as culturally competent in

...some cultures, yes, [but] some I would probably be completely oblivious...I think it depends on the situation...cultural competence is knowing enough about a culture to not do anything horribly offensive or to at least catch on when you have and be able to make amends.

Similarly, Kyle said, “I think I am to a point...I’m aware of other cultures...I don’t know if you can ever be fully culturally competent if you don’t know everything about every single culture.” Randy said, “I personally believe that I am.” Drew responded, “Yeah.”

Experience. Participants did not have a positive view of their academic experience with cultural competence. Danny said, “I feel like [multicultural issues are] always just something that get’s glossed over. It’s not even something I feel like any of us think about.” Randy said, “Cultural competence generally gets tacked on as a lecture or two at the end of other subject areas,” and if there were a class focused on multicultural issues “it would just be kind of a throw away class.” Kyle said, “I think it would be a bad idea to have a class.... It would be impossible to talk about all different cultures.” Sam identified an opposite experience and described an undergraduate multicultural psychology course where

...there were a lot of discussions where people just openly and honestly talked about prejudice and racism and how it feels to be someone in a situation where there is cultural tension or cultural difference. I understood so much more after taking that class.

Sam was not hopeful this class or experience could be easily replicated but indicated the most important thing would be “the ability to put yourself in [a] person’s situation...the empathy aspect.” References to how participants could increase their cultural competence in practice can be summed up in this statement by Cameron: “Your experience is going to be the teacher.” When asked for examples of what those experiences would look like, they identified reading, putting oneself in different cultural environments, research, and learning a second language and indicated it “would be a huge time commitment” (Sam).

Summary

Interviews with six second-year graduate students revealed six themes and 21 categories related to professional identity and cultural competence. These themes and categories were represented in statements made by all participants regardless of their IDI orientations. Themes of professional identity revealed speech-language pathology students are making meaning of the profession by describing what it means to be a speech-language pathologist, and defining the work of the profession through research, methods, and the communities they will work in. They are also negotiating roles and responsibilities they will have when they are practicing professionals and are compartmentalizing the types of disorders, differences, and people with whom they will be working. Participants shared their perceptions of cultural competence by describing culture based on their own cultural self-definitions, cultural interactions they have had with others, details of professional culture, and cultural perspectives that focuses on others and how they are different from themselves. When defining cultural competence, participants provided statements about knowledge, skills, awareness of other cultures, and opinions of their own cultural competence levels and how their academic programs have addressed cultural competence issues. These themes will be discussed in the context of the literature in the following chapter.

Chapter 5. Discussion and Conclusions

When students graduate from an accredited program in speech-language pathology they are assumed to have cultural competence which, in the language of ASHA standards, includes understanding the cultural bases of communication, the impact of culture on communication, the cultural correlates of communication disorders and differences, and cultural considerations in prevention, assessment and treatment (ASHA, 2011). They are also assumed to have had experience with and be able to communicate effectively with culturally/linguistically diverse populations (ASHA, 2011). This study was designed to discover what culture and experience with culture and diversity look like in the eyes of young women and men in transition from student to professional speech-language pathologists. More important than what the participants did say were the concepts missing from the discussions. Much of the literature cited in previous chapters was supported in the themes and categories that emerged from participants' statements, but the theory constructed from the data is grounded in what the participants did not say.

Discussion

The methods used in this study were selected to allow students to share their perspectives of professional identity and cultural competence. Students' perspectives represent their self-awareness, which is intertwined with identity and is a critical component of cultural competence (Leininger, 2002; Munoz 2007). Wenger (1998) states, "Our perspectives on learning matter: what we think about learning influences where we recognize learning" (p. 9). Therefore, knowing what students perceive can

serve as a point of discussion for teaching and learning within speech-language pathology and related fields. The data collected in this study support many of the theories and concepts discussed in the preceding literature review, demonstrate new information about the perceptions of students around the constructs of professional identity and cultural competence, and create a foundation for theory and opportunity for future research.

Professional identity. It is difficult to find an operational definition of professional identity in the literature; however, there is agreement identity is socially constructed or exists within a social context, involves ideas of role, and affects how professionals interpret experiences and interactions (Beijaard et al., 2004; Chreim et al., 2007; Iwama, 2006). The participants' responses in this study supported all of these constructs.

Identity is also suggested to change over time and develop through participation in a CoP (Gee, 2001; Mann, 2011; Rummens, 2003; Wenger, 1998). Several of the participants' responses were reflective of early membership in a speech-language pathology CoP and were evidence of the dimensions of communities of practice described by Wenger (1998)—mutual engagement, joint enterprise, and shared repertoire. This finding is significant because it demonstrates there is a social context for learning in speech-language pathology programs—a context which provides opportunities to encourage further identity development within the profession. In the eyes of the participants, mutual engagement, or what matters most in a CoP, was represented when participants discussed the meaning of the profession and how speech-language pathologists serve and help others to communicate. Joint enterprise, or the process of

accountability and participation within a profession, was apparent when participants discussed the roles a speech-language pathologist plays, like teaching, advocacy and counseling. The final construct of CoPs is shared repertoire, or the discourse of a profession. Participants identified a unique discourse among the profession and demonstrated that discourse when they used compartmentalizing terms of disorder and setting and assumed that the researcher, a fellow speech-language pathologist, would understand the intended meaning—which she did.

While participants' statements did provide evidence they are participating in a speech-language pathology community, they also indicated they feel disconnected from the professional culture at times, which suggests an identity in development. They understand the intentions of the community and can see the activities that take place in the community, but still feel “outside the mold” (Randy).

Other evidence of identity related to language, discourse, and membership in a CoP was found in participants' reference to the medical model. Typical to this model, the language of speech pathology includes symptoms and diagnoses which was evident when participants referred to clients by age, difference, disorder, and setting. Speech-language pathology curricula are full of course titles like Language Disorders or Articulation and Phonological Disorders; and programs are responsible for ensuring students have experience in nine categories of communication and swallowing disorders. Students are taught to define and compartmentalize and professionals are trained in a context that separates and categorizes. It is not surprising the language students use reflects those concepts. It should be noted, participants' cultural descriptions also fit into this discourse

with individual culture descriptions based on race, geography, or other characteristics that could be compartmentalized.

Cultural competence. Participants expressed concepts of culture by discussing self-awareness, cultural interactions, professional culture, and perspective. These statements contained many of the elements of culture noted in the literature including categorical identities (e.g., race and ethnicity), dimensions (e.g., femininity/masculinity), domains or parameters (e.g., work), and general references to values (Endicott et al., 2003; Hofstede & Hofstede, 2005; Mahendra, et al., 2005; Purnell & Paulanka, 2005). They defined cultural competence in ways similar to descriptions in the literature—knowledge, skills, awareness—but a closer look revealed significant differences in how the terminology was interpreted.

As noted earlier, the main components of general and health care models for cultural competence typically include knowledge, skills, awareness, and attitudes. Participants, regardless of their IDI developmental orientation, identified characteristics of cultural competence within the knowledge domain, such as facts and characteristics of specific cultural groups. Cultural competence skills, as noted in the literature, involve effectively engaging and communicating in cultural interactions. Participants in this study, however, neglected the interaction and relationship elements and defined skills simply as applications of knowledge and the avoidance of faux pas in a clinical setting. Deardorff (2004) defines cultural awareness as valuing and understanding differences, experiencing other cultures, and self-awareness, a view different from those that emerged in the data. Awareness, as defined by the participants, was limited to being aware that

other cultures and cultural facts exist. Self-perception of personal cultural competence was limited to whether they believed they are culturally competent. Interestingly, participants were easily able to state whether or not they were culturally competent, even if they could not provide an explanation of the concept. Several participants made statements related to affective attitude aspects including empathy, suspending judgment, and a desire to seek cultural experiences. Missing from the attitude domain were statements related to humility, motivation, cognitive flexibility, curiosity, and the desire to understand relationships with people who have cultures different from their own, all of which could serve to enhance the interactions and relationships with clients and colleagues. References to Goode et al.'s (2006) concept of structure, or policies and practices that affect cultural competence and are outside the participants' control, were limited to one description of cultural experiences that were negatively impacted by the structure of services within a school system. Overall, student perceptions in this study did not illustrate the depth of cultural competence that models in other fields are intended to achieve.

Connecting constructs. While it is not possible to correlate cultural competence and professional identity, there are aspects of this study and evidence in the literature suggesting the two constructs are connected. They are both described as developmental processes and are defined by using the concepts of knowledge, skills, and attitudes, although these concepts can seem superficial (Mann, 2011). For example, knowing what a speech-language pathologist does is not the same as understanding why or the foundations underlying that knowledge. Having the skill to administer a diagnostic test is

not the same as understanding the effects it may have on a person, how the results will be received and interpreted, or what to do about it. Believing speech-language pathology is good and worthy does not allow differing perspectives to be considered. Examples exist for cultural knowledge, skills, and attitudes as well. A simplistic view of professional identity and cultural competence limit how effective a speech-language pathologist can be; and to be effective practitioners students of speech-language pathology must understand their professional identity and cultural competence in context—at the point of interaction between provider and client and among colleagues.

As noted in the previous chapter, participants' responses to questions about both constructs had a unidirectional perspective. For example, students worried about getting their treatment expectations across to families and colleagues and were concerned about whether their message was being accurately interpreted by a translator in a cross-cultural interaction. There was a significant lack of perspective, acknowledgment of a relationship, or taking time to understand both sides of the interaction. This is evidence of a concept Ferguson (2009) uncovered when analyzing the discourse of SLP professional statements; her analysis revealed "Clients were absent as 'actors' of processes, and only occasionally were 'goals'" (p. 107). If identity and culture are socially constructed, students must acknowledge all members of the social structure, which includes fellow students, faculty, colleagues, and most importantly, clients. They can be taught to recognize when they are interacting with community members, they are participating in a cultural relationship. During these interactions, they are representing themselves and the profession; taking time to think about how their actions are being perceived in addition to

whether their treatment methods are working could add dimension to the students' perceptions of those interactions.

Educational Implications

Findings from this study suggest speech-language pathology students are learning exactly what programs are teaching. They are exposed to materials that show them how to work with people based on symptoms and characteristics. This may be effective for attaining treatment goals, but the same discourse is being used for cultural competence where characteristics of culture are being treated like symptoms. Students are taught, through direct courses or information infused in the curriculum, to view multiculturalism as affiliation with marginalized groups (Stockman et al., 2008). Participant responses showed they are focused on the overt aspects of learning such as diagnosis and specific treatment methods supported by evidence or the cultural label they should apply to their clients to know more about them. Identity and cultural competence, however, are represented in more subtle, tacit types of learning. Helping students recognize and seek tacit information will increase their awareness of what they are learning and who they are becoming.

Participants failed to recognize there are differences and similarities among people in every interaction. Instead they reference how others are different from the norm, meaning themselves. Vandenberg (2010) identifies this cultural assumption as an "extreme essentialist view of culture when culture is identified as 'different' from the perceived dominant norm of the 'White, English-speaking, Middle-class'" (p. 242). It appears necessary to remove the term cultural competence, which implies a finite

comprehensive knowledge of facts about others, and focus instead on a theory of *interactive cultural relationships*. Sumpter and Carthon (2011) studied nursing students' perceptions of cultural competence in nursing curriculum and found students "stressed the need for teaching methods that more comprehensively probed the meaning of familiar buzz words such as *cultural diversity*, *cultural sensitivity*, and *cultural competence*" (p. 47). Currently, we are achieving what the structure of multiculturalism in speech-language pathology education is set up to achieve, but it is falling short of the potential speech-language pathology has for setting an example of culturally competent practice. Looking at accredited graduate programs in speech-language pathology, Stockman et al. (2004) found "the infusion of multicultural content into existing courses is now the preferred instructional model" which "relies on the premise that all communication interactions are inherently cultural experiences and the culture can influence human experience" (pp. 6-7). But the manifestations of this infusion model are vastly different among programs (including communication disorders and education) and there is no data to suggest whether they work. There is opportunity for speech-language pathology students to learn from the nuances of interactions with others and this process can begin by helping students recognize who is in their community of practice.

Curricula that include methods to understand interactions and recognize every relationship as a coming together of cultures will teach students "how to learn, as well as what to learn" (Mann, 2011, p. 62). Sumpter and Carthon (2011) also support "establishing definitions that move beyond racial and ethnic identity [to] reduce [student discomfort] while at the same time help students to appreciate the differences (and

similarities)” (p. 47). Another study by Ellenwood and Snyders (2010), which used the IDI as a measure of cultural sensitivity, showed it is possible to increase students’ cultural competence by providing interactions with people other than themselves. Speech-language pathology programs already have a clinical component built into the program, a perfect opportunity to use interactions to understand cultural relationships.

Interactions involve and are affected by communication, the central purpose of speech-language pathology. If anyone should understand the importance of communication in cross-cultural experiences, it should be speech-language pathologists. Unfortunately, the technical, medical model of education for speech-language pathology students may be interfering with this awareness. The statements made by the participants in this study show they lack the concept of connection between culture and identity. Evidence of the Western-centric idea of individualism was provided by statements about what they, as speech-language pathologists, do to or for clients but do not reflect actual communication and interaction with their clients. Ferguson (2009) found the discourse of speech-language pathology uses terms around the concept of collaboration only in reference to interacting with other professionals, not in relation to clients—a concept strongly reflected by participants’ statements. This perspective of individual responsibilities versus an interactive relationship limits student development and makes it difficult to justify the expansion of the profession as is, into other countries and other cultures. Participants’ statements reveal a fundamental absence of relationship between themselves and the people they are purporting to help and serve. There is hope, however. Stockman et al. (2008) found faculty who teach multicultural and multilinguistic topics in

communication disorders courses do not usually have a specific instructional focus, but if they do, it is often communication relationships. Mann (2011) indicates learning is a social, collective process “which includes all the influences and interactions that transpire in the learning environment and occurs through learners’ active engagement” (p. 62). Helping students actively engage with clients as a cultural relationship and a part of their learning environment will give more dimension to the learning they acquire from each interaction. These opportunities would also provide students agency to explore and interact and respond to others, which will aid in developing professional identities and cultural competence.

Concentrating on every interaction and taking the focus off lists of facts about specifically labeled cultural groups achieves three benefits. First, participants in this study suggested in several ways cultural competence is impossible to achieve because there is no way to know everything about every cultural group, and they were right. If we teach students how to consider the needs within every interaction in every cultural relationship, they will learn to read and adjust and respond instead of being burdened with an unachievable task of learning everything about everyone. Second, we begin to shift the discourse away from culture and diversity as a concept of us versus others and the tendency for multicultural terms to be interpreted as minority groups (Stockman et al., 2004). Third, understanding the cultural relationship in every interaction provides the opportunity to develop cultural competence regardless of the region where students live or are being trained. Stockman et al. (2008) reported the majority of respondents (faculty members of communication disorders programs) in their study lived and worked in

geographical areas that were 60% to 90% white. That demographic will change as the population of the U.S. continues to change and will certainly be different as the profession expands into other countries around the world. To view culture as race/ethnicity, or any other group label, is inherently limiting; the alternatives suggested here are intended to avoid that limitation.

Speech-language pathology programs are not the only programs that could benefit from a focus on interactive cultural relationships. Other allied health professions and education programs also have clinical, practicum, or student teaching experiences where students interact directly with the populations they will work with as professionals.

Limitations

While the sample in this study was limited, it was representative of the speech-language pathology second-year graduate population, which is typically a homogenous group if defined by race, SES, and gender. The true homogeneity of speech-language pathology graduate students lies in their professional culture, which participants supported in their consistent descriptions of speech-language pathology. Being part of a seemingly homogenous group can lead to assumptions about other groups as well, and the participants demonstrated this concept with their statements suggesting a belief that culture and cultural competence is about knowledge; and by knowing facts about cultures one can become culturally competent. Vandenberg (2010) warns of this trend by stating, “uncritically accepting individuals as the members of homogeneous ‘cultural’ groups can support and maintain stereotypes and generalizations, rather than dispel them” (p. 242).

The small sample size in general is also a limitation of this study. The themes and categories that emerged from the interviews with participants were well represented and the data were saturated, but there could possibly have been richer information from a much larger sample. In addition, the results of the IDI orientations, which were used to determine the sample, represented only two orientations of the developmental continuum. Perhaps more and richer information could have been gathered from a group that represented a greater distribution across orientations.

There were no differences in the themes and categories of professional identity or cultural competence among those participants who scored differently on the IDI developmental continuum. This could be because the distribution of scores among the volunteers was relatively small and represented only two orientations, polarization and minimization. A group with broader distribution of scores may have yielded different results. On the other hand, the distribution of cultural sensitivity scores in this study may accurately represent speech-language pathology students, which suggests a possible limitation of the field, not a limitation of this study. If students are as homogenous in cultural competence as they are in gender and race it is necessary to ask why is this acceptable.

Recommendations for Future Research

Examining professional identity and cultural competence in a social context means the perspectives of all members should be considered, including students, faculty, practitioners, colleagues, and clients. Similar studies to investigate perspectives of faculty and well-established practitioners in the field would provide a comparison as to whether

students differ from those who are more integrated into the community of practice. A better idea of faculty comfort and levels of cultural competence would address an issue identified by Stockman et al. (2008) who state, “There are multiple challenges to optimizing [multicultural/multilinguistic] instruction across disciplines. They include issues related to the level of faculty preparation for such instruction and the adequacy of resources, models, and strategies to undertake it” (pp. 243-244).

The other set of perceptions essential to this area of study are those of the clients. How they perceive the therapeutic interactions and how they feel their health care provider is perceiving them can serve to connect theory to therapeutic effectiveness. Examples from fields like nursing and medicine (Anand & Lahiri, 2009; Gibson & Zhong, 2005) suggest patients perceive differences in their care based on cultural connections. A study specific to speech-language pathology would give additional perspective on issues of cultural interactions.

Finally, the theory of interactive cultural relationships should be applied to curricula to determine if a new focus would affect students’ actual and perceived levels of cultural competence. A protocol for thinking about and discussing cultural relationships throughout a curriculum would have to be applied with a clear way to measure a change in cultural competence levels. Which leads us to one other aspect of research in this area—assessing cultural competence. Can or should we use tools like the IDI? This study was not designed to find a correlation between IDI scores and concepts of professional identity or perceptions of cultural competence, but it may provide some insight. Because of the fairly homogenous sample (and population of speech-language pathologists) there

was very little variation in IDI scores; there was also very little variation in concepts of cultural identity. The participants did actually provide answers about culture and cultural competence that were expected based on their IDI orientations. They made statements in terms of *us and them*, typical to people in the polarization orientation and typical to people in the minimization orientation, highlighted commonalities, and universal values while failing to recognize and appreciate cultural differences. It could be informative to determine if this limited distribution of cultural sensitivity orientations is representative across the field. Deardorff (2004) and Hamilton (2009) both indicate assessment of cultural competence should occur at multiple points in a program and multiple methods specifically devised to match the concept being measured should be used.

Conclusions

This study was not intended to determine the efficacy of specific methods for teaching cultural competence. Instead it was an attempt to understand how students perceive their professional selves and what it means to demonstrate cultural competence. Results indicate students are learning what we teach them, they believe in their profession, and they understand cultural considerations are part of their job, but there is vast room for improvement.

Faculty in speech-language pathology programs and related fields can design learning opportunities that highlight intercultural relationships. We can help students recognize their professional selves and what that means when they are interacting with clients and colleagues. We can help students recognize multiple perspectives and learn to assess the needs of relationships, not just the facts about a particular marginalized group.

This is not to suggest an absolutist form of cultural relativism that eliminates labels completely and ignores the needs of specific groups of people. Understanding an interactive cultural relationship means asking questions of and about each participant in every interaction, not just those with people who look different from ourselves. It makes cultural competence a part of every academic and clinical experience, rather than a lesson tacked on at the end of a unit. This study has provided a snapshot of how students understand the connection between their professional identities and cultural competence development, and the information can serve as a launching point to make significant changes in speech-language pathology programs and ultimately, the profession.

References

- American Speech-Language-Hearing Association. (2004). Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services. *ASHA Supplement, 24*.
- American Speech-Language-Hearing Association. (2005). *Cultural competence* [Issues in Ethics]. Retrieved from www.asha.org/policy
- American Speech-Language-Hearing Association. (2009a). Role ambiguity and speech-language pathology. *The ASHA Leader*. Retrieved from <http://www.asha.org/Publications/leader/2009/091215/RoleAmbiguity.htm>
- American Speech-Language-Hearing Association. (2009b). *Self-assessment for cultural competence* [Cultural competence awareness assessment]. Retrieved from <http://www.asha.org/practice/multicultural/self.htm>
- American Speech-Language-Hearing Association. (2010a). *Fact sheet for speech language pathology*. Retrieved from <http://www.asha.org/careers/professions/slp.htm>
- American Speech-Language-Hearing Association. (2010b). *Multicultural/multilingual issues courses: A resource for instructors*. Retrieved from <http://www.asha.org/practice/multicultural/faculty/metaanalysis.htm>
- American Speech-Language-Hearing Association. (2010c). Standards for accreditation of graduate education programs in audiology and speech-language pathology. *CAA*

Accreditation Manual. Retrieved from <http://www.asha.org/academic/accreditation/accredmanual/section3.htm>

American Speech-Language-Hearing Association. (2011). *2005 standards and implementation procedures for the certificate of clinical competence in speech-language pathology*. Retrieved from http://www.asha.org/Certification/slp_standards/#Std_IV

Anand, R., & Lahiri, I. (2009). Intercultural competence in health care: Developing skills for interculturally competent care. In D. K. Deardorff (Ed.), *Sage handbook of intercultural competence* (pp. 387-402). Thousand Oaks, CA: Sage.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., ...

Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, *43*(4), 356-373.

Beijaard, D., Meijer, P. C., & Verloop, N. (2004). Reconsidering research on teachers' professional identity. *Teaching and Teacher Education*, *20*, 107-128.

Bennett, J. M. (2009). Cultivating intercultural competence: A process perspective. In D. K. Deardorff (Ed.), *Sage handbook of intercultural competence* (pp. 121-140). Thousand Oaks, CA: Sage.

Bickenbach, J. E. (2009). Disability, culture and the UN convention. *Disability and Rehabilitation*, *31*(14), 1111-1124.

Bronfenbrenner, U. (Ed.). (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.

- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181-184.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Chreim, S., Williams, B. E., & Hinings, C. R. (2007). Interlevel influences on the reconstruction of professional role identity. *Academy of Management Journal, 50*(6), 1515-1539.
- Cohen, J. L. (2010). Getting recognized: Teachers negotiating professional identities as learners through talk. *Teaching and Teacher Education, 26*, 473-481.
- Competence. (n.d.). In *Dictionary.com*. Retrieved from <http://dictionary.reference.com/browse/competence>
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.
- Deardorff, D. K. (2004). *The identification and assessment of intercultural competence as a student outcome of internationalization at institutions of higher education in the United States* (Doctoral dissertation). North Carolina State University, Raleigh.

- Deardorff, D. K. (2006). Identification and assessment of intercultural competence as a student outcome of internationalization. *Journal of Studies in Intercultural Education, 10*, 241-266.
- Department of Communicative Disorders and Sciences. (n.d.). *Home page*. Retrieved from <http://cdswebserver.med.buffalo.edu/drupal/>
- Douglas, M. (2002). Developing frameworks for providing culturally competent health care. *Journal of Transcultural Nursing, 13*(3), 177.
- Duchan, J. F. (2005). *Getting here: A short history of speech pathology in America*. Retrieved from http://www.acsu.buffalo.edu/~duchan/new_history/women_profession.html
- Edwards, H., & Dirette, D. (2010). The relationship between professional identity and burnout among occupational therapists. *Occupational Therapy in Health Care, 24*(2), 119-129.
- Ellenwood, A. E., & Snyders, F. J. A. (2010). Virtual journey coupled with face-to-face exchange: Enhancing the cultural sensitivity and competence of graduate students. *Intercultural Education, 21*(6), 549-566.
- Endicott, L., Bock, T., & Narvaez, D. (2003). Moral reasoning, intercultural development, and multicultural experiences: Relations and cognitive underpinnings. *International Journal of Intercultural Relations, 27*, 403-419.
- Fagermoen, M. S. (1997). Professional identity: Values embedded in meaningful nursing practice. *Journal of Advanced Nursing, 25*, 434-441.

- Ferguson, A. (2009). The discourse in speech-language pathology. *International Journal of Speech-Language Pathology, 11*(2), 104-112.
- Gall, M. D., Gall, J. P., & Borg W. R. (2003). *Educational research* (7th ed.). Boston, MA: Allyn & Bacon.
- Gee, J. P. (2001). Identity as an analytical lens for research in education. In W. G. Secada (Ed.), *Review of researcher in education* (Vol. 25, pp. 99-125). Washington, DC: American Educational Research Association.
- Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional Identity Development: A grounded theory of transformational tasks of new counselors. *Counselor Education and Supervision, 50*(1), 21-38.
- Gibson, D., & Zhong, M. (2005). Intercultural communication competence in the healthcare context. *International Journal of Intercultural Relations, 29*, 621-634.
- Glesne, C. (2006). *Becoming qualitative researchers: An introduction*. Boston, MA: Pearson Education.
- Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. *The Commonwealth Fund, 37*.
- Griffer, M. R., & Perlis, S. M. (2007). Developing cultural intelligence in preservice speech-language pathologist and educators. *Communication Disorders Quarterly, 29*(1), 28-35.
- Hamilton, J. (2009). Intercultural competence in medical education—essential to acquire, difficult to assess. *Medical Teacher, 31*, 862-865.

- Hammer, M. R. (2009). *IDI v3 webinar: Presentation guide. Module 1.2: The developmental continuum*. Retrieved from <https://www.idiinventory.com/webinars.php>
- Hammer, M. R., Bennett, M. J., & Wiseman, R. (2003). Measuring intercultural sensitivity: The Intercultural Development Inventory. *International Journal of Intercultural Relations*, 27, 421-443.
- Hofstede, G., & Hofstede, G. J. (2005). *Cultures and organizations: Software of the mind*. New York, NY: McGraw Hill.
- Horton-Ikard, R., Munoz, M. L., Thomas-Tate, S., & Keller-Bell, Y. (2009). Establishing a pedagogical framework for the multicultural course in communication sciences and disorders. *American Journal of Speech Language Pathology*, 18, 192-206.
- Hunter, B., White, G. P., & Godbey, G. C. (2006). What does it mean to be globally competent? *Journal of Studies in Intercultural Education*, 10, 267-285.
- Iwama, M. K. (2006). *The Kawa model: Culturally relevant occupational therapy*. Philadelphia, PA: Elsevier.
- Iwama, M. K. (2007). Culture and occupational therapy: Meeting the challenge of relevance in a global world [Guest editorial]. *Occupational Therapy International*, 14(4), 183-187.
- Iwama, M. K. (2009). The Kawa model: The power of culturally responsive occupational therapy. *Disability and Rehabilitation*, 31(14), 1125-1135.

- Kim, Y. Y. (2009). The identity factor in intercultural competence. In D. K. Deardorff (Ed.), *Sage handbook of intercultural competence* (pp. 53-65). Thousand Oaks, CA: Sage.
- Kinsella, E. A., Bossers, A., & Ferreira, D. (2008). Enablers and challenges to international practice education: A case study. *Learning in Health and Social Care*, 7(2), 79-92.
- Leininger, M. (1999). What is transcultural nursing and culturally competent care? *Journal of Transcultural Learning*, 10(1), 9.
- Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing*, 13, 189-192.
- Mahendra, N., Ribera, J., Sevcik, R., Adler, R., Cheng, L. L., McFarland, E. D., ... Villanueva, A. (2005). Why is yoghurt good for you? Because it has live cultures. *Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders*, 15(1), 3-7. Retrieved from <http://div2perspectives.asha.org/cgi/reprint/15/1/3.pdf>
- Mann, K.V. (2011). Theoretical perspectives in medical education: Past experience and future possibilities. *Medical Education*, 45, 60-68.
- Mann, L., Howard, P., Nowens, F., & Martin, F. (2008). Professional identity: A framework for research in engineering education. *Proceedings of the 19th Annual Conference for Australasian Association for Engineering Education*. Yeppoon, Queensland, Australia.

- McAllister, L. (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology*, 7(3), 138-148.
- Multiculturalism. (n.d.). In *Dictionary.com*. Retrieved from <http://dictionary.reference.com/browse/multiculturalism>
- Munoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International*, 14(4), 256-280.
- Murden, R., Norman, A., Ross, J., Sturdivant, E., Kedia, M., & Shah, S. (2008). Occupational therapy students' perceptions of their cultural awareness and competency. *Occupational Therapy International*, 12(3), 191-203.
- National Center for Cultural Competence. (n.d.). *Conceptual frameworks/models, guiding values and principles*. Retrieved from <http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#ccdefinition>
- Niemi, P. M. (1997). Medical students' professional identity: Self-reflection during the preclinical years. *Medical Educator*, 31, 408-415.
- Ohlen, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing*, 28(4), 720-727.
- Paige, R. M., Jacobs-Cassuto, M., Yershova, Y. A., & DeJaeghere, J. (2003). Assessing intercultural sensitivity: An empirical analysis of the Hammer and Bennett Intercultural Development Inventory. *International Journal of Intercultural Relations*, 23, 467-486.
- Pilcher, E. S., Charles, L. T., & Lancaster, C. J. (2008). Development and assessment of a cultural competency curriculum. *Journal of Dental Education*, 72(9), 1020-1027.

- Preis, J. (2008). Effect of an undergraduate elective course, cultural diversity in communication, on attitudes and behaviors of communication sciences and disorders students: A pilot study. *Journal of Allied Health, 37*(4), 255-277.
- Purnell, L. D. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing, 13*(3), 193-196.
- Purnell, L. D., & Paulanka, B. J. (2005). *Guide to culturally competent healthcare*. Philadelphia, PA: Davis.
- Rummens, J. A. (2003). Conceptualizing identity and diversity: Overlaps, intersection, and processes. *Canadian Ethnic Studies, 35*(3), 10-25.
- Schindler, A. (2005). Terminology in speech pathology: Old problem, new solutions. *Advances in Speech-Language Pathology, 7*(2), 84-86.
- Seligman, M., & Darling, R. B. (2007). *Ordinary families, special children: A systems approach to childhood disability* (3rd ed.). New York, NY: The Guilford Press.
- Skeat, J., & Perry, A. (2008). Grounded theory as a method for research in speech and language therapy. *International Journal of Language & Communication Disorders, 43*(2), 95-109.
- Spitzberg, B. H., & Changnon, G. (2009). Conceptualizing intercultural competence. In D. K. Deardorff (Ed.), *Sage handbook of intercultural competence* (pp. 2-52). Thousand Oaks, CA: Sage.
- Srivastava, R. H. (2007). *The healthcare professional's guide to clinical cultural competence*. Toronto, Ontario, Canada: Elsevier.

- Stimpson, J., & Martin, K. (2005). Cultural perceptions of Finnish nursing students regarding people and nurses of the United States: A pilot study. *Journal of Transcultural Nursing, 16*(1), 64-70.
- Stockman, I. J., Boulton, J., & Robinson, G. C. (2004). Multicultural issues in academic and clinical education: A cultural mosaic. *The ASHA Leader, 20*, 6-7.
- Stockman, I. J., Boulton, J., & Robinson, G. C. (2008). Multicultural/multilingual instruction in educational programs: A survey of perceived faculty practices and outcomes. *American Journal of Speech-Language Pathology, 17*, 241-264.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Suarez-Balcazar, Y., Rodawaski, J., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Barwacz, D., et al. (2009). Perceived levels of cultural competence among occupational therapists. *The American Journal of Occupational Therapy, 63*(4), 498-505.
- Sumpter, D. F., & Carthon, J. M. B. (2011). Lost in translation: Student perceptions of cultural competence in undergraduate and graduate nursing curricula. *Journal of Professional Nursing, 27*(1), 43-49.
- Sutherland, L., Howard, S., & Markauskaite, L. (2010). Professional identity creation: Examining the development of beginning preservice teachers' understanding of their work as teachers. *Teaching and Teacher Education, 26*, 455-465.

- Trembath, D., Wales, S., & Balandin, S. (2005). Challenges for undergraduate speech pathology students undertaking cross-cultural clinical placements. *International Journal of Language & Communication Disorders, 40*(1), 83-98.
- Van Riper, C. (1939). *Speech correction: Principles and methods*. New York, NY: Prentice Hall.
- Vandenberg, H. E. R. (2010). Culture theorizing past and present: Trends and challenges. *Nursing Philosophy, 11*, 238-249.
- Walsh, R. (2005). Meaning and purpose: A conceptual model for speech pathology terminology. *Advances in Speech-Language Pathology, 7*(2), 65-76.
- Wenger, E. (1998). *Communities of practice: Learning, meaning and identity*. New York, NY: Cambridge University Press.

Appendix A
Invitation Letter

Duluth, Minnesota 55812
_____ November, 2010

(Name and address of Recipient)

Dear (Second-year graduate student);

I am writing to ask you to share your thoughts on cultural competence and what it is means to be a speech-language pathologist with the intention that your perspectives will lead to more effective teaching practices in speech-language pathology programs. I am inviting you to participate in a research study aimed at finding a connection between professional identity and cultural competence.

My name is Shannon Godsey. I am a Doctoral Candidate and faculty member at the University of Minnesota Duluth and a licensed speech-language pathologist. I am writing my dissertation and asking you to participate in my research that will use the words and experiences of current students in speech-language pathology graduate programs to inform the instruction of future students.

You could be of great help to this study as I am inviting only second-year graduate students because of your position of transition from student to professional.

To participate in this study I ask that you will complete the Intercultural Development Inventory (IDI) on-line, which will take approximately thirty minutes and an on-line Demographic Questionnaire that will take 5-10 minutes. Based on the results of the IDI, you may be asked to participate in a face-to-face interview that will take approximately one hour and provide a written response to follow questions sent via e-mail. I am hoping to schedule the interviews in early November or early December. The IDI will be sent to you two weeks to ten days prior to the week of interviews and I will ask that it is completed within two days of receiving it. All results and conversations will remain anonymous.

I am truly interested in students' perspectives on their learning and professional experiences and hope that the results of this study will provide information to make future programs as effective and meaningful as they can be. If you are willing to talk with me, please let me know. I will respond quickly. Please feel free to contact me if you have any questions. I can be reached at (218) 310-2629, or by email at sgodsey@d.umn.edu.

Thank you so much. I appreciate your time and hope to hear from you soon.

Sincerely,

Shannon Rose Godsey

Appendix B
Informed Consent Form

University of Minnesota Duluth
Department of Education

Research Description

Principal Researcher: Shannon Godsey

Research Title: Student Perspectives on Professional Identity and Cultural Competence

You are invited to participate in a study that explores a connection between cultural competence and professional identity. Your participation in this study requires completion of the Intercultural Development Inventory (IDI) and a potential one-on-one interview to explore your perspective on professional identity and speech-language pathology. The IDI will be administered online and will take approximately 30 minutes to complete. The interview will be approximately sixty minutes in duration. With your permission, the interview will be audio taped and transcribed to ensure an accurate record of the discussion. Your name will not be used. A pseudonym will be used on data and transcripts.

This study will be conducted by Shannon Rose Godsey, a doctoral candidate at the University of Minnesota Duluth, with the approved consent of the University of Minnesota Institutional Review Board. The interviews will take place during the week of [dates here] at a day and time that is convenient for you. The IDI will be administered and must be completed prior to the interview.

Risks and Benefits:

This research is intended to develop a theory about the connection of professional identity and cultural competence which could result in potential benefits for teaching and learning in speech-language pathology programs and culturally competent care for clients. Participation in this study carries the same amount of risk as participating in a

speech-language pathology program. There is no financial compensation for your participation in this study.

Data Storage to Protect Confidentiality:

Under no circumstances will you be identified by name in the course of this research study or in any publications about this study. Every effort will be made that all information provided by you will be treated as strictly confidential. All data will be coded and securely stored, and will be used for professional purposes only.

How the Results Will Be Used:

This research study is to be submitted in partial fulfillment of requirements for the Degree of Doctor of Education at the University of Minnesota Duluth, Duluth, Minnesota. The results of this study will be published as a dissertation. In addition, information may be used for educational purposes in professional presentation(s) and /or educational publications.

Participant's Rights

- I have read and discussed the researcher description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in this research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status, or other entitlements.
- The researcher may withdraw me from the research at her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available that may relate to my willingness to continue to participate, the investigator will provide this information to me.

- Any information derived from the research that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the researcher, Shannon Godsey, who will answer my questions. The researcher's phone number is 218-310-2629. I may also contact the researcher's faculty advisor, Sue Damme, at 218-726-6178.
- If at any time I have comments or concerns regarding the conduct of the research, or questions about my rights as a researcher subject, I should contact the University of Minnesota Institutional Review Board. The phone number for the Research Subjects Advocate Line is 612-625-1650. Alternatively, I can write to the IRB at University of Minnesota, D528 Mayo, 420 Delaware St. S.E, Minneapolis, MN 55455.
- I should receive a copy of the Research Description and this Participant's Rights document.
- Audio taping is part of this research. Only the principal researcher and the members of the research team will have access to written and taped materials.
Please check one:

I consent to be audiotaped.

I do NOT consent to being audiotaped.

My signature means that I agree to participate in this study.

Participant's

signature: _____ Date: ____/____/____

Name: (Please print) _____

Investigator's Verification of Explanation

I, _____ (Researcher), certify that I have carefully explained the purpose and nature of this research to

_____ (participant's name). He/she has had the opportunity to discuss it with me in detail. I have answered all his/her questions and he/she provided the affirmative agreement (i.e., assent) to participate in this research.

Investigator's signature _____

Date: ____ / ____ / ____

Appendix C
Demographic Questionnaire

Demographic Questionnaire

Name:

Age:

Sex:

Years of higher education:

Degree(s)/major(s):

Experience with clients (Check all that apply):

- Adult (17 years and older)
- Children (0-17 years)
- Articulation/phonology
- Receptive and expressive language
- Voice
- Fluency
- Hearing
- Social aspects of communication
- Communication modalities
- Cognitive aspects of communication
- Swallowing

Have you studied or lived abroad? Please describe:

What language(s) do you speak? Please indicate if you are fluent and/or describe your level of comfort with the language(s):

Appendix D
Interview Guide

Interview Guide

1. Tell me about your educational experiences leading up to today and how you came to participate in your speech-language pathology program.
2. Tell me what being a speech-language pathologist means to you.
 - a. Tell me about your general experiences interacting with clients.
 - b. When you think about speech-language pathology, what sort of “things” do you associate with it?
3. When you think of yourself as a speech-language pathologist, tell me what you think is most important or what matters in your practice.
4. What do you think is important in your interactions with clients (and colleagues)?
5. How do you see your role as a speech-language pathologist?
6. Tell me how you think others see you or your role as a speech-language pathologist.
7. Tell me about the things you think are unique to speech-language pathology practice.
8. Tell me about the culture of speech-language pathology.
9. Please describe your cultural background.
10. Tell me how you define cultural competence.
11. Do you believe you are culturally competent?
12. Is there anything you need or would like to know to increase your cultural competence as a speech-language pathologist?

Appendix E
Institutional Review Board Approval Letter

10/29/2010

Shannon R Godsey
UMD Comm Sciences/Disorder
Room 179
31 W. College St
Duluth, MN 55812

RE: "Student perceptions of professional identity and cultural competence"
IRB Code Number: **1010P91553**

Dear Ms. Godsey:

The referenced study was reviewed by expedited review procedures and approved on October 27, 2010. If you have applied for a grant, this date is required for certification purposes as well as the Assurance of Compliance number which is FWA00000312 (Fairview Health Systems Research FWA00000325, Gillette Children's Specialty Healthcare FWA 00004003). Approval for the study will expire one year from that date. A report form will be sent out two months before the expiration date.

Institutional Review Board (IRB) approval of this study included the invitation letter and consent form both dated November 2010.

The IRB would like to stress that subjects who go through the consent process are considered enrolled participants and are counted toward the total number of subjects, even if they have no further participation in the study. Please keep this in mind when calculating the number of subjects you request. This study is currently approved for 35 subjects. If you desire an increase in the number of approved subjects, you will need to make a formal request to the IRB.

The code number above is assigned to your research. That number and the title of your study must be used in all communication with the IRB office.

As the Principal Investigator of this project, you are required by federal regulation to inform the IRB of any proposed changes in your research that will affect human subjects. Changes should not be initiated until written IRB approval is received. Unanticipated problems and adverse events should be reported to the IRB as they occur. Research projects are subject to continuing review and renewal. If you have any questions, call the IRB office at 612-626-5654.

On behalf of the IRB, I wish you success with your research.