Underrepresented Voices: Experiences of Asian American Speech-Language Pathologists in Graduate Training and Clinical Practice

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Abstract

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Purpose: Currently, speech-language pathology lacks diversity in its membership. Asian Americans are especially underrepresented among speech-language pathologists (SLPs) compared to other health professions. This phenomenon suggests that there may be unique factors that Asian Americans face in this discipline. The purpose of this study was to investigate the experiences of Asian American SLPs as trainees and as clinicians, and to explore whether these experiences vary based on their cultural affinity to Asian and American identities.
Methods: The study is a qualitative study drawing on the phenomenological tradition. Twenty-six Asian American SLPs who work with adults participated in one-on-one semi-structured interviews. The interviews included open-ended questions about participants' paths to the

profession, their experiences as trainees and clinicians in speech-language pathology that related to their Asian identities, and the influence of their Asian identity on clinical interactions with clients. Participants also completed the Suinn-Lew Asian Self-Identity Acculturation (SL-ASIA) scale and other demographic questions regarding their ethnicity, language, education and work history. Thematic analysis was conducted with a team approach to develop themes and subthemes from codes derived from the interview transcripts. Descriptive measures were used to identify trends between qualitative and quantitative data.

Results: Two sets of themes emerged from the interviews. The first set of themes focused on Asian American SLPs' experiences as trainees during graduate school and clinical fellowship. Participants described how personal factors, including their personal motivation, family influence, and existing perceptions of SLPs played roles in their decisions to pursue graduate study. Once participants entered these graduate programs, they felt constrained by the existing norms within the program. The social environment within their programs that both positively and negatively influenced their experiences included program diversity, peer support, cultural adjustments, and feelings of isolation. The second set of themes explored their experiences in clinical practice. Participants described that their minority background and cross-cultural experiences served as assets for building strong relationships with Asian and other culturally and linguistically diverse (CLD) clients. They were also aware of the positive and negative impact of their language skills on clinical practice. They also faced challenges related to questioning their belonging in the profession from clients, peers, and themselves. Comparing qualitative findings with SL-ASIA responses data showed that experiences varied among participants based on their generational status and their language familiarity with English and Asian languages. While most

participants identified as bicultural and comfortable navigating between cultures, they still faced racial stereotypes and discrimination that affected their sense of belonging.

Conclusions: Previous research in speech-language pathology and other health professions demonstrates that underrepresented minority members experience sociocultural barriers to career entry, a limited sense of belonging, cultural dissonance in their professional identity, and perceived cross-cultural differences in clinical encounters. While minority SLPs may face many challenges similar to those of other professions, there are two findings highlighted in this study pertaining to Asian American SLPs' experiences. SLPs coming from CLD backgrounds bring clinical strengths for working with CLD clients, but they also face discrimination from their clients and peers because of these differences. The significant role that speech and language plays in the profession, and existing racial stereotyping of Asians may also point to why Asian Americans are uniquely underrepresented in speech-language pathology compared to other healthcare disciplines. More research that centers on the experiences of minority SLPs is needed to address professional ideologies that hinder diversity and inclusion in the field.

Plain Language Summary

Having healthcare professionals who represent different racial backgrounds, cultures, beliefs, and perspectives is important for providing the best possible care for patients from all backgrounds. However, currently there is a lack of diversity in the field of speech-language pathology. In particular, there is a surprising lack of Asian Americans among speech-language pathologists (SLPs). The purpose of this study is to hear about the experiences of Asian Americans who attended graduate school in speech-language pathology and now work as SLPs. We also wanted to see if their experiences were related to their cultural background.

In this study we interviewed 26 Asian American SLPs who are working with adults. They were asked open-ended questions about their journey into the profession, and how their Asian identity affected their experiences during training and work. They also filled out a survey about their culture and language background.

The major findings are listed below:

1. Participants chose to become SLPs because of their personal experiences with communication challenges or a genuine interest in the profession. Some received support and encouragement from their families and SLP mentors, while others faced doubts about whether this career path was right for them.
2. During the participants' time in graduate school, they felt the pressure to change who they were to meet the expectations of their programs. They believed they had to adopt a more "American" identity to fit in with these expectations.

3. Asian American SLPs highlighted their unique strengths in working with clients from similar cultural or minority backgrounds. They connected with these clients through shared experiences and effectively addressed clinical goals by combining their personal understanding of their clients' cultural and language practices with their professional expertise.
4. Not all Asian American SLPs had the same experiences. Some factors that influenced their perspectives and experiences included their generational status and the diversity of people in their study or work environment.
5. Asian American SLPs shared instances of encountering racial discrimination and stereotyping from clients, peers, and other health professionals because of their Asian background. The stigma around non-native English accents was particularly significant in their roles as SLPs. These experiences of racial bias influenced how they perceived their place within the profession.

Previous research has consistently found that minority health professionals often experience feelings of loneliness and identity conflicts. Given that speech-language pathology is one of the least diverse health professions, it is crucial to take active steps to ensure that underrepresented students and clinicians are valued and included. The results of this study highlight the importance of raising the voices of these underrepresented individuals to incorporate their unique perspectives in the growth of the profession.

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DEDICATION

This work is dedicated to all Asian American speech-language pathologist colleagues working on the front lines and serving as mentors for future SLPs. This work is also dedicated to their families. It is through their resilience and determination that we are afforded the opportunity today to raise our voices.

CHAPTER 1. INTRODUCTION

Currently, the field of speech-language pathology lacks diversity in its membership. According to the American Speech-Language-Hearing Association (ASHA) Member & Affiliate Profile Survey, 8.8% of speech-language pathologists (SLPs) identified as belonging to racially or ethnically minoritized groups in 2022 (ASHA, 2023a). In contrast, racially and ethnically minoritized (anyone other than non-Hispanic white individuals) individuals comprise 40.7% of the general U.S. population (U.S. Census Bureau, 2022). The current demographic representation of SLPs in the country is not reflective of the diversity of their patient populations. When language and communication are central to speech-language pathology practice, having practitioners who inherently understand how cultural and linguistic factors impact clinical practice is essential in enhancing quality of care and relevance of research inquiry to ensure both are responsive to the diverse needs of the patient population.

The current homogeneity of the speech-language pathology workforce also signals that there are barriers to inclusive and equitable access to professional training (Ellis & Kendall, 2021). Similar concerns of limited workforce diversity across health professions have prompted research examining factors of inequity and disparities for underrepresented minority (URM) members in disciplines such as medicine, nursing, clinical psychology, and physical therapy. Studies from these disciplines report that URM students and health professionals often experience isolation and a limited sense of belonging in their professions (Hammond, Williams, Walker, & Norris, 2019; Loftin, Newman, Dumas, Gilden, & Bond, 2012; Naidoo, Yuhaniak, & Abel, 2020). Cross-cultural studies of professional identity indicate that URM members

experience conflicts between their personal and professional identities (Hammond et al., 2019; Wyatt, Rockich-Winston, Taylor, & White, 2020).

Available research in speech-language pathology has also identified barriers that URM students face in program entry (Girolamo, Politzer-Ahles, Ghali, & Williams, 2022; Guiberson & Vigil, 2020; Kovacs, 2022; Lugo, Wood, Torres-Chavarro, & Garcias-Salas, 2023), and experiences of "othering" related to their minoritized identity (Abdelaziz et al., 2021; Fuse & Bergen, 2018; Ginsberg, 2018; Matthews & Daniels, 2019; Roberts, 2023). The combination of these factors leads to disparities in basic representation in speech-language pathology, which then impacts how minority members can influence disciplinary leadership, clinical standards, research, and workplace culture (Ellis, Jacobs, & Kendall, 2021; Girolamo, Castro, Hendricks, Ghali, & Eigsti, 2022; Horton et al., 2023; Yu, Horton, et al., 2022). While researchers in speech-language pathology have identified actionable areas to increase diversity in the field (Ginsberg, 2018; Mohapatra & Mohan, 2021; Morris & Bellon-Harn, 2021), the slow pace of change and the drastic imbalance of representation have led to recent, increasing demands that greater attention be paid to understanding systemic and race-specific factors that perpetuate existing inequities within the profession (Duchan & Hewitt, 2023; Ellis & Kendall, 2021; Horton et al., 2023; Whitfield, 2023; Yu, Horton, et al., 2022).

One group that is particularly underrepresented in speech-language pathology, compared to other health professions, are Asian Americans. They make up 3.1% of SLPs (ASHA, 2023a) compared to 6.1% in the general U.S, population (U.S. Census Bureau, 2022). Since Asian Americans are often not considered underrepresented in most other health disciplines, their perspectives are not adequately included in existing research on URM groups in health professions overall (Grumbach & Mendoza, 2008). The absence of data regarding Asian

American SLPs risks perpetuating barriers to their entrance and success in the profession and limiting the guidance that is needed to remediate this issue.

The goal of this study was to address the need for more research on the experiences of underrepresented members of the profession by conducting a qualitative investigation of the experiences of Asian American SLPs in graduate training and clinical practice. This study provides insight into the unique experiences of being Asian American in speech-language pathology and as health professionals in rehabilitation. The findings also allows for comparison of experiences with other underrepresented groups in the profession, and identify unique factors related to the Asian American experience. These findings informs speech-language pathology programs and ASHA to enhance current efforts on creating inclusive structures and practices for Asian Americans, and other URM members in speech-language pathology.

Organization of the Chapters

The current chapter provides an overview of the research problem that were addressed by this study. In Chapter 2, a comprehensive review of existing literature that motivates this study will be presented. This will explore the challenges faced by underrepresented minorities in health professions, both across disciplines and more specifically within the field of speech-language pathology. Conceptual frameworks on professional identity formation and cultural integration provided a theoretical foundation for this study. Chapter 3 will present the research design and methodology for this study. The subsequent chapters will present the results of the study, divided into three chapters. Chapter 4 will provide a description of the participants and present the first set of themes derived from participants' accounts of their graduate training experiences. Chapter 5 will focus on the second set of themes, which pertain to the participants' clinical practice experiences. In Chapter 6, a descriptive analysis of a cultural affinity survey, and selected

comparisons to the qualitative interview data will be presented. Finally, Chapter 7 will summarize and discuss the study's findings, as well as outline future directions for research.

CHAPTER 2. BACKGROUND

The values we place on communication, health, and well-being are related to how they are perceived within our cultures and society. As such, it is important for SLPs who have the technical knowledge for assessment and treatment of communication disorders to be comfortable addressing communication disorders in the context of their clients' social and cultural environments. Health professionals such as SLPs need to recognize and appreciate the intersections of race, ethnicity, gender, religion, culture, sexual orientation, and disability status of their clients and themselves in the clinical encounter in order to provide optimal, culturally responsive care.

Currently, the field of speech-language pathology lacks diversity in its membership. The homogeneity of the profession can impact how the profession is able to connect with its diverse patient population and their concerns related to therapy. More broadly, the lack of diversity in the profession also influences the direction of research, resources, and clinical training relevant to issues faced by culturally and linguistically diverse (CLD) patient populations (Ellis et al., 2021; Girolamo, Castro, Hendricks, et al., 2022; Yu, Horton, et al., 2022). CLD individuals are those with cultural and linguistic backgrounds that are different from the dominant culture and language in Western, English-speaking countries. While not concurrent, CLD individuals often encompass those coming from racially or ethnically minoritized backgrounds.

This literature review will address the need for research on the experiences of underrepresented SLPs, particularly Asian Americans, and the impact that underrepresentation may have on professional development of clinicians. The review will begin with a brief overview of the larger scale problem of existing health disparities and their impact on racially and ethnically minoritized groups in the United States. Then, current issues and progress made in

various healthcare disciplines will be presented to highlight the experiences of underrepresented groups in these health professions. This will be examined in the broader healthcare and rehabilitation literature, and then specifically in speech-language pathology. Following this, evidence will be provided for exploring the experiences of Asian American SLPs in particular. This review will conclude with conceptual frameworks that will contextualize the research problem, the literature, and the methodology selected for the proposed study. For the purpose of this study, this review will focus on the influence of cultural identity on training and clinical practice in speech-language pathology at the individual level.

Health Disparities in Racially and Ethnically Minoritized Groups

A seminal report from the Institute of Medicine (IOM; IOM, 2003) provided unequivocal evidence for the disparities that people from racially and ethnically minoritized backgrounds experience in the U.S. healthcare system. In particular, people from racially and ethnically minoritized backgrounds are more likely to receive lower levels of care, and have reduced health care utilization and access compared to non-Hispanic whites (IOM, 2003). In 2020, systemic racism, cultural racism, and interpersonal racism were recognized as threats to public health, with proposals to reconsider existing policies and practices across all healthcare disciplines that may be perpetuating these ideologies (American Medical Association, 2020). Currently, approximately 40.7% of the U.S. population identifies with a racially or ethnically minoritized group, and this percentage is projected to grow in the coming decades, diversifying the cultural and linguistic profiles of the general population (U.S. Census Bureau, 2022). As such, there is a critical need for providers, researchers, and policy makers to address the underlying factors that contribute to the barriers people from minoritized backgrounds experience in the healthcare system.

Factors that contribute to health disparities differ in pediatric and adult populations. This review focuses on the potential disparities faced by adults within the healthcare system. A report of demographic changes in U.S. nursing homes between 1999 and 2008 found that the number of residents in U.S. nursing homes of Hispanic and Asian backgrounds increased by 54.9% and 54.1%, respectively, followed by Black residents at 10.8%. During the same period, the number of white residents in nursing homes decreased by 10.2% (Feng, Fennell, Tyler, Clark, & Mor, 2011). Reasons for this demographic shift in nursing homes are attributed to increasing national demographic diversity, and to the limited access to home and community-based care options for minority populations that would allow them to remain in their homes longer (Feng et al., 2011). Minoritized groups are also more likely to delay seeking healthcare due to past experiences of discrimination or difficulties navigating the system as a result of limited health literacy or linguistic barriers (Amini-Rarani, Karimi, & Gharacheh, 2022; Bifulco et al., 2023; Bussell & González-Fernández, 2011; Lopez Vera, Thomas, Trinh, & Nausheen, 2023). The limited health care utilization early on in preventative stages of illnesses can subsequently lead to worse health outcomes, or increased care needs in minority populations once they are seen for services (Feng et al., 2011).

For specialized services in healthcare such as speech-language pathology, barriers to access for patients from racially and ethnically minoritized groups remain evident. SLPs working with adults provide assessment, treatment, and support for communication and swallowing disorders, aiming to improve speech, language, cognition, swallowing, and overall quality of life. People in racially and ethnically minoritized groups have been found to have limited knowledge of the role of SLPs (Mahendra & Spicer, 2014; Sung, 2014), have culturally-rooted beliefs and attitudes towards causes and treatment of communication disorders that are not consistent with

typical Western SLP practices (Calia, Johnson, & Cristea, 2019; Sagbakken, Spilker, & Nielsen, 2018; Sung, 2014), and encounter linguistic barriers to resources that are only available in English (Mahendra, 2012; Ponce, Hays, & Cunningham, 2006; Sung, 2014). Reduced awareness by SLPs to these factors can impact access to services for people from minoritized groups and contribute to misdiagnosis or delayed referral to other relevant services (Calia et al., 2019; Ponce et al., 2006; Sagbakken et al., 2018; Sung, 2014). For example, SLPs' existing implicit attitudes and biases towards non-standard dialects of English have been shown to negatively influence their clinical decision making regarding whether their clients have a linguistic difference or a disorder (Easton & Verdon, 2021). Similar research showed that the more knowledge SLPs had about African American Vernacular English, the more likely they were to implement alternative assessment and intervention practices that appropriately recognize its linguistic traits (Hendricks & Diehm, 2020). Because the profession's focus is on language and communication, limited awareness of personal implicit biases and nuances related to cultural and linguistic factors in clinical practice can impact the quality of culturally responsive care for CLD clients.

Diversity Gap in the Healthcare Workforce

While there are many reasons for health disparities for racially and ethnically minoritized groups, one contributing factor is the lack of diversity in the healthcare workforce. As the proportion of the patient population belonging to racially and ethnically minoritized backgrounds increases, it has become evident that the same demographic diversity is not reflected in the healthcare workforce. This gap in diversity of representation between the patient population and health professionals led to a collective call from leaders in healthcare to prioritize the need for cultural sensitivity education for care providers and recruitment of a CLD healthcare workforce (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Nair & Adetayo, 2019). A report of

the Sullivan Commission (2004) titled *Missing Persons: Minorities in the Health Professions* is one of the many reports that justified the positive impact of increased diversity within the health workforce on overall health of the nation. The report acknowledged the historical roots of current disparities in workforce and leadership, the current state of limited diversity in schools and clinics, and the need for enhanced pipeline programs to increase diversity in health professions. To do this, the commission identified the need for overall change of the culture of health professions schools, new and nontraditional paths to professional training, and increased commitment at the level of institutional leadership to drive these changes (Sullivan, 2004).

Underrepresented Minorities in Health Professions

The Association of American Medical Colleges (AAMC) defines "underrepresented in medicine" to refer to physicians whose racial and ethnic identities are currently underrepresented in the profession relative to the proportion in the general population (AAMC, 2004). The relevance of this term is to recognize disparities in representation as a result of sociocultural barriers that historically limit recruitment into the medical profession (Wyatt et al., 2020). Similarly, other disciplines also identified URMs within their health professions where there are disproportionately fewer minority background members compared to the demographic makeup in the general population (American Council of Physical Therapy, 2016; Grumbach & Mendoza, 2008; Sullivan, 2004). Groups that are considered underrepresented differ across disciplines. Table 1 provides information on the racial and ethnic makeup of the U.S. population compared to various health professions based on available survey data from 2020 to 2022. While data were compiled from various sources, the combined data point to the lack of diversity across health professions, and particularly in speech-language pathology and audiology, two of the professions in the discipline of communication sciences and disorders (CSD).

Table 1. Percentage of Racial and Ethnic Demographics of the U.S. Population Compared with Health Professions (2020-2022)

	White (%)	**Asian (%)**	**Black (%)**	**Hispanic (%)**	**American Indian and Alaska Native (%)**	**Native Hawaiian and other Pacific Islanders (%)**	**Other / Multiracial (%)**
U.S. Population[a]	75.8	6.1	13.6	18.9	1.3	0.3	2.9
Speech-language pathologists[b]	**91.2**	**3.1**	**3.7**	**6.6**	**0.3**	**0.2**	**1.5**
Audiologists[b]	91.8	3.9	2.5	3.4	0.2	0.1	1.5
Physical Therapists[c]	84.3	6.9	2.5	3.5	0.4	n/a	2.4
Occupational Therapists[d]	84	6.7	5.2	5.3	0.2	n/a	3.87
Registered Nurses[e]	80.0	7.4	6.3	6.9	0.4	0.4	5.5
Physicians[f]	59.1	19.1	5.3	5.4	0.4	0.2	1.9

Note: [a] U.S. Census Bureau (2022). Quick Facts: United States. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045222 accessed April 28, 2023.

[b] American Speech-Language-Hearing Association. (2023a). *ASHA Members and Affiliation Counts, year-end 2022*. https://www.asha.org/research/memberdata/

[c] American Physical Therapy Association. (2020). *APTA Physical Therapy Workforce Analysis*. www.apta.org

[d] Census Bureau and American Community Survey (2022). Data USA: Occupational Therapists Retrieved from https://datausa.io/profile/soc/occupational-therapists#demographics

[d]

[e] Smiley, R. A., Allgeyer, R. L., Shobo, Y., Lyons, K. C., Letourneau, R., Zhong, E., ... & Alexander, M. (2023). The 2022 national nursing workforce survey. *Journal of Nursing Regulation*, 14(1), S1-S90.

[f] Association of American Medical Colleges. (2022). *AAMC State Physician Workforce Data Report.* Washington, DC: AAMC.

A key argument to support increased diversity among health professionals is to recognize the contribution of URM health professionals in addressing health disparities. URM health professionals often come from CLD backgrounds and therefore are more likely to possess experiential knowledge for interacting with CLD patients, and to identify and address specific cultural and linguistic variables that influence clinical services (Lowell et al., 2018). Practice patterns of URMs in health professions suggest that they are more likely to engage in disparities research or work in culturally diverse and underserved communities (Hammond et al., 2019; Komaromy et al., 1996; Naidoo et al., 2020; Pololi et al., 2013). At the organizational and systems level, a leadership team with increased URM representation can drive policies, programs, and processes that will address concerns relevant for the diversity within their communities (Ellis et al., 2021; Horton et al., 2023). Therefore, enhancing representation of racially and ethnically minoritized groups in the healthcare professions serves as an effective strategy to address the healthcare needs of a CLD patient population (Sullivan, 2004).

Issues Faced by Underrepresented Minorities in Health Professions

Despite the recognized benefits for equitable representation in health professionals, inequities and challenges persist for URMs in entering and being successful in various health professions. In the following sections, representative literature from disciplines including

medicine, nursing, clinical psychology, and physical therapy is used to showcase the current understanding of issues URM health professionals face in the various phases of their careers, from career entry to professional training to clinical practice. There were four salient themes in the literature on the challenges that URMs experience across health professions. These pertain to sociocultural barriers, lack of belonging in the profession, cultural dissonance in professional identity, and cross-cultural positionality in therapeutic relationships. The studies that identified these issues also presented strategies that URMs used to overcome challenges they face in their professional training and clinical practice. After exploring findings from the literature in a range of health professions, this review will focus on the current efforts in speech-language pathology to investigate and address these issues.

Sociocultural Barriers to Career Entry and Advancement

URMs are likely to experience sociocultural barriers to career entry in health professions when their perceptions of the professions, or the sequence of career training differ from what is familiar to them. When exploring careers, people from racially and ethnically minoritized backgrounds are less likely to be exposed to the various health professions or to possess adequate knowledge of the role of allied health professionals. Recent studies in nursing (Woods-Giscombe, Johnson Rowsey, Kneipp, Lackey, & Bravo, 2020) and physical therapy (Moerchen et al., 2018) used qualitative and survey methods, respectively, to identify URM students' decisions for pursuing a career in nursing or physical therapy. Woods-Giscombe and colleagues (2020) reported that nursing students from a mixed group of underrepresented backgrounds initially had misconceptions and stereotypes of the nursing profession based on the influence from their families and friends. Some examples of prior misconceptions included the stereotypical portrayal of a nurse (a white female) and the limited awareness for the science,

technology, engineering, and mathematics (STEM) aspects of the scope of the field. Responses from underrepresented physical therapy students revealed that factors that interest URM students in pursuing physical therapy differed slightly and occurred at a later age compared to their white peers (Moerchen et al., 2018). In particular, white students' primary influence for choosing the profession was personal experiences with physical therapy, while nonwhite and disadvantaged (geographically underrepresented, lower socioeconomic strata, and / or educationally disadvantaged) students were more motivated by the values and interests the profession represented. These values and interests included being in the service of helping others, and the science of rehabilitation. White students were more likely to start pursuing physical therapy during their high school and undergraduate years, whereas nonwhite and disadvantaged peers began pursuing physical therapy as a career option between ages 21-30. These findings demonstrate the need for URM students to receive early exposure to health professions, such as through K-12th grade outreach initiatives and pipeline programs that would better prepare them for program admissions (Moerchen et al., 2018; Phillips & Malone, 2014; Woods-Giscombe et al., 2020).

Barriers to successful program completion for URM students included the availability of support in the program that related to their sociocultural adjustment to the health profession training. In a review of factors impacting program success for minority nursing students, limited availability of financial support was identified as a major influence on their training experience (Loftin et al., 2012). Lack of financial aid required some students to maintain long work hours, which impacted their academic progress, or they were advised by instructors to limit outside work without sufficient alternative avenues to meet financial challenges. Minority students' family relationships also influenced their nursing education due to the families' limited

understanding of the profession, or personal conflicts between familial responsibilities and their studies. As minority nursing students adjusted to the pace of their studies, they perceived that there was limited academic, emotional, and social support from the nursing programs that adequately addressed these sociocultural experiences (Loftin et al., 2012). Limited accessibility to support and resources for URM students were echoed in Bond, Carson, and Baxley's (2015) cross-sectional survey. Faculty and program administrators from nursing schools perceived that more resources for financial support, emotional and moral support, and mentorship were available for Hispanic and African American nursing students than what these minority students themselves reported to be available or accessible.

Sociocultural barriers persist after training for URMs who are practicing in their health professions. To understand equality of employment opportunities for nurses and physical therapists, Hammond and colleagues (2017) conducted a phenomenological study to explore the experiences of URMs who had recently graduated from their programs and were seeking employment. Themes derived from participant interviews pointed to the need for self-directed effort and independent preparation for the job search as there were limited programmatic and family supports in the process. In addition to navigating these challenges, URMs had to consider how "ethnic friendly" the organizations and departments were when they pursued job opportunities to make sure that they "fit in" with the organization based on their ethnic background (Hammond et al., 2017). In order for training programs to promote increased workforce diversity, the authors of these studies recommended improved awareness of sociocultural needs of URM students to tailor recruitment and retention efforts that will in turn facilitate successful transition of graduates to the workplace (Bond et al., 2015; Filut, Alvarez, & Carnes, 2020; Hammond et al., 2017; Loftin et al., 2012; Moerchen et al., 2018).

Belongingness in the Profession

The most salient issue that has been reported by URMs in professional training and clinical practice relates to feelings of isolation or being an outsider in the profession. These impressions stem from experiences of being misjudged by others based on their minority backgrounds, and limited availability of minority-identifying mentors in the profession. Feelings of isolation can lead URMs to question their belonging in the profession and further drive the division between URMs and others in their professional communities.

URMs may be led to question their belongingness in the profession early in their professional training. In a phenomenological study of the experiences of Black, Asian, and other minority ethnicity students in a pre-physical therapy program, students reported having an acute sense of being "outsiders" in the program (Hammond et al., 2019). Other themes derived from this study included feeling that peers or faculty members did not know how to approach race / ethnicity in professional conversations, and carrying the responsibility of integrating themselves with the existing professional culture rather than finding acceptance in their diversity. Similarly, cultural and social isolation were perceived as barriers to success by students from racially and ethnically minoritized groups in a Doctor of Physical Therapy program (Naidoo et al., 2020). Other barriers to success reported by racially and ethnically minoritized students in the program included lack of representation and incidences of discrimination at the institutional level. In Loftin and colleagues' (2012) integrative review of nursing literature, isolation and loneliness, racial discrimination, and lack of mentoring opportunities were identified as themes across qualitative studies that examined minority nursing students' personal and educational barriers to succeeding in their training programs. Feelings of isolation and loneliness were experienced by Hispanic, Native American, African American, Asian, Nigerian, and Eastern Indian nursing

students both inside and outside the classroom (Loftin et al., 2012). In these three papers, a lack of minority representation in leadership or mentorship positions contributed to them questioning their belonging in the profession because they did not see themselves exemplified in these career positions (Hammond et al., 2019; Loftin et al., 2012; Naidoo et al., 2020). Sentiments related to a lack of minority mentorship were also present in literature for medical students (Wyatt et al., 2020).

A systematic review by Filut, Alvarez, and Carnes (2020) on discrimination experienced by physicians of color revealed that several qualitative studies provided evidence for URMs often feeling isolated, alone, or being treated like an outsider in their workplaces. These feelings resulted from overt race or gender-related discriminatory acts experienced in their work settings, as well as subtle conduct within their institutions that questioned their competence or devalued their effort. Across racially and ethnically minoritized groups, discrimination in the workplace contributed to limited professional advancement, reduced job satisfaction, and increased workload for physicians, non-physician faculty, and trainees (Filut et al., 2020). Pololi and colleagues (2013) surveyed 2,381 MD and PhD faculty from 26 medical schools across the United States and found that compared to peers from non-URM backgrounds, URM respondents reported higher aspirations for further leadership opportunities combined with lower perceptions of inclusion and efforts to endorse diversity in their institutions. The authors suggested that the lack of support for leadership development in the profession made URMs feel like outsiders within the institution (Pololi et al., 2013).

Beyond overt discrimination, racial microaggressions can also perpetuate a sense of "othering" for URMs (Filut et al., 2020; Hammond et al., 2019; Naidoo et al., 2020) Microaggressions are intentional or unintentional "common, minor, everyday comments and

acts" (Hammond et al., 2019) by peers, instructors, and supervisors that point out cultural differences, create assumptions of academic ability, and drive other racial stereotypes. In a study examining the effects of racial microaggressions on optimal learning and well-being for medical, nursing, and physician assistant students who are underrepresented in their professions (self-identified as Black, Lantinx, Native American, or Southeast Asian), students felt that microaggressions devalued who they were and discounted what they were able to contribute (Ackerman-Barger, Boatright, Gonzalez-Colaso, Orozco, & Latimore, 2020). Students also reported that experiences of microaggressions affected their mental health and academic performance due to the additional burden of navigating social and racial differences in the academic environment. These experiences served as continued reminders for URMs that they were being treated as outsiders in their training programs (Ackerman-Barger et al., 2020; Filut et al., 2020; Hammond et al., 2019).

Cultural Dissonance in Professional Identity

Another challenge faced by URMs as they gain increased awareness of differences between themselves and others in the profession is the integration of their personal identity and their professional identity, or dissonance between these two identities. There is evidence from international studies suggesting that approaches to clinical interactions and decision-making differ across cultures and countries. Cross-cultural comparison studies of medical students' responses to professional dilemmas reported that medical students in Italy rationalized solving professional dilemmas differently from medical students in Taiwan and Canada (Consorti, Ginsburg, Ho, Potasso, & Toscano, 2019; Ho, Lin, Chiu, Lingard, & Ginsburg, 2012). A qualitative study analyzing audio diaries of Taiwanese and Dutch medical students after their encounters with clinical supervisors and patients found that students from the two countries

engaged in professionalism learning differently (Helmich et al., 2017). The studies cited are important to understand as there are likely underlying cultural differences in professional standards, and that professional training is typically presented within the context of the majority cultural lens of that country.

In the United States, several studies describe the experiences of students from racially and ethnically minoritized backgrounds experiencing dissonance between their identity with personal culture and the culture of their profession. Wyatt and colleagues (2020) examined professional identity development in African American / black medical students with the premise that URMs in medicine are tasked with "suppressing their racial identity" in order to take on a professional identity. Participants expressed that it was challenging for others to see them as representing their racial / ethnic identity and professional identities concurrently. Consequently, they carried the mental burden of having to justify their place in the profession by making conscious efforts to reduce behaviors or speech that invoke stereotypic assumptions of their racial group, thereby suppressing some of their personal identity as means to enhance their professionalism. While some medical students expressed pride in representing their racial or ethnic identity, they also felt futility in gaining recognition from the professional community because of their minoritized background. Similar findings related to managing and covering ethnic differences in verbal expression and physical appearance were reported by underrepresented physical therapy students (Hammond et al., 2019). These students also voiced the burden of having to change their verbal expression and physical behaviors to mask as much of their ethnic differences as possible for the comfort of their patients and peers, suggesting that assimilation with the majority group was a source of professional success.

There are various iterations exploring discipline-based professional identity in other health professions, with more literature emerging from medicine and nursing and none from speech-language pathology (Cornett, Palermo, & Ash, 2023). Existing research in this area confronts the notion that the current professional training in healthcare is not designed to reflect the intersectionality of self-identity variables such as gender, race, culture, and economic status on forming professional identity, even though these variables are identified as strong influences on professional identity in URM health professionals (Dombeck, 2003; Martin & Kipling, 2006; Trevino & Poitevien, 2021; Wyatt, Balmer, et al., 2021). As a result, URM health professionals implicitly delineate their personal identity, including their cultural values and perspectives from professional clinical practices.

Cross-Cultural Positionality in Therapeutic Relationships

In addition to navigating identity and inclusion among fellow professionals, cross-cultural positionality also shapes the minority clinicians' therapeutic relationships with their clients. Positionality refers to how an individual's identity, values, and cultural expectations impact their position or relationship with another person (Harley et al., 2002). There are implicit assumptions based on racial and cultural stereotypes in society that influence how the client and the provider regard each other during the clinical encounter (Kadan, Roer-Strier, & Bekerman, 2017; D. W. Sue et al., 2007; Tang & Gardner, 1999; Yakhnich, Michael, & Yanay-Ventura, 2021). Tang and Gardner (1999) described the types of professional relationship dyads that differ in racial or cultural groups (i.e., minority therapist with majority client, minority therapist with minority client, majority therapist with minority client). The authors explained how culturally conditioned power differentials and value assumptions challenge the expectations and positionality during the patient-provider interaction. In culture-specific studies that examined the

influence of existing power differentials between majority and minority ethnicities, findings suggest that cultural assumptions of minority cultures by majority groups can cause majority culture clients to be resistant, uncomfortable, or develop cross-cultural tension in the therapeutic interaction with the minority clinicians (Kadan et al., 2017; Yakhnich et al., 2021).

In one study, Niño, Kissil, and Davey (2016) conducted qualitative interviews with 13 couple and family therapists born outside of the United States who work in the United States to explore the strategies they use in building cross-cultural connections with their clients. Participants spoke to the importance of building a human connection with their clients regardless of cultural differences. However, 12 of the 13 participants reported experiencing discriminatory acts and comments from their clients, including having their clinical competency questioned. These challenges required the therapists to use early sessions to debunk negative stereotypes and "prove themselves to the client" (Niño et al., 2016). Refusal of care by patients was noted as the most predominant issue in discrimination for physicians of color in patient interactions (Filut et al., 2020).

Strategies Used to Overcome Challenges Faced by Underrepresented Minorities in Health Professions

While prior research has identified challenges that URM health professionals have faced related to inclusion and equitable treatment in the profession, the same studies have also identified strategies URMs employ to overcome these challenges. Success in health professions for URMs was attributed to self-directed effort, resilience, and perseverance despite the identified challenges (Ackerman-Barger et al., 2020; Hammond et al., 2017; Loftin et al., 2012). For instance, staying silent, ignoring, or laughing off experiences of discrimination were common strategies to maintain focus on the training or work (Hammond et al., 2019; Naidoo et

al., 2020). One healthcare student from Ackerman-Barger and colleagues' (2020) focus group said, "because I've kind of gotten used to it, which may or may not be a good thing," (Ackerman-Barger et al., 2020, Table 1). Determination and perseverance empowered some URMs to assert their own ethnic identity (Hammond et al., 2019) and to possess high leadership aspirations because they felt the need to represent their identity in leadership positions (Pololi et al., 2013). For others, determination to find success in the profession propelled them to assimilate and adjust to the expected professional culture (Loftin et al., 2012).

Many URM students and health professionals reported that identifying positive mentorship relationships and seeking out peer support from other URMs in the profession were valuable sources of support (Ackerman-Barger et al., 2020; Filut et al., 2020; Hammond et al., 2017; Hammond et al., 2019; Naidoo et al., 2020). Another strategy URM therapists born outside of the United States described was to reframe their "foreignness" (e.g., cultural and linguistic differences) as assets for exhibiting compassion, curiosity, and humility when they interact with their clients (Niño et al., 2016). The above strategies URM students and health professionals use to maintain academic achievement and find a community within the profession allowed them to find success in training and clinical work.

Issues Faced by Underrepresented Minority Health Professionals in Speech-Language Pathology

At present, speech-language pathology is one of the least diverse healthcare professions (Guiberson & Vigil, 2021). According to the ASHA Member & Affiliate Profile Survey of 2022, 91.2% of SLPs identified as white and 96.4% identified as female (ASHA, 2023a). Cultural and linguistic diversity is a frequently used term in speech-language pathology literature to describe diversity that results from differences in language, race, ethnicity, gender identity, age, and

religion (ASHA, 2017). Linguistic diversity, which is the variation of linguistic characteristics such as dialect or multilingualism, often coincides with cultural diversity (ASHA, 2017). URMs are more commonly referred to as CLD individuals in CSD literature to highlight the value of having cross-cultural perspectives and proficiency in non-standard English dialects or other languages for the work in speech-language pathology and audiology (Fuse & Bergen, 2018).

CSD is similar to some disciplines where there has been limited research into the experiences of URMs. For example, in pharmacy, Bush (2020) attributed limitations to progress in recruiting and retaining diversity in their discipline to the lack of academic research in the field. As a result, they relied on medical and nursing literature to understand diversity needs and perspectives, which limited the actionable items that are specific to the diversity needs of their own field. This is also the case in speech-language pathology, where the call to action has been primarily in commentaries and review pieces (Ellis & Kendall, 2021; Girolamo, Castro, Hendricks, et al., 2022; Rodriguez, 2016; Whitfield, 2023) with a smaller, emerging body of research studies dedicated to the topic than what is available in other health professions. Available literature in speech-language pathology that addresses issues faced by URMs in speech-language pathology are presented below to compare similarities in findings to literature in other health disciplines, and to identify needs for further exploration in the field.

With passing years, the calls for better inclusion of cultural and linguistic diversity within the profession have become more frequent and insistent. Earlier publications included opinion articles from members of the profession, including a manuscript by a graduate student of color who wrote an article about the surprising homogeneity of her peers in graduate school that differed from the diversity of the patient population that motivated her to enter the profession (Rodriguez, 2016). Following 2020, the call to acknowledge systemic racism from within the

profession gained increasing importance and urgency. Ellis and Kendall (2021) addressed systemic issues within CSD that perpetuated racism in the discipline. Girolamo and colleagues (2022) presented evidence highlighting the existence of inequities within the research peer review process, which can impede disciplinary advancement that would otherwise benefit minority communities. A critical discourse analysis of the standards for accreditation in speech-language pathology revealed assumed homogeneity of student experiences and a lack of consideration towards racial and cultural differences in constructing the definition of professionalism and the standards of clinical practice (Yu, Horton, et al., 2022). A recent analysis of the writings by ASHA's charter members exposed the presence of professional values that laid the foundation for elitism, racism, and anti-immigrant bias, among other forms of exclusionary biases, at the time of the profession's inception (Duchan & Hewitt, 2023). These viewpoints are echoed internationally, with similar perspectives coming from speech-language pathology scholars in South Africa (Abrahams, Kathard, Harty, & Pillay, 2019) and Australia (Attrill, Davenport, & Brebner, 2022). These papers propose recommendations for a change in focus within institutional spaces. Instead of placing the burden on URM members to conform to the existing professional culture, the emphasis should be on reevaluating the existing normative frameworks that can be oppressive and exclusive of minority perspectives.

More recently, several empirical studies have emerged documenting the training and clinical experiences of students with CLD backgrounds in speech-language pathology. In career entry, the traditional admission process, limited financial support, and a lack of departmental diversity are sources of disparities for students entering CSD graduate programs (Fuse & Bergen, 2018; Girolamo, Politzer-Ahles, et al., 2022; Guiberson & Vigil, 2020; Kovacs, 2022; Lugo et

al., 2023). These are similar to factors that served as sociocultural barriers for minority nursing and physical therapy students in career entry (Loftin et al., 2012; Moerchen et al., 2018).

In a survey of 57 alumni from an undergraduate CSD program, Fuse and Bergen (2018) found that CLD students (those belonging to African American, Latino / Hispanic, Asian / Pacific Islander, and other racially and ethnically minoritized groups other than White) differed from students with non-CLD backgrounds in the type and extent of support they needed to pursue and excel in their CSD program. These sources of support included academic role models that share similar cultural identities as them, financial resources, and strong emotional / moral support networks.

A recent qualitative study examined the perspectives of 104 minority-identifying CSD graduate students from 28 different states regarding their recommendations for enhancing diversity efforts within the discipline (Roberts, 2023). The participants encompassed diverse minority identities, including individuals who were non-native English speakers, came from racially and ethnically minoritized groups or low socioeconomic backgrounds, male, LGBTQ+, and/or disabled. They emphasized the importance of equitable recruitment practices; greater diversification of students, faculty, and educational curriculum; and enhanced social support and mentorship as recommended initiatives to promote diversity within the profession. The results from these studies were similar to literature from other health professions that called for the increased need for URM mentors and stronger peer support to enhance their sense of belonging during graduate training (Ackerman-Barger et al., 2020; Bond et al., 2015; Hammond et al., 2019; Loftin et al., 2012; Wyatt, Rockich-Winston, White, & Taylor, 2021).

A recent study surveying undergraduate, post-baccalaureate, and graduate CSD students from underrepresented groups (including underrepresentation in race and ethnicity, age, gender,

ability, sexual orientation, religion, socioeconomic status, and nationality) sought to explore their experiences of microaggression in their CSD programs (Abdelaziz et al., 2021). They found that microaggressions from their clients, faculty, and peers made them feel "othered," mistreated, or stereotyped based on their minority identity. In a qualitative study of the academic experiences of 10 ethnic and/or racial minority graduate students in CSD programs, Suswaram and colleagues (2022) reported emerging themes of isolation, classroom microaggressions, denied academic support, and intersectional identities as challenges to overcome in their graduate education. These students also identified "building social capital" as strategies to find belonging within the discipline.

While these studies offer insight into the concerns of URM groups in speech-language pathology, they included participants across multiple underrepresented identities and do not specify experiences of individual underrepresented groups. To address identity-specific experiences, some studies have focused on individual underrepresented groups. Ginsberg (2018) interviewed 11 African American SLPs and found that these individuals experienced microaggressions, isolation, and culture shock during their clinical training, but built grit and found support systems that allowed them to achieve academic resilience and career success. Male students in speech-language pathology programs also faced social isolation during clinical training because of their underrepresentation of gender in the profession, and had to implement coping mechanisms and strategies to adapt within a female-majority profession (Matthews & Daniels, 2019). These male students used their gendered experience as a strategy to connect with male clients in clinical practice (Matthews & Daniels 2019). In a recent publication by Attrill, Davenport, and Brebner (2022), a secondary analysis of qualitative data of international students in Australian SLP programs and their clinical educators revealed the presence of sociocultural

pressures regarding "professional fit" within Western educational practices that were perpetuated by clinical educators. Students who were able to conform to the existing behavioral expectations, described as “unspoken rules,” received more professional opportunities, compared to students who struggled to adjust to the sociocultural aspects of their clinical training. URM groups are not necessarily homogeneous in their experiences, and grouping together people from different URM identities risks undermining or misunderstanding the potentially unique perspectives of different URM groups (Abdelaziz et al., 2021).

Asian Americans in Speech-Language Pathology

Intentions to diversify the general healthcare workforce have led researchers to explore the impact of current training and work experience on people from URM backgrounds. However, current research does not consistently account for the experiences of Asian Americans. Asians are not considered underrepresented in some health professions such as in medicine, nursing, and physical therapy because they are overrepresented in the professional membership compared to the U.S. population (Grumbach & Mendoza, 2008). Thus, Asian perspectives are not consistently included in URM research from other health professions. When Table 1 is examined for the composition of Asians in each profession, Asian are underrepresented in speech-language pathology and audiology in the United States. In comparison to 6.1% of the U.S. population, only 3.1% of SLPs certified by ASHA were Asian in 2021 (ASHA, 2023a). Another statistic to note is that among all ASHA members, only 8.3% self-reported that they provide multilingual services. Within this group, Asians account for 15.2% of SLPs and audiologists providing multilingual services in the United States (ASHA, 2023b). Addressing the inclusion of Asian Americans in speech-language pathology is important because they are uniquely

underrepresented in the profession while serving the same diverse patient population as other health professions.

Asian Americans are one of the fastest growing racial minority groups in the United States. They represent people from over 20 ethnic groups with Chinese, Indian, Filipino, Vietnamese, Korean, and Japanese comprising 85% of Asian Americans (Pew Research Group, 2021). The cultures, religions, economic indicators, languages, and education level of Asian Americans are as varied as the ethnic groups they encompass, and they are influenced by immigration history, socioeconomic status, experiences with racial prejudice, and family dynamics (Lee et al., 2022; Yip, Cheah, Kiang, & Hall, 2021). Among all Asian Americans in 2019, over half were foreign-born, although the average age of U.S.-born Asians is younger (age 19) than foreign-born Asians (age 45). The majority of Asians residing in the United States (72%) reported being proficient in speaking English but 66% of them speak a language other than English at home (Pew Research Group, 2021). One estimate is that by 2060, Asians will constitute 9.1% of the total U.S. population (Colby & Ortman, 2015).

There are reasons to suggest that Asian American SLPs' experiences in training and clinical practice differ from the URM groups that have been previously studied in this discipline. Asian Americans are often associated with stereotypes that threaten their sense of belonging in the American culture, but these stereotypes may be different than other racially and ethnically minoritized groups. For example, the model minority myth that Asians are often the "successful" racial minority group can create high levels of stress in college and graduate education (Cokley, McClain, Enciso, & Martinez, 2013; Suzuki, 2002), and in the workplace (Lai, 2013). The negative consequences of the model minority stereotype include reduced awareness of ongoing inequities that Asians face such as racial barriers in leadership, and limited access to mental

health or academic support (Lai, 2013; Suzuki, 2002). Asian Americans are also more likely to be met with a "perpetual foreigner stereotype" than people from other racially and ethnically minoritized backgrounds, where their American identity is less accepted by other Americans regardless of their native status (Huynh, Devos, & Smalarz, 2011; D. W. Sue, Bucceri, Lin, Nadal, & Torino, 2009). The consequence of socially constructed racial bias and stereotyping can also pose a lasting effect on Asian Americans' self-perceptions in the form of internalized racism (Hwang, 2021). The manifestation of internalized racism can lead people from racially marginalized backgrounds to view their own values and believes to be inferior to the majority race (often white), thereby increasing doubts in their own abilities and acceptance of their subordination in the racial hierarchy. Implications of these perceptions, both external and internally applied, increase tension in Asian Americans' bicultural identity, and lead to a low sense of societal membership (Huynh et al., 2011).

Prevalent stereotypes of Asian Americans are relayed in the form of microaggressions, and are characterized to be different from racism experienced by other minoritized groups through quantitative and qualitative measures (Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; D. W. Sue et al., 2009). Sue and colleagues (2009) conducted focus group with Asian Americans to identify categories of microaggression that were ubiquitous among Asian Americans. Themes that emerged from this focus group included microaggressions that alluded to the perpetual foreigner stereotype, model minority stereotype, exoticization of Asian women, ignorance of intergroup differences, invalidating racism experiences, and perception of cultural communication styles as being inferior to Western communication styles. Nadal and colleagues (2014) investigated the impact of racial microaggressions on self-esteem across college students of different racial and ethnic groups by analyzing participants' responses on the Racial and

Ethnic Microaggressions Scale and Rosenberg Self-Esteem Scale. The results indicated that while African Americans, Hispanics, Asian Americans, and Multiracial people reported similar amounts of microaggressions in their everyday lives, Asian Americans reported more types of microaggressions that allude to the absence of, or invalidation of their racial experiences (Nadal et al., 2014). The findings of these studies on microaggression in Asian Americans note the lasting distress and emotional toll caused by these experiences.

Existing evidence on the minority experiences of Asian Americans compared to other racially and ethnically minoritized groups in education, and within society in general, suggest that while Asian Americans may share some experiences as other URM groups, there are likely unique aspects to their minority identity that merit further systematic exploration of the group. The influx of xenophobic and anti-Asian violence since the beginning of the coronavirus 2019 (COVID-19) pandemic has created increased awareness that Asian Americans have historically been racially positioned in a gray zone where they are not adequately represented in racial minority research, nor in mainstream studies (An, 2021; Yoo, Gabriel, & Okazaki, 2022). 'Absence research' is a term used to describe the tendency for research to expand on certain topics while other topics remain under-examined (Paton, Kuper, Paradis, Feilchenfeld, & Whitehead, 2021), and the experiences of Asian Americans as healthcare providers, particularly as SLPs, fall into this category. There have been no studies located at this time that have explored the intersections of being an Asian American and an SLP. Particularly as the field of CSD drives towards greater equity in research and clinical practice through more representative membership in the profession, investigation of Asian American experiences in speech-language pathology is warranted to understand the experiences of this URM group, to remove barriers to

access and success that may be unique to Asian Americans as SLPs, and to ensure their full inclusion in the profession.

Conceptual Frameworks

The two conceptual frameworks that are used in this study to understand the experiences of Asian American SLPs attempt to synthesize the process of identity formation from professional and cultural perspectives. The first framework, professional identity formation (PIF), is the process in which individuals within a professional discipline begin to formulate their understanding of their roles, beliefs, and values as professionals (Hsieh, 2016; Wyatt et al., 2020). PIF is guided by personal factors (e.g., personal experiences and identity), programmatic factors (e.g., educational contexts during professional training), and workplace factors (e.g., work experiences and work environment). The culmination of personal experiences prior to entering the profession and socialization within the professional community shape an individual's sense of self in the context of their profession. PIF has been used as a framework to understand the process of training in various professions, including teaching (Hsieh, 2016) and medicine (Trevino & Poitevien, 2021; Wyatt et al., 2020).

The second conceptual framework informing this study is Berry's model of acculturation, a two-dimensional adaptation model that describes the ways in which individuals navigate their belonging in their environment (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). The model conceptualizes the cultural retention and acquisition process of an individual when they encounter a majority culture different than one with which they are familiar (Suinn, 2010). The two intersecting dimensions of retention of an original culture (heritage culture) and acquisition of a new culture (host culture) create four acculturation categories of 1) assimilation (adapt the cultural norms of the host culture), 2) separation (reject the host culture in favor of preserving

their heritage culture), 3) integration (adapt to some norms of the host culture while maintaining their heritage culture), and 4) marginalization (rejection of both host and heritage cultures). Acculturation has been identified as an important factor in understanding Asian American experiences as it has shown to impact their health, academic performance, and psychological adjustment (Suinn, 2010).

Considering both of the conceptual frameworks just described - PIF and acculturation - is important for this study to appreciate the intersection of these two concepts on the experiences of Asian American SLPs. PIF has been criticized for its limited consideration of racial and ethnic identity in its conceptualization and application in research (Trevino & Poitevien, 2021; Wyatt et al., 2020). The existing PIF framework presumes uniformity in race and ethnicity in reference to personal factors without addressing the intersectionality of racial and professional identity. When an individual's personal identity does not align with the proposed professional identity, the individual must negotiate their relationship with themselves, their community, and their profession (Wyatt, Rockich-Winston, et al., 2021). On the other hand, Berry's model of acculturation focuses on the individual's integration between two cultures. In the process of becoming SLPs, students learn to mimic the perspectives and behaviors of their educators that are representative of the sociocultural context of their graduate programs. Therefore, students' abilities to succeed within the program can be influenced by how well they are able to orient and adapt to the cultural context of their educational settings and what it means to present themselves as SLPs. Accounting for acculturation in the process of PIF provides the facet of intersectionality that is needed to better understand the experiences of URMs, such as Asian Americans, in the practice of speech-language pathology.

Research Aims

The intended impact of this was to identify factors that limit inclusion of Asian Americans in the speech-language pathology profession in order to reduce the diversity gap between clinicians and the patient populations that we serve. The main objective of the proposed study was to understand the training and clinical experiences of SLPs from Asian backgrounds. This study addresses a gap in the literature by identifying the facilitators and barriers for increasing Asian American representation in speech-language pathology. The study consisted of a qualitative study using the phenomenological tradition to address the following research questions:

1. What are the lived experiences of Asian American SLPs as underrepresented minorities in their professional training and clinical practice?
2. To what extent do the lived experiences of Asian American SLPs in their training and clinical practice vary based on cultural affinity as evaluated by the Suinn-Lew Asian Self-Identity Acculturation (SL-ASIA) scale?

CHAPTER 3. METHODS

This study received an exempt status from the University of Washington Institutional Review Board (#STUDY00015456).

STUDY DESIGN

This study was a qualitative research design of the phenomenological tradition. The purpose of a phenomenological study is to describe "lived experiences" of people around a concept or a phenomenon (Creswell & Poth, 2017), in this case being Asian Americans in the speech-language pathology profession.

A qualitative phenomenological study design was selected to use an inductive approach to address the research questions. Qualitative methods are ideal when information on the topic is limited in the literature, and allows the researcher to capture the depth and breadth of participants' perspectives and context that cannot be captured quantitatively (Creswell & Poth, 2017). There is currently limited literature on the underrepresented minority (URM) experiences of practicing SLPs, and no research that singles out the Asian American experience. The goal of the study is to conduct a deep inquiry that can bring to light many possible facets of the participants' experiences that are difficult to capture using a quantitative paradigm.

PARTICIPANTS

The inclusion criteria for participants were SLPs over 18 years of age and self-identified as Asian or Asian American. They must have also attended graduate school programs in speech-language pathology in the United States that were accredited by the Council on Academic Accreditation for graduate programs in speech-language pathology (CAA). Additionally, participants must have obtained their Certificate of Clinical Competence (CCC) for speech-

language pathology from ASHA for at least one year prior to the study. Recruitment focused on SLPs who were working clinically with adult populations. All participants spoke English sufficiently to participate in the research interview. The exclusion criteria included SLPs working in academic environments in faculty roles (in teaching and / or research) to ensure that participant experiences were primarily related to clinical settings, and SLPs whose primary clinical role is working with pediatric populations.

It is important to note that Asian Americans encompass people of multiple ethnicities and generational backgrounds, depending on when immigration to the United States occurred. Therefore, there were no inclusion / exclusion criteria based on heritage beyond Asian self-identification and current residence in the United States in order to welcome a range of experiences that relate to this identity.

Participants were recruited nationally using flyers and social media posts in targeted groups, including the Asian Pacific Islander Speech-Language-Hearing Caucus (APISLH Caucus), Washington Speech-Language-Hearing-Association, and through word-of-mouth with existing SLP contacts. The recruitment process lasted for three months. Recruitment concluded when saturation was reached, when no new concepts emerge from subsequent interviews during the process of concurrent coding (Saunders et al., 2018).

The strategy for recruitment aimed to capture a variation in participant experience based on years since graduation and geographic location. Purposive sampling of participants based on years of experience was conducted to determine if participant experiences differed depending on the recency of their training and the length of their clinical practice. Similarly, sampling participants based on geographic location aimed to acknowledge the potential impact of geographic diversity on participant experiences. Recruitment specific to Washington state was

added toward the end in effort to meet a larger target sample size. See Appendix A for additional consideration based on data collected from the APISLH Caucus.

Candidates who expressed interest in the study were screened for inclusion criteria via email. After determining eligibility, the consent process was conducted in accordance with the approved guidelines of the Institutional Review Board.

Data Collection

This section reports the data collection procedure for the study. Data were collected from participants during a one-on-one videoconference interview with the dissertation study investigator (LJ). The interview was hosted over Zoom video conferencing to encourage equitable participation from broader geographic regions. All interviews were recorded via the Zoom recording feature.

Interview Guide Development and Interview Protocol

The interview guide for this study was developed based on the framework for qualitative semi-structured interview guides by Kallio, Pietila, Johnson and Kangasniemi (2016). This framework contains five phases: 1) identifying the prerequisites for using semi-structured interviews, 2) retrieving and using previous knowledge, 3) formulating the preliminary semi-structured interview guide, 4) pilot testing the guide, and 5) presenting the complete semi-structured interview guide (Kallio et al., 2016).

Semi-structured interviews allow for some flexibility in the interview process to further explore issues that were meaningful for participants, while still focusing on the study topic. Prompts within the interview questions were used when participants lacked salient experiences or stories in a topic, enabling questions to be rephrased to address related areas. The initial draft of the interview guide was developed by the dissertation study investigator (LJ), drawing on

topic areas gathered from the literature review, an interview guide used in a previous study about professional identity formation in underrepresented minority physicians (Wyatt et al., 2020), and consultation with co-investigators with qualitative training. The proposed interview guide was reviewed by the full research team for feedback and revision.

The initial interview questions were field-tested with two eligible participants recruited using purposive sampling in known community groups (see Appendix B). These two participants served as pilot participants, helping to trial the question wording and the scope of the questions. Their feedback was used to further develop the interview guide. Data collected from these field-testing interviews were included in the final data analysis, as pilot participants found the scope of the interview questions to be appropriate during the feedback process, and no major revisions to the interview guide were made before proceeding with subsequent interviews.

Each interview began with a review of the purpose of the study, positionality of the interviewer, and centering the participants as experts of their lived experiences. Participants were encouraged to share any experiences they wished to share. Interview questions began with the prompt, “Can you describe to me the decisions that lead you to become an SLP?” Following this prompt, the interview continued with broad questions regarding the training and clinical experiences to facilitate conversation and maintain consistency across major topics. Subsequently, the interview focused on specific areas raised by the participants. Topic areas asked in the interviews included participants’ experiences during graduate school, descriptions of the cultures in their graduate program and work settings, the impact of their Asian American identity on their role as SLPs, and their incorporation of cultural competency or culturally responsive caring principles in clinical practice. Participants were encouraged to share any relevant experiences that they wish to share, and the interviewer sought clarification and

examples to ensure a thorough understanding and accurate capture of these experiences during the interview.

Throughout the interview, brief field notes were made to augment the recording. After most questions from the interview guide were addressed (approximately 60 minutes into the interview), participants were instructed to complete the SL-ASIA scale and demographic questions on Microsoft Forms. Each participant's entry was assigned a participant identifier number and otherwise anonymized. During this time, both the interviewer and the participant were muted and cameras were turned off. Participants were also invited to take a short break at this point before resuming the rest of the interview. After regrouping, the interviewer asked the participant follow up questions about their impression of SL-ASIA scale and any reflections they had about their cultural affinity and their practice as SLPs. The interviewer also followed up on any topics from prior to the survey administration as needed. After each interview concluded, the interviewer spent 30 minutes to complete more detailed field notes and initial summary of the interview. Participants were paid $35 for their participation.

The Suinn-Law Asian Self-Identity Acculturation (SL-ASIA) scale

The SL-ASIA scale is a cultural affinity scale designed to measure the acculturation level of Asian populations residing in the United States (Suinn, Ahuna, & Khoo, 1992). It is the most widely used acculturation scale for Asian Americans in the literature (Zhang & Tsai, 2014), and has been psychometrically validated in a broad sample of working-age Asian Americans (Ownbey & Horridge, 1998). The SL-ASIA scale consists of 26 multiple choice and rating scale questions that ask about the respondent's level of acculturation, cultural values, behavioral competency, and self-identity in relation to their Asian heritage versus American (also referred to as Western) culture (see Appendix C for the full list of items). The original 21 items use 5-point

Likert-type scaled responses and are used to calculate the respondent's acculturation score. The final acculturation score is an average of the 21 responses ranging from 1.00 indicating low acculturation (maintaining strong Asian identification) to 5.00 indicating high acculturation (strong American identification).

The remaining five items contribute to three supplementary scores that describe the multidimensionality of acculturation in participants. Items 22-23 are scored in relationship to each other to calculate the values score that represent the respondent's identifying cultural values. Items 24 and 25 are similarly scored to calculate the behavioral competency score, indicating their fit or belongingness within the American culture. These two scores have possible responses that include American-classified, Asian-classified, bicultural, or neither. Finally, the response to Item 26 provides a self-identity score, which is a self-reported overall cultural identity that includes being Asian self-identified, American self-identified, or Bicultural self-identified.

The four SL-ASIA scores can be analyzed in combination with one another to understand the impact of the respondent's values, behavioral competency, and self-identity on predicting behaviors and satisfaction with their decision making (Suinn et al., 1992). This measure is freely available for research use through the Columbia University Psychosocial Measures for Asian Americans Populations project (www.columbia.edu/cu/ssw/projects/pmap). One minor modification was made to the original wording in the SL-ASIA prior to data collection to make relationship with parental figures to be more inclusive of different family structures (i.e., "Which identification does (did) your *mother* use?" to "Which identification does (did) your mother/father/primary caretaker use?").

Demographic Information

Demographic information collected included age, gender, race/ethnicity, current geographical region, and employment status (e.g., full-time, part-time, or hourly). Profession-related demographic information included years since graduation, geographical region of graduate training, current clinical population, current clinical setting (e.g., hospital, outpatient clinic, private practice, etc.) based on categorization of healthcare settings used in ASHA membership employment information at the time of recruitment, and racial / ethnic diversity of current clinical population. Culture and language-related demographic information were collected as part of the SL-ASIA responses, including language proficiency and preference, generational background, and where participants were raised. See Appendix D for the demographic survey.

Data Analysis

Data analysis included thematic analysis of the qualitative interviews, as well as descriptive analysis of participant acculturation data collected using the SL-ASIA scale and demographic data.

Qualitative Interviews

Voice recognition and automatic transcription technology by Zoom was used to directly create a written transcript of each interview from the session. Twelve transcripts were manually reviewed in their entirety against the audio recording by the dissertation study investigator or a graduate student volunteer to ensure accurate verbatim transcription. The remaining fourteen interviews were transcribed by professional transcription companies (Rev.com and Transcription Hub). Unclear words were marked by the transcription company, which were reviewed by the lead investigator for accuracy.

The thematic analysis process followed guidelines published by Nowell, Norris, White, and Moules (2017) to ensure trustworthiness and methodical rigor. Phase one of thematic analysis included familiarization and organization of data. Interview transcripts were uploaded to Dedoose qualitative data analysis software (SocioCultural Research Consultants, 2021). Deidentified individual participant summaries and memos were recorded on Microsoft Word. The initial generation of codes in phase two was carried out by four research team members including the dissertation candidate (LJ), her mentor (CB), a PhD student from a related health profession (MY), and a graduate student in speech-language pathology (SZ) with follow up checking by another member of the dissertation committee (JT). The research team identified important codes following systematic and thorough reading of the data. Four transcripts (15% of the interviews) chosen to represent the range of participant experiences (e.g., variations in age, clinical experience, acculturation, geographical region, etc.) were read fully by the four investigators as the basis for developing the initial codebook (see Appendix E). Members of the research team began with individual readings of these four transcripts to code sections of text with key words that they felt emerged from the data. Then, the members of the research team met to deliberate the emergence of codes as the selected four transcripts were read together until there was agreement on the initial codebook through careful discussions and triangulation of researcher perspectives. The research team repeated this process of independent coding sections of representative transcripts and meeting to compare codes until the team agreed that continued reading was yielding no new codes. The resulting codebook with detailed definitions and example excerpts, agreed upon by the research team. The dissertation study investigator coded the remainder of the transcripts on Dedoose while participating in reflexive journaling through the coding process. Coding of four transcripts (15% of total transcripts) was checked by a second

coder (MY) to ensure agreement of coding application. Any discrepancy in coding, which were minimal, were discussed until both parties reached consensus.

Phase three of analysis is the development of themes after all the data have been initially coded. Coded excerpts under were exported from Dedoose into separate Word documents for each code for further analysis (e.g., all "Peer Interactions" excerpts were grouped together). A systematic and thorough reading of excerpts within each code was completed, where repeated thoughts, ideas, and experiences were additionally reorganized into child codes. Accounts that differed from the majority were also included to present the diversity of experiences. Summary paragraphs of each child code were written. The summary paragraphs for each child code were then used to formulate one-to-two-page summaries of the parent code. The summaries of each code were reviewed by the lead investigator, and formulated meanings within and between codes were used to derive themes of the most salient messages that captured the essence of the participants' lived experiences. The thematic analysis process occurred iteratively, with triangulation across data (including demographic and cultural affinity variables) to ensure that the themes were authentic to the participant experiences, and that experiences of all participants were captured in the resulting themes.

Phase four is the refinement of the first set of themes. Once themes and subthemes were developed and documented, three investigators (LJ, CB, and MY) debriefed and consulted the data to make sure that the themes sufficiently captured the meanings and experiences evident in the data. If relevant issues in the data did not appear to be captured by existing themes, or certain codes were not sufficiently used in the previous phase, themes were revised through team discussion to better reflect the data set as a whole. In phase five, themes and subthemes were further renamed and defined. These themes were compared against the entire dataset and

reflected against the research questions. This process was validated through debriefing with the research team and an invitation to all participants for member checking. A total of eight participants expressed interest in participating in this process, and two participants responded with feedback. Both participants responded that they saw their own experiences reflected in the themes, and no changes were made. Clear records were kept in this iterative process to explain the rationale behind theme modifications when feedback was provided by the research team and the participants. Finally, in phase six, the consolidated criteria for reporting qualitative research (COREQ) reporting guidelines (Tong, Sainsbury, & Craig, 2007) were used to report the findings and the data analysis process.

Quantitative Survey Data

Descriptive statistics were used to analyze quantitative data collected from the participants using the SL-ASIA scale and demographic survey. The SL-ASIA scores were calculated for each participant following the scoring guide (Suinn et al., 1992). Responses for categorical questions (e.g., generational status, languages spoken, self-rating of cultural identity, heritage ethnicity) were also analyzed across participants to determine frequency counts and percentage endorsing each response category in the sample. Responses for numerical questions (e.g., age, years since graduation, etc.) were calculated for mean and range. Trends that emerged from the qualitative data were compared against acculturation, values, behavioral competency, and self-identity scores from the SL-ASIA to see if there were similarities and differences in experiences among participants based on these features. In addition, demographic variables such as age, levels of clinical experience, and geographical location were considered, in addition to SL-ASIA scores, for any patterns emerging in the data according to these variables.

Trustworthiness and Rigor

Steps were taken to ensure trustworthiness of the data (Lincoln & Guba, 1985; Merriam, 2009). Credibility refers to the degree of believability, accuracy, or the soundness of the data. Credibility was addressed through collaboration among members of the research team in data collection and analysis. All interview transcripts were reviewed by a graduate student volunteer or the lead investigator for accuracy in the verbatim transcription. Interviews were reviewed and discussed between the interviewer and a second research team member (CB) throughout the data collection process. Preliminary coding and thematic analysis were checked against raw data. Member checking of the developed themes was planned into the analysis process and completed with two participants. Transferability refers to the external validity of data. Transferability was addressed through triangulation and saturation by collecting a large sample size to encourage representation along a diverse range of experience in the field, and ethnic / cultural diversity within the Asian American categorization that was representative of the available APISLH Caucus membership data. Dependability refers to the consistency of the research process and findings to ensure replicability of findings. Dependability was addressed by providing a clear, logical, and traceable audit trail of the data collection, analysis, and interpretation process. Confirmability refers to the degree in which the findings are neutral to the researchers' biases and preconceived notions in the research process. was addressed by taking a reflexive approach as the investigator of this study to acknowledge the influence of her own background and positionality in the research process (see the section below), and to assess the potential for bias or distortion in the data collection, analysis, and interpretation process. The analysis team included multiple researchers, including Asian clinician researchers, health professionals from other allied health disciplines, and individuals with qualitative research expertise.

Sociocultural Positioning Statement and Researcher Reflexivity

The researcher's identity and relationships with participants are influential to data collection and analysis in qualitative research methods (Creswell & Poth, 2017). There is a possible influence of their positionality, including their personal experiences, prior knowledge, and views on the research topic, on the direction of the conversations during data collection and the interpretation of data during analysis.

The dissertation candidate and the lead investigator of this study (LJ) is a female Asian SLP. She is Chinese-Canadian and therefore may have different experiences than Asian Americans, but may share similar experiences due to the presence of overlapping cultures. She was born in China, grew up in Japan as a child, and immigrated to Canada with her family to an immigrant-dominant community at age 10. She received her speech-language pathology training from a bilingual university in Canada and immigrated to the United States as a working adult. She is a first-generation immigrant to Canada as a child, and also a first-generation immigrant to the United States as a working adult. English is the third language she speaks but her most comfortable language. She shares the identity of URM in the field of speech-language pathology with the participants in this study as someone with an Asian heritage background. As an SLP, she has provided care to CLD adults in Canada and the United States in outpatient, acute in-patient, in-patient rehabilitation, and skilled-nursing facility settings. She has also worked in supervisor and instructor roles in American university settings in the training of graduate clinicians in speech-language pathology.

CHAPTER 4. RESULTS – GRADUATE TRAINING EXPERIENCES

This chapter is the first of three chapters that present the results of the study. Chapter 4 begins by describing the participants. The themes that emerged from the participants' salient experiences were separated into two different topic areas. This decision was based on the changes in the tone of the data and participants' changed role from being trainees to independent clinical professionals. The first set of themes, which will be further discussed in this chapter, focuses on the participants' experiences during graduate programs and as clinical fellows (CFs), exploring how their Asian American backgrounds influenced their training to become SLPs. In Chapter 5, the second set of themes describes the participants' experiences as they transitioned into independent clinical SLPs, highlighting their engagement in clinical practice and their perception of cultural responsivity from an Asian American perspective. Following the two sets of themes, Chapter 6 provides descriptive data from the SL-ASIA and identifies patterns in the qualitative findings in relation to the participants' cultural affinity data.

DESCRIPTION OF THE PARTICIPANTS

A total of 26 individuals participated in this study. A summary of participants' demographic characteristics can be found in Table 2. Participant information is presented collectively to anonymize individual characteristics, reducing the high risk of identifying specific participants among this small minoritized group in the current SLP population. Participants had a mean age of 34.4 years with a range of 25 to 64 years. The majority of the participants (88.5%) were female. All participants in this study self-identified as Asian in the racial category, although 80.8% reported to belong to one racial group while 19.2% reported to belong to two or more races. None of the participants identified as Hispanic or Latino. Participants' heritage ethnicity

among Asian nationalities ranged. The three most frequent ethnicities were Chinese (42.3%), Filipino (15.4%), and more than one heritage ethnicity (11.5%). Over 80% of the participants reported speaking more than one language. Over half of the participants were born in the United States (57.7%), while nine participants (36.6%) were born in an Asian country and two participants (7.7%) were born elsewhere.

Table 2. Demographic description of participants

Characteristic	n	%
Age (mean, in years)	34.4	range (25-64)
Gender		
Female	23	88.5
Male	3	11.5
Race		
Asian	21	80.8
Two or more races	5	19.2
Non-Hispanic or Latino	26	100.0
Heritage Ethnicity		
Chinese	11	42.3
Filipino	4	15.4
Korean	2	7.7
Indian	2	7.7
Vietnamese	2	7.7
Indonesian	1	3.8
Taiwanese	1	3.8
More than one	3	11.5
Languages spoken		
More than one language	22	84.6
English only	4	15.4
Place of birth		
United States	15	57.7
Asia	9	36.6
Other	2	7.7

Participants were also asked to provide information about their education and clinical work information (see Table 3). Mean years since graduation from their graduate training programs was 8.6 years with a range of 1.7 to 31.8 years. Twenty participants (76.9%) were currently employed full-time as SLPs, two participants (7.7%) were employed part time, and four

participants (15.4%) held a PRN / per diem position, meaning that they are employed on an on-call or flexible basis as needed by their employer. The top four work settings reported by participants were hospital (46.2%), outpatient clinic (19.2%), skilled nursing facility (11.5%) and home health (11.5%). Participants also represented all four regions of the United States in their current employment, including 16 participants (61.6%) from the West region (specifically from the states of California and Washington), four participants each (15.4%) from the South and Midwest regions, and one participant from the Northeast region.

Table 3. Participants' clinical background

Characteristic	n	%
Years since graduation (mean, in years)	8.6	range (1.7-31.8)
Employment		
Full time	20	76.9
Part time	2	7.7
PRN / per diem	4	15.4
Current work setting		
Hospital	12	46.2
Outpatient Clinic	5	19.2
SNF	3	11.5
Home Health	3	11.5
Private practice	1	3.8
Teletherapy	1	3.8
Subacute	1	3.8
Years in current work setting		
< 2 years	9	34.6
3-5 years	8	30.8
6-14 years	4	15.4
15+ years	5	19.2
Region of the U.S. for employment		
West (California)	8	30.8
West (Washington)	8	30.8
South	4	15.4
Midwest	4	15.4
Northeast	1	3.8

Note. PRN = "pro re nata", describes healthcare employment on an on-call or flexible basis as needed by their employer. SNF = skilled nursing facility.

Table 4 displays a collection of responses and scores from each participant's SL-ASIA scale, providing insights into their Asian American identity. This information sets the context before introducing the qualitative findings. All 26 participants in this study completed the SL-ASIA scale. The mean acculturation score was 3.02 (*SD* = .64), ranging from 2.05 to 4.05, suggesting that participants, on average identified with medium level of acculturation. Twelve participants were first generation (e.g., born in a country other than the United States), 10 participants were second generation (e.g., born in the United States but had one or both parents born in another country), and the remaining five participants were third generation or later (e.g., they and their parents were born in the United States, their grandparents may have been born outside of the United States). The majority of the participants in the study (80.8%) self-identified as Asian-American, five participants (19.2%) self-identified as Asian, and none used the term "American" only for their self-identity. More details of these data and their association with the qualitative findings will be reported in Chapter 6.

Table 4. Portion of the participants' cultural affinity survey results

				SL-ASIA Score Categories			
Participant	Languages Spoken	Language Preference	Generation	Acculturation score*	Values Score	Behavioral Competency Score	Self-identity
P01	Asian language(s) and English equally	Mostly Asian language(s), some English	First	2.05	Bicultural	Asian	Asian-American, blend of both
P02	Asian language(s) and English equally	Asian language(s) and English equally	First	2.38	Bicultural	Asian	Asian-American, Asian leaning
P03	Mostly English, some Asian language(s)	Mostly English, some Asian language(s)	First	3.33	American	American	Asian-American, Asian leaning
P04	English only	English only	Fourth	3.76	American	Bicultural	Asian-American, blend of both
P05	Asian language(s) and English equally	Asian language(s) and English equally	First	2.52	Asian	Asian	Asian
P06	Mostly English, some Asian language(s)	English only	Second	3.43	Bicultural	Bicultural	Asian-American, American leaning
P07	Asian language(s) and English equally	Mostly English, some Asian language(s)	First	3.10	American	American	Asian-American, Asian leaning
P08	Mostly English, some Asian language(s)	Mostly English, some Asian language(s)	Second	2.95	Asian	Asian	Asian-American, Asian leaning
P09	Asian language(s) and English equally	Mostly English, some Asian language(s)	First	2.14	Bicultural	Bicultural	Asian

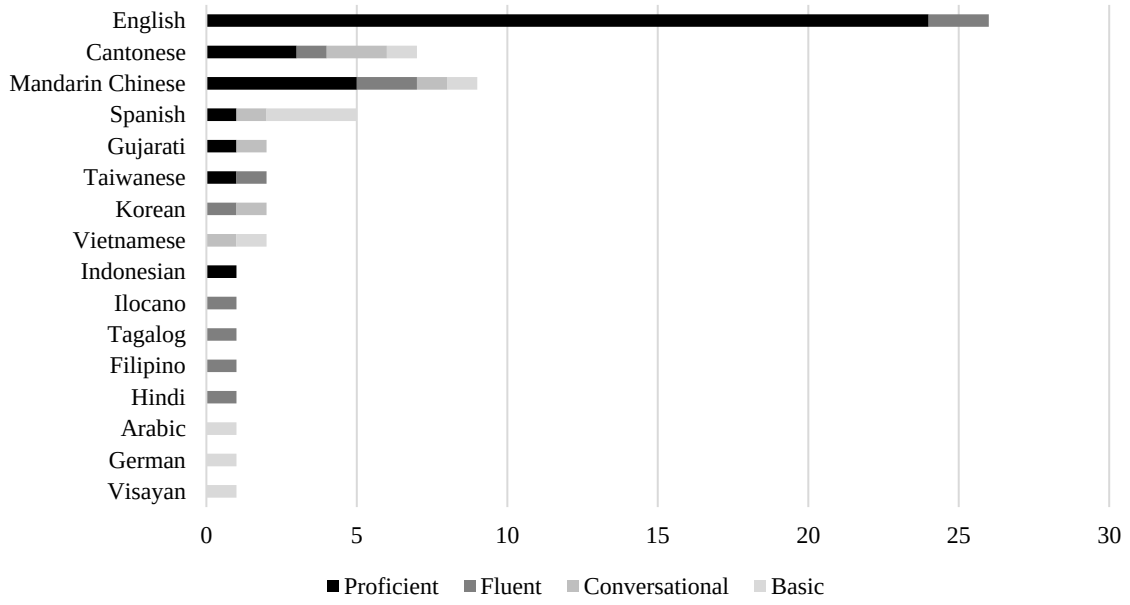
				SL-ASIA Score Categories			
Participant	Languages Spoken	Language Preference	Generation	Acculturation score*	Values Score	Behavioral Competency Score	Self-identity
P10	Mostly English, some Asian language(s)	Mostly English, some Asian language(s)	Second	2.86	Asian	Asian	Asian-American, blend of both
P11	Asian language(s) and English equally	Asian language(s) and English equally	First	2.33	Asian	Asian	Asian-American, Asian leaning
P12	Asian language(s) and English equally	Asian language(s) and English equally	First	2.05	Asian	Bicultural	Asian
P13	Asian language(s) and English equally	Asian language(s) and English equally	First	2.14	American	Bicultural	Asian
P14	Mostly English, some Asian language(s)	English only	Second	3.33	Asian	Bicultural	Asian-American, American leaning
P15	English only	English only	Second	3.81	Asian	Bicultural	Asian-American, blend of both
P16	Mostly English, some Asian language(s)	Mostly English, some Asian language(s)	Second	3.29	American	American	Asian-American, American leaning
P17	Asian language(s) and English equally	Asian language(s) and English equally	First	2.76	Asian	Bicultural	Asian-American, Asian leaning
P18	Mostly English, some Asian language(s)	English only	Second	3.67	Bicultural	Bicultural	Asian-American, blend of both
P19	Mostly English, some Asian language(s)	English only	Second	3.43	Bicultural	Bicultural	Asian-American, blend of both

				SL-ASIA Score Categories			
Participant	Languages Spoken	Language Preference	Generation	Acculturation score*	Values Score	Behavioral Competency Score	Self-identity
P20	Asian language(s) and English equally	Asian language(s) and English equally	First	2.24	American	Bicultural	Asian
P21	English only	English only	Fourth	4.05	American	American	Asian-American, American leaning
P22	English only	English only	First	3.14	Bicultural	Bicultural	Asian-American, Asian leaning
P23	Mostly English, some Asian language(s)	English only	Fifth	4.05	Bicultural	American	Asian-American, blend of both
P24	Asian language(s) and English equally	Asian language(s) and English equally	Second	2.71	Asian	Bicultural	Asian-American, blend of both
P25	Mostly English, some Asian language(s)	English only	Second	3.62	Bicultural	Bicultural	Asian-American, blend of both
P26	English only	English only	Third	3.38	American	Bicultural	Asian-American, Asian leaning

Note. SL-ASIA = Suinn-Lew Asian Self-Identity Acculturation scale.
*Scores ranged from 1.00 to 5.00. Higher numbers suggest higher American cultural affinity.

Figure 1 presents the participants' self-reported languages spoken and their respective fluency levels. To ensure confidentiality, the data from all participants were combined, avoiding any identification of participants by language proficiency. There were nine participants who reported speaking three or more languages at different fluency levels.

Figure 1. Participants' self-report of languages spoken and fluency levels (participants can be represented in multiple categories).



In the following paragraphs, the participants' personal definitions of their identities as people from Asian backgrounds living in the United States are presented. These descriptions serve as cultural affinity descriptions, aimed at providing a contextual understanding of the participants' cultural backgrounds for the subsequent results chapters. Participants who immigrated to the United States as young adults for college (n = 8) felt that even though they were raised in Asia, their identities are now embedded within the American culture. P02 explained that because she has lived in the United States longer than her country of origin, she would be a tourist now if she went back to her birth country. "I'm Asian but I also live in

Western culture right now…My Asian culture goes back to the 1980s when I first came to USA. It stopped there," (P02). Similarly, P01 explained that despite being raised in Asia and feeling "100% Asian," most of her adult life experiences have been shaped in the United States. Other participants, who were partially raised in Asia (e.g., came to the United States at a young age; n = 3), felt that they did not exclusively identify with being "Asian" or "American." P07 defined her two cultural identities as a "split personality" which she described as, "A battle of two cultures trying to merge itself at the same time." P22 described this feeling as an "identity crisis of not being Asian enough for some of your Asian family and not American enough for your American side."

Second generation immigrant participants who were born and raised in the United States (n = 10) struggled with the acceptance of their dual-cultural identity, but learned to embrace their belonging in both cultural identities over time. In childhood and early adulthood, these participants expressed a desire to identify culturally and physically as American and, "Become more white: How can I dress like the others, how can I look like others. I would get excited when people would compliment, 'You have such big eyes for an Asian!'" (P04). Another participant described herself weighing the value of her two cultural belongings and saw them separately:

> As a young Asian-American, you're embarrassed by your culture. You have identity problems early on, because you don't quite fit in to the American bucket and you don't quite fit in to the Asian bucket. You are this beautiful blend, but you don't think you're so beautiful and you just feel mismatched and like you don't belong anywhere. (P16)

The participants developed increased comfort in embracing their Asian identity in adulthood. A few participants attributed their emerging Asian pride to increased diversity representation in media in the recent years:

> I think being surrounded by, and seeing more Asian American representation in our media, just having those positive messages and people surround me, really encourage me. I was lacking those type of role models who are so proud of their culture and heritage until recently. (P21)

On the other hand, other later generation immigrant participants and biracial participants (n = 5) felt that they have always been comfortable navigating the two cultural identities. “I'm bi-racial, I'm very comfortable in both areas. I can fit in when the whole room is white and I can fit in the whole room as Asian. I could because I can relate to both types of people because I have both types of experiences,” (P15). Results from the SL-ASIA scale and supplementary qualitative responses from participants illustrate that while all participants acknowledged having aspects that reflected both their Asian and American identities in some capacity, their understanding and definition of what it means to be "Asian American" varied based on their individual connections and experiences with these two cultures.

Graduate Training Experiences

This section will report on themes that emerged that speak to the participants’ experiences during their training to become an SLP in graduate programs and in their CF. Overall, participants recalled a range of training experiences encompassing both positive and negative aspects related to their Asian American backgrounds. The themes presented below illustrate the continuum of participant experiences, highlighting both the shared commonalities and the varying degrees of experiences along the gradient. The three themes include: factors that influenced the participants’ path to the profession; the perceived barriers to Asian American students’ inclusion in graduate training; and the influence of the social environment on the

graduate training experience. See Table 5 for an overview of the themes and subthemes related to participants' graduate training experiences.

Table 5. Themes and quotes of the participants' graduate training experiences

Themes and descriptions	**Subthemes**	**Quotes**
Theme 1: Finding my place in the profession Experiences navigating into the profession, including facilitators and barriers that influenced participants' career decisions	Subtheme 1.1: Path to the profession	"Something that is, very white dominant, English based, and it would be hard for me to jump into that. Coming from the perspective of, I'm stepping into a completely different realm. I think that was scary for my family and also for me." (P20)
	Subtheme 1.2: You have every right to be where you are	"Just go for it. Don't let your Asian-ness, or don't let other people's views of your Asian-ness hold you back. It is an important and influential part of who we are, but it's also just one part of who we are." (P19)
Theme 2: I invested in you, I wish you would invest in me Reciprocity between the participants' investment in the profession as students and the program's investment in the participants as future SLPs	Subtheme 2.1: Don't stir the pot	"I'm gonna comply. From my family upbringing, you never ever directly address issues. It's so far under the rug it's not even there. You just put your head down, you work hard, and that's what is valuable and good." (P15)
	Subtheme 2.2: Pressure to assimilate	"As a student in speech pathology program, I had to mold myself. You have to fit in with the group a little bit…I have learned what being an American is throughout all of my educational experiences, including graduate school." (P16)
	Subtheme 2.3: Missed learning opportunities	"We talked about it in our classes, but it wasn't something that was explicitly its own thing. I don't really remember there being explicit opportunities to work with diverse population." (P26)
Theme 3: The social end of things Peer support and social environment influenced	Subtheme 3.1: I'm lucky	"I consider myself luckier than a lot of my colleagues in other states and areas, because [City] was kind of a little melting pot." (P07)
	Subtheme 3.2: Culture shock	"When [graduate] school starts, I've only been in the US for a couple month. I'm not exactly sure how we express certain things because it's different. So sometimes, I might not using the expression that they can understand. So I

participants' sense of belonging		think that's kind of challenging for me at school." (P13)
	Subtheme 3.3: Building friendships outside of academics	"When it came to school, everyone just did group projects or whatever collaboration they needed to do, that was okay. It was more of the social aspect of it [that was challenging]." (P04)
	Subtheme 3.4: Lonely Endeavor	"I do think it was a more lonely endeavor when I was in school and when I first started out than it is now." (P25)

Note. SLP = speech-language pathologist

Theme 1: Finding my place in the profession.

The first theme describes the participants' experiences entering the speech-language pathology profession and the factors that influenced their perception of themselves as future SLPs. Initially, participants navigated whether speech-language pathology was the right career choice and described their perception of a successful SLP, along with factors that either supported or deterred them from pursuing the profession.

Subtheme 1.1: Path to the profession

Participants were asked to describe the decisions that led them to become SLPs, highlighting what initially attracted them to the profession, the reactions from their families, and their internal perception of SLP characteristics. Unanimously, participants expressed a deep passion for being in the service of improving communication for their clients, leveraging their expertise in science, medicine, education, and linguistics. Alongside their personal decisions, several external factors contributed to their determination to continue this path, described below.

A Calling. Some participants attributed their attraction to the field of speech-language pathology to personal encounters with communication challenges stemming from their multicultural and multilingual backgrounds. They believed that these personal perspectives would contribute to clinical work as SLPs. These participants shared examples such as going to

speech therapy themselves or having had family members with communication disorders. Coming from multilingual backgrounds, they perceived communication as a means to connect across languages and believed that they could bring a diverse range of perspectives to their role as clinicians. P14 stated, “To me, language, and understanding how people learn language, is really important as someone was told that typical myth of you can't learn, or you can't use more than one language.” Another participant reflected on her personal struggles with communication after her immigration to the United States as a teenager, which fostered her empathy towards individuals with communication barriers:

> At that time, I felt there were ideas that I wanted to share, but I did not have the language to do so. I felt like I was intelligent in some ways, but I could not express myself in an intelligent way to others. In that way, I felt like I could understand the experience and that let me dive a little deeper into the profession. (P20)

One participant described herself as, “everyone’s interpreter,” while growing up, as she had the most fluent English in her family. When it came time to choose a program, her lifelong role of supporting communication resonated with the path of speech-language pathology. She affirmed, “I really felt like I was built for it,” (P24).

Influential Mentors. Several participants emphasized the significant role of a mentor figure within the speech-language pathology profession that paved their path to the profession. When participants were uncertain if this profession was the right fit for them, personal encouragement from individuals already working in the field motivated them to apply to graduate school. For instance, after attending speech therapy as an adult client in her local departmental clinic, P07 reached out to the professor who responded enthusiastically to her inquiry about a career in SLP: “The minute I emailed her, she answered, ‘I think you would be

the most amazing SLP. There is just something about you. I'll write your recommendation letter and we're getting you to grad school.'" Similarly, while pursuing a different healthcare degree, connecting with a male SLP was monumental for P05's decision to pursue speech-language pathology. He recalled their first conversation, saying, "When I called him, he says, 'I'm so happy you are going into the field. Do you know how many of us [male SLPs] there are?' I said, 'No.' He says, 'Three percent.' Really. Okay." Throughout the graduate school application process, this SLP mentor's suggestions and guidance played a vital role in P05's acceptance into a graduate speech-language pathology program.

Family Influences. The extent of family support for pursuing the profession ranged amongst participants. Only three participants who grew up in the United States mentioned that their families were familiar with the profession and explicitly encouraged them to become SLPs. The majority of participants reported that their families and friends were not familiar with the profession. In particular, participants with families in Asia or families who are first-generation immigrants expressed the difficulty of describing the role of an SLP to their families. P01 shared, "It was 12, 13 years ago when I make that choice [to pursue SLP]. There's absolutely no information online or nobody in China, no one knows what it is." P20 also reflected, "I think it's a field that is not well understood at least in the immigrant community, and even in the Asian community as well."

Participants' experiences of family support were often based on the perceived educational achievement and employability of the profession rather than a deep understanding of its content and nature of work. For instance, P15 shared, "My grandmother, she worked so hard to send her children over to the States so they could go to college. She's so proud that I went to college, and went to a good grad school." Another participant stated, "Both of my parents also really value

higher education, so they also like that I went to grad school," (P10). P03 described her challenges in explaining the profession to her parents:

> [My parents] had no idea… I had a hard time trying to explain what it was to them. After [I got a job] my family was much more understanding. They still don't really get what I do, I think. But they were at least appreciative that I was able to get a job after I graduated.

None of the families overtly disagreed with the participants' decision to become SLPs, although some families and friends expressed hesitation due to the perception of speech-language pathology as a language-focused profession:

> I got more push back from pursuing a field that is so language heavy, thinking that, why do you think you can do this, what makes you think that you can. However verbal or nonverbal these comments are, I know that they are being thought of… I guess push back is a strong word. I don't think they necessarily say don't do this, but I felt that they felt that this would be a hard path for me to pursue. Something that is, very white dominant, English based, and it would be hard for me to jump into that. Coming from the perspective of, I'm stepping into a completely different realm. I think that was scary for my family and also for me. I think the unknown is adding to their concern as well, unknown in the sense of what [SLPs] do. (P20)

Existing Perceptions of the SLP. Some participants faced hesitation in their decisions to become SLPs due to their own and others' perceptions of successful SLPs. Similar to P20's description of the SLP profession in the above paragraph as "white dominant" and "English-based," some participants initially believed that they lacked inherent qualities of being an SLP because of their Asian identity. P02 described being an SLP as needing to "know the American

culture background." She asked herself, "Asian like me, do I understand American culture?... Can this foreign Asia student CROSS the cultural differences and put herself into American culture?" When P09 volunteered at an SLP department prior to entering graduate school, she noticed that "everybody was white American." She explained:

> At that time, I felt maybe you have to have perfect American accent to work in the medical setting, because that's what I saw… When people hear the term speech pathology, they associate you with someone who will teach language. All about talking, so you have to be really native speaking.

Similarly, P25 expressed her initial concerns about being accepted as an SLP although she admitted that she could not pinpoint the source of that impression:

> I did feel in the early days that people preferred not having an Asian therapist. They preferred having a white therapist, because speech pathology, again, we don't look like we should speak English. I don't know where I got that impression. I no longer feel that way, but in the very beginning, I think you're always doubtful and not quite as confident as you need to be.

External biases were also evident in some cases, further fueling internalized bias. In some instances, faculty members in a CSD department shared perspectives that made participants feel unqualified for the career based on their personal background. P02, a student who entered the profession in the late 1980's, recalled being conditionally enrolled as her graduate program's first international student. She explained that the department expressed hesitation about her success in the program, stating, "[The professor] told me, 'Probably, when you reach [clinical placements] you may see some difficulties.' He didn't really tell me why. He just tell me, 'See, because as a foreign born person, you will see a lot of challenges'… Later after I become a

speech pathologist, I gradually understand what they mean." Twenty years later, in the 2000s, P20 received a similar comment while exploring the profession. During a visit to a potential graduate program, the dean of the department provided P20 with information about the curriculum and the program and answered her questions about the field. At the end of their conversation, he solemnly said, "'If you really want to be a speech pathologist, you really need to work on your English.'" This comment caught her off guard and instilled doubt about her decision to pursue the profession:

> It's a comment that I took to heart and that made me think twice, and even many more times about my decision. Is [speech-language pathology] really for me, am I going to be successful in this field, who is going to look at me very differently, who is going to judge me for my accent, and who is going to not see me for who I am. (P20)

While many participants reported a mix of facilitating factors for entering the profession (a calling, a mentor, family support) as well as concerns about their ability to fit in and fulfill their responsibilities in the field, over time, their initial hesitations transformed into motivation to demonstrate their success, as discussed next in subtheme 1.2. As for P20, she used the comment about her English proficiency as a driving force to prove her capabilities in her profession, stating, "It was me being rebellious. I don't want you to define me. I don't want you to say that I can't. I'm going to show you that I can."

Subtheme 1.2: You have every right to be where you are

During the interviews, participants provided insights into how they affirmed their position in the speech-language pathology profession. Participants shared the advice that they would give other minority or Asian students who were starting their schooling in speech-language pathology. The main message participants shared as they reflected on their own

graduate experiences was asserting their right to be studying in a speech-language pathology program. This assertion was a response to their own doubts that were formulated over their observations of the field, as well as the actions of others that initially undermined their suitability for the career.

Go for it. The majority of the participants' reflections of their own graduate experiences focused on encouragement and empowerment in pursuing speech-language pathology, despite racial barriers. As participants gained independence and confidence as working clinicians, they were finally able to move past internalized biases and initial hesitations about assuming the role of an SLP and recognize their worth in the profession. The three quotes below exemplify the reassurance of their passion for the profession as valid reasons for aspiring SLPs to pursue it, regardless of racial factors:

> There are no girls' toys, no boys' toys. They are just toys. Professions are the same. There are no professions for whites, no professions for Asian folks. If it is something that you enjoy doing, this is the profession for you. Don't let what the society thinks about the profession affect your decision. (P20)

> I want to give [future Asian SLP students] permission to tap into their compass and follow that guide. Just go for it. Don't let your Asian-ness, or don't let other people's views of your Asian-ness hold you back. It is an important and influential part of who we are, but it's also just one part of who we are. (P19)

> "Don't be afraid, just because we're minorities we're not second-class citizen per se," (P09).

Other participants conveyed messages that emphasized the importance of cultivating confidence in their sense of belonging within the profession. One participant would advise an aspiring Asian graduate student, “If people sense that you’re insecure and you’re not confident, they’re going to harness that and try to use it to bring you down. You got in for a reason, and don’t let anybody take that away from you. If you get in, you deserve it,” (P17). Another participant stated, “If you earned a spot in graduate school or in this internship, you have every right to be there,” (P25).

Work hard. The same participants further reaffirmed their advice to persist in pursuing the profession, acknowledging that it may require additional effort to establish their position in the profession due to preconceived stereotypes or doubts about the place of Asian American students in the profession. One participant reflected, “You definitely have to be more cultural savvy and put in more work compared to your white American counterparts, because people might not buy in. They might not trust you right away because you look Asian,” (P09). Similarly, P02 said, “You have to work hard, and you had to put in more effort than anybody else if you want to be a good competent therapist.” P17 was another participant who expressed that the labor put in by Asian students was different. She stated, “Fake it ‘til you make it. But put in the work overtime, because we have to prove ourselves ten times more than the person sitting next to us,” (P17).

Be who you are. Some participants recognized the value of their cultural and linguistic background in their clinical career and emphasized the importance of embracing and cultivating their differences as strengths during their graduate training. However, participants acknowledged that there may be barriers to achieving this authenticity. One participant expressed, “Be who you are, but this is going to be hard. But along the way you, you will learn that being yourself is just

the best way," (P01). Another participant highlighted the challenge of recognizing themselves as different from the mainstream:

> [Minority SLPs] have unique skill sets that we need in our field. I would encourage them to not feel pressured to fit a mold of what you think an SLP should be. But instead use their own strengths because they'll be able to serve a certain group that they might not be able to serve. (P21)

Participants also raised the issue of potential discrimination they may face in the profession, both from colleagues and clients, as a cautionary message to future minority students. Several participants including P01, P05, P06, and P10 shared their experiences of encountering discrimination and the need to prepare for potential racism as an inherent aspect of their professional journey. "There's likely to be some biases, whether it's covert, or my case, a little bit more overt. But be aware that there will be that, whether it's in placements or fellowship, or even in the workplace," (P05).

Theme 2: I invested in you, I wish you would invest in me

This theme highlights the participants' perceptions of shortcomings in graduate programs to adequately address multicultural or racial issues through the lens of their own minority experiences. Overall, most participants expressed generally positive experiences in their graduate programs and felt that they received good education and training for becoming SLPs, particularly as it came to gaining knowledge and skills. Most participants spoke highly of positive overall graduate experiences for professional preparation. However, participants described their experience navigating the program as an Asian American student to be separate from the general quality of the program. For instance, P17 expressed her expectation of mutual investment between the program and its students, stating, "I invested in you, you invested in me." She had

chosen to attend the program to pursue a career in speech-language pathology, while the program had selected her to train as a future professional in the field. However, she did not feel a strong sense of reciprocity towards her inclusion in the program as a URM student. Witnessing how their programs addressed or overlooked minority concerns deepened participants' feelings of alienation from the profession, even if they knew they were receiving good training in basic clinical skills.

There are three subthemes in this section that depict different aspects of the participants' training experiences in speech-language pathology. The first subtheme highlights the participants' inclination to stay silent and endure their own discomfort in the face of racial discrimination. The second subtheme illustrates the participants' perception of, and the pressure to conform to the mainstream culture in order to achieve success as future SLPs. Lastly, the third subtheme describes the participants' perception of missed cultural learning opportunities for all students in the program.

Subtheme 2.1: Don't stir the pot

One aspect of graduate education where participants felt their Asian American background played a role was navigating hierarchical power structures and their relationship with their graduate programs as students. For example, participants felt hesitant to speak up about racially discriminatory experiences that made them uncomfortable during their time in training. These instances manifested due to power differences between participants and authority figures in the program in the classroom, in the clinical assignments they were given, and during clinical encounters in those placements, which are each described below. While power differences between students and their instructors / supervisors were a common experience for trainees in graduate education, participants identified how they experienced additional layers of

power differences based on their status as URMs and the racial discrimination they faced. These power differences were further amplified because of their specific cultural upbringings which emphasized respecting authority and avoiding conflict rather than challenging the status quo, even if that meant enduring discrimination and discomfort:

> As a graduate student, I was very much a subject of the program, which often meant that I operated within the biases and values of the people running the program… I was constantly questioning how much I wanted to stir the pot, or just keep my head down, get my degree and get out. (P19)

In the Classroom. The dynamic of power differences with those in authority roles manifested in the classroom setting, where the participants as graduate students felt compelled to maintain a low profile in the presence of their professors, even when the participants were exposed to racial discrimination. In one example, P06, a second-generation Asian American, became racially profiled in her multicultural class where she was the only minority student. She recalled that every time the professor described a stereotypic Asian custom, the professor turned to her for validation on the cultural custom. She felt uncomfortable with the interactions but did not have an avenue to address the microaggressions in the classroom:

> I'm not FROM Asia, I was born here. A lot of these things, I guess it's true for Asian people, but it's not just like one shoe fits all. I thought it was really awkward just every time there was a Chinese culture or a Korean culture, she looks at me and ask, 'Is this what your family does?' … I didn't really like being the spokesperson for all Asian culture. But I was also really afraid of the professor. She was a really, really stern person and very intimidating. (P06)

The response to race-related experiences in the classroom were different based on the Asian American students' personal histories with racial discrimination. P13, an international student who came to the United States for graduate school, gave an example of a professor using the word "Oriental" in the classroom to describe the Asian population. His U.S.-born Asian classmates were upset by this comment, and P13 only realized the discriminatory nature of this interaction afterwards. He said, "I didn't even realize, to be honest. After some learning, I realized some of the history behind that [word]." Another participant shared an example of racial-related discomfort that stemmed from witnessing an interaction between her peers and an Asian professor. P21, a U.S.-born monolingual English speaker, experienced discomfort when a group of students in her cohort complained about an Asian professor's non-native accent in English. The situation escalated to the point where P21 witnessed the professor in tears. In this case the bias came from the participants' peers, but it elevated her awareness of her own race:

> It made me feel uncomfortable with that type of dynamic, knowing that my peers were frustrated with her accent. Knowing that myself, I don't have an accent, I don't speak another language besides English. But that could be my grandma or different people in my family that I can think of. That accents can be such a barrier for people, for respecting certain person. (P21)

Clinical Assignments. In general, participants had positive or neutral recollections of the range of clinical opportunities in their programs. Participants emphasized good clinical experiences as important components in their graduate training. P24 expressed gratitude for attending a program with strong clinical connections, stating, "It was worth getting in [to the program] and staying in because my resume is just filled with all these experiences because they were so well established."

However, multiple participants noticed that clinical assignment decisions were sometimes based on their race rather than their clinical interests. Participants had different reactions to race-matching in their clinical assignments. P07 questioned the reasoning behind being assigned to an Asian client for accent reduction at her speech clinic, “I remember, [the clinic was] very particular about assigning me to this patient…Maybe they thought I could connect with him better. I don't know if it was more for his comfort, or maybe it was for ours.” In other instances, both P17 and P19 were assigned to Asian clients who spoke different languages and had different ethnicities from themselves. P19 felt it was a missed opportunity to work with a client population that aligned with her interests. She described, “I’m looking around the room at all of the white clinicians assigned to the white families and seeing the Asian clinician assigned Asian family.” P17 similarly observed differences in how clients were being assigned to her and her peers:

> My friend had an articulation case. Somebody else had a fluency case… I have this bilingual two-year-old that speak [Asian language] in the house… I can't speak [Asian language]. I don’t think it was irony that both [Asian] patients that came into the clinic were given to me.

P17 further explained that the frustration stemmed not from the assignment itself, but from the limited support from her supervisor for navigating the multilingual clinical interaction. “They a hundred percent planned it. [They] know that this could be a good patient-clinician relationship. But what have you done to prepare? They didn’t give us any guidance.” The participants perceived an indirect message from their race-matched clinical assignments, suggesting that the program assumed that different Asian ethnicities and languages would be

similar enough, and expected Asian students to independently execute appropriate therapy based on this connection.

In the Clinic. The most common situation where participants experienced limited power in influencing the course and the quality of their clinical training was during one-on-one interactions with clinical supervisors. In one instance, the authority of the clinical supervisor was specifically emphasized to the Spanish-speaking participant who recalled her supervisor getting her in trouble for using Spanish with a client without an interpreter present:

> I literally just said hi. 'Ola! Como estas?' I do not understand. It, to me, just spoke to this insecurity that she felt, like she had to be better and get this little grad school student put in her place for not following the rules… It was just building some rapport and comforting the family. I wasn't even trying to do the evaluation in Spanish. It stands out vividly as one of the most surprising experiences, but not necessarily because I was Asian, but, cultural linguistic kind of things. (P15)

Six participants described explicit racial discrimination in their individual encounters with clinical supervisors. The examples described below highlight portions of these experiences. Participants responded to discrimination differently during their clinical rotations based on the availability of program support.

Two participants described discriminatory experiences during their first full-time external clinical rotations outside of the department. P05's clinical supervisor expressed dissatisfaction with the participant's style of interaction with clients, attributing it to him being "the first person of color she's had [as a SLP student]." The supervisor requested him to write scripts of his interactions with the clients for approval prior to the session. P11's clinical supervisor commented on her non-native English, stating that she "speaks like [the pediatric clients with

speech and language disorders].” Consequently, the supervisor did not allow P11 to conduct therapy, a required part of her clinical rotation. In both cases, the participants did not feel that they were in positions to advocate for themselves due to intimidation factors in the supervisor-student dynamic and their unfamiliarity with reasonable expectations in the training process. In P05’s case, he recalled thinking that the discriminatory demands (i.e., script writing) as “part of the evaluation process.” Both participants later described their experiences as embarrassing and hurtful. While the participants recalled that the graduate programs were later supportive and reassuring of the participants’ capability as clinicians, the situations were handled quietly without addressing the supervisor’s behavior.

A striking example of power difference was portrayed in P17’s story of multiple evidence of racial discrimination throughout her graduate clinical training. She described her experiences throughout the graduate program as being “picked on”, “bullied”, “put down”, and “belittled” by her instructors. Example comments from her supervisors and professors reported by P17 included, “You’d be better off as a SLP assistant,” and, “You don’t belong in this program.” She stated:

> The only difference between me and all my other classmates was truly just skin color. I was just as competent as them. I got the same grades as them, but the only difference was, they were white. I was [Asian]. Why, for a long time I was in my head… So again, you do a lot of introspection. What am I doing wrong? (P17)

When P17 tried to escalate the issue to the director of the program and to the dean of the school, no one would comment on, or address the issue. In this example, the participant sought out support from the program but did not receive acknowledgement from them.

P15 also recalled her CF supervisor placing “roadblocks” in the way of her completion of the required ASHA hours. Throughout the long process she thought to herself, “But I'm gonna comply. From my family upbringing, you never ever directly address issues. It's so far under the rug it’s not even there. You just put your head down, you work hard, and that's what is valuable and good.” She felt that the discriminatory treatment she received throughout her CFY was race-related because she felt that “there could have been nothing else:”

> She has supervised many, many CFs in the past who have never had issues. And it seemed coincidental that all of those CFs were Caucasian… I did everything she asked for. Even when I wanted to scream, I nodded nicely and did everything she asked. And so there's nothing she possibly could have complained about. (P15)

Finally, some examples were shared in which participants had experienced acts of racism directly from clients during their training placements. If supervisors did not provide any support or discussion with them about the incidents, participants, as trainees, felt they could not raise the issue. Participants internalized this as a message of acceptance on behalf of their supervisors for this behavior from clients, which will later resurface in their clinical interactions as SLPs (see Chapter 5):

> One of the patients at the time said derogatory words towards me regarding my race. That supervisor was not very helpful. They said, ‘It's okay, I'll just see the person.’ They didn't provide any support towards myself, they didn't provide support towards how to transition or deal with it. It was just pushed under the rug with that clinical supervisor. (P14)

Subtheme 2.2: Pressure to Assimilate

Participants expressed their experience of feeling internalized pressure to “assimilate” in order to meet the perceived expectations of being a "good SLP." The use of assimilation as a metaphor for success in the profession was derived from their self-perception and standards that they believed others held for them. Beliefs regarding the connection between American cultural assimilation and being an SLP was often translated into having to “work harder than [their] white counterparts” during graduate school in order for their professional competence to be perceived by others. They expressed self-consciousness regarding what they viewed as limitations in their English proficiency and American cultural knowledge compared to peers who grew up in the United States. For instance, P02, who arrived in the United States as an international student over 30 years ago, strongly emphasized the importance of assimilating with American culture to achieve success as an SLP:

> As a speech therapist, we have to use our everything – our language skills, our feelings, and our cultural understandings to know American culture background. Because we are in the USA… You don't want people to use colored eyes to see you. You want them to treat you as a competent speech pathologist…You don’t want to be special. (P02)

The distinguishing driving factor for assimilation also stemmed from their personal evaluation of the extent of their Asian identity. Second or later generation Asian American participants who were born and raised in the United States also expressed having the pressure to become more American or felt that they were not American enough. P16, a second generation immigrant, saw educational experiences as opportunities to learn about American culture. “As a student in speech pathology program, I had to mold myself. You have to fit in with the group a

little bit…I have learned what being an American is throughout all of my educational experiences, including graduate school," (P16). Similarly, P14 explained:

> I grew up in America, and I grew up speaking English as my primary language. However, there are American sayings or cultural sayings that I did not grow up with. Contextually, yes, I can understand them. But at the same time, I did not grow up with them. (P14)

There is evidence that the need to assimilate remained for participants who were later-generation immigrants. One second generation and two fourth generation participants (P10, P21, and P04) expressed their conscious effort to "hide" being Asian, which P04 interpreted it as her "trying to be more American" and P21 admitted to feeling the need to "acclimate to be like other people." P25 reflected that she was used to growing up in an "all-white environment" and studying in a program where she was the minority, but it also resulted in her letting go of her Asian culture in the process. "I do think in retrospect, because I was surrounded all the time by white people, I didn't foster the Asian part of me," (P25). P21 as a fourth-generation Asian American acknowledged the impact of her race on her sense of belonging in speech-language pathology. She expressed this sentiment by comparing herself with first generation Asians:

> I felt like I had that pressure, and I was already somewhat assimilated. I can chameleon my way into that American culture. I'm curious if [first generation Asian SLPs] felt like they had to do a whole kind of switch to feel like a good SLP in that type of community. (P21)

Subtheme 2.3: Missed learning opportunities

The above subthemes describe the participants' direct experiences and relationships with members of their programs that impacted their graduate training. This last subtheme of perceived barriers to inclusion of Asian Americans in speech-language pathology graduate training will

describe the participants' impressions of the extent and quality of cultural responsivity education present in their programs for all students. Many of the participants come from culturally and linguistically diverse backgrounds, and therefore possess unique insider perspectives on the nuances of applying clinical perspectives to cultural contexts. Participants reported their impressions based on their lived experiences as Asian Americans and as current working SLPs. There was a gradient of participant experiences with cultural responsivity training. Some participants expressed appreciation for existing culturally inclusive learning opportunities while others noted token training in which cultural responsivity was raised as a topic but with little depth or application, and then others reporting entirely missed opportunities for cultural responsivity training.

Some participants were in programs that offered specialized initiatives and approaches for cultural responsivity training, and viewed these opportunities as indications that the programs were actively considering and incorporating cultural diversity and inclusivity into their curriculum and practices. Examples included standalone courses on cultural and linguistic diversity as well as departmental caucus groups. Some programs also offered cross-cultural clinical rotations either in the departmental clinic or through international clinical rotation opportunities. Participants who had more recent graduate experience with schools in more diverse communities were more likely to report having more culturally diverse and inclusive experiences in their programs.

Participants attributed the availability of these opportunities to the presence of faculty members who expressed a vested interest in expanding these areas within their department. For P14, one of the reasons for choosing that specific graduate school was the presence of a professor who specialized in multiculturalism. P07 described her department as having a rich

multicultural education and a strong emphasis on diversity, which she deemed "progressive" for a speech-language pathology department. P16 expressed a deeper appreciation for the discussions on bilingualism and cultural competency in her graduate program due to their relevance to her own background, “I think I just appreciated that more, having been raised in a bilingual household, having been raised in a different culture.”

For some participants, this cultural responsivity extended to their clinical placements as well. In contrast to subtheme 2.1 which highlighted the discrimination participants faced in their clinical placements, at least one participant (P12) felt that her supervisors were able to differentiate between her clinical skills and potential cultural factors when she was faced with cultural challenges in clinical interactions as an international student, “[My professors and supervisors] know it’s because of my background, it’s not because I lack clinical skill or something like that.” Participants warmly described experiences such as these as indicators of their programs’ inclusiveness efforts and their recognition of differences that arise from cultural and linguistic diversity among the student body.

In contrast to the positive feedback, however, some participants expressed concerns about the delivery of cultural responsiveness training and diversity topics in the classroom setting. P19 highlighted “missed opportunities” as the most prominent issue in her recollection of her cultural competency education during graduate school. “There was so much repetition of the same – often vague ideas, and often providing stereotypical examples,” (P19). Even in a program that P09 praised for its emphasis on diversity, she recalled, “When you're taking the class it's all theory and it's all very vague. You kind of get it, but you will never understand how to do it until you're actually in that position of doing it.” Similarly, P04 described cultural responsiveness education as, “Throwing buzzwords around,” without direct application to clinical situations. She

explained, “It wasn't so much pertaining to SLP it was more just general cultural considerations.” Another participant felt that application of knowledge was missing in cross cultural clinical training, stating, “We talked about it in our classes, but it wasn't something that was explicitly its own thing. I don't really remember there being explicit opportunities to work with diverse population,” (P26). In this way, participants noticed that coverage of cultural responsiveness did not equate to practical knowledge for clinical practice.

One participant reflected on a particular experience learning about Asian cultures. P04 recalled that her professor explained that in the Asian culture, individuals may nod their head or say yes without necessarily meaning that they agree or fully understand. The participant expressed familiarity with this concept and questioned, “I know that but how does that help us as speech therapists? It felt like it was common sense, and I wonder how it felt to other people who aren't Asian. I wonder if they were thinking, wow, that was so interesting.” This participant sensed a missing connection between cultural knowledge and its utility in specific clinical examples.

The participants’ reflections shed light on the influence of innate cultural familiarity and self-developed strategies as shaping their application of cultural knowledge in clinical practice. P09 reflected on how her personal cultural background, rather than classroom learning, influenced her application of cultural knowledge. “Because of my cultural background, once I got into [a multicultural] type of setting it [was] just natural to me to know what to do,” (P09). P08 also attributed the clinical application of multicultural considerations to her own development. “Working with Asian patients and their families, I had to kind of work through on my own. Oh, this is how I’m going to break it down from the knowledge that I have and to make it so that I can make it understandable or to connect with these patients.” When P19 was asked

how her training could be applied to clinical practice, she recalled the limited discussion on implicit bias, where she was left wanting for more:

> There wasn't really anything tangible offered, as far as how do you know your bias or what do you do when your bias is discovered or how can biases evolve? These kinds of things we never got into. It was just one slide, right? [Bias] exists. Don't let bias get in the way. Okay. Next slide.

At the other end of the spectrum, some participants recalled receiving minimal to no education related to cultural or linguistic diversity. Recent graduate experience did not guarantee that their education on cultural responsivity was more comprehensive. P23 noted that this topic "did not exist" when she attended graduate school in the 1990's because "it was a different time." However, even participants who graduated in 2020 (P21 and P17) expressed that their programs also lacked emphasis on diversity and advocacy for minority individuals. They described instances where diversity and cultural competency were only briefly mentioned on "one or two slides," indicating a limited focus. One participant gave examples of clinically relevant cultural knowledge that she brought up to the program because she felt it important that future SLPs shared this knowledge in their clinical practice:

> Let's say you have a Muslim patient come into the clinic, and you want to work with the kitchen set, and you hand them a toy bacon. Is the clinician going to know that's technically not allowed? Or a Hindu patient comes in, and you give them a hamburger. Do our clinicians know we should have a basic understanding of people's cultures and rituals? (P17)

Participants coming from multicultural backgrounds were highly conscious of the limited coverage of non-mainstream cultures in their graduate education. They were motivated to deepen

their knowledge in cultural and linguistic diversity because it allowed them to connect with their own personal experiences and shed light on how minority cultures, including their own, were viewed within the discipline.

Theme 3: The social end of things

This theme explores the impact of the social environment within the graduate program on the experiences of Asian American students pursuing speech-language pathology training. Participants generally found their graduate programs to be academically demanding and rigorous, expecting hard work and dedication as typical at the graduate level. Participants noted that their overall experience in graduate school was influenced by their engagement with the social environment. Aspects of their social environment included their interactions with peers, and the diversity in the communities surrounding the graduate program. One participant highlighted the importance of the social environment as a key factor in the graduate school experience, sometimes as much or more so than the formal educational training experiences. “I just didn’t have that kind of relatability with anyone in grad school. So, it’s more like on the social end of things that stand out,” (P22).

The subthemes speak to the range of experiences that participants had in their respective social environments. The first subtheme describes the participants’ appreciation for the diversity around them, recognizing that it is not the standard experience in the profession. The second subtheme describes the different degrees of culture shock participants experienced coming into the graduate program, and in engaging in clinical interactions for the first time as student clinicians. The third subtheme shares the importance of the peer support network in getting through the graduate school experience. The final subtheme illustrates the isolation some

participants felt by virtue of their intersecting identities while studying in the speech-language pathology program.

Subtheme 3.1: I'm lucky

Participants who had positive graduate experiences and came from institutions with high diversity often reflected on their experiences as being uncommon compared to the norm. Four participants (P02, P09, P07, and P12) used the word "lucky" to describe themselves because they went to graduate schools in racially and culturally diverse geographic areas in the country where they were not a minority. For example, P07 said, "I consider myself luckier than a lot of my colleagues in other states and areas, like more rural areas, because [City] was kind of a little melting pot." In the same vein, P18 worried if she was going to "skew the study results" because she attended graduate school in a program with predominantly racial minorities. She explained, "I was like a local. People thought I was from there. And the Caucasians were in the minority in all the classes," (P18). P03 described her perception of SLP racial demographic makeup as follows:

> I had looked up on ASHA about how we [Asians] are only 8% and I was like okay, maybe the 8% is only [here]. I conceptually knew, the numbers are showing that the vast majority of clinicians are all white. But where I was growing up, where I chose to go to school, and where I ended up working it was just huge pockets of multicultural population. I see a lot of other people talk about their experiences being THE only minority person. That was not my experience.

The sense of luck in the above examples suggest that the participants perceived having diverse representation in their graduate experiences to not be the prevailing experience. The above participants who attended schools with high racial diversity felt that program offerings,

diversity in clinical population, and education on culturally responsive practice was enriched. P03 further explained the relevance of diversity in her community and her program:

> I wouldn't say [diversity made graduate school] easier because I was surrounded by minorities, but it wasn't made harder. I had other things to deal with like schoolwork, but that aspect [of being the only person] wasn't something that was weighing down on me.

Subtheme 3.2: Culture shock

When discussing the social environment during their professional training, some participants referred to their experiences as “culture shock”. They used this term to describe sudden differences in the community’s culture or attitudes within their immediate environment upon entering graduate school as opposed to where they grew up or where they went to school before a graduate program in speech-language pathology. As they encountered shifts in culture and diversity in their surroundings, participants had to adapt not only to the academic curriculum but also to the local culture. Their awareness of these cultural shifts influenced their comfort within the social environment of their programs, and also their interactions with clients from different cultural backgrounds as student clinicians.

P11 used the term “culture shock” to describe moving from a culturally diverse undergraduate program to a small rural university for graduate school. “I had huge culture shock when I moved to the area when I started the program. And it was a very small program. It was not easy,” said P11. Conversely, P18 used the same term to describe moving from a small rural town where she was the only Asian family to a diverse university for her graduate program:

> Definitely a culture shock the other way around. When I got there, I feel like, I’m not unique and special. I looked like everybody else. For the first time in my life, it felt kind of assimilated. I’d never felt that way before where you kind of just blend into the crowd.

One participant described the differences in cultural perspectives between the community she grew up with and the diversity of her cohort and clinical populations she worked with to be “eye-opening.” She expressed, “It was really interesting to engage with people from different backgrounds at the graduate school level and who are all working for the same goal to be a SLP in the end,” (P21).

Participants who arrived in the United States after their teenage years or as international students reported undergoing a more significant social cultural shift during their time in graduate school experience, both during peer and clinical interactions. For example, a participant who had various international travel experiences prior to graduate school expressed the differences in social communication in the United States compared to other places:

> Even thinking about words, thinking about some expressions. When [graduate] school starts, I've only been in the US for a couple month. I'm not exactly sure how we express certain things because it's different. Every place, Canada, US, in the Europe, or in South America, people have different expressions. So sometimes, I might not using the expression that they can understand. So I think that's kind of challenging for me at school. (P13)

Another participant humorously recounted conversations with her classmates that may have been lost in translation. She said, “I would tell them, ‘I don't understand your joke! Tell me again!’ and they’ll say, ‘Do you understand?’ And I say, ‘Yeah I understand every single word but I don’t understand the joke.’ And they all laughed,” (P02).

These participants also described facing additional challenges in adapting to the education and healthcare systems in which SLPs work, as well as in navigating interactions with

clients beyond the basic therapy skills. P12 described spending more time learning the sociocultural aspects of interpersonal interactions during her graduate training:

> There's some pop culture and references that I have no idea. When we had clients, sometimes you chat with them and prepare materials. That makes a little bit difficult for me because I want to find some materials that's really relevant for US people. It's definitely taken me a little bit more effort versus other people that grew up here, no matter what background they have, they know a lot about current political issues or pop culture, things like that.

P09 provided a specific example of the cultural content with which she had to familiarize herself. She mentioned the need to learn American nursery rhymes, games, and books for pediatric rotations. She explained, “I didn't grow up here. So, when I prepare therapy materials I struggle a little bit with those things. Because you have to incorporate those materials into your therapy sessions.” P20 described a clinical placement where 90% of the caseload consisted of Hispanic clients. Along with facing prejudice from clients who were unfamiliar with having an Asian SLP, she also found navigating the linguistic differences a challenge in the clinical setting. She explained:

> I don’t know if they have ever seen an Asian person, the let alone an Asian speech teacher. And then the kids were like, ‘I know Jackie Chan, are you related to Jackie Chan?’ It was for them to see me in a role of a teacher versus an actor. Well, this alone wasn’t challenging. The challenge is more about the language. They were mostly Spanish speaking Hispanic children. I was trying to do therapy in my very limited Spanish, which was very challenging. (P20)

Participants who had limited experiences in the United States and felt the cultural differences sometimes found support through their peers and professors in the program. They were able to seek answers to cultural questions and receive suggestions for using culturally appropriate materials when working with American clients. Another important aspect of reducing challenge related to cultural differences was increased social connection. One participant expressed, “As I have more interaction with the patients, with clients, with even supervisors, I feel like I just get more comfortable with that,” (P12). Some former international students also shared their strategy of portraying cultural similarity as an important part of their adaptation to American schooling. They felt the need to overcome differences by quickly adopting the desired cultural behaviors. One participant explained, “I learned that early on, you just have to fake it until you make it. You can't show people that you're not from here. You just have to carry yourself with confident,” (P09).

Subtheme 3.3: Building friendships outside of academics

Participants emphasized that establishing strong peer support within their graduate programs was important to their overall graduate school experience. Those who went to racially diverse programs found validation and representation within their disciplinary training, either through their peers or through the presence of diverse faculty members. Participants who were racial minorities in their programs actively sought out social support from peers and the external community by finding commonalities in personal experiences. This support network played a vital role in reducing feelings of isolation in their graduate journey. P04 explained that the sense of isolation was not related to coursework, but rather the challenge of forming friendships within the program beyond academic pursuits. She stated, “When it came to school, everyone just did

group projects or whatever collaboration they needed to do, that was okay. It was more of the social aspect of it [that was challenging],” (P04).

When participants were asked about their experiences in graduate programs coming from Asian backgrounds, they often responded by describing the friendships they formed during the program. Nine participants mentioned having one close friend or a small group of friends throughout graduate school that served as their main source of social support. Even if they did not feel a connection with everyone in the cohort, having few close friends within the cohort had a positive impact on their overall graduate experience. Many of these close friends happened to be the few other Asian students in the cohort, even if this grouping was not intentional. One participant brought up this connection by saying, “By nature, we kind of stuck together and we became really close friends,” (P04). For P26 and P14, the presence of their closest friends in the program diminished any concerns they might have about the lack of racial representation. P26 shared:

> My roommate was also Asian, and we would do everything together. I tell her sometimes, ‘Oh I don't know how this would have been if you weren't here.’ I'm not as close with everyone else in our cohort. I'm closest to her. In grad school too it's a lot of different people coming from different areas of the U.S. and so we're all very, very different. It’s a little bit harder to connect with people if you're that different. (P26)

Similarly, P14 described his Asian friend as his “partner in crime” throughout the program, saying, “There's a lot of things that we related to a lot, and that helped both of us. Especially as both of us were not as familiar with the [state] culture. Both of us would confide in each other.” The close friendships participants formed within the program were not always

limited to those who shared an Asian background. P01, the first and only international Asian student in her program, spoke fondly of her two best friends in the program:

> When I was in graduate school I don't really talk. But the way three of us get together, we do our projects, we have lunch, and all that. Those time together, I don't feel I was excluded at all, I was part of the group. (P01)

The emphasis participants placed on having a social peer support system within the program is not unique to being Asian American. Four participants observed that social circles within speech-language pathology graduate programs can be "cliquey" irrespective of race. P07 realized this dynamic during graduate school, noting the formation of social groups. She expressed, "If you're still trying to figure out what exactly your identity is, I wouldn't say this is the best career to do it because it is cliquey. You have to get along with others quite fast. It can be a lonely career if you don't have those skills. An alienating career." Participants in the study often found themselves on the periphery of larger "predominant" social circles within their cohort, but found friendships that helped them feel included. P22 mentioned, "I didn't necessarily feel like I connected as close to folks as it seemed like some of them were connecting with each other." Furthermore, P04 reflected on the situation:

> It seemed like other cohorts above us, they were all friends and they were all doing things outside and for someone's birthday. But with my cohort it seemed like it was our [Asian] group celebrating our stuff and then the other groups, we would know about it, but we weren't really participating or included in it. And it was okay, because at that point we didn't really want to be. We were happy with the friendships we had we had made. (P04)

Subtheme 3.4: Lonely endeavor

Most participants expressed a sense of isolation during their graduate school experience stemming from their identity, even if they had access to peer support. Half of the participants interviewed (13 out of 26) mentioned feeling a limited sense of belonging within the profession as members of a minoritized group. P25 reflected on her graduate experience and noted that the feeling of isolation was more pronounced at the beginning of her professional training, stating, “I do think it was a more lonely endeavor when I was in school and when I first started out than it is now.” Participants used the terms “misfit,” “oddball out,” and “anomaly” to describe their position in the discipline during their graduate training. During the program P01 questioned, “why is it that I am so rare,” as an Asian, multilingual speech-language pathology student.

Participants’ acute awareness of their different physical appearance compared to the dominant racial group served as a reminder of their distinction from the majority of their peers. For example, P22 shared an anecdote, “One of my classmates had a Christmas party and she was like, ‘It’d be really cute if everyone brings a baby picture. We’ll guess who it is.’ I’m like, ‘Well, y'all know which one is mine.’” Similarly, P04 highlighted the influence of the surrounding area on her sense of isolation during graduate school, explaining, “That made it feel more isolating. It felt very different. You see a lot of blond hair and blue eyes and I'm very different from what they're used to.” These examples illustrate the immediate physical comparison participants made about themselves and others in their environment.

Participants who had additional underrepresented identities in addition to their Asian background often attributed their feelings of isolation to the intersection of their multiple identities. For instance, an Asian male participant described himself as a “unicorn” in the profession, emphasizing the rarity of his identity. Participants brought up other intersecting

underrepresented identities besides gender, including age (being younger or older than the average graduate students), marital status, religious beliefs, LGBTQ+ status, immigration status, and whether they were local or out-of-state students. P20, as a first-generation immigrant, felt that her immigration status distinguished her from other Asian students in the program. This distinction created a sense of disconnect with other students who shared her racial background, and heightened her self-consciousness during her time in graduate school. She explained, “My status being an immigrant probably set me apart from the other Asian folks in the class. The other Asians were born here and fairly Americanized. They might not speak the native languages,” (P20). The intersection of multiple identities intensified the participants' feeling of isolation within the speech-language pathology program, as they felt even more distinct from others who shared their Asian identity. This compounded their sense of being different and further contributed to their sense of isolation. The participants' reflections on their feelings of isolation and the influence of their personal identities underscore the impact of the social environment during their graduate school on their sense of belonging within the discipline.

CHAPTER 5. RESULTS – CLINICAL PRACTICE EXPERIENCES

This is the second of three chapters that present the results of this study. This section will report on themes relating to the participants' experiences working as SLPs in the clinical setting. As participants completed their graduate training and began working clinically as independent clinicians, their identity as SLPs shifted from being a trainee to a working professional. The three themes that emerged relating to the Asian American SLPs' clinical practice experiences include: the participants' ingroup empathy towards clients from Asian or other CLD backgrounds; the role of language in speech-language pathology; and finding belonging in the professional identity of Asian American SLPs. See Table 6 for description of themes and subthemes.

Table 6. Themes and quotes of the participants' clinical practice experiences

Themes and descriptions	**Subthemes**	**Quotes**
Theme 1: For the reason that I can understand it implicitly Ingroup membership and minority background became an advantage during clinical practice	Subtheme 1.1: It is part of me	"People appreciate you. They see that you are one of their kind. Because of that appreciation, that gives me more confidence and you feel better when you have that…It feels good because you're connecting on a deeper level." (P01)
	Subtheme 1.2: Inviting curiosity	"Whenever I work with someone from a minority background, I always tried to be sensitive to their culture based on what they tell me and not based on what the textbook tells me about their culture." (P06)
	Subtheme 1.3: I feel like that hyphen	"There are times in this field, I do feel like that hyphen where I'm nothing. I'm neither Asian nor American unless my patient wants me to be. I learned to adapt one way or the other and that's important." (P10)
Theme 2: The "language" in 'Speech-Language Pathologist'	Subtheme 2.1: I don't look like I should speak English	"You have to have a perfect command of standardized English…It is what gives us good job security." (P18)
	Subtheme 2.2: Direct communication	"I see value, and [the clients] see value in me being able to provide therapy in their first language. It's just one less layer of

Perception of speech and language proficiency in the SLP role		needing to be interpreted. They enjoy that direct communication." (P20)
	Subtheme 2.3: Multilingual exposure	"I would not call myself a bilingual SLP, but because I can speak [ethnic language] conversationally it helps to bridge the gap for a lot of these patients. Even if I may not know all the technical terminology, I can explain it to them in a way that they still understand. For those patients there's a comfort level in that these people can speak my language." (P08)
Theme 3: Am I part of this bigger group? Finding belonging and recognition in the profession as Asian Americans	Subtheme 3.1: Judged by my race	"Initially, I'm definitely judged by my race. People are like, 'What are you?' or 'Where is your name from?' I get that a lot. The clinical fellow that I'm mentoring never gets that, right? It's just me." (P16)
	Subtheme 3.2: On a daily basis	"I can make the jokes, the socially appropriate pragmatic talk, and make everybody comfortable. And it's fine when I have a question about Mr. so and so's ankle boot. We just do our jobs." (P24)
	Subtheme 3.3: Beyond clinical responsibilities	"I want to be involved in more of those different committees so that I can represent the minority voice or presence of a different face. It just feels important." (P12)

Note. SLP = speech-language pathologist

Theme 1: For the Reason That I Can Understand It Implicitly

In the first theme, participants shared about the contribution of their Asian American background to clinician-client relationships between themselves and clients from CLD backgrounds. Participants built connections with their clients from CLD backgrounds given their shared identities and/or perceived similarity between themselves and their clients. The shared factor is not exclusive to racial concordance between the SLP and the client (e.g., Asian SLP and an Asian client), but could be due to similarity in immigration experiences, heritage ethnicity, religion, cultural customs, or language. More points of connection increased the participants' perceived empathic connection with their clients. P10 expressed that while she has gained skills

to work cross culturally with diverse populations, she felt “more in tune” with clients that shared her heritage culture and language. “Just because, for the reason that I can understand it implicitly,” said P10.

The subthemes under this theme include the inherent connection and familiarity that participants shared with their Asian clients, increased opportunities for exercising sensitivity and humility with other CLD clients, and the presence of internal conflict straddling their hyphenated cultural identities.

Subtheme 1.1: It is part of me

Participants described the influence of their personal cultural background on shaping their interactions with their clients who were also from Asian backgrounds. In these instances, participants described the ingroup familiarity they felt between themselves and their clients. The participants' sense of belonging to the same group as their clients helped them understand and consider the challenges that clients may face in their speech-language pathology-related clinical care from a holistic perspective. These perspectives were developed based on innate knowledge participants had about the broader social and cultural context in which their clients live. The different aspects of the clinician-client relationship that are influenced by ingroup relationships are described below.

One of their kind. Participants conveyed a sense of mutual familiarity when they were working with Asian clients. While the various cultures within Asia present with distinct differences, presence of some shared cultural connections across Asian cultures helped participants build stronger rapport with their Asian clients through their innate familiarity with social and cultural customs. They reported that their clients seemed to appreciate that they were able to connect more deeply with each other on a cultural level. P01 who worked in an Asian-

centered facility noticed, “People appreciate you. They see that you are one of their kind… Because of that appreciation, that gives me more confidence and you feel better when you have that…It feels good because you’re connecting on a deeper level.” P04 described feeling an instant connection when meeting Asian clients in a predominantly non-Asian community:

> As soon as I walked into the room, their faces lit up. I just felt like our rapport was instantly built…I just really feel like they trusted me and they truly believed everything that I was saying. They will definitely carry over and think about what I was saying when they go home. I don't feel that with most patients.

Many participants used the word “easier” to describe working with clients that shared similar cultural backgrounds. For example, P09 explained, “It makes you more personable and just makes the overall therapy sessions a little bit easier.”

Participants explained that having innate cultural understanding helped build better engagement in therapy. P16 associated the foundation of this engagement with their mutual understanding of typical Asian cultural customs:

> When I tell [my patients] I’m [ethnicity], they’re ready. They know. They know how my family operates, that my upbringing was very similar to theirs. Simple things like drinking chai tea in the middle of the day, just a cultural thing. They do appreciate me more. They open up to me more. I find out more about them that I can relay to the doctor.

In another example, P22 described the prioritization of maintaining harmony and respect for authority in many Asian cultures to be portrayed as “general approach of deference to medical professionals” in her Asian clients. This cultural awareness required that she carefully distinguished the difference in her clients between general agreeableness versus true comprehension of clinical recommendations. She described this process as:

> You have to try to figure out, is this [the client's] preference, or are they being agreeable because the healthcare provider is saying this is how it is? Who will speak up for them when a bunch of incorrect assumptions are being made because the patient is being very agreeable… Sometimes with [agreeableness], they are sacrificing the ability to understand what's going on medically. (P22)

Additionally, P14 highlighted the advantage of utilizing cultural connection when conveying challenging clinical information. He used the word "we" with Asian clients when sharing difficult diagnoses that are culturally stigmatized:

> I was able to relate to it, like 'I'm also from [country], and we don't talk about [diagnosis].' ...That kind of "we" language makes a difference for some families… It might hit something that they know or are familiar with as an example piece, it's a lot easier for that buy-in. (P14)

Similarly, P16 related, "I can provide significantly more counseling than if I was somebody who didn't know that background."

They remind me of family. Eight participants commented that their Asian American clients reminded them of their own family members. Most of these comments came in the context of working with elderly clients in acute or post-acute settings. The familial association immediately created a sense of connection that the participants felt towards their clients. Two participants described treating clients who were not fluent in English using their heritage languages as "speaking to my grandma" (P11) and "talking to family" (P10). P04 also described her initial meeting with an Asian client as "a sense of family."

One result of characterizing their connections with patients as similar to their familial connections was that participants were particularly sensitive to the potential vulnerability of

these clients as minorities navigating the healthcare system. In addition, they projected the impact of communication disorders in the context of their clients' sociocultural environments based on their familiarity with the sociocultural contexts of their own family members. P03 highlighted this:

> There's something about seeing older Asian patients, I always think of them as my parents. I feel worried because some minorities, especially if they may not speak the language, they might not have as good of an understanding of what we are either asking them to do or the implications of our therapies. They're potentially more inclined to not do as much to self-advocate, that they may potentially not get the care that they need, or they don't understand everything that we're explaining to them. For me, maybe specifically Asian [clients], I get protective of them. Because they remind me of my parents.

P08 and P25 illustrated how their personal family experiences informed their perspectives on contextual factors that may interfere with therapy when working with older Asian clients. P08 explained:

> I feel like I can relate to [my clients] better, like some of the family struggles that they might go through. I see it in my own parents and in my own family, and so I definitely understand and can empathize with that.

P25's familiarity with her parents served to predict the approach she should adopt when dealing with Asian clients who remind her of her family:

> If [my client] was somebody like my parents – first of all, if my parents were ever in a situation where they would need a speech pathologist, I fear for the speech pathologist. They would not do anything the speech pathologist would say to them to do…So

> understanding that about older Asian people might change how I would educate them about, or recommend what they should do.

One participant expressed seeing familial association with appreciation but sorrow:

> It's been really nice to see myself in a lot of these families, but there's also sadness. I'm like, 'Oh my God, this could be my cousin. This could be my mom.' Because I see myself in them. But working in this setting, it's rewarding. Because these people trust you a lot. (P17)

Application to clinical management. Beyond building client-clinician relationships, participants integrated their inherent cultural knowledge as part of clinical evaluations and interventions. The most common example that participants highlighted was how cultural food preferences can impact recommendations for modified diet textures in dysphagia management. P06 expressed difficulty envisioning her parents or grandparents eating at a post-acute care facility due to the lack of culturally inclusive dysphagia diet options. P08 shared the challenges of adapting diet recommendations to clients' cultural contexts, asking, "What kind of foods do you recommend because some cultures don't eat this kind of food and to blend it up would be like an atrocity." Participants' familiarity with food items from their own cultures allowed them to recognize the limitations of using mainstream diet texture examples when making diet texture recommendations for clients. P05 explained his cultural background as an advantage to clinical management, stating, "[My background] made it easier to probe [the client] because I had some sense of awareness… Having that personal connection with the Asian communities made easier to develop [dysphagia] goals and to work on them."

Participants working with Asian dysphagia clients felt that they must integrate their cultural food knowledge and clinical dysphagia knowledge to ensure that their care management

met quality of life factors for their clients in addition to swallow safety. Prior knowledge about cultural food items provided them with the advantage of making diet recommendations that seamlessly incorporated cultural cuisines without the need for external cultural interpretation or mediation. As one participant expressed:

> We get to talk about what their home life is like, what foods they're eating. Their foods are not your normal food, right? It's like dhal and roti and curry and subsea. I know what all of that is and I know their consistencies. They don't have to explain everything to me. (P16)

Many participants brought up the example of congee as a specific food item commonly found in Asian cuisines that posed a challenge in fitting into the existing modified diet texture structure used in the American system. P08 explained, "If they're eating congee that's a mix between - it's not quite pureed because it could be kind of mushy." P01 also acknowledged the lack of guidance in addressing this cultural gap in dysphagia management during their clinical training: "Would you consider [congee] as pureed or minced? What is it? I don't think they have collected enough samples in Asian food style." This led to the need for participants to make their own, independent, critical evaluations to be culturally inclusive in clinical management:

> I'm making my own decision on what this diet is. I'm looking at the food, the patient's preferences… I just name every [cultural food items] I could think of and that become their diet. The food options part was not taught in graduate schools and you just have to be creative. (P01)

Beyond dysphagia and diet management, participants provided various other examples of how innate cultural knowledge influenced other aspects of clinical management in medical speech-language pathology. One participant presented a clinical example that emphasized the

significance of cultural communication patterns and lifestyle factors associated with clients' cultural customs in the management of voice disorders:

> [My clients] know that I have this understanding of what their household is like, especially with voice disorders. I know that when you speak in your native language, you're probably speaking louder, you're probably speaking over folks. You are probably in the basement speaking to somebody on the top floor of the house. It's just how our culture works. That's just my culture. (P16)

In general, participants acknowledged that their clinical training primarily focused on English-speaking contexts and the mainstream American culture, leaving them to navigate cultural modifications independently based on personal knowledge:

> We were schooled in English. I feel like the graduate school knowledge that I have with swallowing, with language, helps me connect with my English-speaking families. With Asian patients and their families, I had to work through on my own – oh, this is how I'm going to break it down from the knowledge so that I can make it understandable, or to connect with these patients. (P08)

Subtheme 1.2: Inviting curiosity

Beyond their natural affinity with clients with Asian backgrounds, participants felt that coming from a minority background in general has been helpful for approaching all clinical interactions with heightened sensitivity and humility. P18 emphasized that her adaptability skills extend beyond working with clients from her own cultural background. She highlighted the significance of cultural inclusion when working with CLD populations, drawing from her personal experiences of navigating cultural divides. She accentuated the importance of adapting and gaining trust in different cultural contexts, stating, "Learning how to adapt and be accepted

in that kind of culture and having [clients and their families] trust you," (P18). Participants were able to establish common ground and shared values with CLD clients by exercising sensitivity in cultural conduct, even if their specific cultural backgrounds differed. P07 attributed her sensitivity to broader minority perspectives as an advantage of her minority background:

> The biggest advantage [of my Asian background] would be that I have always been sensitive to the patient in the room…When I say sensitive, I mean almost curious, like inviting curiosity… I invite that curiosity of, how does that person feel being in that position.

The minority experience. Participants expressed a positive sense of the shared minority experiences they had with clients from other minority backgrounds, who were not Asian. P11 expressed, “Just coming from a different cultural background, it just provides me more patience and a broader perspective to see what challenges my clients are going through.” Similarly, P14 stated, “Being BIPOC as a whole has been helpful. When I can share my similar experience of what they're going through, it makes it a little bit easier to adjust because I've also been through that process with that as well.” These participants went further to describe specific shared examples they had with other CLD clients, such as sharing the challenges of being an immigrant or navigating their own healthcare as a minority. In another example, P17 shared being aware of cultural celebrations and holidays for scheduling therapy that differed from the mainstream holiday calendar:

> [The clients are] always so appreciative that I have background knowledge…I think we just appreciate cultural awareness. They appreciate it when I text them, ‘Okay, I know on Monday it’s Eid. Do you want to cancel the session?’ They're like, ‘Thank you. I was gonna tell you but I forgot.’

Countering cultural generalizations. Participants also expressed concerns about perpetuating stereotypes and cultural generalizations when working with CLD clients. Their own experiences of being stereotyped based on their racial background helped them prioritize the individual needs of their clients. Participants emphasized that culturally responsive care involves recognizing that cultural expressions vary among individuals from the same cultural background. P20 highlighted the importance of moving beyond broad labels or categories and treating each individual's culture as unique:

> It is easy to put anything in boxes and say we're providing culturally diverse, culturally sensitive care, responsive care to populations, but it's very individualized too. I think by being culturally responsive, we are responding to each individual's culture too. Where we are right now is probably having broad labels or categories for people to go into, oh, Hispanics are like this, we should treat them like this. And when we do that, we are being culturally responsive. But really, that's only the first step. That's not the end goal.

This participant's personal experiences as someone from a non-mainstream ethnic background shaped her perspective on valuing the individuality of cultural expressions in clients rather than reducing them to their ethnic characteristics:

> I don't want people to look at me, see that I'm Chinese and treat me like a Chinese person. There are so many different things about different Chinese people, and I think the key is really being responsive to the person that you are really treating, and be open to learning about their culture and not [showing] the slightest amount of judgment that you may have. (P20)

Similarly, P06 emphasized the importance of directly hearing about a client's cultural background from the client themselves rather than relying solely on her own interpretation or textbook knowledge:

> Whenever I work with someone from a minority background, I always tried to be sensitive to their culture based on what they tell me and not based on what the textbook tells me about their culture. (P06)

P22 gave a specific example highlighting how cultural presentation can vary among clients of different age groups due to generational differences. She noted that she would approach the treatment of a CLD client closer to her own age differently compared to an older CLD client, acknowledging that cultural values can evolve across generations. She explained, "there's a bit more of [younger people] wanting to be seen as the individual amongst the family unit, versus as an older, grandma, grandpa type of generation. That does play into certain things, and just having awareness of that," (P22).

Application to clinical management. Much as with Asian clients, cultural sensitivity and humility for clients from other CLD backgrounds went beyond general rapport building and directly impacted their clients' care management. P25 highlighted the importance of understanding temporal orientation, such as age calculation in Asian cultures and the use of different calendars in different parts of the world. This knowledge allowed the participant to conduct cognitive communication evaluations with cultural sensitivity, considering clients' perspectives and cultural norms:

> In the Asian culture basically you're one year older than you are. In other African cultures, they also don't use the Gregorian calendar, they may use a different kind of calendar. Yes, your date of birth says it's 1/1/42, but actually you've arbitrarily assigned

> 1/1 as your birthday… If I'm asking orientation questions and I ask about their date or their age and they give me that reason I'm going to give them credit for that, because that's culturally appropriate. It's not just about Asian cultures, but about other cultures too. You realize certain [clinical] questions aren't fair because you're basing it on this kind of English American culture and not on their culture. (P25)

Subtheme 1.3: I feel like that hyphen

As summarized in the Description of the Participants section in Chapter 4, participants described their challenges in reconciling and integrating their dual identities, grappling with the process of merging their Asian and American identities. They navigated the complexities of meeting expectations from both their Asian and American cultural identities, requiring them to balance what they perceived to be two distinct and separate aspects of their identities. Subsequently, their personal identities outside of work influenced how they present themselves to their clients as SLPs during clinical interactions.

The participants' abilities to first identify, and then adapt to the culture of their client stemmed from their general life experiences reconciling the incongruities they felt in their own dual cultural identities. P10 described this separation of her Asian and American identities as the hyphen that is typically placed in the descriptions of hyphenated terms, such as Chinese-American, or Indian-American. She relayed that this hyphenated identity adequately described her clinical interactions, where she gauged how much of her cultural background she needed to portray in her professional presentation. P10 explained, "There are times in this field, I do feel like that hyphen where I'm nothing. I'm neither Asian nor American unless my patient wants me to be. I learned to adapt one way or the other and that's important."

Having a coexisting bicultural identity helped participants tap into their familiar cultures for the benefit of their clients, or exercise adaptability when interacting with their clients. While some participants did not initially consider the role of their cultural background in their profession, they acknowledged that it became more prominent when they encountered clients from diverse cultural backgrounds:

> When it comes to the profession, I don't really think about my cultural background. I'm just a person in this SLP profession. It's only when I started encounter with clients who have different cultural backgrounds, then my Asian identity will jump out. (P11)

When P16 reflected on her cultural identity in relation to being a SLP, she felt that the background of her clients shaped how she perceived the cultural integration of the profession to her clinical work:

> As a SLP, I identify myself as more American and more western. Predominantly, most of the people I work with are not Asian. You use what you know from western culture to treat them. When you come across specific patients and specific scenarios, then you can use your Asian experiences to supplement that.

THEME 2: THE 'LANGUAGE' IN 'SPEECH-LANGUAGE PATHOLOGIST'

Participants frequently brought up their English language proficiency when discussing their suitability for the profession, emphasizing the importance of proficiency in both "speech" and "language" for success as SLPs. In this theme, participants delved into the impact of their English language proficiency and their proficiency in other languages as SLPs. The three subthemes revealed the bias participants experienced towards non-native accents in English, the clinical advantages of bilingual therapy, and non-English centered perspectives on

communication disorder management. These discussions provided insight into the intricate dynamics surrounding language proficiency in the speech-language pathology profession.

Subtheme 2.1: I don't look like I should speak English

Many participants, regardless of their English proficiency, held strong internalized biases against non-native accents in English and emphasized the importance of high English proficiency and clear speech production in the field of speech-language pathology. P18, who is U.S.-born and does not have a foreign accent, theorized that SLPs, "have to have a perfect command of standardized English…It is what gives us good job security." P10, another U.S.-born participant who is a native-English speaker, lamented that pronunciation and articulation skills in English sometimes overshadowed education and experience in the field, "Unfortunately, we're stuck in this field where sometimes your mastery of how you pronounce and how you articulate in English is more important than where you went to school and how long you been working.". P11, a first-generation immigrant, expressed that having a non-native accent in English was her "greatest fear" when starting out in this profession. These internalized beliefs about clarity of English production reflecting SLP competence, regardless of their own English accents, led to self-doubt among participants about their overall clinical competency.

The participants' perceptions of their language abilities were influenced by stereotypes associated with racial appearance. Even second or later generation immigrants who grew up speaking English faced insecurity about their English proficiency due to these stereotypes. As P25 expressed, "because I don't look like [English] should be native [to me]." Another participant, P10, who was raised in the United States speaking English, felt a strong internal motivation to showcase her English competence during clinical interactions. She stated, "I need

[clients] to know that I know how to speak English very well if it's going to make them believe me and my professionalism more," (P10).

Participants also encountered bias from clients regarding their speech, further reinforcing the emphasis placed on speech articulation. For example, P05 shared a significant memory in which a parent requested a different SLP for their two-year-old child because they believed that P05's non-native accented speech interfered with his ability to facilitate communication for their child. P05 shared, “I understand it's patient’s choice, but that really hurts. You do everything you can to give the best care, but they just see your language skills as if that will make a difference to how well their child will communicate.” These quotes exemplify that some participants and clients associate professionalism and clinical competency with having a standard American English articulation.

However, a smaller subset of participants, particularly those with ten to twenty years of work experience, held a different viewpoint suggesting that having a standard American English accent should not be seen as an indicator of clinical competency in SLPs. They emphasized the importance of separating speech presentation from other aspects of an SLP’s role. P25 stated, “You’re going to see patients that are like you, right? It’s important for the therapist to represent the populations they see and treat. Very rarely in my practice do I actually get to the point of nitpicking grammar.” Another participant argued that being monolingual in English does not make someone a proficient SLP. She explained:

> It comes down to how skilled is that person in learning the things that they need to learn and then being able to communicate it... Does [accent] mean that you can't get a degree and know about communication disorders and know about voice therapy and know about

> gender affirming voice, or all of these other kinds of things that we do? I think you absolutely can. (P23)

P20 acknowledged the value placed on English proficiency in the field but questioned its significance, stating:

> English just happens to be the language that most people in the U.S. speak, and that's why it is more valued but I don't think it should be. I do agree in order to communicate, [SLPs] need to have a working command of English. I don't think an accent will be in the way. (P20)

P11, who initially expressed fear in her ability to serve as a SLP due to her non-native accent in English, later admitted a change in perspective and gained confidence in clinical competency after years of work experience. She reflected, "It's not until years of practice that I realized, well there's a lot more skills that I can present to my clients," (P11).

Subtheme 2.2: Direct communication

Contrasting the emphasis on English proficiency, participants who had opportunities to utilize languages other than English in their clinical practice viewed their ability to conduct therapy in those languages as an asset to their clinical competency. Over eighty four percent of participants in this study (22 out of 26) reported that they speak another language in addition to English. Multilingual participants took pride in their ability to convey their clinical skills in multiple languages.

Multilingual participants found significant advantages to conducting therapy sessions entirely in their clients' preferred language, particularly when they shared the same linguistic background. This approach eliminated the need for interpreter services, resulting in improved resource allocation and increased efficiency during therapy. Direct communication facilitated a

stronger connection between participants and their clients, enhancing the overall therapy experience. P20 emphasized this by stating:

> I see value, and [the clients] see value in me being able to provide therapy in their first language. They do enjoy working with me more. It's just one less layer of needing to be interpreted. So they enjoy that direct communication.

Participants who initially felt self-conscious about their non-native accent in English experienced a boost in confidence as SLPs when they recognized the value of their additional linguistic skills in therapy. P01 shared her excitement:

> It was the first time I feel that my skills are really unique because none of the other therapists can speak [two ethnic languages redacted]. I was very proud that I could speak both… I was so cool! I feel I was shining! I was like Oh, my goodness, nobody else can do this! (P01)

P11 also described the empowering process of translating their clinical knowledge from English to another language, stating, "It was very cool because all my knowledge was gained in English. All of a sudden, I had to say everything in [another language]. My brain was so busy transferring all the knowledge that I know through [another language] channel."

Participants shared powerful stories that demonstrated the impact of their language skills on their clients' therapy progress. P01 described a case where she was able to help a global aphasia client, who did not speak English, regain basic communication abilities in her native language:

> At the end of our treatment, she was able to do yes's and no's, and she'll make choices. She can read [her language] at the word level and amazingly, she was able to write. Even

> though she's still far away from her baseline, I was able to restore that basic communication at least, so that she was not left in bed.

P12 shared a story about a head and neck cancer client who had previously received therapy in English but did not fully comprehend his swallowing challenges. By speaking in the client's native language, P12 was able to provide clearer clinical information that the client had not realized he was missing before. She explained:

> I started to speak [in native language] with [the client] and all of a sudden, he was talking a lot about challenges and he was actually pretty articulate in [the native language]. What I heard from my colleague was that speech intelligibility was very low. It was mostly because of English, because [in the native language] I understand him no problem. We started talking about his swallowing issues. I described the whole thing and he's like, 'Now I realize what the problem is. Before, the other speech pathologist was really nice but I never understood what was the problem. They tried to explain but it never came across.'

In these examples, multilingual participants saw their language skills as more than a translation tool. They integrated language as a valuable clinical resource that allowed them to engage with their clients on a deeper level and target treatment goals that would have been challenging otherwise. Participants explained their use of language as an elicitation tool for communication across diagnosis groups. P11 described how she used language to engage clients with dementia, stating, "In terms of treatment for clients with dementia, it's all about engagement. I find myself very intuitive to find the easiest factor to engage my clients. With this particular client it happened to be languages." P01 highlighted the use of multiple modalities in treating English-speaking patients with aphasia, such as visual, auditory, verbal, and tactile

techniques. She explained that when treating a patient who spoke the same language, incorporating language into their clinical skills was a natural next step. She said, “When I was treating [a patient who spoke the same language], I incorporated the language into my skills. It's almost natural after you feel comfortable with your clinical skills.”

Subtheme 2.3: Linguistic responsivity

Regardless of the participants’ individual linguistic backgrounds, they offered clinical insights that went beyond an English-centric perspective. They attributed their ability to respond to their clients’ linguistic needs to the participants’ firsthand familiarity with multilingual environments in their personal lives. This subtheme illustrates examples of linguistic responsivity mentioned by participants, which went beyond using languages directly in clinical care. Participants demonstrated considerations for clients’ preferred languages, adapted appropriate language support, recognized the impact of dialectal differences in effective communication, utilized conversational proficiency of other languages in clinical settings, and embraced collaborative opportunities with interpreters.

Language preference is not static. Participants recognized the importance of identifying and accommodating their clients' preferred language to optimize effective communication, without assuming that the preferred language would necessarily be English or their native language. Several participants, including P10, P12, P22, and P33, explained that individuals whose first language is not English may not necessarily prefer an interpreter to work in their first language during therapy. P12 stated, "They do speak English and don't like to have interpreters. They have enough English to have conversations and to understand their condition.” In such cases, participants described ways in which they maintained attention to the client's comfort level and readiness to engage with the necessary levels of language support at different timepoints

during therapy. These participants acknowledged that language accommodation needs may need to be modified over time based on the specific clinical task. For example, P22 mentioned adjusting her language use based on the client's understanding and offering a medical interpreter as needed, rather than as the first step:

> When they start to have the brow furrow, or the glazed look when I'm talking more medically, okay, we'll have to get a little less jargon. If they're still not quite getting it, then offering the opportunity to have a medical interpreter.

Language of assessment. Having familiarity of their own languages' relationships with dialectal variations also made participants more aware of potential miscommunication about language preferences that could impact cognitive or communication assessments. In one example, P22 explained that in certain languages, different dialectal variations are not commonly understood by speakers of other dialectal variations. Consequently, she recognized that the cognitive evaluation conducted with the wrong language interpreter was not indicative of the client's cognitive status:

> They'll say in the chart the [Filipino] patient speaks Tagalog. But they actually weren't. They spoke different dialects of the Philippines. And some people are just not understanding, even among speech therapists, that the dialects are not necessarily mutually understood. And it's like, well, no, you are using Tagalog interpreters. He actually speaks Bisayan. So, he has a level of delirium. But he just wasn't as confused as people made him out to be. (P22)

Conversational language. Participants who considered themselves to be less than fluent in a language other than English still recognized the value of their language familiarity in clinical practice. They shared experiences where basic conversational skills in their clients' native

languages contributed to a more personable and comfortable therapeutic environment. For example, P25, who has basic conversational skills in her ethnic language, explained, “Even though my [ethnic language] is pretty bad, and I still need an interpreter just to be sure, it helps me to connect a little bit better with that population.” Similarly, P26 shared her experience of using Spanish she learned in high school with clients from a Hispanic background. She received positive feedback from these clients, stating, “I've had feedback from some of my patients, ‘I can tell that you're really trying to help versus someone who is just doing their job.’”

Some participants who did not meet requirements to be considered bilingual SLPs explained how they utilized their language skills to facilitate therapeutic tasks within the scope of meeting the clients’ treatment goals. The following three quotes exemplify the participants’ acknowledgement of their language proficiency limitations, while also highlighting their ability to optimize therapy by leveraging their existing linguistic abilities: “My mastery of the language is mainly speaking with my parents. I know elementary level. When patients have aphasia, I'm like, ‘Okay, I can handle that,’” (P10); “We can address more cognition tasks and speech tasks in their native language. Even though my Mandarin is not that advanced, but I think basic conversation wise I can manage,” (P09);

> I would not call myself a bilingual SLP, but because I can speak [ethnic language] conversationally it helps to bridge the gap for a lot of these patients. Even if I may not know all the technical terminology, I can explain it to them in a way that they still understand. For those patients there's a comfort level in that these people can speak my language. That helps a lot. (P08)

Supporting interpreters. Participants also felt that their familiarity in another language supplemented professional interpreter services. P25 explained that her comprehension skills in

her heritage language gave her collaborative advantage while working alongside interpreters, ensuring that the interpretation aligned with the clinical conversation:

> I understand a lot more than I can speak, so I can tell when [the interpreter]'s messed up. I'll stop him and say, 'That's not what I said' or 'that's not what [the client] said.' So he knows that I'm listening at the same time. Even though I don't speak as well as I could, I do understand enough to correct things.

For P16, her appreciation for linguistic differences provided her with more patience while enlisting interpreter services. When another clinician expressed impatience in the prolonged process of interpreters' work, P16 explained to the other clinician, "Sometimes you need more words to explain what you're trying to explain. Sometimes the word that you have in English is not necessarily one word in a different language, it's going to take some time to translate."

Overall, the experiences and insights of these participants highlight the significance of acknowledging and addressing diverse language needs in order to provide clinical services that are inclusive to the clients' language preferences. Their ability to adapt and respond to linguistic needs of the clients were built on their own multilingual background.

Theme 3: Am I part of this bigger group?

The final theme discusses how the participants' Asian American background influences their professional identity as SLPs. While clinical activities primarily involve direct assessment and treatment of clients, being an SLP encompasses broader professional responsibilities, representation, and roles. When considering these roles that ranged from clinical patient care to engagement in other, non-clinical aspects of the profession, participants did not always feel a sense of belonging within the profession. P20 expressed difficulty in pinpointing the factors contributing to her sense of belonging:

> I don’t have a strong sense of belonging, and I can’t tell you why. It’s a profession that I love and it’s something I enjoy doing. But do I feel like I am part of this bigger group? I don’t feel that, and I don’t know why it is, apart from the fact that everybody else looks very different from me, and then they see me as very different.

The subthemes illustrate various aspects of the participants’ interactions within the professional sphere that shape their recognition as Asian American SLPs. The first theme reveals their experiences of racial microaggressions during initial clinical encounters with clients. The second subtheme highlights the presence of racial differences in their everyday professional interactions in the workplace. Lastly, the final subtheme presents the participants’ perspectives on their role in the profession beyond clinical responsibilities.

Subtheme 3.1: Judged by my race

This subtheme highlights the common experiences of racial microaggression faced by the participants during initial clinical encounters with their clients. Common racial microaggressions reported by participants included comments about their names, appearance, and place of origin. Such inquiries unrelated to their professional capacity made the participants feel that their credibility as SLPs was being questioned based on their racial background. As a result, they felt compelled to justify their qualifications further to these clients in order to establish their position as health professionals in the interaction.

Participants perceived that the personal questions directed towards them, usually during initial clinical encounters, were race-related, as they noticed that their white peers did not experience similar situations. P09 expressed, “Being Asian, you still encounter racist patients who will question your credibility or your background because you look like this. In comparison to the white therapists, they don't get questioned as much, they don't have to prove themselves

that much." P16 similarly described these comments to be assumptions based on racial differences, stating, "Initially, I'm definitely judged by my race. People are like, 'What are you?' or 'Where is your name from?' I get that a lot. The clinical fellow that I'm mentoring never gets that, right? It's just me," (P16). Furthermore, P20 shared an example that highlighted assumptions based on racial appearance when she, as the clinical supervisor, walked into a client's room with her white graduate student:

> [The patient] immediately thought my student was the SLP, and I was the student. That is something that could happen very easily in this dynamic. If I walk with a white person, that white person actually has some privilege over me that I don't.

The above participant experiences underscore the immediate scrutiny faced by Asian American SLPs during the initial clinical encounter with clients. P01 and P06 brought up racial discrimination as a common component of their SLP experiences as Asian Americans. P01 stated objectively, "Discrimination is probably going to happen anyway. It doesn't really matter, whether you speak perfect English. Probably they're just judging you because of your appearance." P06 described experiences of racial microaggression as a reminder of her differences from the mainstream group, regardless of her own perceptions of her identity, "I don't even realize I'm Asian sometimes until someone points that out, or it reminds you that you're not white… It probably happens more than I'm aware of." Participants must navigate these challenges to establish their position as SLPs and reinforce their credibility in their clinical competency.

The question "where are you from?" posed by their clients emerged as the most common example of racial microaggression experienced by participants. They shared different scenarios in which the question were raised, but the common thread was that it typically emerged early in

the initial encounter and was irrelevant to the topic of conversation. P05 expressed, “That question always comes up, almost every time I meet [clients].’” P21 further explained the impact of this question, stating that it disrupted the clinical interaction and reminded her that the client was focused on her racial background rather than her role as the SLP:

> It sometimes catches me off guard no matter how many times I get it. It just throws me off. I’m like, oh, you don’t even see me as a speech-language pathologist first. You don’t even see me as a healthcare provider first. You just see me as an Asian.

P26 described these encounters as, “A little off putting. So they can label me or something.”

Participants developed various strategies to respond to questions about their race. Overall, participants felt that these questions interrupted the clinical management of the client’s care as they were put in the position of redirecting the client's focus. P05 explained, “It takes a little bit more time, because I have to go over that, really tear down whatever preconceived notions they have about Asian therapists.” Some participants reacted to the questions by redirecting the conversation to the client rather than explaining their background:

> I usually try to brush it off as quickly as I can just to move on. To me it's just so irrelevant. You don't need to know about me. Usually, I say something really brief and then segue into whatever we're doing. ‘Let’s talk about you.’ (P04)

Most participants who shared experiences of being questioned about their place of origin initially took offense to the question. Over time, some participants developed understanding towards these inquiries by rationalizing them as follows: “it’s because I look ambiguous,” “they’re genuinely interested,” or “I work with people with brain injuries” (suggesting that abrupt race-focused questions may be due to the clients’ cognitive-communication disorders). Others have become accustomed to the frequency of these questions. P16 explained, “I try not to

take offense to it. Sometimes it can be a little berating, but usually it's fine. Yeah. It depends on the context. And usually, it's okay."

The phrase "I have to prove myself" commonly arose when participants described the pressure to be seen beyond the assumptions that were made based on their racial background. These participants felt that in order to overcome racial bias based on appearance, name, or non-native accent, they "have to prove themselves ten times more than the person sitting next to them," (P17). Hard work and "putting in more effort than anybody else" were the foundation of P02's success as a SLP. She explained that part of the hard work involved presenting clinical knowledge so effectively that her race became less noticeable. She explained, "Knowledge is very important, ongoing education. Because we are Asian and we look like Asian. How do we get other people's respect to let other people trust us? We have to let them don't think about we are Asian." P10 dealt with the anticipation of the clients' questions about race by avoiding disclosing her background, stating, "I'm not as forthcoming about being [ethnicity]. It's me trying to be more American. So that I don't get the "Where are you from," because I got that." P25 reflected that this pressure was greater earlier in their career, when she said, "I no longer feel that way, but in the very beginning, you're always doubtful when you're not quite as confident as you need to be."

Specific instances where initial clinical encounters were explicitly racially targeted were interactions between female Asian American SLP participants and Vietnam war-era veteran clients in general acute care facilities. Four participants recounted examples where their clients made physical advances or explicitly "racist and lewd" comments, which created challenging dynamics as the participants attempted to establish professional client-clinician relationships. P19 expressed feeling nervous about a potential clinical placement due to the anticipation of

potential racism at a facility because of the age range and the background of her potential clients. These behaviors left her in disbelief, prompting her to assert the need to establish new boundaries with the client. P19 described, “In the moment, I was like, what is happening. No, it’s not happening, right? This is not the way that we can be interacting right now. I might have said something like, ‘We need to start over.’” The participants found themselves in uncomfortable working environments where their professional and personal boundaries felt undermined based on their race and gender. To cope with these experiences, some participants reasoned with themselves to downplay the gravity of the situation, often ignoring or not reporting the incidents to their administrators. P21 shared:

> It’s hard because sometimes I think, ‘Oh, let’s ignore it.’ ‘It’s not that bad.’ They didn’t call me something outright – I just felt uncomfortable. I didn’t even think of bringing it up with higher up. Sometimes the patients just get a pass because they’re just old men.

Subtheme 3.2: On a daily basis

Participants provided perspectives on how their Asian background influenced their experiences in the context of collegial interactions at work with other SLPs, and more commonly, with health professionals from other disciplines. In day-to-day interactions, clinical SLPs often work as part of a multidisciplinary healthcare team where work conversations are primarily focused on patient care. Most of the participants reported that they did not experience discrimination in their workplace due to their Asian background. P25 reflected that race, “doesn’t come to mind on a daily basis.” Furthermore, P13 cited the general existence of anti-discrimination laws as the protection against racial discrimination. P14 expressed that his company’s diversity and inclusion mission statements have been portrayed in their conduct with

clients as well as colleagues. For other participants such as P03, working in a team with diverse racial representation in the clinical team minimized race-focused challenges in the work setting.

However, a small group of participants shared experiences where differences in race became evident in the work setting. P01 shared experience of having another therapist in her rehabilitation team make constant racist remarks towards her related to her appearance and accent. She dealt with the experience by physically avoiding the racist coworker for two months. As P01 reflected on her reaction, she said, “I'm not that kind of person that would ever stand up too strongly to [the coworker], I think I have reminded her to just leave me alone.” In another example, P25 and two other rehabilitation colleagues were redeployed to the hospital to assist with acute cases in the early days of the COVID-19 pandemic. P25 noticed that all three individuals chosen for this assignment were Asian. She later reflected, “I think there might have been something to the fact that we wouldn’t complain about being pulled. And it wasn’t fair.” Acute awareness of racial discrimination was a factor of consideration for some participants who were looking to switch to a new work setting. P19 reflected:

> I wonder if it is kind of a survival tactic of testing the waters in a company, just waiting – to see if any microaggressions come up…If I take that job because it checks so many other boxes, then I will have to come in with that open heart, open mind, honest mouth, careful mouth.

The characteristics of work settings differently influenced the impact of being Asian American as SLPs. For instance, participants who worked in home health settings often did not encounter other health professionals in their daily work routines. The three participants working in this setting expressed a more general sense of isolation in their work environment that was less focused on their minority identity within the profession and simply on the nature of home health

practice. Participants who worked in facilities where Asian employees were in the minority in general acknowledged their overall racial underrepresentation in the workplace. P21 described a work setting where she was the only Asian American on the entire hospital staff, apart from one other physician. She felt that this aspect of being one of the only Asian in the workplace influenced her sense of isolation that was separate from her professional role as an SLP. Similarly, P06 described frequent instances at work where she was mistaken for the only other Asian staff in the company. She said, “It's jarring because, I would never be so confident in my answer. I would look at their name tag. Little experiences like that remind me that I am still seen as Asian,” (P06).

Some participants described the impact of sociocultural differences between themselves and their colleagues in the workplace. P13, P22, and P24 expressed the perception that they exercised a certain level of cultural adaptation when they were interacting with colleagues from white culture background. They recognized that they would engage in discussions with colleagues from the mainstream culture openly, but conversely the same colleagues may not fully comprehend their ethnic experiences. According to P22, “I can get a lot of things that my white colleagues will say, but there’s a lot of things that they can’t get about what I say in terms of my upbringing and experiences.” Similarly, P24 described adapting to the social cultural norms of the workplace as part of her job, but not as an expression of her authentic self. She explained, “I can make the jokes, the socially appropriate pragmatic talk, and make everybody comfortable. And it's fine when I have a question about Mr. so and so’s ankle boot. We just do our jobs.”

On the other hand, some participants reflected on obtaining sociocultural familiarity by building friendships with Asian health professionals from other disciplines. They became sources

of support and solidarity, particularly when dealing with racist experiences in the workplace or in processing race-related hate crimes in the media. P21 explained:

> I'm the only Asian American SLP. OTs and PTs, there are some other Asian Americans. There's just a small little bond that you have with them that I gravitated towards them - maybe it's communication or it's just seeing someone that looks similar to you. It definitely made me feel a little bit more comfortable.

Subtheme 3.3: Beyond clinical responsibilities

Participants' Asian background also influenced their experiences as SLPs in other aspects of the profession beyond clinical responsibilities. This encompassed involvement in advocacy, career development, and participation in professional organizations. When contemplating their role in the profession beyond client care, participants reflected on their overall position in the field and their future in the career as URMs in the profession.

The consideration of race in making the next career step varied among participants based on their current stage in their career. Those who were newer in the field placed less emphasis on race and focused more on factors such as family plans and personal life as influencing their career decisions. Participants in mid-career (approximately 6 to 10 years of work experience) considered increasing their involvement in areas such as diversity, equity, and inclusion (DEI) initiatives, and clinical mentorship. Participants with more extensive experience in the profession (15+ years) expressed greater consideration for pursuing leadership advancement within their respective organizations. The following sections provide insight into the participants' professional considerations based on their national representation within the profession, commitment to inclusivity in their professional work, and challenges for career growth.

National representation. Participants shared examples from their experiences as SLPs within the broader professional sphere, including state association meetings and national assemblies, where their racial identity became evident. The reflections of participants in this section were focused on their perceptions of Asian representation within the profession based on their participation at professional gatherings. However, it is important to note that not all participants reported that they regularly engaged in state or national professional communities. For P10, her limited involvement in ASHA was influenced by racial considerations. She expressed, “I’m just a paying member so I can get my C’s [credentials]. I don't want to say [ASHA] feels like a white thing, but sometimes it does. I feel like there's not a lot of minorities actively participating in ASHA.” P20 highlighted their distinctiveness as a minority at national conventions, stating, “I would stand out - you can very easily find me in the hall because there are not many other people like us at a national convention.”

In contrast, P12 actively engaged in national-level professional activities due to the same recognition for underrepresentation of minorities within larger professional organizations. She stated:

> If none of the minority SLPs are actively seeking those opportunities or reaching out to them, then you will never have this chance…I want to be involved in more of those different committees so that I can represent the minority voice or presence of a different face. It just feels important.

P01, who had limited Asian presence in her immediate work environment, appreciated the networking opportunities at national conventions to connect with other minority SLPs:

> The root of my interest in gathering people is because I was so lonely. [At ASHA conventions] I went on searching all the Asian looking names and just pop up at their

> posters and courses and trying to make connections. I did make my very first few good friends in this field. That was the first time I realized, there are other, Asian bilingual therapists out there and I'm so glad to find each other. I'm not the only one, because I struggled with that.

Two participants shared their involvement in professional interactions as the presenters at conferences. These experiences highlighted the reactions they received from fellow SLPs when they were placed in a position of authority and expertise within the profession. P20 described the surprised expressed by other attendees when they discovered that she was a poster presenter at the national conference:

> People were almost surprised that I was the presenter. It's the way they look at me versus how they look at my coworkers who are not Asian. They're looking at the posters, seeing that I'm standing next to the poster, but would not think that I am the person who did the poster.

Similarly, P05 encountered shock from other professional attendees when he presented at a virtual nationwide conference:

> There was a lot more Caucasian participants. One of them was shocked, 'You're our presenter?' I said, 'Yes, that's right, that's what we're here for.' That comment that stood out. But for [other presenters], did they say anything? They were just there ready to learn.

Commitment to inclusion and diversity. Some participants in the study shared their engagement in supporting inclusion and diversity initiatives within their workplaces and their desire to give back to the minority community. They recognized the importance of their backgrounds and experiences in contributing to DEI-related efforts. For example, two participants felt that their respective involvement as role models for promoting the SLP

discipline to underrepresented communities was meaningful work. P15 shared, “I feel pride and unique in bringing more to the table regarding my cultural and linguistic diversity. I would love to bring more people with that so that the patients are better served.” However, some participants also acknowledged the weight and burden that came with this responsibility. P14 took pride in the efforts of his workplace to promote more inclusive services for their clients. However, he reflected on his service participation in the DEI committee with mixed feelings:

> I'm the only male, and only Asian American who's participated in it. I think it's important to have that voice at the table, so there is that consideration. But it does get a little tiring, I will admit to that sometimes.

Additionally, several participants who had witnessed the impact of communication and swallowing disorders both from cultural and medical perspectives felt a sense of obligation to give back to the minority community. P07, referred to this as “"breaking the fourth wall[1]." She envisioned opening a clinic focusing on minority care, explaining, “I'll always kind of hold that space for my background, my culture, my educational training. I’m in a good position to give back to my culture in some way…I feel like I almost owe it to the profession.” Participants such as P01 and P02 already engage in culture-specific education by working as international consultants outside of the United States and using their heritage language for community education.

Barriers to career growth. Participants acknowledged the risk of burnout and feeling underappreciated within the healthcare system. Some participants in early- or mid-career

[1] The fourth wall is a performance convention used to describe an imaginary wall that separates the storytelling from reality. “Breaking the fourth wall” is a colloquial term used to signify breaking down the barriers or boundaries between the two worlds (in this case, speech-language pathology and Asian culture), allowing for a direct interaction. It implies an effort to integrate perspectives in the two realms that are unknown to each other and create a more inclusive and culturally responsive approach within the practice of speech-language pathology.

considered alternative degrees or career change while discussing these challenges. While these factors were not explicitly tied to race for most participants, some experienced the additional burden of navigating racial issues, which further contributed to their exhaustion. For P22, the challenges of dealing with anti-Asian hate crimes during the pandemic further strained her emotional well-being and impacted their desire to continue working:

> It was just beyond what I felt like a lot of my colleagues were going through with the pandemic and healthcare burnout. I had that additional piece that no one else was really going through. I do remember thinking, no one's really having to think about this in the same way, you know? In general, my emotional bucket was full. And you do provide a lot of emotional support for people [as a SLP]. So, it was very draining.

On the other hand, participants with over 15 years of experience considered the implications of career advancement, particularly in gaining leadership opportunities. For example, P23 observed a younger Caucasian male colleague being promoted to a leadership position over them, causing them to reflect on their own qualifications and years of experience. She reflected, "Maybe my application wasn't that good, but I've been in the field at least 10 years longer. It makes you think, right?" Participants acknowledged that racial considerations were challenging to prove or disprove as a factor, highlighting the underlying awareness that race might be taken into account. P25 stated, "It always enters my mind a little bit because you can't ignore race, right? Even though people say they're color blind, when positions of leadership come up, I think it is something they consider and they look even though they're not supposed to really."

Participants felt the influence of their race in their interactions with clients and peers, and in finding their place within the profession. While some participants stated that race did not play

a role in their careers as SLPs, others provided evidence of discriminatory experiences that influenced their day-to-day decisions and career trajectory. Participants developed adaptations and strategies to respond to their racialized experiences. Experiences that highlighted the effect of race on their overall sense of belonging in the profession became powerful reminders of the need for increased diversity within the field, where they now can play a part as part of that membership.

CHAPTER 6. RESULTS – SURVEY

This chapter describes the participants' SL-ASIA responses as a measure of their acculturation to American culture, and comparison of these results and demographic data presented in the beginning of chapter 4 to the qualitative findings from chapters 4 and 5. This section will begin with descriptive analysis of the SL-ASIA scores, followed by analysis of similarities and differences to qualitative findings.

CULTURAL AFFINITY RESULTS

As previously introduced in Chapter 3, the SL-ASIA is a cultural affinity scale that is widely used to assess cultural identity and acculturation of Asian Americans in the United States (Suinn et al., 1992). The original 21 items are used to calculate the participants' acculturation score, where higher scores indicate greater acculturation to Western / American cultural identity compared to their heritage Asian identity (possible range of 1.00 to 5.00). The mean acculturation score of the participants was 3.02 (*SD* = .64), ranging from 2.05 to 4.05, suggesting that participants, on average identified as having a medium level of acculturation. Additional items contribute to three other supplementary scores to describe the multidimensionality of acculturation measurement. The "values score" is used to classify acculturation based upon cultural values of the respondents. The "behavioral competency score" is used to classify acculturation based on their perception of "fitting in" with a cultural group. The final "self-identity score" is a participant-reported self-identification of overall cultural identity. Relevant SL-ASIA items that align with the study's topic based on emerging trends in the qualitative findings, along with the three supplementary scores, are presented in Table 7. Content of this table will be further described in the following sections.

Table 7. Descriptive data of participants' cultural affinity characteristics based on SL-ASIA survey results

Characteristic	n	%
Languages spoken		
Asian and English languages equally (bilingual)	11	42.3
Mostly English, some Asian language	10	38.5
English only*	5	19.2
Language preference		
Only English	11	42.3
Mostly English, some Asian language	6	23.1
Asian and English languages equally (bilingual)	8	30.8
Mostly Asian language, some English	1	3.8
Asian identity		
Asian	12	46.2
Asian-American	11	42.3
Chinese-American, Japanese-American, Korean-American, etc.	3	11.5
Generational background		
1st Generation	12	46.2
2nd Generation	10	38.5
3rd Generation	1	3.8
4th Generation	2	7.7
5th Generation	1	3.8
Values score		
Hold more Asian values	9	34.6
Hold both cultural values equally	9	34.6
Hold more Western/American values	8	30.8
Behavioral competency score		
Fit better with other Asians	6	23.1
Fit with both cultures	15	57.7
Fit better with non-Asians (e.g., Americans)	5	19.2
Self-identity score		
Asian self-identified	5	19.2
Bicultural, Asian self-identified	8	30.8
Bicultural, American self-identified	4	15.3
Bicultural, bicultural self-identified	9	34.6

Note. 1st Generation = born in Asia or country other than U.S.; 2nd Generation = born in U.S., either parent was born in Asia or country other than U.S.; 3rd Generation = born in U.S., both parents were born in U.S, and all grandparents born in Asia or country other than U.S.; 4th Generation = born in U.S., both parents were born in U.S, and at least one grandparent born in Asia or country other than U.S. and one grandparent born in U.S.; born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
*English only speakers also included participants who spoke additional languages that were not categorized as Asian languages (e.g., Spanish, German, etc.)

While most participants felt that the survey accurately represented their cultural affinity, a small number of participants provided feedback pointing out certain limitations of the SL-ASIA in capturing the full cultural diversity within their American communities. This feedback may influence the interpretation of the data based on SL-ASIA results. First, one participant mentioned that the survey did not include an option for speaking Spanish, a non-Asian language that she spoke fluently. Consequently, one participant who spoke a non-Asian language was unable to report the full extent of their multilingualism beyond proficiency in Asian languages and English. Second, some participants noted that the survey primarily focused on a binary distinction between Asian and American cultures, without accounting for the diversity within the American culture itself. For instance, a participant mentioned that her food preferences were not solely limited to Asian or American cuisines, and she felt that the survey did not provide a space to indicate preferences for other international cuisines, such as Mexican cuisine. This limitation restricted participants' ability to fully express their cultural preferences in terms of food or music beyond the Asian and American categories. Lastly, some participants emphasized that the sense of belonging and fit can vary based on the specific environment. The survey items only addressed general fit, but this may differ among various personal, social, and professional contexts. Some participants indicated that their sense of fit and belonging was consistent across

both personal and professional contexts, while others expressed that the two domains differed for them.

Connection to Qualitative Results

Below are general descriptive trends that emerged in comparing the qualitative data and the participants' SL-ASIA scale responses. Patterns emerged based on the participants' immigrant generational status and their language familiarity. Following their survey responses, participants also provided qualitative commentary on whether their cultural values, fit within cultures, and cultural self-identity impacted their clinical practice.

Generational Status

As part of the SL-ASIA scale, the participants reported their generational status in the United States. These groups were categorized by their and their parents' place of birth as follows: first generation (born in a country other than the United States), second generation (born in the United States with one or both parents born in another country), and third generation (born in the United States with grandparents born outside of the United States), and fourth generation or later (born in the United States with great-grand parents and earlier generations born outside of the United States). Of the 26 participants, 12 participants were first generation, 10 participants were second generation, and the remaining five participants were third generation or later. The findings from the qualitative analysis revealed that participants belonging to different generations had distinct experiences in graduate training and clinical practice.

First-generation participants were more likely to express limited familiarity with the field of speech-language pathology, either personally or within their families, compared to later generation participants. As a result, they sought external mentors to support their pursuit of the profession. Additionally, first-generation participants were also more likely to feel self-conscious

about their English fluency compared to later generation participants and had a heightened awareness of cultural factors involved in planning clinical sessions. These experiences were particularly salient during their clinical training placements rather than in didactic learning. First-generation participants were also more likely to be multilingual and comfortable using both English and other languages in clinical practice than later generation participants. Consequently, both first and second-generation immigrants showed a tendency to prioritize clinical practice with culturally and linguistically diverse groups or to use their profession to support individuals from diverse backgrounds.

Second-generation participants faced similar challenges related to their families' limited familiarity with speech-language pathology. However, three participants whose families actively supported their pursuit of the field were also second-generation immigrants, indicating some variation based on other factors. Second and later generation participants showed more interest in whether content in their didactic classes during their graduate training addressed the impact of culture on clinical practice. This contrasted with first generation participants who were more focused on exposure to American culture during graduate training. Second and later generation participants shared that sometimes their graduate program experiences did not present adequate depth of cultural understanding for clinical application.

Regardless of generational status, participants felt pressure to assimilate into mainstream culture in their daily lives, as well as during their time as graduate students and practicing SLPs. First and second-generation immigrants often faced challenges in balancing their heritage culture with the American culture in which they are immersed. Conversely, individuals from later generations experienced a stronger inclination to shed their Asian identity to appear more aligned with the mainstream American culture in the process of their graduate training. Participants

across generational statuses felt that their own experiences as Asian Americans were different from Asian Americans from other different generational statuses. For example, P06 who was second-generation felt herself distinct from first generation Asian Americans, stating, “It is a big difference compared to someone who is actually from Asia. I'm Asian but I’m not from there, I’m from here. I think the Asian American background is very different from an Asian background.”

Language Familiarity

Twenty-one participants reported that they spoke at least one heritage Asian language in addition to English in some capacity. Out of these, 11 reported being equally proficient in both Asian and English languages, while ten reported being more proficient in English than in Asian languages. The remaining five participants reported that they spoke English only. (These results do not include participants’ fluency in non-Asian languages, such as Spanish. One participant was grouped into the English only response in this item, but she has bilingual proficiency in English and Spanish.) As part of the SL-ASIA individual item responses, 17 participants expressed a preference for using only English or mostly English in their communication while eight participants indicated an equal preference for English and Asian languages, and one participant preferred communicating in Asian languages over English. The qualitative interview data align with participant responses to the language items in the SL-ASIA, indicating that participants who primarily use English with some proficiency in Asian languages, are less likely to identify themselves as bilingual SLPs. Nevertheless, these participants still reported utilizing their language skills for clinical purposes.

Cultural Values

The participants' values score showed a relatively equal distribution of the three categories. Nine participants (34.6%) reported holding more Asian values, another nine participants reported holding both Asian and American cultural values equally, and eight participants reported holding more American values. When discussing their beliefs in Asian versus American values, participants reflected on the values instill in them by their parents and upbringing. They considered various aspects of life and work, such as marriage, child-rearing, work-life balance, family dynamics, and education, in order to define what these values encompassed. Some were uncertain about how these values related to their clinical work, while others did not perceive personal values as significant influence on their clinical work.

Belonging and Fit across Cultures

More than half of the participants (57.7%) reported to fit well with both Asian and American cultures, while six participants (23.1) reported to fit better with other Asians, and five participants (19.2%) reported to fit better with Americans. The flexibility of fitting in with both cultures was reflected in the participants' qualitative interviews. They described their connection to their hyphenated bicultural status, where they shifted towards exhibiting more Asian or American cultural traits in their approach to meet the expectations of the graduate training program or the client in their clinical settings.

Upon reflecting on their SL-ASIA survey responses, participants also considered how these responses related to their sense of fit or belonging within the field of speech-language pathology. Four participants who reported fitting with both cultures acknowledged the presence of a dominant cultural group within the profession, leading to a perceived responsibility to conform and fit within the dominant cultural group. For example, P13 highlighted the origins of

the profession in Western countries and the prominence of researchers and practitioners from those backgrounds as reason for heavier American influence in professional practice. P14 noted the lack of representation from minority backgrounds and a need to figure out how they fit within the profession. P07 recognized her comfort across two cultures as a reason for finding her place as a minority SLP, “I always felt more comfortable around white people and that it doesn't even faze me to be the only Asian in a room full of white people.”

As participants considered their personal connections within the profession, such as their local surroundings and the skills they had developed as speech-language pathologists, their sense of belonging began to shift over time in the profession. P09 highlighted the local presence of Asian colleagues and mentor, which made her feel less left out in her professional environment as compared to her perception of the field overall. She stated, “Here, all my SLP friends are pretty much Asian too. My mentor is also Asian, so if I look at it from that perspective, then I don't feel left out as much,” (P09). P20 described how her sense of belonging grew with years of experience in the field as “having more confidence in my skills and knowledge and knowing that I can do well and not letting my difference be in the way.” P19 emphasized the importance of her individuality and unique perspectives in providing clinical care:

> I see how I am obviously, surface level, different from everybody else. But I also know we can work together and that we have differences that are invaluable. That is something that we want in these interdisciplinary teams. Not just our different technical training, but also these different kinds of ideas and experiences. I can show up and be like, yeah, this 90-year-old Vietnamese woman is not going to want to eat macaroni and cheese. It’s not a failure to thrive. Let’s get her some porridge.

These sentiments align with recurring themes that emerged from the participants' experiences during graduate training and clinical practice. Some participants felt like outsiders within the profession and faced pressures to assimilate to succeed as SLPs. However, when engaging in clinical practice, participants found the ability to adapt and tailor their approach to meet the needs of their clients, reflecting their capacity to demonstrate responsivity to the cultural contexts in their professional interactions. Overall, the participants recognized the challenges of fitting within a dominant cultural group. However, they also highlighted the importance of their unique perspectives and the valuable contributions they bring to their professional practice.

Cultural Affinity Self-identity

When participants were asked to select a statement in the SL-ASIA that most closely describes how they view their cultural identity (see Item 26, Appendix C), twenty-one participants (80.8%) considered themselves to be bicultural. Within these 21 participants, eight participants resonated with the statement, “deep down I always know I am an Asian;” nine resonated with the statement, “I have both Asian and American characteristics, and I view myself as a blend of both;” and four resonated with the statement, “deep down, I view myself as an American first.” The remaining five participants (19.2%) selected the statement, “I consider myself basically an Asian person. Even though I live and work in America, I still view myself basically as an Asian person.”

Participants who saw themselves as bicultural felt that they possessed characteristics of both cultural groups. Several participants articulated their sense of not fully identifying with either Asian or American cultures, which prompted them to identify partially with both groups. P20 stated, "I don't think I identify completely with Asians. At the same time, I don't identify

100% with white folks as well." Three participants used the phrase "right in the middle" to identify themselves as bicultural. P25 said, "I really feel like I'm a blend of both. I feel like I'm kind of right in the middle, I don't feel more Asian or more western." Similarly, P24 expressed the feeling of not fitting in well within a specific group and described herself as "falling in that lukewarm" space in between where she can fit in anywhere, but it does not mean that she finds herself to be a member of a specific group.

Participants from different generational statuses had different perceptions on the importance of establishing their American cultural identity. P23, a fifth-generation participant whose parents grew up in the United States during World War II, recalled her father instilling the importance of appearing American while growing up Asian in the United States:

> [My dad] was always like, I'm an American, you're an American. He grew up in a time where they were discouraged from speaking [Asian language]. When the war hit, you didn't want to be associated with being Japanese for sure and you sure didn't want to be speaking [a foreign language].

This type of upbringing influenced her home culture to be more American-influenced compared to other Asian American participants whose families were their primary ties to the Asian culture through their use of a heritage language in the home setting. Both P06 and P10 explained the connection of their Asian culture to their parents because they are the only people that they speak with using Asian languages. Participants who moved to the United States from a different country in their lifetime were more cognizant of their cultural differences from other Americans than those who were born in the United States and therefore more likely to self-identify as Asians.

Most participants in this study felt themselves to be bicultural, yet their qualitative responses on training and clinical experiences as students and SLPs suggest that their experiences of discrimination were largely based on common Asian stereotypes and bias (e.g., not a native English speaker, familiarity with traditional Asian customs, must get along with other Asians). There were no apparent patterns on whether self-identity shaped their professional identity.

The descriptive analysis of participants' cultural affinity factors highlighted the diversity in their perceptions of being Asian American. Factors such as generational status, language familiarity with other languages, and their sense of belonging across cultures shaped their experiences as graduate students and SLPs. In addition, the participants' feedback on aspects of their cultural and linguistic identity not fully captured by the SL-ASIA survey highlighted the nuanced diversity among the Asian American population sampled in this study.

CHAPTER 7. DISCUSSION

The field of speech-language pathology recognizes the significance of workforce diversity in effectively serving diverse client populations by making increasing efforts to recruit and retain members with CLD backgrounds (Mohapatra & Mohan, 2021; Morris & Bellon-Harn, 2021). However, there is limited research on the perspectives of these minority stakeholders within the professional membership of speech-language pathology, particularly among Asian Americans. The aim of this study was to address this gap by conducting a qualitative phenomenological investigation to explore the experiences of Asian American SLPs during their graduate training and clinical practice. The research questions were designed to explore the lived experiences of Asian Americans as underrepresented minorities in the field, both as students and clinicians. An additional aim was to explore the extent to which these experiences varied based on participants' cultural affinity and acculturation. The study findings provide insight into a group of minority SLPs who are underrepresented in the profession. In addition, the findings highlight the diversity of cultural and linguistic perspectives that contribute to the practice of speech-language pathology.

SUMMARY OF FINDINGS

Key findings summarizing participants' experiences in training and clinical work are presented in this section.

Minority students may face additional challenges during professional training

Findings from this study are consistent with previous studies in speech-language pathology and related health professions that acknowledge URM students are likely to face additional challenges in pursuing and completing their graduate training, beyond typical

challenges encountered by students from majority backgrounds. Some challenges that were identified in their pursuit of SLP careers included their family members' limited familiarity with the profession and the prevailing perception that successful SLPs are typically white and native English speakers. Upon entering their graduate studies, some participants experienced microaggressions from authority figures, which made them feel powerless to address these issues and constrained within the programs' ideologies. The findings also revealed how participants viewed cultural responsiveness education in SLP programs from a minority perspective. Some participants felt that certain cultural information presented in their graduate courses risked perpetuating racial stereotypes or did not directly tie in with clinically relevant applications. Whether consciously or unconsciously, participants began to distance themselves from their Asian identity in favor of "becoming more American" to fit within the ideal of the mainstream SLP.

Findings from this study are consistent with previous studies in speech-language pathology and related health professions that acknowledge URM students are likely to face additional challenges in pursuing and completing their graduate training, beyond typical challenges encountered by students from majority backgrounds. One of the most commonly cited experiences among URM students across health professions has been the feeling of isolation and limited sense of belonging in their professions (Abdelaziz et al., 2021; Hammond et al., 2019; Loftin et al., 2012; Naidoo et al., 2020; Suswaram et al., 2022). While power dynamics between students and graduate programs can be experienced by all students regardless of race, there may be added effects of power imbalances for URM students that are reflected in their process of socializing into the profession. There are unspoken pressures on URMs to conform to existing professional standards historically centered on the dominant perspective held by the majority

group in the profession (Duchan & Hewitt, 2023; Ellis et al., 2021; Yu, Horton, et al., 2022). Research in medicine also revealed that the process of professional identity formation of physicians does not adequately account for minority and underrepresented experiences (Trevino & Poitevien, 2021; Wyatt et al., 2020). Similar to Asian American SLPs in this study, African American medical students have expressed dissonance between their personal and professional cultures, where their personal values and speech patterns were viewed by themselves as less desirable for representing the profession (Wyatt et al., 2020). In speech-language pathology, Attrill and colleagues (2022) found that the sociocultural expectations exemplified by clinical educators and the influence of the programs' "power" to compel students to meet these expectations can be described as an acculturative process for URM students to adapt to the majority cultural practices as professionals. These power dynamics risk limiting the inclusion of minority perspectives and validation of their race-related experiences as these individuals continue in their professions.

Asian American SLPs recognize and appreciate diversity efforts and supports during training

Some study participants who reported to have received culturally diverse and inclusive learning opportunities reflected positively on these experiences. In addition, the few participants who had influential mentors with shared underrepresented racial or gender identities credited these connections as encouraging their professional growth. Participants also emphasized the strong influence of social support in shaping their experiences in graduate school. Support for sociocultural adjustment and establishment of other social support systems within the program (e.g., peers, minority faculty mentors, and departmental) have been identified as key factors in nurturing a sense of belonging for URM students in other healthcare professions (Ackerman-

Barger et al., 2020; Bond et al., 2015; Hammond et al., 2019; Loftin et al., 2012; Naidoo et al., 2020; Pololi et al., 2013). The responses from study participants provide some assurance of the qualitative effectiveness of these approaches.

Asian American background evolved into a strength in clinical practice

As participants transitioned into the role of practicing clinicians, there was a shift in their perception of their Asian American background as SLPs. They developed awareness and appreciation for their cultural and linguistic diversity as valuable clinical assets. Participants referenced the interconnectedness of their languages, familial connections, and racial identity to support their connections with their CLD clients. For example, they leveraged their personal experiences navigating between Asian and American cultures to effectively respond to their clients' cultures and languages in clinical practice. Those who were fluent in their heritage languages described the advantages of accomplishing “direct communication” with their clients and using the clients’ preferred languages in therapy. The participants’ descriptions of cross-cultural navigation between themselves and their clients portray humility and sensitivity to cultural differences.

The effect of cross-cultural and intracultural therapeutic relationships on clinical outcomes, such as engagement and rapport between the client and the clinician, has been more extensively explored in psychotherapy research (Kadan et al., 2017; S. Sue, Zane, Nagayama Hall, & Berger, 2009; Tang & Gardner, 1999; Yakhnich et al., 2021). Research examining the clinical outcome of strong therapeutic relationships in addition to clinical competence is also emerging in speech-language pathology (Connery, Pender, Yaruss, & McCurtin, 2022; Ebert & Kohnert, 2010; Fourie, 2009; Melvin, Meyer, & Scarinci, 2020), but the cultural and linguistic dimensions of these relationships are often not integrated into these frameworks. Particular to

linguistic diversity, a survey conducted by Parveen and Santhanam (2021) with monolingual and bilingual SLPs found that bilingual SLPs felt significantly more comfortable providing language-appropriate assessments and managing clinical interactions with non-English speaking clients. Similarly, Lopez Vera and colleagues' (2023) survey study on language concordance between medical providers and Spanish-speaking patients demonstrated that language concordance increases comfort and satisfaction in the clinical encounter compared to using an interpreter. While the previous literature largely assumes full proficiency in another language to benefit therapeutic relationships, the findings from this study suggest that even some degree of multilingual familiarity can heighten clinicians' sensitivity to the necessary relational linguistic adaptations required by CLD clients.

Asian American SLPs continue to face discrimination

Despite experiencing positive aspects of their Asian backgrounds in their work as SLPs, participants continued to struggle with doubts about their belonging in the profession well beyond their gradauate training and into their years of clinical work. From their time as clinical students, they faced client comments and behaviors focused on their racial appearance or negative racial stereotypes, which persisted into their clinical practice. Microaggressions, such as the assumption that they were not from the local community (i.e., "where are you from?"), served as a reminder that they were being seen by others primarily through the lens of their race rather than their clinical expertise. These experiences are consistent with findings in other literature on the experiences of minority healthcare professionals navigating racial discrimination in their work (Filut et al., 2020; Kadan et al., 2017; Niño et al., 2016; Tang & Gardner, 1999; Yakhnich et al., 2021). However, specific microaggressions linking to perpetual foreign stereotype is more profound for Asian Americans than other racially or ethnically minoritized

groups (D. W. Sue et al., 2009). Some of the strategies participants used to navigate uncomfortable encounters with clients who might judge them based on their race were to prove their clinical competence further or downplay the discriminatory nature of these encounters. These strategies were also implemented by URMs in other health professions (Ackerman-Barger et al., 2020; Hammond et al., 2019; Naidoo et al., 2020).

Participants also reported to experience microaggressions and discrimination among their peers in the profession, including not being perceived as holding educator or leadership roles in the profession. For example, participants shared experiences of their peers being surprised that they were the presenters at conferences. Participants with several years of clinical experience recognized the importance of serving as minority mentors and engaging with the profession at the national or state level because of this limited visibility, similar to views expressed by URM clinicians in other health professions (Hammond et al., 2019; Pololi et al., 2013).

Continuous exposure to racial discrimination has negative cumulative effects on the well-being of Asian Americans, impacting their sense of belonging in America and causing conflicts between their cultural identities (Huynh et al., 2011; Lai, 2013; Nadal et al., 2014; D. W. Sue et al., 2009). As an often "invisible" minority, Asian American experiences are frequently overlooked when addressing minority concerns, despite the deeply felt impact, as evidenced by the continued experiences of racial discrimination as working clinicians.

Diverse experiences among Asian American SLPs

When considering the results of this study, reflecting on the diversity among Asian Americans is important. There were some experiences that were common across most participants, such as the tension between their Asian and American identities, and the strong inclination to conform to mainstream American culture in order to fit in professionally. They

often saw themselves as the "outliers" in the profession due to their race and other intersecting identities. All participants also reported experiencing some degree of discrimination at some point in their training or careers. However, notably there were differences in experiences among this group of participants. One key trend was variability across generational status. First-generation participants experienced distinct sociocultural and linguistic adaptation pressures compared to second- and later generation participants, owing to their unique experiences immigrating to the United States and their overall adaptation to American cultures and languages. Consequently, first-generation participants' experiences did not fully align with those of Asian Americans from other generational groups, and vice versa.

Do URM SLPs face unique challenges compared to URMs in other health professions?

To some extent, the experiences of racial discrimination and stereotyping described by the participants are not unique to the field of speech-language pathology. They are commonly shared experiences among other Asian Americans (Cokley et al., 2013; Suzuki, 2002) and across URM groups in health professions cited throughout this chapter. However, some experiences may be unique to SLPs due to the nature of the field. One key issue is the role of speech and language in the profession. Participants often brought up their own language proficiency during the interviews, indicating the need to address the manner in which language is viewed as a key professional skill for SLPs specifically. Participants expressed heightened awareness of their own speech and language patterns, particularly accents, and how they might be tied to perceptions of clinical competency by peers and clients. This aspect is not well-represented in existing literature of URM experiences in other health professions, although differences in speech patterns has been alluded to in a study on professional fit of African American medical students (Wyatt et al., 2020). Having linguistic differences as a health professional could be an

intensified burden for individuals aspiring to be SLPs (Attrill et al., 2022). There has been recent recognition that discrimination based on linguistic presentation may be more pronounced in speech-language pathology over other disciplines (Grover, Namasivayam, & Mahendra, 2022). While the profession of speech-language pathology continues to move towards accent-inclusive policies and practices (ASHA, 2023c; Grover et al., 2022), the deeply ingrained perceptions of Asian American SLPs towards their language proficiency, namely perceptions of foreign accent, provide evidence that the intertwined nature of race and linguistic discrimination in certain URM groups runs deeper than current efforts attempt to address (Yu, Nair, et al., 2022).

IMPLICATIONS

The study findings have three main implications for the future training of minority graduate students in speech-language pathology and the overall direction of the profession towards being more inclusive and diverse. First, current ongoing diversification efforts have focused on increasing the number of URM students enrolled in, and complete graduate programs. However, evidence in recent literature and findings from this study points to the presence of white-dominant, color-blind professional expectations, policies, and standards that URMs are compelled to adhere to in the process of their professional training. Therefore, more focus needs to be placed on retention of these students through inclusive approaches to critically engage with and empower URM students to reduce isolation and increase their sense of belonging in the profession. The stress of adapting to fit within the prevailing normative frameworks of the professional culture can lead to feelings of alienation and internalized undesirability among URM members (Abrahams et al., 2019; Attrill et al., 2022; Duchan & Hewitt, 2023; Ellis et al., 2021; Yu, Horton, et al., 2022). Embedding social support, access to resources, and enhanced multicultural/multilingual training are actions endorsed by minority

students to diversify professional ideologies that may have been historically discriminatory to minority students (Ginsberg, 2018; Matthews & Daniels, 2019; Roberts, 2023; Suswaram et al., 2022). In addition, the process of socializing URM trainees into the profession and fostering their professional identity as SLPs are areas that need to be brought to conscious awareness in the scholarship of teaching and learning. This approach aims to assist URM students in understanding how their individual personal identities align with their professional identity (Abrahams et al., 2019).

Second, there is a need to increase consistency and clarity for cultural responsiveness education in speech-language pathology across graduate school programs. Surveys of accredited programs across the country continue to report inconsistencies in how cultural responsiveness is incorporated in speech-language pathology education (Guiberson & Vigil, 2021; Parveen & Santhanam, 2021). The findings from this study provide qualitative evidence of insufficient cultural knowledge to guide students in applying this knowledge effectively with CLD populations. Students from underrepresented backgrounds look towards the quality of the cultural responsiveness education to gauge the profession's understanding of, and respect for, cultural and linguistic differences, whether related to themselves or their client populations. Therefore, strengthening educational approaches to cultural responsiveness has the dual benefit of portraying acceptance of diversity from a professional standpoint, and equipping SLPs with the skills to engage in effective cross-cultural interactions with their clients.

Lastly, in addition to inclusive efforts in graduate training for URM students, SLPs with underrepresented backgrounds who are currently working clinically also need ongoing social and professional support as professionals. Examples of such support can include fostering connections to both local and national multicultural constituency groups and promoting diversity

in disciplinary mentorship, leadership, and research (Ginsberg & Mayfield-Clarke, 2021; Girolamo, Castro, Fannin, Ghali, & Mandulak, 2022; Morris & Bellon-Harn, 2021; Roberts, 2023). These measures can help URM SLPs feel acknowledged and supported within the profession, strengthen the pipeline to further recruit more URM trainees into the profession, and elevate minority issues as factors that impact professional development.

LIMITATIONS

The data collected in this study were restricted to the perspectives of Asian Americans who were successful in pursuing a career as SLPs, and thus did not include the experiences of Asian Americans who were not admitted to a graduate program, did not complete their degree, or chose to change careers at any point after graduation. Therefore, perspectives shared in this study were restricted to those who navigated the path of past and recent graduate training with sufficient 'adaptability' to join the profession.

A common critique of research focusing on specific racial groups is that it may not provide comprehensive understanding of experiences of URMs across groups (Abdelaziz et al., 2021; Nadal et al., 2014). However, focusing only on Asian Americans revealed the diversity within this one racial group based on the social conditions during their time of graduate training, generational status, and work environments. Trends across Asian American experiences speak to the particularities of racial, cultural and linguistic impact that may be more prominent in this group, although other characteristics may be shared with other minoritized groups. For instance, the effect of internalized racism is shared among marginalized racial groups, although specific racial biases may differ between groups.

Another reflection on the study methods is to consider participants' feedback on the use of the SL-ASIA scale as a measure of their acculturation. Originally published in 1992, some

items of the SL-ASIA scale, may no longer accurately reflect the cultural evolution of Asian American or the diversification of what is deemed American culture at present. Despite this limitation, the SL-ASIA scale remains the most widely used and referenced cultural affinity tool in Asian American literature, which has linked acculturation to health behaviors, education, and metal health (Suinn, 2010). For the present study it provided valuable insights into the diversity of cultural and linguistic backgrounds of Asian American participants. However, the constraints of the instrument limited the manner in which the SL-ASIA results were integrated with qualitative findings. Further exploration and development of an updated multidimensional evaluation of cultural affinity could potentially enhance the ability to capture the nuances and complexities of contemporary Asian American experiences and enrich the interpretation of the participants' interview data.

Future Directions

Given the span of this study covering both aspects of graduate training and clinical practice, there are several potential directions for future research. First, the current study offered a retrospective perspective on the experiences of Asian American SLPs who are currently working, varying from one to over thirty years since their graduate school attendance. Future research addressing barriers and facilitators to minority success in speech-language pathology could utilize a longitudinal study design to capture the experiences of current minority students, starting from the undergraduate level. Including students who may have encountered obstacles along the academic pipeline would provide valuable insights into the barriers that hindered their progression in the field.

Second, the cultural strategies described by Asian American SLPs in this study for engaging with clients highlight the need for observational studies to directly evaluate client-

clinician interactions. Such studies could help identify and analyze specific skills that SLPs utilize or do not utilize but should be done in cross-cultural encounters for achieving desired clinical outcomes. The findings will serve as a vital foundation for the redesign or improvement of SLP education approaches.

Another direction for future research is to explore the processes of professional identity formation in SLPs. Understanding professional identity will help SLPs define their own role within the profession, how it aligns with their personal identity, and how they present themselves as SLPs to others (Trevino & Poitevien, 2021). A qualitative study focusing on the influence of URM SLPs' self-identity on their professional identity formation can provide valuable insights into the current educational processes and areas of professional values that may contribute to a deficit- or value-based view of URM members within the profession.

Conclusion

The current study used a qualitative phenomenological approach to understand the graduate training and clinical practice experiences of Asian American SLPs. Findings indicate that there were similarities between the experiences of Asian Americans in professional training and clinical practice as minorities in the speech-language pathology profession with trainees from other healthcare professions cited in the literature. This study also makes two novel contributions to the literature. First, this study focused specifically on the experiences of Asian Americans as an URM in a healthcare profession, which differs from other professions where Asians are typically not underrepresented. Second, this study identified racialized experiences of being Asian American specifically in speech-language pathology which, due to the focus on speech and language, may create different experiences than individuals in other healthcare professions. This study enhances the profession’s understanding of social and environmental

factors that may perpetuate marginalization of minoritized students from program entry to program completion. This study also presents specific examples of cultural and linguistic responsiveness strategies used by Asian American SLPs to enhance culturally concordant or cross-cultural clinical relationships. The findings from the current study further contribute to the field of speech-language pathology on how their educators, leaders, and researchers can support inclusion of minority members in the profession.

Despite the challenges that many participants encountered while trying to fit into certain professional expectations of SLPs, all participants shared a common passion for helping individuals communicate and connect, which served as the underlying motivation for their interest in the field. Over time, they developed strategies to adapt and navigate discrimination, and recognized their differences as assets that contribute to the ongoing professional mission of promoting diversity and inclusion within the field. P05 eloquently described his pursuit of the profession. His message gently reminds us that regardless of the paths we take, our common goal as SLPs is to build human connections through communication:

> If I would talk from the heart, there's a passage in the Bible where Jesus heals the deaf mute man, and he says, ‘apatha,’ which means ‘be open.’ I thought that was a great representation of our field. We open lives, we open stories. That was the mission that kept me going, and that's what reminds me of how amazing this field is.

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APPENDIX A

Demographic Data of Asian Pacific Islander Speech-Language-Hearing (APISLH) Caucus

The APISLH Caucus is a non-profit professional organization whose mission is to connect Asian and Pacific Islander members to support API communities in need of speech-language-hearing services and professional members of the speech-language-hearing professions of API communities and API descent. To understand the likely pool of participants in this study, and to document representativeness of the sample, unpublished data available from the APISLH Caucus membership survey data on the ethnicity, gender, age, language status of current Asian American SLPs is presented in Table 8. The dataset comprised responses from 86 SLPs and graduate students who self-identified as Asian, and not involved in research or academia, collected between 2017 to 2018.

Table 8. Unpublished APISLH Caucus membership demographic data of Asian SLPs and graduate students (2017-2018) (n = 86)

Characteristic	n	%
Age (in years)		
23-30	28	32.6
31-40	36	41.9
41-50	17	19.8
51-60	3	3.5
Gender		
Female	82	95.4
Male	2	2.3
Nonbinary	1	1.2
Ethnicity		
Chinese	17	19.8
Indian	15	17.4
Taiwanese	14	16.3
Korean	10	11.6
Japanese	8	9.3
Vietnamese	6	7.0

Characteristic		n	%
	Filipino	5	5.8
	Hmong	2	2.3
	Indonesian	1	1.2
	Malaysian	1	1.2
	Other / Multinational	7	8.1
Language			
	More than one language	60	69.8
	English only	21	24.4
Generational background			
	First generation (Born outside of the U.S.)	42	48.8
	Second or later generation (Born in the U.S.)	43	50.0
Working with API clients			
	Yes	49	57.0
	No	9	10.5
	No response	28	32.6

Note. Percentages may not add up to 100% due to missing responses

APPENDIX B

Interview Guide

- Ask for permission to record the session.
- Provide interviewer's positionality and background.
- Provide brief introduction to the purpose of this study and that the purpose of the interview is to learn about their experiences.

Interview Questions:

- I will start with a broad question. I don't have scripted list of questions for you, but a few areas I want to touch upon, so we will just see where our conversation takes us today. Can you describe to me the decisions that lead you to become an SLP?

Note: Following this first question, the ordering of the questions varied based on the direction of the conversation set by the participant. The rest of the questions listed here served as a guideline for the areas covered during the interview if they did not come up naturally in the conversation.

- Tell me in what ways do you think your race/ethnicity played into your experiences as a SLP?
- Can you describe what it was like being an Asian graduate student in speech-language pathology?
- Tell me about the diversity of fellow students and faculty where you did your clinical training (graduate program). How did that shape your experience?
- We are in the era where culturally responsive care is getting a lot of attention in healthcare. I'm interested in your experiences and thoughts on what this means in your clinical practice. How has who you are and your training shaped how you practice culturally responsive care?
- Tell me about how your identity as Asian playing into the choices or decisions you make in pursuing your career path?

Approximately 60 minutes into the interview, participants were provided instructions to fill out an online survey containing the SL-ASIA scale and demographic information.

Post-Survey Questions:

- What was your overall impression of this survey? Do you feel that your responses accurately describe you, why/why not?
- One of the things I want to do in this study is to get a sense of where people are on this continuum of merging cultural identities and tie that into our conversation about where that fits within how we see ourselves as speech-language pathologists.
    - What are some values or practices you have encountered in your profession that were the same or different from your personal beliefs? How did you handle that / how did that resonate with you?
    - Something I'm really interested in talking to people about is their feeling of belonging / fit in the profession. I heard you talk today about ____+ ___. I'm curious in hearing overall about your sense of belonging. How do you see yourself fitting in as a SLP and Asian?

Following questions specific to cultural affinity, the interviewer had the opportunity to pose follow up questions related to any information shared prior to the survey.
The interview closed with advice questions as time allowed:

- For other Asians entering the speech pathology profession, what advice would you/do you give them?
    - What advice would you give your younger self?
- For clinical supervisors, instructors, or administrators in academic settings, what advice would you give them about working with minority students or with Asian students?
- For your colleagues or administrators in your work setting, what advice would you/do you give them about working with minority SLPs?
- I am still in the process of recruiting participants for this study. Do you have advice for me on where I might find other Asian American SLPs who might be interested in participating in this study?

Wrap up:

- Now that you have a good idea of my interests in this topic and the type of questions I have asked you, is there anything else you want to tell me that you haven't had a chance to share?
- Gratitude and arrangement for participant payment
- Ask participants if they would be interested in being contacted in the future for member checking

APPENDIX C

Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)

From: Psychosocial Measures for Asian Americans: Tools for Practice and Research www.columbia.edu/cu/ssw/projects/pmap

INSTRUCTIONS: The questions which follow are for the purpose of collecting information about your historical background as well as more recent behaviors which may be related to your cultural identity. Choose the one answer which best describes you.

1. What language can you speak?
    1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
    2. Mostly Asian, some English
    3. Asian and English about equally well (bilingual)
    4. Mostly English, some Asian
    5. Only English

2. What language do you prefer?
    1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
    2. Mostly Asian, some English
    3. Asian and English about equally well (bilingual)
    4. Mostly English, some Asian
    5. Only English

3. How do you identify yourself?
    1. Oriental
    2. Asian
    3. Asian-American
    4. Chinese-American, Japanese-American, Korean-American, etc.
    5. American

4. Which identification does (did) your mother/father/primary caretaker use?
    1. Oriental
    2. Asian
    3. Asian-American
    4. Chinese-American, Japanese-American, Korean-American, etc.
    5. American

5. Which identification does (did) your mother/father/secondary caretaker use?
    1. Oriental
    2. Asian
    3. Asian-American
    4. Chinese-American, Japanese-American, Korean-American, etc.
    5. American

6. What was the ethnic origin of the friends and peers you had, as a child up to age 6?
    1. Almost exclusively Asians, Asian-Americans, Orientals

2. Mostly Asians, Asian-Americans, Orientals
3. About equally Asian groups and Anglo groups
4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

7. What was the ethnic origin of the friends and peers you had, as a child from 6 to 18?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

8. Whom do you now associate with in the community?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

9. If you could pick, whom would you prefer to associate with in the community?

   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

10. What is your music preference?
    1. Only Asian music (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
    2. Mostly Asian
    3. Equally Asian and English
    4. Mostly English
    5. English only

11. What is your movie preference?
    1. Asian-language movies only
    2. Asian-language movies mostly
    3. Equally Asian/English English-language movies
    4. Mostly English-language movies only
    5. English-language movies only

12. What generation are you? (circle the generation that best applies to you:)

1 1st Generation = I was born in Asia or country other than U.S.
2 2nd Generation = I was born in U.S., either parent was born in Asia or country other than U.S.
3 3rd Generation = I was born in U.S., both parents were born in U.S, and all grandparents born in Asia or country other than U.S.
4 4th Generation = I was born in U.S., both parents were born in U.S, and at least one grandparent born in Asia or country other than U.S. and one grandparent born in U.S.
5 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
6 Don't know what generation best fits since I lack some information.

13. Where were you raised?
    1. In Asia only
    2. Mostly in Asia, some in U.S.
    3. Equally in Asia and U.S.
    4. Mostly in U.S., some in Asia
    5. In U.S. only

14. What contact have you had with Asia?
    1. Raised one year or more in Asia
    2. Lived for less than one year in Asia
    3. Occasional visits to Asia
    4. Occasional communications (letters, phone calls, etc.) with people in Asia
    5. No exposure or communications with people in Asia

15. What is your food preference at home?
    1. Exclusively Asian food
    2. Mostly Asian food, some American
    3. About equally Asian and American
    4. Mostly American food
    5. Exclusively American food

16. What is your food preference in restaurants?
    1. Exclusively Asian food
    2. Mostly Asian food, some American
    3. About equally Asian and American
    4. Mostly American food
    5. Exclusively American food

17. Do you
    1. Read only an Asian language?
    2. Read an Asian language better than English?
    3. Read both Asian and English equally well?
    4. Read English better than an Asian language?
    5. Read only English?

18. Do you
    1. Write only an Asian language?
    2. Write an Asian language better than English?
    3. Write both Asian and English equally well?
    4. Write English better than an Asian language?
    5. Write only English?

19. If you consider yourself a member of the Asian group (Oriental, Asian, Asian-American, Chinese-American, etc., whatever term you prefer), how much pride do you have in this group?
    1. Extremely proud
    2. Moderately proud
    3. Little pride
    4. No pride but do not feel negative toward group
    5. No pride but do feel negative toward group

20. How would you rate yourself?
    1. Very Asian
    2. Mostly Asian
    3. Bicultural
    4. Mostly Westernized
    5. Very Westernized

21. Do you participate in Asian occasions, holidays, traditions, etc.?
    6. Nearly all
    7. Most of them
    8. Some of them
    9. A few of them
    10. None at all

22. Rate yourself on how much you believe in Asian values (e.g., about marriage, families, education, work):

1	2	3	4	5
(do not believe)			(strongly believe in Asian values)	

23. Rate your self on how much you believe in American (Western) values:

1	2	3	4	5
(do not believe)			(strongly believe in American values)	

24. Rate yourself on how well you fit when with other Asians of the same ethnicity:

1	2	3	4	5
(do not fit)				(fit very well)

25. Rate yourself on how well you fit when with other Americans who are non-Asian (Westerners):

1	2	3	4	5
(do not fit)				(fit very well)

26. There are many different ways in which people think of themselves. Which ONE of the following most closely describes how you view yourself?

1 I consider myself basically an Asian person (e.g., Chinese, Japanese, Korean, Vietnamese, etc.). Even though I live and work in America, I still view myself basically as an Asian person.
2 I consider myself basically as an American. Even though I have an Asian background and characteristics, I still view myself basically as an American.
3 I consider myself as an Asian-American, although deep down I always know I am an Asian.
4 I consider myself as an Asian-American, although deep down, I view myself as an American first.
5 I consider myself as an Asian-American. I have both Asian and American characteristics, and I view myself as a blend of both.

APPENDIX D

General Demographic Information

The following three sections ask about your general demographic information, cultural history, and speech-language pathology training and work history.

Please answer the following questions to the best of your ability. If there is a question that you do not want to answer, you may skip that question.

1. What is your age? _____
2. What is your gender? _____
3. What is your race?

   White

   Black / African American

   Asian

   American Indian or Alaskan Native

   Native Hawaiian or Pacific Islander

   Two or more races

   Other: _____
4. What is your heritage nationality / ethnicity? (Chinese, Japanese, Korean, Vietnamese, etc.)

   _____
5. Are you from a Hispanic or Latino origin? Yes No
6. In what state do you reside: _____

Your Cultural / Linguistic History

7. Were you born in the United States? Yes No

   If No, where were you born? _____
8. Have you lived outside of the United States? Yes No

   If Yes (you have lived in other countries), list those countries and indicate how long (and what ages) you lived in each country.

   _____

   _____
9. What languages do you speak? Indicate your fluency / comfort level in each language.

   Fluency descriptions:

   Basic – I can communicate on simple topics or know some phrases in this language

   Conversational – I can communicate on everyday topics with minor grammar or vocabulary mistakes

Fluent – I can communicate formal and informal topics comfortably with good vocabulary and grammar, and people understand me easily

Proficient – In addition to being fluent, I have deeper linguistic understanding of the language. I can use idiomatic expressions and colloquialisms comfortably

Your Speech-Language Pathology Training and Work History:

10. What is the name of the institution where you completed your Master's degree in Speech-Language Pathology / Communication Sciences and Disorders?

    _____

11. When did you graduate from your Master's degree in Speech-Language Pathology / Communication Sciences and Disorders? If you do not know the exact date, please use an approximate date.

    _____

12. (Optional) If you have other degrees related to your clinical work, include the degree, and the year you obtained it here:

    _____

13. When did you obtain your Certificate of Clinical Competence (CCC) from ASHA? If you do not know the exact date, please use an approximate date.

    _____

14. What is your employment status?

    Full-time

    Part-time

    PRN / As needed with irregular work hours

15. What is the primary clinical setting that you work in?

    Hospital

    Outpatient Clinic

    Subacute/Transitional Care

    Skilled Nursing Facility

    Home Health

    School

    Private practice

    Other: _____

16. Referring to your primary clinical setting, how long have you worked in this setting?

    _____

17. Referring to your primary clinical setting, if you tend to specialize in a particular population, describe it here:

    _____

18. (Optional) If any, what is the secondary clinical setting that you work in, or that you have recently worked in the past?

    I do not have a secondary clinical setting
    Hospital
    Outpatient Clinic
    Subacute/Transitional Care
    Skilled Nursing Facility
    Home Health
    School
    Private practice
    Other: _____

19. (Optional) Referring to your secondary clinical setting, how long have you worked in this setting?

    _____

20. (Optional) Referring to your secondary clinical setting, if you tend to specialize in a particular population, describe it here:

    _____

This is the end of the survey.

Thank you for completing this survey! Let the interviewer know when you are ready to resume the final portion of the meeting.

APPENDIX E

Initial Codebook

Parent Code	**Child Code (if any)**	**Description**
Academic Environment		Experiences during SLP training / education phase, whether it is at the undergrad, post-bacc, or grad level, didactic or clinical training. If the experience fits more specifically under the following codes, use those codes. Otherwise, code generally as 'Academic Environment'. Does not include academic experiences in other disciplines (those would go under General life experiences)
	Clinical Practicum	Any clinical experiences relating to working with clients as a SLP student, whether it being in university clinic or externship that would be under the advisory of the graduate school. Does not include CF
	Peer interactions	Interactions with a fellow trainee (from the same cohort or in different stages of the program), positive or negative. Examples include peers shared notes, or helped with a clinical rotation, participating in social events with peers during their academic training. Topics do not have to be culturally related.
	Program diversity	Descriptions of diversity of peers or faculty. Description of availability of diversity resources (caucuses, support groups), movements to generate more discussions surrounding diversity, or lack there of.
	Relationship with prof/instructor/supervisor	Interaction, meeting, commentary, conversation with someone within the field that holds the power position in their academic setting. This could include one-on-one interactions, professor in the class, or advisory relationship. This relationship exists usually because there is a power differential between the participant and the professor / instructor / supervisor. This also includes supervisory relationship in the clinical fellowship (CF) stage. Positive or negative.
Advice to students		What participants wished they knew going into the profession, or anything they would tell new students entering the profession. This specifically refers to when participants asked to provide advice for other students or to their younger self near the end of the interview.
Advice to workplace		Recommendations participants have for the workplace or for other colleagues to support minority SLPs. This specifically refers to when participants are asked to

Parent Code	Child Code (if any)	Description
		provide advice for colleagues or the work administration near the end of the interview.
Applying to grad school		Descriptions of factors that influenced the participant's decision for selecting grad school, such as qualities of the graduate program, anything in the application process for grad school, decisions related to finalizing on where they will go, and post-bacc decisions in preparation for grad school. Examples include: only applying to one school, pursued a school because of the professors or available scholarship. If family context is an influential factor, then double code with Family Context in SLP.
Background story		Information about the participant relating to who they are. Information about themselves that they shared to "set the stage". Example: information about family status, life experiences that did not occur during their SLP training or clinical practice.
	General life experience	Description of personal experiences, day-to-day stories, that don't relate to their SLP training or clinical experience. Examples include previous degrees they have received prior to becoming a SLP, events that occurred in their previous careers (if any). Stories about theirs or their family's immigration to the US if relevant (e.g., My parents immigrated to the U.S. when I was a baby) but any cultural experiences related to that transition would be coded 'Multicultural – General'
	Generational Status	Any experiences or perspectives related to their generational status in the US (first gen, immigrant, second gen, etc.)
	Path to SLP	Description of how they found out about the profession, the process surrounding their decision to pursue SLP, and any experiences leading to them getting accepted into the grad program.
Belonging within the profession		Descriptions of their sense of fit within the profession, or examples of stories where their sense of fit or belonging would come into play at any stage of training or clinical practice.
Career goals		Description of their career aspirations in SLP

Parent Code	Child Code (if any)	Description
Cross-cultural experience – General		Multicultural experiences that are personal and did not occur during SLP training or professional interactions. Examples include being "foreign born" (experiences specifically related to coming from another country), experiences related to their understanding of cultural values, descriptions of their own, or others' cultures not occurring during SLP work, description of how their generational status in the U.S. influences their perspective / behavior on culture (e.g., I talk to my grandparents in Chinese; Because my English is better, I am usually the interpreter for our family), interactions with friends or family who are of a different ethnicity. Includes their navigation of cultural differences in these experiences
Cross-cultural experience - SLP		Descriptions of experiences that speaks to cultural differences between the participant and others, whether it is with peers, community, patients, or others from the same culture with different views, that occurred during their SLP training or clinical practice. Includes comparing and contrasting themselves and other Asian SLP experiences. Includes things that are not concrete requirements to clinical competency but impacts clinical practice (e.g., familiarity with nursery rhymes to work with pediatric population, idioms, familiarity with cultural foods).
	Acculturation	Any experiences of needing to conform to Americanized cultural notions to perform as an SLP
Culturally responsive care		Participant descriptions of their practice of culturally responsive care in working with patients of any cultural or linguistic background in navigating to meet patient's clinical needs from a cultural perspective. Use this code if the experience is about the participant's cultural approaches to care in general, or conversation about how the participant envisions culturally responsive care being taught based on their clinical experiences. Includes any "misses" in cross-cultural interactions in clinical settings that could have been handled with more cultural sensitivity / responsivity.
	Using heritage culture in clinical work	Descriptions of how their heritage background (culture, appearance, language) had an influence on clinical practice. Includes facilitation of clinical practice by speaking the same language as the patient, knowledge of food textures that facilitate diet recommendations, or understanding of cultural context in clinical decision making. Includes how they can envision their cultural skills supporting the profession and expanding cultural reach of the profession (e.g., participating in cultural TV and radio shows to provide education to Chinese speakers (overlap with

Parent Code	Child Code (if any)	Description
		other professional activities), translating resources available in their clinic for everyone's use)
Expectation/Professionalism of SLP		Descriptions of what is perceived as the underlying expectation that a certified clinician should have, that is expressed by the participant or conveyed to the participant by someone else. Examples include certain English proficiency, having certain knowledge and competency, appropriate conduct with patients, having a certain personality, appearance, or communication style "as a professional".
External factors influencing SLP training		Descriptions of factors that impact progress in SLP training, that are outside the academic environment. Key events in the participants' life that is outside the academic program's support. Examples include financial resources, health, life responsibilities, daily commute, etc. that influenced their trajectory in SLP training. Does NOT include admission decisions from grad school programs.
Family context		Descriptions of how family had played a role in the participant's decision to pursue the field, positive or negative. Includes how the participant may be experiencing the profession in the context of their family dynamic. Examples include the family's feelings about the participant going into SLP, and their involvement in the participant's life throughout their career. Family can include the nuclear family (e.g., mom, dad, sister), or anyone with close familial relationships in their life (e.g., partner). Any description of family interactions that are NOT in the context of their SLP training / work will be in General Life Experiences or Multicultural – General as appropriate.
Finding Employment		Descriptions of the process of looking for clinical employment (including a CF position), decision process in choosing a workplace, interaction with potential workplaces before employment (e.g., interview). This also includes non-clinical factors that impact employment such as obtaining a visa, assessing work culture. Internship or externship assigned during their graduate program will be coded under Academic Environment.
Good Quotes		any quotes that would be good to keep track of for publication

Parent Code	Child Code (if any)	Description
Implications for SLP program		Recommendations and advice to SLP programs for supporting Asian SLPs (or underrepresentation in general), such as requesting for accommodations, accent reduction. Any commentary related to something programs can do/ should do in the future, that was not implemented in their own academic environment. These are the statements such as "I wish my program had…." Or "Programs should…."
Language abilities		Descriptions of how language abilities influenced being, or becoming a SLP, or current practice - whether it is positive or negative. Includes feeling that accented English poses a barrier to the profession (e.g., barriers to entry to the grad program, patient comments that the person may not be able to provide care due to their accent), or the relevance of language in SLP work. It also includes the contribution of speaking multiple languages to clinical care, or comments about desires to speak other languages.
Male SLP		Any experiences that relate to being a male SLP
Mentorship		Specific description of someone that had a strong influence in the career trajectory
Miscellaneous		Anything that should be captured that do not fit in other categories
Other professional activities		Any career-related activities that are not direct clinical work, such as going to conferences, pursuing a certification program, presenting / speaking at events, pursuing additional degrees, teaching, guest speaking.
Patient diversity		Descriptions of diversity of their patient populations. May refer to differences in race, ethnicity, education, socioeconomic status, age, gender, etc.
Patient-centered care		Any descriptions of clinical practice, clinical decision making, or therapeutic management with the patient in mind doesn't specifically refer to culture umbrella (e.g., you have to ask the patient what their goals are)
Personal factors		Any trait or behavior that participants indicate are a result of individual differences, personality, or "who they are" rather than a cultural or an ethnic characteristic. This includes their work ethic, mindset, attitude, internal motivators, beliefs and values, religion, other identities (LGBTQ status, religion). Any instances where participants say they are not sure if it's culture or "if it's just me".
Racialized experiences		Any experiences that is explicitly related to Asian or a minority identity
	Microaggressions	

Parent Code	Child Code (if any)	Description
Relationship with other professionals		Descriptions of interactions with others in the professional setting, which could include interactions with coworkers, colleagues, or people outside of the work setting (researchers, interactions during conferences). This could include people they interact with in the work environment.
Relationship with patient		Examples of their interactions with patients for rapport building, and for purposes outside of providing clinical recommendations (those will be in culturally responsive care or patient-centered care). This includes how participants may have navigated uncomfortable interactions that occur with patients (example: how they deal with patients when they ask "where are you from"?) Includes any changes in this relationship over time. Includes ways that participants present themselves to patients as a professional. The interaction does not have to be culturally related in nature
Responses to advantages/challenges in being an AA SLP		Participant response to questions about advantages / challenges in being an SLP as cued by a question prompt about advantages and challenges.
Survey feedback		General comments about their impressions specifically about the cultural affinity instrument. Includes any general comments on whether the survey captured their cultural affinity, or not. Does not include details of their responses (may fall under multicultural experiences – General or SLP). It includes any discussion generated from the survey questions that stem from cues from the survey questions, that are not captured in the latter two codes about belonging and values.
	Survey belonging	Participant response to belongingness as cued by responses to #25 and #26 of the survey.
	survey values	Participant response to questions about cultural values as cued by responses to #23 and #24 of the survey.
Work Environment		Descriptions of work environment, whether it is their perspective as an employee or an employer. Stories of anything that happened during their employment as an SLP, whether it is related to clinical work, cultural perspectives, or not. Includes experiences during their clinical fellowship year in their workplace.