Students with communication difficulties in master level speech-language pathology programs: prevalence academic and clinical progress and related program policies

Harold Rock Pederson

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STUDENTS WITH COMMUNICATION DIFFICULTIES IN MASTER LEVEL SPEECH-LANGUAGE PATHOLOGY PROGRAMS: PREVALENCE, ACADEMIC AND CLINICAL PROGRESS, AND RELATED PROGRAM POLICIES

By

Harold Rock Pederson

B.A., University of North Dakota, 1986

Presented in partial fulfillment of the requirements for the degree of Master of Arts

UNIVERSITY OF MONTANA

1988

Approved by:

[Signature]
Chairman, Board of Examiners

[Signature]
Dean, Graduate School

Date

December 15, 1988
This study addressed the prevalence of graduate students in speech-language pathology programs who have communication disorders or who speak English as a second language (ESL). This study also addressed the existence and components of written departmental policies regarding these students.

A questionnaire was mailed to all 160 master level speech-language pathology programs accredited by the Educational Standards Board of the American Speech-Language-Hearing Association. Ninety-eight of these programs returned the questionnaire, for a response rate of 61%. These programs reported that 3945 master level students entered their programs in the past two academic years. Sixty-one students (1.5%) were reported to have had a communication disorder and 104 students (2.6%) were reported to be ESL speakers.

When compared to the typical student enrolled in the graduate program, the majority of the communicatively disordered and ESL students were reportedly progressing at an average or a faster than average rate in both academic and clinical work. For those students who were rated, 17% progressed at slower rate in academic work and 24% progressed at a slower rate in clinical work. The data also indicated that those students with the highest severity ratings (i.e., more deviant communication pattern) progressed at a slower rate in academic and clinical work than those with milder severity ratings.

Of the 93 programs that responded to the question of written policy existence, 16 programs (17%) reported having policies regarding graduate students who have communication disorders or ESL students. Most of these 16 programs' policies had a listing of a person responsible for carrying out the policy, a section dealing with clinical assignments, a means for a student to appeal a decision, and a course of action to treat the communication problem of the student. In addition, four programs reported using the Test of English as a Foreign Language (TOEFL) as one component in the admission requirements for ESL students. Of the programs that did not have written policies, 27 programs suggested therapy for the student. Other common responses for programs without written policies included counseling, the use of the TOEFL, the importance of an acceptable communication model, and dealing with the student on a case by case basis.

Since students with communication disorders and ESL students comprise a sizable population of students in master level speech-language pathology programs, it was suggested that written policies be developed to deal with this special population. Written policies have the potential to enhance communication between faculty and students on this issue and may facilitate the student's progress through the program.
ACKNOWLEDGEMENTS

The writer wishes to thank his thesis committee, Dr. Michael K. Wynne, Dr. Donald M. Goldberg, Ms. Beverly Reynolds, and Dr. William H. McBroom, for their time and guidance concerning this study. A special thanks is due to Mike Wynne, who gave more time and effort than the author had a right to expect.
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CHAPTER 1: INTRODUCTION

If one examines the field of speech-language pathology from a historical perspective, it becomes apparent that many individuals with communication difficulties have become clinicians and researchers. Two exceptional examples were Charles Van Riper and Wendall Johnson, who were stutterers.

Clinicians working in speech-language pathology who have a communication disorder or who speak English as a second language can present advantages as well as disadvantages in their interaction with clients. One possible advantage includes their expertise or insight gathered through their own personal experience. These clinicians may also have developed greater empathy for their clients, as they share a common experience. While many of these individuals eventually resolved their speech or language difficulty, others functioned successfully in the field with no or little improvement in their communicative ability. For these clinicians, this may lead to a lack of credibility when they try to teach others what they have not mastered themselves. In addition, the communication difficulty may interfere with the therapy process itself and may reduce the cost accountability of the therapy program.

As the expertise, credibility and effectiveness of the clinician can be significantly impacted by the clinician’s communication skills, graduate training programs must consider
the viability of successfully training speech-language pathologists who have communication difficulties. The purpose of this study was to determine the prevalence of students with communication difficulties in speech-language pathology programs and these students' academic and clinical progress through their respective programs. This study also investigated both the written and unwritten policies regarding these students and how programs without policies deal with these students. This information has, to the author's knowledge, never been gathered before this study.

Russ Malone from the Public Information Division and Carl Hyman from the Demographic Office of the American Speech-Language-Hearing Association (ASHA) recently reported during a telephone interview that ASHA has not gathered information on the prevalence of students with communication difficulties in graduate programs. They also reported that ASHA does not currently have guidelines regarding the placement and training of these students once they are in graduate programs.

The lack of guidelines may be related to two factors. First, very little is known about the number and characteristics of students with communication difficulties who are in graduate speech-language pathology programs. There may be so few of these students that they do not warrant national or an individual graduate program's guidelines. Second, the lack of a standard or conventional philosophy regarding the potential and effectiveness of these students
as clinicians may pose serious questions and difficulties in designing and implementing a training program.

Information regarding the prevalence of students with communication difficulties and training programs' guidelines or policies concerning this type of student could be beneficial to several individuals. The faculty of graduate programs with students with communication difficulties clearly must decide how, and sometimes if, these students should progress through their programs. In addition, the students with a communication difficulty who are pursuing speech-language pathology as a career must decide if it is indeed realistic for them to enter a graduate program in speech-language pathology, given their communicative handicap. Finally, this information is perhaps most important to the clients, who must rely on the graduate training programs to produce competent and accountable clinicians. Quality academic and clinical training is essential. While it would be a mistake to reject the next Van Riper because the student may have a communication difficulty, it is also unwise to accept ineffective and incompetent clinicians in the profession.

Graduate education in speech-language pathology is ever-changing. Reports have indicated that fewer students are now receiving bachelor's degrees in speech-language pathology than in previous years (Cooper, Mann, Helmick, Newberry, and Ripich, 1988) and that fewer "quality" students are now
applying to graduate programs in speech-language pathology (Sarnecky, 1987). In light of these findings, students with communication difficulties should be closely examined for their potential to become competent and accountable clinicians.

**Problem and Purpose**

The purpose of this exploratory study was to determine the prevalence of graduate students in speech-language pathology programs who have a communication disorder or who speak English as a second language and these students' academic and clinical performance. This study also investigated the existence and components of written policies regarding these students. The following research questions were examined for accredited master-level programs in speech-language pathology in the United States:

1. What was the prevalence (i.e., percentage) of students with communication disorders and English as a second language speakers who were enrolled in graduate programs for the past two years?

2. How were students with communication difficulties progressing in their academic and clinical work in comparison to students without communication difficulties? Was their progress related to the type and severity of the communication difficulty?

3. What is the percentage of programs that have written policies regarding these students' training and treatment? What are the common components of the
policies? How would programs without policies deal with these students?

4. Were the programs which have recently had a relatively large number of these students more or less likely to have a written policy regarding their training and treatment? Were the programs who had students with more severe communication difficulties more or less likely to have a policy?
Numerous individuals with communication difficulties have entered the field of speech-language pathology and have overcome or compensated for their handicap. Many of these individuals were stutterers, including perhaps the most recognized expert on stuttering, Charles Van Riper. He often wrote of his own severely disfluent speech as a young adult. In a recent general textbook on speech-language pathology (1978), Dr. Van Riper described one of his silent blocks as lasting "six minutes by a classroom clock." Another example of an clinician with a communication disorder is David Daly who is a speech-language clinician with a private practice specializing in stuttering. In reporting his personal experiences, Daly (1988) wrote:

Stuttering clients whom I was treating as part of my graduate school training complained to the clinic director that my stuttering was worse than theirs. They requested (and got) a more fluent clinician.

These two examples illustrate that speech-language pathologists with communication difficulties can indeed be successful in practicing their craft. However, very little is known about who comprises this special population and how these individuals progress in their training programs. To address this issue, it is first necessary to review the prevalence of communication difficulties in the general population. Next, this review will describe the characteristics and traits of students enrolled in graduate
training programs for speech-language pathology. Finally, the discussion will conclude by addressing the rights of handicapped students, as applied specifically to students with communication difficulties.

**Prevalence of Communication Difficulties**

There have been numerous studies on the prevalence of communication disorders among the general population. The statistics reported in these studies depend on three factors: the definition of a "communication disorder", the method used to collect the data, and the population sampled. The reader is referred to Leske (1981) and Healey, Ackerman, Chappell, Perrin, and Stormer (1981) for a comprehensive summary of the literature regarding the prevalence of communication disorders among special groups and age populations. Milisen also produced a comprehensive summary of early research on the prevalence of communication disorders (Travis, 1971).

In a 1952 report, an American Speech-Language-Hearing Association (ASHA) Committee produced an often quoted estimate that 5% of the population in the United States between the ages of 5 and 21 years had "defective speech" (Shames and Wiig, 1986). The authors of this study stressed that this was a conservative estimate, and did not account for those individuals who had minor speech and voice problems.

Recently, Fein (1983) reported that just under 1% of the general population (civilian, noninstitutionalized people) have a speech and/or language impairment. Fein reported that
his estimates would be consistent with ASHA's previously reported 5% estimate if the deaf population and residents of long-term care institutions were included in his study. Fein also determined the prevalence rate of speech and/or language impairments in nine age groups. For the age range of 18-34, the "traditional" age for college students, Fein reported a prevalence rate of 0.67 to 0.69 percent for speech and language impairments.

There have been few studies specifically investigating the prevalence of communication difficulties among college students. Cooper, Parris and Wells (1974) performed a study of 7090 college freshmen at the University of Alabama-Tuscaloosa in the early 1970's. They found approximately 1% of the students evidenced a speech problem. Of these 74 students, 51% had articulation disorders, 24% had voice disorders, 16% had rhythm disorders, and 8% had unknown disorders.

Cooper's study was continued by Culton (1986) using the same methods and population. Culton found that, of the 30,586 students in the combined sample, 2.42% had disorders of articulation, voice or fluency. Of this group of 739 students, 57% had articulation disorders, 31% had voice disorders and 12% had fluency disorders. Neither Cooper or Culton included hearing or language disorders in their studies.

Shames and Wiig (1986) reported that "nearly 15,000,000 Americans have partial hearing impairments that interfere with
communication", which amounts to approximately 7% of the population. An earlier study by Punch (1983) was in close agreement with Shames and Wiig as he listed approximately 16,000,000 Americans with hearing impairments. Punch further broke down the prevalence into nine age groups. Of the college age population, 18-34 years, 2.32 to 4.29% had hearing impairments.

Language disorders among adults are more difficult to identify, unless they severely affect communication, such as with the aphasias. For this reason, studies are lacking regarding the prevalence of adults with mild and moderate language disorders, and no studies reporting the prevalence of language disorders in college students have been found by the author. As is the case with language disorders, the prevalence of English as a second language speakers among adults or college students has not been studied.

An extensive literature search indicated very little research has been directed on the prevalence of communication difficulties among the college population. There has been no clearly documented research on the prevalence of communication disorders or English as a second language speakers among students in speech-language pathology programs. In the section below, the characteristics and traits of students enrolled in graduate training programs in speech-language pathology will be discussed.
Graduate Student Characteristics

Numerous studies have addressed the personality characteristics and traits of graduate students in speech-language pathology. However, information regarding the prevalence of communication difficulties among this population has not been presented in these studies.

Flocken (1980) administered the Cattell Sixteen Personality Factor Questionnaire to 60 graduate students in speech-language pathology and discovered that they had personalities that were similar to those of other closely allied professions (e.g., elementary school teachers, nursing students). Flocken noted "one of the most striking aspect of the personality profile of the communicative disorders students was that there were no high or low scores on any of the sixteen factors studied," indicating that the students' personalities were similar to that of the general public. Flocken did find a mild tendency for the students in her study to be experimenting, assertive, reserved, bright, emotionally stable, imaginative and forthright.

Shriberg and his colleagues (Shriberg, Bless, Carlson, Filley, Kwiatkowski, and Smith, 1977) investigated the factors relating to the "clinical performance" in graduate students. They used the Wisconsin Procedure for Appraisal of Clinical Competence and clinical practicum grades to determine clinical performance. Shriberg and his colleagues found that the student's grade point average was the best predictor of
clinical performance and that the students with high grade point averages were the better clinicians in their study. Shriberg and his colleagues did not relate clinical performance to the communicative characteristics of the clinicians.

A recent study by Crane and Cooper (1983) focused on the relationship between "clinical effectiveness" and personality variables of female graduate students in speech-language pathology. They found that the "good" clinicians (as determined by supervisor ratings) had good interpersonal skills and technical skills. Crane and Cooper also found that these students had better interpersonal skills than technical skills (again, this was determined by supervisor ratings). Applying the Minnesota Multiphasic Personality Inventory, Crane and Cooper reported that the typical student tended to be passive, compliant, stereotypically feminine, sensitive, anxious, highly imaginative, creative and energetic. Some of these personality characteristics are different than those previously identified by Flocken (e.g., assertive vs. passive; reserved vs. energetic).

Legal Rights of Handicapped Students

Since public colleges and universities receive federal funding, they must comply with the laws protecting students with handicaps. This protection extends to students' acceptance into higher education programs and treatment once they are enrolled into these programs. For example, graduate
programs may not ask if a person has a handicap. This protection is offered to handicapped students by Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and the Rehabilitation Act of 1973" (University of Montana, undated). Section 504, which is a widely quoted section of the Rehabilitation Act of 1973 states:

No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal Financial Assistance.

These laws provide the legal rights of acceptance and participation to "qualified" students with handicaps, including those with communication difficulties. A clear definition of a "qualified handicapped individual" is absent from these laws. Section 504 has yet to be tested by the legal system as it applies to students with communication difficulties in speech-language pathology. It is unclear whether students with communication difficulties have the legal right to work with clients who have better communication skills than the student clinician. For example, should a clinician who speaks English as a second language be allowed to work with a child with a relatively minor articulatory problem? Although students with communication difficulties have specific legal rights, clients also deserve effective and competent treatment.
Research Summary

In performing an extensive literature search, there appeared to be nothing specific to the number of graduate students with communication difficulties in speech-language pathology or on available guidelines describing how to deal with these students. In fact, this particular population was not included in any of these studies. The ASHA national office also had no specific additional information regarding the prevalence of students with communication difficulties in graduate speech-language pathology programs, nor did they have established guidelines on how to deal with these students once they are enrolled in graduate programs.

Before it is possible to make suggestions regarding written policies, it becomes necessary to first determine the prevalence of students with communication difficulties in graduate speech-language pathology programs and how these students are progressing in academic and clinical work. Next, the existence and components of written policies and how programs without policies deal with students with communication difficulties will be examined.
CHAPTER III: PROCEDURES

Subjects

A questionnaire was mailed to all 160 U.S. speech-language pathology master’s programs accredited by the Educational Standards Board of the American Speech-Language-Hearing Association (ASHA). The programs were selected using ASHA’s most recent 1988 listing (see Appendix A).

Questionnaire/Follow-up

A cover letter explaining the purpose of the study (see Appendix B) and the questionnaire (see Appendix C) was mailed to the graduate programs in mid-August, 1988. The questionnaires were identified by the corresponding number from the list of accredited programs and no other identifying information was included on the forms. The cover letter requested that a faculty member who is the most knowledgeable about recent and current graduate students complete the questionnaire. A self-addressed postage-paid envelope was included with the questionnaire.

Approximately four weeks after the initial mailing, a follow-up letter (see appendix D), another questionnaire, and a self-addressed postage-paid envelope was mailed to all programs who had not returned the first questionnaire.

Data Analysis

Descriptive tables and frequency histograms were constructed for the questionnaire items for communicatively
disordered and English as a second language (ESL) students. Frequency counts and prevalence information were obtained for the severity rating and the academic and clinical progress for each communication disorder and ESL speaker. Also compiled were the number of written policies and the components of these policies. Chi-square statistical analysis at the alpha level of 5% (α = 0.05) was used to analyze this information. The student t-test was also used for analysis of the number of communicatively disordered and ESL students in each program and whether or not the program had a written policy.

The responses for dealing with communicatively disordered and ESL students were analyzed for similarities, using reports of the components of policies, actual policies, and responses to the question of "If you do not have a written policy, how do (or would) you deal with communicatively disordered and/or English as a second language graduate students?"

Telephone contacts were made to those programs whose respondents incorrectly completed the question regarding the number of students who have entered their program in the past two academic years. The questionnaire responses that were filled out incompletely or incorrectly were tallied as "not reported" (e.g., the existence of a written policy) or "not rated" (e.g., the severity of the communication disorder).
CHAPTER IV: RESULTS

This study addressed the prevalence of graduate students in speech-language pathology programs who have communication disorders or who speak English as a second language and these students' academic and clinical progress. This study also investigated the existence and components of written policies regarding these students and how programs without policies dealt with these students.

Of the 160 programs that received the survey, a total of 98 questionnaires were returned, leading to a response rate of 61%. Sixty-eight programs responded to the first mailing and 30 programs responded to the second mailing. All 98 questionnaires included in this study were received within 16 weeks of the first mailing and within 11 weeks of the second mailing.

Frequency and Severity

The 98 questionnaire respondents reported having 3945 students enter their masters' program pursuing a clinical degree in speech-language pathology in the past two academic years. There was a total of 61 individuals who reportedly had some form of a communication disorder and 104 English as a second language (ESL) students. This data indicates a prevalence rate of 1.5% for communicatively disordered students and 2.6% for ESL students.
Figure 1 illustrates the total number of communicatively disordered students and their severity ratings. Figure 2 illustrates this information for ESL students. This information for communicatively disordered and ESL students is also presented in Table 1. Articulation disorders were the most prevalent among the five communication disorders listed in the questionnaire, occurring in 21 students. There were 12 students with voice disorders and 11 students with fluency disorders. Six students each had language and multiple disorders, while there were 5 students in the category of hearing impaired. Sixty-six of the 98 respondents (67%) reported having had at least one communicatively disordered or ESL student enter their graduate program within the last two academic years.

When the numbers of communicatively disordered students and the ESL students are combined, 69 students (42%) of the students were in the mildest category of communication difficulty. There were consistently fewer students as the severity of the disorder increased or the degree of the unintelligibility increased. Forty-seven students (28%) were rated as having mild/moderate difficulties, 25 students (15%) were rated as having moderate difficulties, 10 students (6%) were rated as having moderate/severe difficulties, and 3 students (2%) were rated as having severe difficulties. Eleven students (7%) were not rated by their institutions.
Figure 1. Number of communicatively disorder students and their severity ratings.
Figure 2. Severity ratings for the 104 students who speak English as a second language.
TABLE 1. Number of communicatively disordered students and ESL students and their severity ratings.

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SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.

SEVERITY RATING ESL = "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.
Academic Progress

Most of communicatively disordered and ESL students reportedly progressed about average in both academic and clinical progress in relation to a "typical" student enrolled in the graduate program. The specific academic and clinical progress for each student with a communication disorder and each ESL student is presented in Appendix E.

Table 2 presents the academic progress among communicatively disordered and ESL students. Academically, 110 of these students (67%) reportedly progressed at an average rate in comparison to the typical student. Twenty-five students (15%) progressed at a faster rate academically and 27 students (16%) progressed at a slower rate academically. Three students (2%) were not rated in terms of academic progress by their institutions. Using a chi-square analysis, there was a significant difference between the observed and expected frequency of the disorder type or ESL classification and academic progress ($X^2 = 27.859$, df = 12).

All of the students with articulation and fluency disorders were reported to progress at an average rate or faster than average rate in academic work. Three of the six students with language disorders and four of the six students with multiple disorders progressed at a slower rate academically.

The data defining students' academic progress and severity of their communication difficulties are presented Table 3. When comparing academic progress with the severity of the
TABLE 2. Academic progress among communicatively disordered and English as a second language students.

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<th>Artic</th>
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<td>24</td>
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<tr>
<td>Average</td>
<td>18</td>
<td>3</td>
<td>9</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>65</td>
<td>111</td>
</tr>
<tr>
<td>Slower</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td>Not Rated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>6</td>
<td>11</td>
<td>12</td>
<td>5</td>
<td>6</td>
<td>104</td>
<td>165</td>
</tr>
</tbody>
</table>

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**TABLE 3. Students' academic progress and severity of their communication difficulties.**

<table>
<thead>
<tr>
<th>ACADEMIC PROGRESS</th>
<th>SEVERITY OF DIFFICULTY</th>
<th>No Rating</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;1&quot;</td>
<td>&quot;2&quot;</td>
<td>&quot;3&quot;</td>
</tr>
<tr>
<td>Faster</td>
<td>15</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>49</td>
<td>34</td>
<td>14</td>
</tr>
<tr>
<td>Slower</td>
<td>3</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Not Rated</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>47</td>
<td>25</td>
</tr>
</tbody>
</table>

**SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.**

**SEVERITY RATING ESL = "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.**
disorder or the intelligibility of the ESL speaker, students’
progressed slowed as the severity rating increased.
Significant differences were seen between the observed and
expected frequencies of the students’ academic progress as a
function of severity of their difficulties ($X^2 = 26.777$, df =
8). Of the students who were assigned a severity rating, 15
students (22%) who fell within the mildest severity rating
progressed faster in terms of academic progress than other
communicatively disordered and ESL students. Only three
students (4%) who fell within the mildest severity rating
progressed slower than the typical student.

When compared to mildly communicatively disordered
students and completely intelligible ESL students, the
academic progress was slower for communicatively disordered
students who were rated as having moderate, moderate/severe,
and severe communication disorders and ESL students who were
rated as being moderately, moderately/severe, and severely
unintelligible than it was for the typical student. Fourteen
of the 38 students (37%) in these categories progressed slower
than the typical student, while only one student (3%)
progressed faster than the typical student.

Clinical Progress

Table 4 presents the clinical progress among
communicatively disordered and ESL students. For clinical
work, 97 communicatively disordered and ESL students (59%)
reportedly progressed at an average rate in comparison to the
TABLE 4. Clinical progress among communicatively disordered and English as a second language students.

<table>
<thead>
<tr>
<th>CLINICAL PROGRESS</th>
<th>Artic</th>
<th>Lang</th>
<th>Fluen</th>
<th>Voice</th>
<th>Hear</th>
<th>Multi</th>
<th>ESL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faster</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Average</td>
<td>16</td>
<td>4</td>
<td>9</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>56</td>
<td>97</td>
</tr>
<tr>
<td>Slower</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>25</td>
<td>35</td>
</tr>
<tr>
<td>Not Applic.</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Not Rated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>6</td>
<td>11</td>
<td>12</td>
<td>5</td>
<td>6</td>
<td>104</td>
<td>165</td>
</tr>
</tbody>
</table>
typical student. Sixteen students (10%) progressed at a faster rate while 35 students (21%) progressed at a slower rate. Fourteen students (8%) were reported to have not yet doing clinical work and 3 students (2%) were not rated in terms of their clinical progress. Using a chi-square analysis, there was not a significant difference between the observed and expected frequency of the type of communication difficulty and the students’ clinical progress ($X^2 = 12.683$, $df = 12$). Only two of the 21 students (10%) with articulation disorders progressed slower than the typical student. Of the students who were rated, two of the four language disordered students (50%) and two of the four multiply disordered students (50%) progressed slower than the typical student in clinical work.

The data defining students’ clinical progress and severity of their communication difficulties are presented in Table 5. Students who had communication disorders and ESL students progressed at a significantly slower rate in their clinical work than the typical student as the severity of the disorder increased ($X^2 = 30.391$, $df = 8$). Of the 64 students who were rated for clinical progress and assigned the mildest severity rating, 13 students (20%) progressed faster, 48 students (75%) progressed average, and 3 students (5%) progressed slower than the typical student. Students with the more severe disorders or who were more unintelligible progressed at a slower rate in clinical work than those.
TABLE 5. Students’ clinical progress and severity of their communication difficulties.

<table>
<thead>
<tr>
<th>CLINICAL PROGRESS</th>
<th>SEVERITY OF DIFFICULTY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;1&quot;</td>
</tr>
<tr>
<td>Faster</td>
<td>13</td>
</tr>
<tr>
<td>Average</td>
<td>48</td>
</tr>
<tr>
<td>Slower</td>
<td>3</td>
</tr>
<tr>
<td>Not Applic.</td>
<td>3</td>
</tr>
<tr>
<td>Not Rated</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
</tr>
</tbody>
</table>

SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.

SEVERITY RATING ESL = "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.
students who were assigned a mild severity rating. This group included the communicatively disordered students who had a severity rating range of from mild/moderate to severe and the ESL students who had a severity rating range from mild to severe. From this group of 73 students, only 3 students (4%) progressed faster, while 41 students (56%) progressed average, and 29 students (40%) progressed slower than the typical student.

Written Policies

Of the 98 programs that responded to the study, 16 programs (16%) reported that they have a written policy regarding graduate students who have communication disorders or who speak English as a second language. Seventy-seven programs (79%) reported that they did not have a written policy and five (5%) programs did not respond to the question.

Of the 16 programs who reportedly had a policy, six programs provided copies of their policy, as was requested in the questionnaire. These policies are presented in Appendix F. The written policies varied in length from two sentences to full pages which included detail about communication requirements, therapy suggestions, and the right of the student to appeal a decision.

For the 16 programs with a written policy, the respondents were asked to indicate the components of their policies from a list of six possible choices listed in the questionnaire. Table 6 lists the six possible choices of
TABLE 6. The six possible choices of components as listed in the questionnaire and the frequency of "yes" responses for the 16 programs with a written policy.

<table>
<thead>
<tr>
<th>POLICY COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FREQUENCY &quot;YES&quot;</td>
</tr>
<tr>
<td>1. Operational definition of &quot;communication disorder&quot;</td>
</tr>
<tr>
<td>2. Listing by departmental position designating who can make decisions about the student's academic and clinical progress</td>
</tr>
<tr>
<td>3. Section dealing specifically with practicum assignments</td>
</tr>
<tr>
<td>4. Means to dismiss the student with a communication disorder from your program</td>
</tr>
<tr>
<td>5. Means for the student to appeal a decision</td>
</tr>
<tr>
<td>6. Course of action to treat the communication problem of the student</td>
</tr>
</tbody>
</table>
components as listed in the questionnaire and the frequency of "yes" responses for the 16 programs that reported having policies.

In Appendix G are the responses of eight programs who responded to the request to list other components of their written policy. In these eight responses, the Test of English as a Foreign Language (TOEFL) was listed as being a part of admission requirements by four programs. Other responses included the option of non-clinical tracks for ESL students, denial of clinical practicum until the communication difficulty is remediated, and the consideration of personality characteristics as a basis for counseling and dismissal.

For the programs that did not have a written policy, the respondents were asked: "How do (or would) you deal with communicatively disordered and/or English as a second language graduate students?" Seventy-two programs responded to this question. Twenty-seven respondents stated that they suggested or required therapy for their students with communication disorders and ESL speakers. Six programs only indicated therapy as the way to deal with these students. "Counseling" was included in the responses by 12 programs and the use of the TOEFL for ESL students was included by 5 programs. The importance of an acceptable model (i.e., ability to produce the target behavior for the client) was included in five responses. Finally, there were 12 short answers to this question which indicated that the faculty would deal with the
communicatively disordered and ESL student individually or on a case by case basis. Appendix H presents the responses to this question.

The number of communicatively disordered and ESL students in each program and whether or not the program had a written policy is presented in Table 7. As measured by the t-test, there was not a significant difference between the observed and expected frequencies of the number of these students in master level programs and whether or not the program had a written policy \( (t = 0.359) \).

The most severe communication disorder or the poorest ESL rating was tallied for each program with and without a written policy. The highest severity rating for the students in each program and whether or not the program had a written policy is presented in Table 8. Using a chi-square analysis, there was not a significant difference between the observed and expected frequency of the severity of the communication disorder or the intelligibility of the ESL students' speech and the existence of written policies \( (X^2 = 3.225, df = 4) \).

Forty-two programs requested a summary of the results of this study. The cover letter for this mailing is included in Appendix I and the summary is included in Appendix J.
TABLE 7. The number of communicatively disordered and ESL students in each program and whether or not the program had a written policy.

<table>
<thead>
<tr>
<th>POLICY?</th>
<th>NUMBER OF STUDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 Total</td>
</tr>
<tr>
<td>Yes</td>
<td>6 2 2 2 2 2 0 0 0 0</td>
</tr>
<tr>
<td>No</td>
<td>22 24 14 6 3 4 2 1 0 1</td>
</tr>
<tr>
<td>Not Stated</td>
<td>4 0 0 0 1 0 0 0 0 0</td>
</tr>
<tr>
<td>Total</td>
<td>32 26 16 8 6 6 2 1 0 1</td>
</tr>
</tbody>
</table>
TABLE 8. The highest severity rating for the students in each program and whether or not the program had a written policy.

<table>
<thead>
<tr>
<th>POLICY?</th>
<th>&quot;1&quot;</th>
<th>&quot;2&quot;</th>
<th>&quot;3&quot;</th>
<th>&quot;4&quot;</th>
<th>&quot;5&quot;</th>
<th>No Rating</th>
<th>N.A.*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>20</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>22</td>
<td>77</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>26</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>32</td>
<td>98</td>
</tr>
</tbody>
</table>

SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.

SEVERITY RATING ESL = "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.

*N.A.* = No communicatively disordered or English as a second language students in program.
CHAPTER V: AD HOC ANALYSIS

Using chi-square analysis, the academic and clinical progress as it relates to written policy existence or non-existence was examined. A significant difference was found between the observed and expected frequencies of academic progress ($X^2 = 7.032$, df = 2), but not for clinical progress ($X^2 = 2.425$, df = 2). Table 9 presents the academic progress among students with communication disorders and ESL students in each program and whether or not the program had a written policy. Table 10 presents this information for clinical progress.

For academic work, a larger proportion of communicatively disordered and ESL students progressed faster than would be expected for the programs with policies. The opposite was true for the programs without policies, where a smaller proportion of students progressed faster than would be expected. There was an expected number of students who progressed average and slower than average in academic work for programs both with and without policies.

Two possible reasons may account for these differences in the students' academic work. First, it may be that those programs with policies limit communicatively disordered and ESL students' enrollment, and therefore accepting only the "best" students (e.g., those with high grade point averages). Secondly, it was shown that more communicatively disordered
TABLE 9. Academic progress among students with communication disordered and ESL students in each program and whether or not the program had a written policy.

<table>
<thead>
<tr>
<th>POLICY?</th>
<th>ACADEMIC PROGRESS</th>
<th>Not Rated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Faster</td>
<td>Average</td>
<td>Slower</td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>92</td>
<td>23</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>111</td>
<td>27</td>
</tr>
</tbody>
</table>
TABLE 10. Clinical progress among students with communication disordered and ESL students in each program and whether or not the program had a written policy.

<table>
<thead>
<tr>
<th>POLICY?</th>
<th>CLINICAL PROGRESS</th>
<th>Faster</th>
<th>Average</th>
<th>Slower</th>
<th>Not Applic.</th>
<th>Not Rated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>5</td>
<td>15</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>11</td>
<td>79</td>
<td>27</td>
<td>13</td>
<td>1</td>
<td>131</td>
</tr>
<tr>
<td>Not Stated</td>
<td></td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>16</td>
<td>97</td>
<td>35</td>
<td>14</td>
<td>3</td>
<td>165</td>
</tr>
</tbody>
</table>

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and ESL students were progressing slower in clinical work than they were in academic work. Thus, if the student is restricted from doing clinical work, he or she may be able to devote more time to academic work and, as a result, progress faster than the typical student in academic work.

There were 14 students who were reported not yet doing clinical work. Table 11 presents information on the number of students who were not yet doing clinical work and those students who were doing clinical work as listed by the severity of their communicative difficulty. Of the students with communication disorders rated as having mild or mild/moderate disorders and the ESL student rated as being completely intelligible or mildly unintelligible, only 3 of the 114 students (3%) were not yet doing clinical work. Of the students with communication difficulties of a severity greater than this, 11 of the 37 students (30%) were not yet doing clinical work.

In simpler terms, a larger proportion of students with relatively severe communication difficulties were not doing clinical practicum when compared to those students with lesser communication difficulties ($X^2 = 25.099$, df = 4). This pattern suggests that those students with conspicuous communication difficulties may be denied clinical practicum until they can improve or normalize their communicative skills. Conversely, it could be that these students improve their communication skills as they advance in the program, so
### TABLE 11. Number of students who were not yet doing clinical work and those students who were doing clinical work as listed by the severity of their communicative difficulty.

<table>
<thead>
<tr>
<th>DOING CLINICAL WORK?</th>
<th>&quot;1&quot;</th>
<th>&quot;2&quot;</th>
<th>&quot;3&quot;</th>
<th>&quot;4&quot;</th>
<th>&quot;5&quot;</th>
<th>No Rating</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>64</td>
<td>47</td>
<td>17</td>
<td>7</td>
<td>2</td>
<td>11</td>
<td>148</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Not Stated</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>47</td>
<td>25</td>
<td>10</td>
<td>3</td>
<td>11</td>
<td>165</td>
</tr>
</tbody>
</table>

**SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.**

**SEVERITY RATING ESL = "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.**
that the "newer" students in the program are not yet doing clinical work because they were not at the stage of doing clinical work.
CHAPTER VI: DISCUSSION

This study addressed the prevalence of graduate students in speech-language pathology programs who have communication disorders or who speak English as a second language (ESL) and these students' academic and clinical progress. This study also investigated the existence and components of written policies regarding these students and how programs without policies dealt with these students.

Review of Findings

A total of 98 of the 160 U.S. programs accredited by the Educational Standards Board returned questionnaires. From a reported total of 3945 master level students in speech-language pathology programs in the past two years, 61 students (1.5%) had communication disorders and 104 students (2.6%) were ESL speakers. Students in the two mildest severity ranges composed 75% of all the students who were assigned a severity rating.

Academically, roughly two-thirds of the communicatively disordered and ESL students were reportedly progressing at about the same rate as the "typical" student enrolled in the respondents' programs. The other third of these students were nearly equally divided between those who progressed faster than the typical student and those who progressed slower than the typical student. Clinically, 59% of the students progressed at the same rate as the typical student. Ten
percent of these students progressed faster and 21% progressed slower than the average student in clinical work. The remaining students were either not yet involved in clinical work or their clinical progress was not rated.

Sixteen of the 98 programs reported having written policies regarding students with communication disorder and/or ESL speakers. Most of these 16 programs had a person responsible for making decisions regarding the student, a section dealing with practicum assignments, a means for the student to appeal a decision, and a plan of treatment. Many of the 77 programs without written policies suggested or required therapy and/or counseling for the student. Five programs did not respond to this question.

A greater number of students than expected progressed faster in academic work for programs with written policies, although the same was not true for clinical work. There was a larger proportion of students with relatively severe communication difficulties who were not yet doing clinical work, when compared to those students with lessor communication difficulties.

Comparison to Previous Research

Table 12 provides the reported prevalence rate of students with communication disorders in previous studies in comparison to the current study. The prevalence rate of communication disorders in this study (1.5%) was greater than Fein's 1983 estimate of approximately 0.68% of the college age
TABLE 12. Reported prevalence rate of students with communication disorders in previous studies in comparison to the current study.

<table>
<thead>
<tr>
<th>STUDY</th>
<th>POPULATION</th>
<th>PREVIOUS STUDIES</th>
<th>CURRENT STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fein (1983)'</td>
<td>Speech and/or Language Impairments</td>
<td>0.68%</td>
<td>1.42%</td>
</tr>
<tr>
<td>Culton (1986)</td>
<td>Articulation, Voice, or Fluency Disorders</td>
<td>2.42%</td>
<td>1.12%</td>
</tr>
<tr>
<td>Culton (1986)</td>
<td>Articulation Disorders Among the Disordered Group</td>
<td>56.70%</td>
<td>47.72%</td>
</tr>
<tr>
<td>Culton (1986)</td>
<td>Fluency Disorders Among the Disordered Group</td>
<td>12.44%</td>
<td>25.00%</td>
</tr>
<tr>
<td>Culton (1986)</td>
<td>Voice Disorders Among the Disordered Group</td>
<td>30.86%</td>
<td>27.27%</td>
</tr>
<tr>
<td>Punch (1983)</td>
<td>Hearing Impaired</td>
<td>2-4%</td>
<td>0.13%</td>
</tr>
</tbody>
</table>
population as having speech and/or language impairments. Fein did not include hearing impaired individuals in his study. When subtracting the number of students with hearing impairments (5) in this study, the prevalence rate for communication disorders becomes 1.42%, which is still two times larger than Fein’s 0.68% estimate.

Culton (1986) found 2.42% of college freshman at the University of Alabama - Tuscaloosa exhibited articulation, voice, or fluency disorders. This study found that 1.12% of the graduate students in speech-language pathology (or about half Culton’s estimate) had one or more of these disorders. This study also found a different proportion of articulation, voice, and fluency disorders than Culton found in his recent study. Of the students with communication disorders, Culton found that 57% had articulation disorders, 12% had fluency disorders, and 31% had voice disorders. The percentages for these three disorders in this study were: 48% articulation disorders, 25% fluency disorders, and 27% voice disorders.

The five hearing-impaired subjects in the current study accounted for 0.13% of the students in graduate speech-language pathology programs. This prevalence level is much less than Punch’s (1983) estimate of approximately 2-4% of the college age population as having hearing impairments.

There were several differences between this study and previous research which may account for the variation in findings. The studies included in the literature review often
used different definitions of a "communication disorder", which did not include language disorders and hearing impairment. They also used personal interviews to collect data on the frequency of communication disorders, whereas this study used questionnaire sampling of faculty members.

Probably the most relevant difference between this study and previous research on the prevalence of communication disorders was the population sample. This study sampled a very select group of individuals, namely master level students in accredited speech-language pathology programs. Students with communication disorders or ESL speakers may be naturally drawn to study speech-language pathology due to their history of past communication difficulties and their previous experience with speech-language clinicians. These students may enter the field not only to learn about their own communication difficulties, but also to learn how to identify and treat others who share these difficulties.

Conversely, other students with communication disorders or ESL speakers may not even consider studying speech-language pathology because of the belief that they cannot compete in a profession that teaches what they themselves, as clinicians, have not mastered. These students may not enroll in speech-language pathology courses because they feel self-conscious or helpless regarding their own communication difficulty, thus believing they don't belong in the profession.
Academic Progress

As a group, ESL students and students with articulation, fluency, voice, and hearing disorders generally progressed at about the same rate as the typical student in their academic work. A relatively large proportion of language disordered (three of the six students) and multiply disordered students (four of the six students) progressed slower than the typical student. Because of the small sample of these students, the following interpretations of these results may not apply to most students with language disorders and with multiple disorders.

The students with language disorders may have had difficulty understanding class lectures or understanding the reading material. These students may have also encountered problems in expressing themselves, as would be required on written tests. Therefore, difficulty with either language comprehension or expression may have led to slower academic progress.

Slow academic progress among students with multiple disorders may be due to difficulties encountered in competing in a world with normal communicators, leading to a sense of isolation and a lack of reinforcement from peers. These students may be motorically handicapped, making their progress that much more difficult. Students with multiple disorders may also encounter more resistance from faculty, who may feel that such students do not belong in a profession that
emphasizes normal communicative function. This pressure and lack of reinforcement may decrease the student’s motivation to do well, therefore slowing his or her academic progress.

Twenty-two percent of the students with the mildest severity rating reportedly progressed faster than the typical student in academic work, while only 4% of these students progressed slower. Students with the more severe communication difficulties consistently progressed slower in academic work. Therefore, those students with the mildest severity rating can generally be expected to progress through the graduate programs in speech-language pathology at an average or a faster than average rate in academic work, as was the case with 96% of the students in this study.

Thirty-seven percent of the students who were rated as having moderate to severe communication disorders or as being moderately to severely unintelligible (for ESL students) were rated as progressing slower than the typical student in academic work. These students may have progressed slower in academic work because they needed to devote time and energy towards improving their own communication skills. The handicap may have directly interfered with academic work (e.g., an ESL student having reading difficulties). Also, these students may have encountered resistance from the faculty regarding their potential to become competent clinicians, adding stress and decreasing their motivation to perform well in academics.
Clinical Progress

Most students included in this study progressed at an average rate or faster than average rate in clinical work, although more students encountered difficulty than was the case with academic work. Of the students who were rated, two of the four language disordered students (50%) and two of the four multiply disordered students (50%) progressed slower than the typical student in clinical work. Because of the relatively small number of students with these communication disorders in this study, the results may not generalize to other students with these communication difficulties.

The students with communication difficulties who progressed slower in clinical work than the typical student may have done so for many of the same reasons these students encountered greater difficulties in their academic work. The students' communication problem may have lead to poor clinical progress because of a sense of isolation, lack of reinforcement from peers, or resistance from faculty members. Also, the students with communication difficulties who progressed slower than the typical student may have been less adept in working with clients who have encountered similar communication difficulties.

Just as with academic work, a large proportion of the students with the mildest severity rating progressed at an average or faster than average rate in clinical work. Of the students who were rated, twenty percent of the students with
the mildest severity rating reportedly progressed faster than the typical student in clinical work, while only 5% of these students progressed slower. Students with mild severity ratings can generally be expected to progress through graduate programs in speech-language pathology at an average or a faster than average rate in clinical work, as was the case with 95% of the students in this study.

As was the case with academic work, students with the more severe disorders or lessened intelligibility consistently progressed slower in clinical work. Of the students who were rated, Forty percent of the students who were rated as having greater than a mild communication disorder or as being less than completely intelligible (for ESL students) were judged as progressing slower than the typical student in clinical work. These students may have progressed slower because of their difficulties in teaching what they themselves had not mastered. These students may also have lacked some credibility in working with clients, in addition to difficulty in establishing rapport and providing the client with a normal communication model. If this did occur, the faculty may have resisted or refused to assign them clients until they improved their own communicative abilities. These students may also have experienced added stress in working towards their graduate degree because of non-acceptance by the faculty. This stress may have made the student overly self-conscientious, thus negatively affecting clinical work.
Written Policies

There was not a significant difference between the observed and expected frequencies of programs having policies and the number of communicatively disordered students or ESL students in the programs. In addition, there was not a significant difference between the observed and the expected frequencies of policy existence and the most severely rated communicatively disordered student or poorest ESL rated student that the program attracted. Therefore, the programs which attracted the greatest number of students with a communication disorder and ESL students or which attracted the students with the most severe communication difficulties were not more or less likely to have a policy.

In the past two academic years, students with communication disorders and ESL students comprised just over 4% of the students of 98 accredited master level programs in speech-language pathology that responded to the questionnaire. Assuming the programs that returned the questionnaire are representative of the 160 accredited programs in the United States, these students merit special attention. The majority of speech-language pathology graduate programs do not have policies, despite two-thirds of the accredited master level programs reported having had at least one communicatively disordered or ESL student in the past two years.

For the programs without a written policy, it was frequently reported that students with communication disorders
and ESL students are handled on a "case by case" basis. This has the advantage of considering the unique characteristics of the student and his or her communicative abilities. A problem does exist, though, with the expectations that are formed both by the communicatively disordered student or ESL student and the faculty. The faculty may feel that the student's communication skills are not adequate to work with some (or perhaps even most) clients, although the student may be unaware of these concerns. The students with severe communication difficulties may form unrealistic employment expectations.

Establishing written guidelines regarding communicatively disordered and ESL students can help facilitate mutual faculty and student understanding by opening up communication channels between the individuals. A written policy can serve as the foundation for the discussion of the communication difficulties posed by the student. With this foundation, the faculty can state what they expect of the student's communication proficiency and/or improvement desired. When a student knows what is expected, he or she can move towards making changes to satisfy departmental requirements. If there are different expectations, the student and faculty can discuss their disagreement further.

Discussion of this issue between students and faculty can facilitate the student's progress through graduate school by setting up a course of action to treat the communication
difficulties of the student. A student who could benefit from therapy may not participate in therapy unless otherwise prompted to do so by the faculty. Some students may benefit from course work which is not required for a speech-language pathology degree (e.g., a basic class in English for an ESL student). Additional tutoring or assignments may benefit some communicatively disordered and ESL students to the point where they could effectively work on their own communication difficulty.

**Suggested Policy Components**

Based on the responses to the questionnaire, the following items were chosen as being important components of a policy regarding students with communication difficulties. This list was compiled using the components of the six policies which were submitted with the returned questionnaires and the responses to the last question on the questionnaire ("If you do not have a policy, how do (or would) you deal with communicatively disordered and/or English as a second language students?"). Table 13 lists suggested written policy components for students with communication disorders and students who speak English as a second language.

A definition of which communication difficulties the policy will cover is considered important. ESL speakers and individuals with articulation, language, fluency, voice, and hearing disorders should, by the very nature of their speech characteristics, be included in the policy. It is less clear
TABLE 13. Suggested written policy components for students with communication disorders and/or who speak English as a second language.

1. Definition of which communication difficulties the policy covers.
2. Specifying who will be responsible for defining the presence and character of the communication difficulty.
3. Explanation of what will be required of the student with the communication difficulty or ESL student for successful program completion.
4. Listing by departmental position of who will be responsible for insuring policy will be carried out.
5. Specification of special considerations and/or restrictions for the student with a communication difficulty.
6. Plan of remediation for the communication difficulty, if applicable.
7. Procedure to deal with students who cannot meet the departmental communicative standards.
8. Means for the student to appeal a decision.
9. Maintain the students' legal rights.
10. Flexibility in the policy to allow the faculty to consider the unique characteristics of the student and his or her communicative abilities.
if handicaps which are not purely communicative in nature should be included in policies. These may include emotional problems, learning disabilities, cerebral palsy, and severe visual problems. These handicaps have the potential to affect the clinical interaction, though in different ways. These handicaps may not prevent the clinician from providing the client with an acceptable communication model, but may limit therapy materials that could be used or may cause the client some initial discomfort.

The policy should specify who will be responsible for defining the presence and character of the communication difficulty. Since students with communication difficulties are enrolled in a program where they are required to meet the departmental standards, it would seem appropriate that their communication skills would be assessed "in house" by the faculty, who will likely be the final authority on the students' standing in the program.

Another seemingly important component of a written policy is an explanation of what will be required of the communicatively disordered or ESL student for successful program completion. This may include achieving changes in communication function that ranges from normal function to minimal improvement to just the expectation of effort on the part of the student to improve his communication skills. Normal communicative function cannot realistically be expected for all individuals. It may be best to require either
improvement or have a non-clinical degree option for these students. It seems reasonable to be able to extend the time needed for a communicatively disordered or ESL student to meet departmental standards, although time limits may need to be imposed for some students.

The written policy should also contain a listing by departmental position of who is responsible for insuring the policy will be carried out for these students. Obviously, if a program is going to have a policy, one must decide who is going to be responsible for implementation and execution. The student’s advisor and the departmental chair would seem best to shoulder that responsibility.

It seems important to specify special considerations and/or restrictions that will be extended to the communicatively disordered and/or ESL student in the written policy. These may include special client assignments and/or practicum restrictions, therapy offered at a reduced cost or at no charge, or the use of tutors and/or speech aids.

If applicable, the written policy should contain a plan of remediation for the communication difficulty. With some communication difficulties, (e.g., hearing impairment) the student may already be functioning at or near their full potential and as a result additional intervention would not provide sufficient benefits to justify its cost. However, most students with communicative difficulties would likely receive benefit from some sort of intervention, such as
enrollment in therapy, consultation with a faculty who is an expert on the communication difficulty, or the additional requirement of course work (e.g., an English class for an ESL student).

The written policy should also have a procedure to deal with students who cannot meet the departmental communicative standards. This may include offering an alternative degree (e.g., a non-clinical degree) or counseling the student to withdraw from the program. For those students who wish to continue to pursue a clinical degree despite departmental recommendations, the faculty could deny them clinical work until they meet the departmental communication standards.

A means for the student to appeal a decision made by the faculty should be included as a part of the policy. A democratic policy necessitates an appeals process, and this may include giving the student a chance to speak to the faculty, either in person or through his or her advisor. The faculty could then vote on how to deal with the individual circumstances of the student.

In some cases, the student may not agree with the final decision of the faculty and seek advice of a higher authority outside the department, such as the university’s legal counsel. Speech-language pathology programs should devise their written policy with this in mind so as not to violate the students’ legal rights. At this time, the authors of the policy can, at best, avoid blatantly violating the students’
legal rights. Since it remains unclear as to exactly what rights a student with a communication difficulty has in speech-language pathology programs, the authors of the written policy may choose to be conservative in devising their written policy and not automatically exclude these students from any part of their program.

Additionally, it is desirable to have some flexibility in the written policy for dealing with the communicatively disordered and ESL student. Although it is possible to outline basic procedures, some flexibility in policy implementation allows the faculty to consider the unique characteristics of the student and his or her communicative abilities.

Study Limitations

Information was not obtained on the progress of graduate students without communication difficulties in this study. In all graduate programs, there will students with normal communicative abilities who progress slower and those who progress faster in academic and clinical work than the typical student. As a whole, the communicatively disordered and ESL students in this study may have progressed at a similar rate in academic and clinical work as those students without communication disorders and who speak English as their primary language. Therefore, it is unclear if a similar proportion of "normal" students would progress as the communicatively disordered and ESL students in this study.
Due to the relatively small numbers of students within each category of communication disorders, it remains to be seen whether these students are typical of other students with these same communication disorders. It is possible that the students rated clinically and academically in this study are not representative of the other students with the same disorder. For ESL students, who numbered 104 in this study, this may not pose any problems due to the large sample group. It appears then that most ESL will progress at an average or faster than average rate in both academic and clinical work, with the students who are rated as being more severely unintelligible exhibiting greater difficulty in both academic and clinical work.

As with all survey research, there is the danger that the sample is not representative of the population. Programs may have been more or less likely to respond based on their experiences with students with communication disorders and students who speak English as a second language.

Reliability may come into question in a survey such as this, where there may be disagreement among faculty members regarding which students are identified as having communication difficulties, the students’ severity rating, and judgements on their academic and clinical progress. Three programs responded to both the initial and second mailing, with each questionnaire from the same program completed in different hand writing. With two of these programs, neither
of the two respondents listed having any communicatively disordered or ESL students in their program in the past two academic years. The initial respondent for the third program listed only having one of these students (a student with a mild fluency disorder). The second respondent for the third program also listed having one of these students, but with a different communication difficulty (an ESL student who was mildly unintelligible). As suggested previously, a policy may remedy this problem by forcing faculties to look more closely at students in their program with communication difficulties and evaluate the students' communication competence.

There may also have been reliability problems with responses to the question of the total number of master level students who had entered speech-language pathology programs in the past two academic years. None of the three programs who responded to both the initial and second mailing responded with the same number of students. The initial responses from the three programs were "71", "35", and "0." (The "0" was probably an incorrect interpretation of this question where the respondent replied with the number of communicatively disordered or ESL students enrolled in the past two academic years.) The second responses from the same three programs, the responses were "45", "40", and "25", respectively. Only one of the three programs who submitted two questionnaires came close to agreeing on the total number of students who had entered their program in the last two academic years.
In some cases, the total number of students in master level programs in this study may have been inflated due to incorrect responses to this first question on the questionnaire. The author made telephone contact with 18 graduate programs who did not answer this question or answered by recording the number of communicatively disordered and ESL students. These informants often responded to this question by adding together their total enrollment for the previous two academic years, instead of just including the total number of students who had entered their program during these two years. There were 27 programs that reported having 50 or more students enter their program in the past two academic years, with the range extending up to 90 students.

Given that some programs misinterpreted this question and reported having had more students enter their program than there actually were, the prevalence rates presented here are a low estimate. Thus the consequences of the findings of this study may be even more important, given that there may be an even larger proportion of master level students with communication disorders and ESL students in speech-language pathology programs than this study found.

Further Research

Further research in this area should seek to narrow the focus of the findings in this study. Additional information is desired on students with communication disorders and ESL students regarding reasons for faster or slower academic and
clinical progress. Although information was obtained on how these students progress in academic and clinical work, it is not known why they perform as they do. The reasons for differences in progress may include characteristics of the communication difficulty, such as poor comprehension for a student with a language disorder. Differences in progress may also be due to personality characteristics, motivation, or reinforcement by faculty members and fellow students.

Information regarding how students with communication disorders and ESL students function once they enter the work force would also be useful. This would help determine how these students should be dealt with in graduate speech-language pathology programs. If they perform satisfactorily, as have many of the well-respected individuals identified at the beginning of this study, programs may adopt more liberal standards regarding the students' progress through the program. If these students encounter difficulties in their professional work, then the reasons for these difficulties could be explored, and possible ways to alleviate these future problems could be addressed in the graduate program's policy.

The reasons for developing written policies could also be investigated, as could the policies' effectiveness in dealing with communication disorders and ESL students. The existing policies could be rated on a continuum such as "restrictive" (e.g., preventing communicatively disordered students from obtaining a degree) to "facilitative" (e.g.,
enhancing the chances for success in obtaining a degree) to the students' academic and clinical progress. Future research may focus on identifying those policy components which are particularly effective and those components which are deemed unnecessary.

Further research may also address the related issue of non-standard dialects. In many ways, a student with a non-standard dialectal may be similar to the ESL student. Having a non-standard dialect for a given region of the country can call attention to the speaker, and has the potential to affect the clinical process.

Conclusions

Compared to the typical student, the majority of the communicatively disordered and ESL students were reportedly progressing at an average rate in both academic and clinical work. Overall, there were more students who progressed at an average or a faster rate in academic work than there were who progressed at similar rates in clinical work. Those students with the highest severity ratings (i.e., more deviant communication pattern) tended to progress significantly slower in academic and clinical work than those with milder severity ratings.

Of the 93 programs that responded to the question, only 16 programs (17%) reported having written policies regarding graduate students who have communication disorders or ESL students. Since these students comprise 4% of the students
in master level speech-language pathology programs, they merit special attention. A written policy for students with communication disorders and ESL speakers may facilitate a mutual understanding between faculty and students as well as assist the student's progress toward his or her goal of obtaining an advanced degree in speech-language pathology.

Further research is needed to investigate why some communicatively disordered and ESL students progress slower or faster than the typical student. Research is also lacking on the effectiveness of practicing speech-language clinicians with communication difficulties. Additionally, the effect of written policies on communicatively disordered and ESL students could be investigated.

Students with communication disorders and those who speak English as a second language compose a sizable portion of master level students in speech-language pathology. Given the importance of service to those individuals with communication handicaps, the population of students with communication difficulties should be closely examined to assist them to help others. Written policies are a step in this direction.
REFERENCES


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APPENDIX A

Listing of the 160 accredited programs in speech-language pathology.

1. Alabama - Auburn University
2. Alabama - University of Alabama
3. Alabama - University of Montevallo
4. Alabama - University of South Alabama
5. Arizona - Arizona State University
6. Arizona - University of Arizona
7. Arkansas - University of Arkansas-Fayetteville
8. Arkansas - University of Arkansas-Little Rock
9. Arkansas - University of Central Arkansas
10. California - California State University-Chico
11. California - California State University-Fresno
12. California - California State University-Fullerton
13. California - California State University-Long Beach
14. California - California State University-Los Angeles
15. California - California State University-Northridge
16. California - California State University-Sacramento
17. California - California State University-Stanislaus
18. California - San Diego State University
19. California - San Francisco State University
20. California - San Jose State University
21. California - University of California-Santa Barbara
22. California - University of the Pacific
23. Colorado - Colorado State University
24. Colorado - University of Colorado
25. Colorado - University of Northern Colorado
27. Connecticut - University of Connecticut
29. District of Columbia - Howard University
30. District of Columbia - Univ. of District of Columbia
31. Florida - Florida State University
32. Florida - University of Central Florida
33. Florida - University of Florida
34. Florida - University of South Florida
35. Georgia - University of Georgia-Athens
36. Hawaii - University of Hawaii
37. Idaho - Idaho State University
38. Illinois - Eastern Illinois University
39. Illinois - Governors State University
40. Illinois - Illinois State University
41. Illinois - Northern Illinois University
42. Illinois - Northwestern University
43. Illinois - Southern Illinois Univ. at Edwardsville
44. Illinois - Southern Illinois University-Carbondale
45. Illinois - University of Illinois-Urbana-Champaign

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46. Illinois - Western Illinois
47. Indiana - Ball State University
48. Indiana - Indiana State University
49. Indiana - Indiana University
50. Indiana - Purdue University
51. Iowa - University of Iowa
52. Iowa - University of Northern Iowa
53. Kansas - Fort Hays State University
54. Kansas - Kansas State University
55. Kansas - University of Kansas
56. Kansas - Wichita State University
57. Kentucky - Eastern Kentucky University
58. Kentucky - Murray State University
59. Kentucky - University of Kentucky
60. Kentucky - University of Louisville
61. Louisiana - Louisiana State University
62. Louisiana - Louisiana State University Medical Center
63. Louisiana - Louisiana Tech University
64. Louisiana - University of Southwestern Louisiana
65. Maryland - University of Maryland
66. Massachusetts - Boston University
67. Massachusetts - Emerson College
68. Massachusetts - Northeastern University
69. Massachusetts - University of Massachusetts
70. Massachusetts - Worcester State College
71. Michigan - Central Michigan University
72. Michigan - Eastern Michigan University
73. Michigan - Michigan State University
74. Michigan - Northern Michigan University
75. Michigan - University of Michigan
76. Michigan - Wayne State University
77. Michigan - Western Michigan University
78. Minnesota - University of Minnesota
79. Minnesota - University of Minnesota-Duluth
80. Mississippi - University of Mississippi
81. Mississippi - University of Southern Mississippi
82. Missouri - Central Missouri State University
83. Missouri - Northeast Missouri State University
84. Missouri - Southeast Missouri State University
85. Missouri - St. Louis University
86. Missouri - University of Missouri
87. Montana - University of Montana
88. Nebraska - Kearney State University
89. Nebraska - University of Nebraska-Lincoln
90. Nebraska - University of Nebraska-Omaha
91. New Jersey - Wm. Patterson College of New Jersey
92. New Mexico - University of New Mexico
93. New York - Adelphi University
94. New York - Columbia University
95. New York - CUNY, Brooklyn College
96. New York - CUNY, Hunter College
97. New York - CUNY, Lehman College
98. New York - CUNY, Queens College
99. New York - Hofstra University
100. New York - Ithaca College
101. New York - New York University
102. New York - SUNY College at Buffalo
103. New York - SUNY Geneseo
104. New York - SUNY University Center-Buffalo
105. New York - Syracuse University
106. North Carolina - East Carolina University
107. North Dakota - Minot State University
108. North Dakota - University of North Dakota
109. Ohio - Bowling Green State University
110. Ohio - Case Western Reserve University
111. Ohio - Cleveland State University
112. Ohio - Kent State University
113. Ohio - Miami University
114. Ohio - Ohio State University
115. Ohio - Ohio University
116. Ohio - University of Akron
117. Ohio - University of Cincinnati
118. Oklahoma - Oklahoma State University
119. Oklahoma - University of Oklahoma
120. Oklahoma - University of Tulsa
121. Oregon - Portland State University
122. Pennsylvania - Pennsylvania State University
123. Pennsylvania - Temple University
124. Pennsylvania - University of Pittsburgh
125. Rhode Island - University of Rhode Island
126. South Carolina - University of South Carolina
127. South Dakota - University of South Dakota
128. Tennessee - Memphis State University
129. Tennessee - Tennessee State University
130. Tennessee - University of Tennessee
131. Tennessee - Vanderbilt University
132. Texas - Lamar University
133. Texas - Our Lady of the Lake University
134. Texas - Southwest Texas State University
135. Texas - Texas Christian University
136. Texas - Texas Tech University
137. Texas - University of Houston
138. Texas - University of North Texas
139. Texas - University of Texas at Austin
140. Texas - University of Texas at Dallas
141. Utah - Brigham Young University
142. Utah - University of Utah
143. Utah - Utah State University
144. Vermont - University of Vermont
145. Virginia - Hampton University
146. Virginia - James Madison University
147. Virginia - Radford University
148. Virginia - University of Virginia
149. Washington - University of Washington
150. Washington - Washington State University
151. Washington - Western Washington University
152. West Virginia - West Virginia University
153. Wisconsin - Marquette University
154. Wisconsin - University of Wisconsin-Eau Claire
155. Wisconsin - University of Wisconsin-Madison
156. Wisconsin - University of Wisconsin-Milwaukee
157. Wisconsin - University of Wisconsin-River Falls
158. Wisconsin - University of Wisconsin-Stevens Point
159. Wisconsin - University of Wisconsin-Whitewater
160. Wyoming - University of Wyoming
APPENDIX B

COVER LETTER FOR SURVEY

August 17, 1988

Dear Faculty Member:

This letter is to request your participation in a survey. The attached questionnaire addresses the prevalence of graduate students in speech-language pathology programs who have communication disorders and/or who speak English as a second language. The questionnaire also addresses departmental policies regarding these students.

Would you (or a member of your faculty you feel knows the most about your recent and current graduate students) please take the time to complete the questionnaire and return it in the enclosed envelope? Your responses will be confidential and the name of your institution will not be identified with your responses.

If you are interested in a summary of the results, please complete the coupon below and return it with your completed questionnaire to the address listed above. You may also return the coupon in a separate envelope, if you so desire. Thank you in advance for your participation.

Sincerely,

Harold Pederson, B.A.

Michael K. Wynne, Ph.D.

Please send me a summary of the results of your study.

Name

Address

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APPENDIX C

Graduate Program Survey

The following questions address the prevalence of graduate students in speech-language pathology programs who have communication disorders and/or who speak English as a second language. The questions also address departmental policies regarding these students. Please answer the questions as they apply to your graduate program. All responses will be confidential. Thank you for your participation.

I. For the past two academic years (not including this fall term), please list the total number of students who have entered your master's program pursing a clinical degree in speech-language pathology. Include both those with and without communication disorders and English as a second language speakers.

Total number of students in the past two years: ____________

II. For the purposes of this study, a communication disorder is defined as a deviation from normal communicative abilities that:
   a. calls adverse attention to the person possessing it, and/or
   b. interferes with communication

Do not include students who speak English as a second language in this section. If you have not had any students with a communication disorder in your program in the past two years, please go onto page 2.

Severity will be rated on this scale: 1 2 3 4 5

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A. For the past two academic years (not including this fall term), please rate the severity of the disorder of any student with a communication disorder who has entered your master's program in speech-language pathology. Please use one column for each student. If you have more than 10 students, please continue on a separate sheet.

B. Please indicate how these students are progressing through your academic program in relation to a typical student enrolled in your program. Please rate each of the students listed in A above.

C. Please indicate how these students are progressing through your clinical program in relation to a typical student enrolled in your program. Please rate each of the students listed in A above.
III. The intelligibility of students who speak English as a second language will be rated on this scale:

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<td>Moderately unintelligible</td>
<td>Severely unintelligible</td>
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If you have not had any students who spoke English as a second language in your program in the past two years, please go onto page 3.

STUDENT SPEAKING ENGLISH AS A SECOND LANGUAGE

A. For the past two academic years (not including this fall term), please rate the intelligibility of any student who spoke English as a Second Language who has entered your master's program in speech-language pathology. Please use one column for each student. If you have had more than 10 students, please continue on a separate sheet.

B. Please indicate how these students are progressing through your academic program in relation to a 'typical' student enrolled in your program. Please rate each of the students listed in A above.

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C. Please indicate how these students are progressing through your clinical program in relation to a 'typical' student enrolled in your program. Please rate each of the students listed in A above.

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IV. Do you have a written policy or guidelines regarding graduate students who have communication disorders or who speak English as a second language?  

yes___  no___

IF "YES", DOES YOUR WRITTEN POLICY HAVE A(N):

1. Operational definition of "communication disorder"?  
   yes___  no___

2. Listing by departmental position designating who can make decisions about the student's academic and clinical progress?  
   yes___  no___

3. Section dealing specifically with practicum assignments?  
   yes___  no___

4. Means to dismiss the student with a communication disorder from your program?  
   yes___  no___

5. Means for the student to appeal a decision?  
   yes___  no___

6. Course of action to treat the communication problem of the student?  
   yes___  no___

7. Please list other components of your written policy:

IF YOU DO NOT HAVE A WRITTEN POLICY, HOW DO (OR WOULD) YOU DEAL WITH COMMUNICATIVELY DISORDERED AND/OR ENGLISH AS A SECOND LANGUAGE GRADUATE STUDENTS?

Please enclose a copy of your written policy (if your program has one) and the questionnaire in the envelope provided to:

Harold Pederson  
Department of Communication Sciences and Disorders  
University of Montana  
Missoula, MT 59812
FOLLOW-UP LETTER FOR SURVEY

September 20, 1988

Dear Faculty Member:

About a month ago, you were sent a questionnaire which addresses the prevalence of graduate students in speech-language pathology programs who have communication disorders and/or who speak English as a second language. The questionnaire also addresses departmental policies regarding these students. As of September 20, your completed survey had still not been received. If you have recently returned your survey, please disregard this letter.

Enclosed please find another copy of the survey and a postage-paid envelope. Would you (or a member of your faculty you feel knows the most about your recent and current graduate students) please take the time to complete the questionnaire and return it in the enclosed envelope? Your responses will be confidential and the name of your institution will not be identified with your responses.

If you are interested in a summary of the results, please complete the coupon below and return it with your completed questionnaire to the address listed above. You may also return the coupon in a separate envelope, if you so desire. Thank you for your help.

Sincerely,

Harold Pederson, B.A.

Michael K. Wynne, Ph.D.

Please send me a summary of the results of your study.

Name __________________________

Address _________________________

_______________________________

73
APPENDIX E

Academic and clinical progress for each student with a communication disorder and each ESL student.

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| Average                | 9         | 3     | 3     | 0     | 1     | 0     | 16    |
| Slower                 | 1         | 0     | 0     | 0     | 0     | 1     | 2     |
| Not Appl.              | 1         | 0     | 0     | 0     | 0     | 0     | 1     |
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| Average                 | 1         | 2     | 1     | 0     | 0     | 0     | 4     |
| Slower                  | 0         | 1     | 1     | 0     | 0     | 0     | 2     |
| Not Appl.               | 0         | 0     | 0     | 0     | 0     | 0     | 0     |
| No Rating               | 0         | 0     | 0     | 0     | 0     | 0     | 0     |
| Total                   | 1         | 3     | 2     | 0     | 0     | 0     | 6     |

SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.
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**SEVERITY RATING FOR ALL CATEGORIES, EXCEPT ESL = "1" is mild, "2" is mild/moderate, "3" is moderate, "4" is moderate/severe, "5" is severe.**
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- **SEVERITY RATING ESL**: "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.

### CLINICAL PROGRESS

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- **SEVERITY RATING ESL**: "1" is completely intelligible, "2" is mildly unintelligible, "3" is moderately unintelligible, "4" is moderate to severely unintelligible, "5" is severely unintelligible.
APPENDIX F

EXISTING WRITTEN POLICIES

POLICY #1:
I. Academic faculty, clinic supervisors and supporting staff will participate in the screening of undergraduate students prior to entrance into clinical practice courses.

A. Evidence of academic achievement will be provided by the Department Secretary. Grades of C or better in all Department courses and a GPA of at least 2.75 in the major are required for entrance into Clinical Methods I.

B. Screening to evaluate the candidate's entry skills and requirements necessary for advancement to clinical practice courses will take place during Junior 1 and Junior 2 courses, and will be conducted by a faculty screening committee. The candidate must demonstrate competence in entry skills and meet requirements as follows:

Junior 1 Level

1. Hearing screening will be provided by the University's audiologic clinic:
   a. Demonstrating a level of hearing acuity which meets credential requirements.
   b. Passing SRT screening of 20 dB in better ear.
   c. Attaining a speech discrimination score of at least 90% in the better ear.

2. The candidate will be interviewed by one or two staff members in a 5-minute interview during which the following will be rated:
   a. Articulation--The student's speech must be free from misarticulations in his/her native language. Phonology may be obviously foreign, regional or nonstandard in habitual speech, but the student must be able to maintain and teach standard phonology in therapeutic situations.
   b. Fluency and rate--The student must demonstrate fluency and rate which do not detract from the transmission of his message.
(POLICY #1:)
c. **Voice**—The student must demonstrate appropriate vocal use including pitch, quality, intonation, and loudness.
d. **Grammar**—The student must demonstrate verbal language which is free from grammatical errors in conversation and in therapeutic situations. The student must be able to teach standard English in the therapeutic situation and use standard English consistently in reports and other professional writing.
e. **Presentation**—The student must demonstrate verbal presentation free from visual and acoustic mannerisms which interfere with message transmission.

3. Pass the Junior-Level Writing Proficiency Exam in English Composition which is given once each semester, or enroll in English 119, Writing for Proficiency, and pass the exam as a part of the course.

II. Hearing screening will be provided by the University’s audiology staff at the time of the interview.

III. Students will be given written notification regarding the outcome of the screening evaluation.

A. In the event of failure of any section of the screening, the student will be directed to see designated faculty members for a more complete evaluation.

B. The designated faculty member will be prepared to provide the following information:

1. Specific area of deficiency and level of competence required
2. Availability of remediation programs
3. Re-examination date
4. Grievance procedure

**POLICY #2:**

**Other Requirements**

Students pursuing the master’s degree in speech pathology or audiology are expected to have writing and speaking abilities acceptable for purposes of employment as a speech and language clinician or audiologist. Students who do not possess these skills will be expected to pursue remedial work.
POLICY #3: Speech-Language Competence of Students

The procedures described below were adopted by the faculty to help assure that graduates exhibit speech-language skills adequate for satisfactory performance as professionals working with the communicatively handicapped:

All Students enrolled in the Department of Communication Sciences and Disorders will be screened (usually during CSD 310) for speech and oral language.

Students identified by this screening or by individual faculty members as having potentially disordered speech or language will be referred to the department’s Speech and Hearing Clinic for a speech-language evaluation and, if recommended, subsequent speech-language therapy. Students who have been enrolled in therapy as a result of the foregoing process must be approved by a committee of three CSD faculty members for admission into course work involving clinical practice. Should a student be admitted by the committee to practicum course work prior to full completion of therapy, committee approval must be obtained until completion of therapy for each subsequent enrollment in a clinical practice course.

Students identified by this screening or by individual faculty members as presenting non-disordered oral or written language patterns which may interfere with the clinical aspects of training will be alerted to that possibility by a faculty member. Tutoring will be provided through the Speech and Hearing Clinic at the request of the student. Even though the student will not be required to participate in tutoring at this Clinic, the student will be responsible for exhibiting adequate clinical speech-language skills.

Petitions

Clinic and/or program policies may be challenged by the student petition for concession on a particular point. All petitions should be in writing, addressed to the department head, and contain the following information: (1) Name of the petition; (2) specific rule or policy which is being challenged; and (3) specific reasons why the student feels the petition should be granted.

Petitions concerning clinical policy will be referred to the Clinic Director who will convene the Clinic Committee to discuss the petition. The Clinic Director will then forward the vote of the Clinic Committee to the Chair. The Chair will consider the action of the Clinic Committee and report his/her decision in writing to the student. The same procedure will be used in case involving program policy except that a committee will be appointed by the Chair to consider the petition.

Petitions should be used only in extreme or unusual circumstances by the student. The student should first discuss any problems or concerns with supervisors or faculty directly involved before initiating an appeal and should indicate this in the petition.
POLICY #4:

Our policy regarding student involvement in clinic is tied directly to ESB Standards on Clinical Practicum. Particularly ESB Standard 4.10 states, "Major decisions by student clinicians regarding evaluation and management must be implemented . . . only after approval by the supervisor holding CCC."

Professional ethics require protection of clients, therefore, all clients are assigned to supervisors not students. Through the supervisor the Department is responsible for clients. Decision on who may be assigned to any client or the treatment of any client is the responsibility of the Department or its' designee who holds appropriate certification. Each accredited department or program must show how this standard is met.

Professionals who have earned the CCC in the appropriate area and have met University standards for experience and skill make clinical judgments and decisions on which students may be assigned specific clients. Level of training, student clinical skills and client needs are all taken into consideration before assignments for clinical practicum are made.

Our accreditation application relates to these issues on pp 63 and 64 where we state that supervisors are responsible for clients not students and that students cannot usurp that authority and responsibility. All accredited programs must specify how ESB Standards are met and therefore according to these standards and the professional Code of Ethics, Principle of Ethics 1 F & G which requires that client protection is of paramount importance in making any decisions regarding delivery of services insure that only qualified professionals are allowed to make decisions on client care.

POLICY #5:

The following policy applies only to students who desire to meet ASHA CCC requirements and obtain a graduate degree with a clinical emphasis. Furthermore, this policy is based on the assumption that a student has successfully completed the academic prerequisites to participate in clinic practicum. The Graduate Admissions Committee will inform incoming graduate students of this department policy.

A student's communication ability must not interfere with clinical interaction. This includes clinician, client, parent, and supervisory exchanges. Of paramount concern is the protection of the client's welfare. The faculty recognize that a variety of communication strategies may be employed effectively in the clinic situation, and assessment and management procedures must be conducted in an effective and efficient manner. If a supervisor determines the student's
(POLICY #5:)
communication is interfering with adequate clinic progress, 
the opinion of a second supervisor must be sought before it 
is decided to terminate the clinical experience. Following 
withdrawal from a clinical assignment, the student must seek 
remedial help. If a student is withdrawn from the clinic 
situation, the faculty will assist the student in finding 
appropriate resources to improve his/her communication skills. 
It should be noted that certain communication behaviors only 
emerge over a period of time. For this reason any faculty 
member can make a referral at any time.

After a student has improved his/her communication 
skills, he/she may request clinic practicum a second time, a 
majority of a full faculty vote is required for approval. If 
after a second attempt the student’s communication is again 
assessed to interfere with the clinic interaction, the student 
will not be allowed to enroll in further practicum. A second 
supervisor’s opinion must be sought prior to terminating this 
practicum.

POLICY #6: 
SPEECH AND LANGUAGE DIFFERENCES
As a student in the Communication Disorders Program you 
should be aware that your speech and language differences 
(social-cultural or foreign language based) or disorders may 
affect your professional performance and career advancement. 
Therefore, if we notice such differences or disorders, any 
individual faculty member may counsel with you to determine 
if you are able to self-correct or code switch adequately for 
the professional requirements in this field. Formal 
evaluation and/or intervention may be recommended by the 
faculty member or requested by you.

PROFESSIONAL-PERSONALITY POSITION STATEMENT
Not everyone is suited to work with clients in the 
clinical fields of speech-language pathology and audiology 
even though they may maintain a satisfactory academic record 
in terms of C.D. grade point average. The faculty of the 
Communication Disorders program therefore may discuss its 
concerns about perceived professional-personality 
incompatibilities, inappropriate behavior or similar problems 
with a student. In such instances, the student may have 
several options available, including an opportunity to 
demonstrate a change in professional behavior with or without 
the benefit of counseling available at the Student Counseling 
Center, or to work with Career Services and Communication 
Disorders faculty to identify a viable career option 
culminating in a change of major. If a mutually acceptable 
resolution cannot be reached, and the problem persists, the 
student may not be permitted to continue in the Communication 
Disorders Program.
APPENDIX G

Answers to page 3 of survey, question number 7: "Please list other components of your written policy."

1. Admission criteria re: TOEFL/TSE scores.
2. Require minimum on TOEFL or equivalent test
3. TOEFL may be used as a substitute for GRE or MAT in some circumstances.
4. We have a clinical & non-clinical tracks for students having English as a 2nd language. Students in the clinical track (decision based on evaluation of speaking proficiency) are treated like all others. Non-clinical track students do not intern and have limited clinical experiences, functioning mainly as aids.
5. If the faculty feels the communication disorder is remediable and that, if untreated, the disorder will interfere with the student’s ability to provide effective service, that student may not be permitted to register for clinic practice until the disorder is remediated, or effectively controlled in the context of the clinic. The faculty will arrange for treatment at no cost to the student if the student so wishes.
6. ESL only must pass TOEFL and are interviewed by faculty committee.
7. Oral & written examinations in English & Spanish. All clinical & academic decisions are made by Dir. of clinic & coordinator for bilingual students in sp-lng. pathology.
8. Personality characteristics also a basis for counselling / dismissal.

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Appendix H

Answers to survey question: "If you do not have a written policy, how do (or would) you deal with communicatively disordered and/or English as a second language graduate students?"

1. Consensus of faculty concerned, then a course of action would be decided upon. Recommended course of action explained to student through advisor.

2. Although we do not have a formal policy (albeit, we probably should have one) we do have some general guidelines. These guidelines are not official, however, and therefore could be cause for concern if challenged. Basically, the guidelines we follow are based upon two factors: (1) the laws pertaining to discrimination against the handicapped, and (2) guidelines pertaining to selection/retention.

Essentially, this boils down to the fact that with respect to selection of students, any qualified student can begin the program; however, retention in the program requires successful performance in terms of the academic, research and clinical requirements of the graduate program. Likewise with respect to discrimination against a "communication handicap" a student would be allowed to enroll in a practicum course. If the student's own communication skills were such that they detracted from clinical interactions with the client and or client's family, then this could be reflected in the practicum grade. And, if the student felt the grade to be "unfair" it could be appealed through the university grade appeal policy. Student assignments to practicum are made by the appropriate coordinator (audiology or speech pathology).

You survey concerns graduate students. I should note that all undergraduate students taking the introductory course are screened for language, hearing and speech. Those for whom therapy is recommended are strongly urged to participate -- but this is not a requirement.

3. The student is placed in therapy.

4. Counseling prior to acceptance into graduate program regarding means to improve communicative impairment and regarding anticipated effect on future ability to deliver speech-language e services as a function of particular setting.
5. We require TOEFL score of 650 or above. We review the student's oral language skills when they arrive (clinical panel composed of director of the clinic, graduate advisor and chairperson of dept.). We are experiencing an increase in number of foreign student applications. (1986 - 4 applications 1988 - 12 applications)

6. Upon acceptance of student into pre-clinical phase of program the communicatively disordered student is identified & counseled re: need to bring speech, artic, voice or language to the point at which they can present an acceptable "model" to communicatively handicapped patients. Therapy in our clinic is made available to them & intensive therapy is pursued.

ESL students are advised that they cannot pursue clinic practicum unless an acceptable "model" is achieved. Students from foreign countries who want to return to their country & who do not articulate appropriately, may not pursue the clinical phase & are, assuming they successfully complete academic course work and clinic observation, awarded a non-clinical M.A.

7. Provide every assistance with spoken and written English available on campus or therapy services for disorders. Extend the program if necessary.

8. We tell students that enrollment in practicum & program completion is dependent upon improvement in communication abilities.


10. Work with the student on a case by case basis.

11. Personal interview / score(s) on TOEFL.

12. Ea. applicant is interviewed and counselled.

13. Require therapy, limit students program so that certification is no possible or advise out of program.

14. Students w/ a communication disorder are advised to enroll in remedial clinic. ESL students are admitted into the graduate program based on TOEFL scores & the dept. chair’s & faculty’s recommendations.

15. Students must receive speech therapy from a source external to the program at the University. All remediable disorders must be remediated prior to full admission.
16. Handled on individual basis. Student is scheduled into therapy with the understanding that he/she will make every effort to improve. We have had several hearing impaired in the program in past years but not recently. Decisions are by consensus amongst the clinical supervisors and faculty. One faculty has major responsibility focusing on university students, regardless of major, and her judgement is usually the deciding factor.

17. On an individual basis. We certainly allow them to prove their ability to be successful.

18. We have had students with written skill deficits, but no spoken skill problems.

19. ESL students are informed that they can not be assured w/ accumulating all ASHA clin. pract. hours prior to their enrollment.

20. If there is a problem, the person noticing the problem notifies the clinic director. The person with communication difficulty is counselled and urged to seek treatment. Treatment may be with a faculty member or with an advanced student.

In the case of international applicants, we ask them to submit an audiotape, which we then evaluate in terms of intelligibility.

21. Advisor is 1st contact. If a communication disorder appears to exist, advisor consults clinic committee who interviews the student and determines intervention strategies and time allowance for remediation. If remediation does not occur in given time allowance, student may be counseled out of program.

22. Require that the student receive therapy (in-house) for the disorder.

23. Faculty decision based on individual cases.

24. We do not have a policy at this time. We are in the beginning stage(s) of dealing with this issue. Currently we have a number of undergraduate students who have "English" as a second language. Frankly, most of these students do not have control of English in terms of comprehension, reading, writing or speech.

25. Each student is evaluated and referred for therapy to a faculty member or to a nearby facility.
26. No policy. Foreign students must pass TOEFL. Depending upon score, some must take additional English classes on campus.

27. On a case by case basis.

28. Need has never arisen to "deal" c a case; if so would deal c individually by chairman / clinic director in consultation c professors.

29. We require their English to be sufficient as a model for our clients. (They are informed of opportunities to obtain assistance in this area through the University.) They would be admitted to the practicum courses only if/when they have met the approval of the clinic director with respect to their English proficiency.

The University has standardized testing & set criteria for ESL students. However, we also have a departmental contingency.

30. On individual basis.


32. Each student would be handled individually and decisions made relation to his/her specific case.

33. We have few such students here. When so, advisors and/or clinical staff ask student to seek remediation of problem, generally in our own clinic. The importance of a good speech model is stressed. We expect the student to take care of the problem, particularly when circumstances require it.

34. On the acceptance form, we write a statement that continuing enrollment depends not only on GPA but also on proficiency of spoken and written English.

35. Refer to director of ESL programs for tutoring; refer to English Language Institute; schedule articulation therapy in speech and hearing center - unlikely.

36. Student must be able to provide appropriate model for clinic clients. We have had no problem with students who speak English as a second language as long as we are able to accommodate the client to this language. Students have graduated & are employed in clinic & educational settings & are in high demand as consultants.

37. Counseling by academic advisors.
38. If the student's communication disorder / difference is significant enough to interfere with his/her clinical effectiveness and/or ability to provide appropriate models in therapy, the student is advised to enroll in therapy in the Univ. clinic for remediation / modification. Both students noted on this survey are currently in therapy along with carrying assigned clinical work.

39. Students are given more time for their academic program and lighter loads. Clinically they must demonstrate proficiency w/ language before entering clinic appropriate to the needs of the clients.

40. On an individual basis - related to severity of loss / disorder & what special needs would be required & availability of resources to provide for meeting the needs.

41. We would deal with them on an individual basis by:
   A. providing a course of action to treat the problem, and
   B. working with them to understand the implications of how their particular problem might affect them as a professional (speech-language pathologist); including both positive and negative implications.

42. Graduate committee would handle any decisions.

43. Counseling. Legally you cannot prove that the accent impairs clinical effectiveness.

44. On individual basis.

45. If problem is sufficiently distracting students are placed in treatment during their first (academic) year of graduate work. If adequate progress is made students may continue to their second (clinical) year. Treatment may be continued if needed.

46. The student would be asked to enroll in therapy to correct the problem.

47. We need to develop one. Currently we deal with the student on a case-by-case basis. We have not had good luck with students for whom English was a second language. All so far have been in Sp-Lang. Path., none in Audiology.

48. Individualized plan (assessment, recommendations) to counsel student re: personal & professional goals.
49. The student with the voice disorder was scheduled for therapy with one of our staff supervisors, the voice improved significantly. If a student’s disorder was such that it would interfere with his or her competence as a professional, the student would be counseled regarding alternative career choices.

50. Through counseling.

51. Communicatively disordered would be assessed & offered therapy.

52. A. Communicatively disordered receive therapy, tutoring, and/or other assistance.
B. University requires that students pass certain tests re: English before being admitted to college level courses -TEOSL, etc. - University has separate instructors for students from other countries.

53. Individual review of credentials. Services would be offered to a student, but would not require clinical treatment as a condition of graduate study. Our philosophy is to handle the student individually as we do all other students.

54. A. We require TOEFL scores (no particular cut-off score)
B. - We interview prior to admission & give "conditional" admission.
C. We require the student to continue English as a 2nd lang. study on campus
D. We require therapy in our clinic for phonological & dialect work beyond the minimum in Eng. or 2nd language.

55. Case by case.

56. A. The student is enrolled as a "Special" graduate student (taking no more than 9 hours and must maintain a B average with concurrent therapy.
B. At present all students must be able to use the mainstream language.

57. Require (re)habilitation.

58. We do not discriminate!

59. Provide personal instruction to improve intelligibility of spoken English.
60. We deal with each student on an individual basis. A committee is appointed and this committee deals with the student’s program plan and particular needs.

61. If there is a substantial difference or disorder that appears to be affecting academic and/or clinical performance, a faculty committee is appointed to address the matter and to formulate recommendations designed to facilitate the student’s progress through the program—essentially to assess the problem and develop an IEP-like set of recommendations.

62. Require either Rx or help from our ESL program on campus.

63. We have not in my 25 yrs here had any students who were communicatively disordered or spoke English as a second language and were unable to function as SPA professionals.

64. Individual attention by staff.

65. We would help the student by putting him/her into a personal therapy plan and monitor the progress very carefully. We have had hearing impaired students in the past in our program, all of whom had speech & language problems. Over the two years of their graduate study they were able to handle their own communication problems and are doing well as clinicians.

66. A. Disorder must be under control and of mild severity.
B. 2nd language must be intelligible in all situations—academic and clinical.

67. These students are tested and enrolled in therapy services—clinical records are maintained as with all other clients. Program faculty counsel these students regarding career choices. Precaution taken with concern for discrimination and Rehab Act ramifications.

68. All students enter the master’s program with conditional status. They are reviewed at the completion of 12 credit graduate hours in the field. Other aspects are also reviewed, including speech & language skills. If they are thought to be deficient in any area, they remain on conditional status and are so informed by their advisor. A plan is developed and implemented to remove the deficiency. They may eventually be removed from conditional or be withdrawn from the program. Usually, students with speech disorders or deviancies receive treatment.
69. The student is required to receive remedial services from our clinic or self-imposed treatment:
   A. If the disorder or difference directly impedes management of a given client(s) and his/her parent/spouse.
   B. If such disorder or dialect continuously disrupts clinical experiences, student will be advised of non-clinical track option.

70. Clinic Director identifies or is advised of individual who demonstrates communication disorder. With advice of advisor and other supervisors, a clinical program is devised and implemented. In most cases, a formal diagnostic evaluation is conducted.

71. We do not have either type of student. We have foreign students who must complete course work in our American Language Institute before they may enter any program in the University.

72. Informally, plus all internationals must take a TESL exam to establish English fluency.
December 14, 1988

Dear Faculty Member:

This fall you completed a questionnaire which addressed the prevalence and progress of your students with communication disorders and ESL students who are enrolled in your speech/language pathology graduate program. We have enclosed a summary sheet discussing the results of this study as per your request.

If you have any questions or desire further information regarding this study, please do not hesitate to contact us. Thank you for your participation.

Sincerely,

Harold Pederson, M.A.

Michael K. Wynne, Ph.D., CCC-A/SLP
Assistant Professor

Enclosure
APPENDIX J

SUMMARY OF SURVEY RESULTS


This study addressed the prevalence of graduate students in speech-language pathology programs who have communication disorders or who speak English as a second language (ESL). This study also addressed the existence and components of written departmental policies regarding these students.

A questionnaire was mailed to all 160 master level speech-language pathology programs accredited by the Educational Standards Board of the American Speech-Language-Hearing Association. Ninety-eight of these programs returned the questionnaire, for a response rate of 61%. These programs reported that 3945 master level students entered their programs in the past two academic years. Sixty-one students (1.5%) were reported to have had a communication disorder and 104 students (2.6%) were reported to be ESL speakers.

When compared to the typical student enrolled in the graduate program, the majority of the communicatively disordered and ESL students were reportedly progressing at an average or a faster than average rate in both academic and clinical work. For those students who were rated, 17% progressed at slower rate in academic work and 24% progressed at a slower rate in clinical work. The data also indicated that those students with the highest severity ratings (i.e., more deviant communication pattern) progressed at a slower rate in academic and clinical work than those with milder severity ratings.

Of the 93 programs that responded to the question of written policy existence, 16 programs (17%) reported having policies regarding graduate students who have communication disorders or ESL students. Most of these 16 programs' policies had a listing of a person responsible for carrying out the policy, a section dealing with clinical assignments, a means for a student to appeal a decision, and a course of action to treat the communication problem of the student. In addition, four programs reported using the Test of English as a Foreign Language (TOEFL) as one component in the admission requirements for ESL students. Of the programs that did not have written policies, 27 programs suggested therapy for the student. Other common responses for programs without written policies included counseling, the use of the TOEFL, the importance of an acceptable communication model, and dealing with the student on a case by case basis.