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Professional Issues Statement

The Clinical Education of Students With Accents

About this Document

This Professional Issues Statement was developed by a Subcommittee of a former American Speech-Language-Hearing Association Executive Board working group on language proficiency. Members of the group were Catherine J. Crowley, Erika S. Levy, Nidhi Mahendra, and Vicki R. Deal-Williams (ex officio). Julie B. Noel, ASHA vice president for speech-language pathology practice (2009–2011), served as the monitoring officer. This document was approved by the ASHA Board of Directors (BOD 31-2011). ASHA members must consider all applicable local, state, and federal requirements when applying the information in this policy.

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Introduction

By all reports, the demographic shifts in our country's population that were projected to occur over the past decade have now become a reality. Increased cultural and linguistic diversity is noteworthy in educational, health care, and corporate settings, as well as in the caseloads of

many speech-language pathologists (SLPs) and audiologists. For years, the American Speech-Language-Hearing Association (ASHA) has been concerned with and focused on the recruitment and retention of a more diverse student population for our discipline. These efforts appear to have been fruitful, as we have seen, for example, a change from 11.7% of new ASHA affiliates in 2007 to 13.3% in 2010 who are from racial/ethnic backgrounds that have been historically underrepresented in our professions. These new affiliates are also likely to increase the linguistic diversity of the overall ASHA membership, which was only at about 5% according to 2009 data (ASHA, 2010a).

Additionally, many colleges and universities have embraced the notion that a more diverse student population enhances their campus climate and enriches educational outcomes overall, and these schools have launched their own diversity recruitment programs, often seeking out international students. These students will potentially be available to help provide speech, language, and hearing services to those who need our services from among the approximately 20% of the U.S. population that speaks a language other than English at home (U.S. Census Bureau, 2009). The United States is one of the few nations where the majority of people are monolingual; these students' linguistic diversity helps move our professions closer to the global norm of bi- or multilingualism. Additionally, there may be an increased level of cultural awareness that is present in students from historically underrepresented racial/ethnic backgrounds (Engberg, Meader, & Hurtado, 2003) that could serve ASHA and our clients well in terms of increasing our overall cultural competence. Still, a more diverse student pool brings both opportunities and challenges to the academic setting. One of those challenges with major consequences for our professions is the clinical education of students with nonnative accents.

It is important to note that “each of us has an accent” (Morley, 1996, p. 142; see also ASHA, 1998a, 2004), whether it is a regional accent or an accent influenced by another native language. The accompanying perceptions of our accents vary. Additionally, the English spoken in Great Britain or South Africa is more often deemed acceptable in the United States than the English spoken by individuals from India or Sierra Leone (De Kleine, 2009; Lippi-Green, 1997), for example. For the purpose of this document, accents are defined as English pronunciation that is not the result of pathology and is perceived to be different from the listener's, whether the English was learned as a first, second, or other language. Accents include aspects of speech sound production, prosody, rate, and fluency (Celce-Murcia, Brinton, & Goodwin, 1996), all of which have been shown to affect intelligibility. Of interest here are accents that individuals in university programs consider sufficiently different from their regional norm to affect a student's and future professional's clinical effectiveness.

The ASHA Office of Multicultural Affairs has fielded many calls from faculty members struggling with decisions about when and whether to allow students with accents to participate in clinical practicum, when and whether to provide accent modification for these students, and how to determine whether a student with an accent can be effective in our professions. Students too, have sought assistance when they have been denied opportunities to participate in clinical practicum, when externship site supervisors or a client's family members have complained about their speech, or when they are approaching graduation or have graduated without the needed clinical training to obtain the ASHA Certificate of Clinical Competence. Anecdotal reports also include student inquiries to faculty and administrators about their abilities and potential to be effective clinicians, given their accents.

The following true cases of speakers with nonnative accents illustrate how difficult and emotionally charged these situations can become, even when the underlying intention was to demonstrate great care and concern. One student from Latin America who spoke English with a Spanish accent was advised by a professor in her graduate program to reconsider her choice of profession because of her accent. She ignored the professor's advice and is now the head of speech and hearing services at a prestigious university hospital in the Northeast. An Asian Indian woman who was a simultaneous bilingual and had attended English schools all her life was advised by a faculty member in her doctoral program to consider a research-only track. She was told that no university would hire her as faculty due to her accent. This professional had a successful clinical career in long-term care and is now a tenured professor in a prestigious Southwestern university who receives excellent student course evaluations. In yet another case, a professor told a bilingual student who spoke up in class that if he did not get rid of his accent, he would never graduate from the master's program. The student did what many students do; he rarely spoke in class and kept a low profile until he received his degree. Now he is a speech supervisor in a large urban school district. These stories are examples of those who persevered and were able to successfully negotiate their way through the obstacles they faced despite the advice they were given. It is important to recognize, though, that not all students who encounter this questionable advice are able to do so.

A 1998 position statement provides ASHA's stance that students and professionals in the communication sciences and disorders (CSD) professions who speak with accents and/or dialects can effectively provide speech, language, and audiological services as long as they have

- the expected level of knowledge in normal and disordered communication,
- the expected level of diagnostic and clinical case management skills, and
- if modeling is necessary, the ability to model the target phoneme, grammatical feature, or other aspect of speech and language that characterizes the client's particular problem (ASHA, 1998a, p. 1).

The age of the aforementioned document might give the impression that this position is no longer valid; on the contrary, it is still relevant. At the heart of the document and its accompanying technical report (ASHA, 1998b) is that all individuals, whether clients or professionals, speak with an accent and/or dialect. For this reason, all students and professionals should know that there is no single standard that can be appropriately applied in every clinical interaction, and that variation is the norm. SLPs and audiologists must manage cases across linguistic variation as a matter of routine. On the other hand, the reference in the document to “modeling” may be dated. Technological advances and applications for clinical service delivery today are such that modeling can be provided through a variety of means in the clinical setting. The use of computer applications, software, recordings, and the like give clinicians multiple options for providing models or presenting auditory stimuli, so their accent may be less of an issue for providing an appropriate model in some cases. The dynamics of clinical service delivery, though, have also changed, and clinician engagement with clients is generally much more extensive than a clinician simply providing a model and a client attempting to repeat it. In addition, speaking with an accent is often related to hearing with an accent (Flege, 1995); thus, it is likely that a clinician's ability to model particular speech sounds may well be influenced by his

or her ability to perceive the client's speech accuracy and to internalize features of target productions.

There have been similar changes in how accent modification is viewed by our professions. Formerly referred to as *accent reduction*, this terminology has largely shifted due to the challenges involved in reducing an accent and related negative connotations (see Morley, 1994). More recently, there has been a shift in the major focus of research on second language learning from achieving native-like speech to more emphasis on increasing intelligibility. Thus, by extension, it may be time for a similar conceptual shift in speech-language pathology and audiology when thinking about students and professionals with nonnative accents. Our focus needs to move beyond how strong an individual's accent is to how intelligible the person is or can become as he or she provides clinical services, and to helping students expand their speech production options.

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Scope of This Document

Even as we keep in mind that our own accent often serves as the “standard” by which we perceive others' accents, multiple concerns have been brought forward that relate to students' accents. This document cannot address all of these concerns adequately. It is beyond the scope of this document to address issues such as students' writing abilities, the impact of accents on non-English languages, or students' interpersonal skills given cultural differences. The issues addressed here, however, may be relevant and applicable, at least in part, to some of these issues. Individuals who are native speakers of English and who speak “nonstandard” varieties or dialects of English often encounter similar issues faced by speakers of English as a second language. Some varieties of English, like accents, are valued more than others, and the social stigma associated with some English dialects has been documented and debated by linguists, sociologists, and many others for years (Braverman, 2011; Preston, 1999). While there may be some parallel issues involving nonstandard dialects, and though similar strategies may apply, it is not the intent to include them specifically here.

It should also be noted that many of the specifics and examples provided relate to speech-language pathology, generally because the issues are so salient and apparent in that profession. However, the recommended strategies and the due consideration advised as a part of a students' overall clinical education, is applicable to both speech-language pathology and audiology. This document is intended to focus on addressing concerns about determining the effectiveness of students with nonnative accents in providing clinical services, and the subsequent issues arising from those determinations. More specifically, the intent is to address situations in which the intelligibility of students' accents has become a concern to them or to their program.

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Purpose

Students, faculty members, and clinical professionals in CSD are in urgent need of specific guidance to facilitate the success of students with accents participating in clinical practicum. However, there are no specific, prescriptive solutions to this issue that can be applied across the board to all situations involving all students. There are emerging empirical data that may eventually be used to establish a foundation for such specificity, but the data are by no means conclusive. The frustration experienced by students and professionals involved in these situations can be minimized, though, with a proactive problem-solving approach that is customized for each student at each academic program. This Professional Issues Statement is intended to provide information and assistance that will result in increased objective deliberation and full consideration of relevant issues and variables to ensure that the best decisions are reached for students, academic programs, and, in the long term, clients receiving professional services for communication and related disorders. This document will provide an overview of related literature and describe strategies for encouraging more student- and client-focused approaches to planning, academic advising, and clinical education of students with nonnative accents.

An underlying premise of this document is that faculty, administrators, and students each have a role and are all responsible and accountable, on some level, for defining and maximizing the potential for student success. As all of these stakeholders come together to determine the best course of action for an individual student with an accent, there will need to be mutually agreed upon expectations and ongoing open communication. This will ensure that everyone involved is clear on actions to be taken to help a student accomplish his or her desired objectives and meet reasonable requirements. Students will need to reflect on their abilities, motivations, and willingness to take advantage of available support, as well as the resources available to them. Further, students will need to be aware of the potential impact of their accent and how this influences their provision of clinical services. Faculty members and administrators need to bear in mind their subjective perspective about students' nonnative accents and the influence of their perceptions on both the student's and client's ability to meet expected standards. In addition, it is important to maintain equity in the requirements imposed on all students and to consider the potential means by which students might provide clinical services with the varied tools and resources now available. Clinical educators will need to be careful not to succumb to stereotyping and must balance their perspectives with an expanded and nuanced understanding of the influence and impact of a student's accent, and in turn, the potential for successful service delivery by student clinicians.

The 1998 ASHA position statement cited earlier also states that

…the nonacceptance of individuals into higher education programs or into the professions solely on the basis of the presence of an accent or dialect is discriminatory. Members of ASHA must not discriminate against persons who speak with an accent and/or dialect in educational programs, employment, or service delivery, and should encourage an understanding of linguistic differences among consumers and the general population. (ASHA, 1998a, p. 1)

ASHA's Code of Ethics also provides direction for ASHA members to ensure that they do not discriminate (ASHA, 2010b). The Issues in Ethics Statement titled *Cultural Competence* explains the application of the Code in more detail as it relates to diverse

populations: “ASHA members … [must recognize] their own cultural/linguistic background or life experience and that of their client/patient/student” (ASHA, 2005, p. 1). Of particular relevance to this obligation is an individual's recognition and understanding of cultures—their own and those of students and clients with whom they interact. Our personal experiences and exposure to behaviors, events, and activities, as well as the standards to which we have been held, create a natural and inherent human bias that may lead us to expect others to conform to our expectations. ASHA members are obliged to go beyond their personal expectations, to acknowledge this bias, and, in essence, hold it in reserve, to fully meet the needs of each student and client they serve. Once there is recognition and acceptance of the student's experiences and skills, faculty and staff in CSD academic programs can begin to determine how best to help a student meet the expectations that make up the broad, generally accepted norms within our professions or find alternate ways to achieve the same end results—successful clients and patients.

It is critical to keep in mind that not every ASHA-certified clinician may be able to appropriately serve each client he or she encounters. The Code of Ethics requires that we engage in only those aspects of the professions that are within the scope of our professional practice and competence, considering our education, training, and experience. Many of us specialize in specific areas of the expansive scopes of practice of our professions. It would be possible and probably necessary then for students to begin to determine their own personal scope of practice based on preferences and limitations identified in their academic performance and clinical practicum experiences, but with a recognition that there are some foundational, essential functions (albeit not consistently defined) expected of every clinician.

The complexity of these issues does not lend itself easily to sorting through and addressing all related variables. This document is intended to provide mechanisms for intentional deliberation and decision making that could result in better outcomes for students and clients.

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Literature Review

Little has been documented about the effects of SLPs' and audiologists' mastery of any aspect of spoken language on the quality of service delivery to clinical populations (Langdon, 1999; Wilkinson & Payne, 2005). This section discusses relevant extant literature on how accented speech affects speech perception and comprehension by individuals with and without communication disorders, with a focus on clinical populations. It is not intended to provide an exhaustive literature review, but rather some findings from research that can inform clinical practice. Readers are cautioned that a strong bias is suspected to exist in the literature on accent effects, in that articles with null results (i.e., no perceptual differences found when speakers have accents) may be less likely to be published than the more compelling results that show an adverse effect of accent.

Empirical evidence on the impact of accented speech on intelligibility for listeners without communication disorders reveals two salient findings:

1. The relationships among accent, intelligibility, and comprehensibility (i.e., listener ratings of how easy/difficult utterances are to understand) are quasi-independent (Derwing & Munro, 1997; Munro & Derwing, 1995). Although there is a general correlation between stronger accents and both lower intelligibility and lower comprehensibility, some speakers with strong accents are as intelligible as other speakers with milder accents. Intelligibility depends upon multiple factors, including characteristics of the speaker, listener, particular language pairings, stimuli, and task (Bent & Bradlow, 2003; Bradlow & Bent, 2008; Levy & Law, 2010; Mahendra, Bayles, & Tomoeda, 1999).

2. Perceptual accuracy increases with exposure to an accent (Bradlow & Bent, 2008; Clarke & Garrett, 2004). Thus, if a client has had exposure to the speech of any Cantonese-accented speaker, for example, this may subsequently lead to increased comprehension of a Cantonese-accented clinician. Furthermore, a nonnative clinician's speech might be even more intelligible to a nonnative client than native speech would be, even if the accent were different from the listener's (see Bent & Bradlow, 2003).

Regarding how accented speech is perceived by listeners with communication disorders, researchers have documented the following:

- When listening to accented speech, accuracy on a lexical decision task decreases more for children with speech sound disorders than for those with typically developing speech (Nathan & Wells, 2001; cf. Wilkinson & Payne, 2005). Older adults tend to have more difficulty than younger adults in comprehending accented speech, especially when noise is present and when they have a hearing loss. Even for younger adults, perception of accented speech is less accurate in noisy environments (Adank, Evans, Stuart-Smith, & Scott, 2009; Burda, Overhake, & Thompson, 2005; Burda, Scherz, Hageman, & Edwards, 2003; Gordon-Salant, Yeni-Komshian, & Fitzgibbons, 2010a, 2010b; Munro, 1998; Rogers, Dalby, & Nishi, 2004; see also Schmid & Yeni-Komshian, 1999).

- Adults with dementia reveal poorer speech discrimination and comprehension as a function of a speaker's accent than do age-matched adults without dementia (Burda, Hageman, Brousard, & Miller, 2004; Mahendra et al., 1999).

- Accuracy in comprehension is more affected by accent when listeners have aphasia (including Wernicke's, Broca's, and conduction aphasia) than in age-matched peers without aphasia (Burda, Brace, & Hosch, 2007; Dunton, Bruce, & Newton, 2011).

This body of evidence, although scant, suggests that accented speech may be particularly difficult to decode for individuals with communication disorders. Despite the paucity of research on this topic, the daily work of serving multilingual clients by multilingual clinicians continues. A survey by Levy and Crowley (2011) revealed that in speech-language pathology training programs at universities in New York State, policies and practices were variable when a student had a foreign accent, ranging from no action taken to accent modification by a peer. Moreover, these authors and Langdon (1999) found that accents in English were perceived more negatively than accents in other languages. With the few relatively objective assessments such as percentage of consonants correct (Shriberg & Kwiatkowski, 1982) or standardized tests, accent ratings may

be affected by preconceptions of accents. For example, Rubin and Smith (1990) asked native English listeners to judge recorded utterances paired with a photograph of a woman who appeared Caucasian versus a woman who appeared Asian. Interestingly, the same spoken utterances were assessed as more accented when paired with the photograph of the Asian woman than with that of the Caucasian woman. Clearly, further research is needed to advance our empirical knowledge about (a) the effects of accented speech on perception by individuals with communication disorders and (b) strategies for facilitating communicative effectiveness when needed.

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Strategies for Supporting Students When There Are Concerns About Their Accents

University programs and students share a common goal: to work toward ensuring that future professionals possess the ability to provide effective clinical services. Universities challenge students to learn what they do not yet know and to self-identify strengths and weaknesses. As a part of this process, universities must identify student weaknesses and sometimes even ultimate aptitude or fitness to work as SLPs and audiologists. During this process, it is necessary to make specific recommendations for students for their progression through a professional program. The following strategies are proposed for maximizing the likelihood of success when there are concerns about a student's accent in delivering clinical services.

1. Provide early support.

    - *Universities.* Expect that students' accents may have no effect or a variable effect on their clinical abilities across the scope of practice; some students with accents will be extremely successful on their own, while others may need a greater amount of external support. Do not automatically assume that a student will have difficulty delivering clinical services.

    - *Universities.* Include information on the academic program's website and in printed materials and/or brochures describing resources available to students with concerns about intelligibility due to their accents. Consider sharing this information at initial departmental orientation meetings for new, incoming students and at initial advising meetings as relevant. Include information on research and clinical work being undertaken at the institution related to cultural and linguistic differences, as the faculty members doing this work may be resources for students with accents. Further, identify staff/faculty who were international students, are bilingual, or are successful SLPs with nonnative accents, as such individuals can serve as allies for students with accents.

    - *Universities.* Invite students with accents who have raised concerns to speak with faculty advisors or other appropriate faculty as soon as they enroll in the program.

- *Universities.* Provide early and frequent opportunities for faculty and students to meet and identify students' communicative strengths and needs.

- *Universities.* Have a plan and procedure already established to offer accent modification services on-site or a list of referral resources for students with accents. Programs should be aware that on-campus training is often more affordable for students and may allow opportunities for independent study credit in lieu of time spent in accent modification training. Have a system or process in place that incorporates a team approach and provides additional perspectives in determining how to best meet these students' needs. Partnerships can be established with other departments, such as Linguistics, English, Communication, Second Language Acquisition and Teaching, Modern Languages, or Teaching English as a Second or Other Language, to assist in obtaining objective input and assistance for students and faculty. Provide a list of resources to all students in materials disseminated at orientation.

- *Students.* Ask for time to process and respond to any recommendations received. Seek input or feedback from faculty advisors and campus resources such as the university's Office of International Students or the Office of Diversity and Equity.

- *Students.* Approach supportive faculty or clinical supervisors early with concerns about how an accent could have an impact on clinical work. Adopt an open, objective stance on self-assessment of verbal communication and be attentive to common responses from communication partners (e.g., requests for repetitions or a reduced speech rate, or confusion expressed by the listener).

2. Provide an accent modification/intelligibility enhancement plan.

    - *Universities.* Provide a written description of the specific sounds and linguistic behaviors that may affect the student's ability to provide effective services. Identify the support the university will provide to the student with specifics such as who will provide the accent modification/intelligibility enhancement services, long- and short-term goals, and the amount of time the university recommends per week to work on the issues.

    - *Universities.* Communicate in writing the criteria for successful completion of the accent modification/intelligibility enhancement plan so that the student can participate in clinical experiences.

    - *Universities.* Discuss the possibility of lengthened duration of academic study if accent modification/intelligibility enhancement services are necessary.

    - *Universities and students.* Schedule regular meeting times throughout the student's enrollment to discuss progress.

    - *Universities and students.* Expect that the student with an accent can become more intelligible over time, but that the time needed may be variable. Additionally, keep in mind that listeners may comprehend more over time.

3. Avoid communicating inferiority.

    - *Universities.* Avoid offering accent modification/intelligibility enhancement by a fellow student. This can lead to the perception that the student with a nonnative accent is inferior to his or her peers and may have an impact on the student's confidence and motivation. When this is unavoidable, consider the following recommendations:

        a. Do not have a student clinician in the exact same cohort of peers. Instead, pick a student a year or two ahead of the student receiving services.

        b. Consider designating this as a session that cannot be observed by other students in training.

        c. Have an open conversation with a student participating in accent modification about a choice of in-clinic services or comparable services available through the international student center, office of faculty development, or the English department, for example.

        d. When services are offered by a student clinician, it is recommended that supervisors be knowledgeable about contemporary methods for accent modification/intelligibility enhancement and view the goal of these services as maximizing the communicative effectiveness and intelligibility of students with accents.

    - *Students.* Discuss concerns with supportive faculty or clinical supervisors about how accent modification/intelligibility enhancement services are provided. Have frank conversations with faculty/staff/professionals who also have nonnative accents, to gain insight from their experiences and recommended strategies.

4. Be respectful of what the student brings to the profession.

    - *Universities.* Students with nonnative accents often have a significant understanding of culturally and linguistically diverse issues germane to our discipline. In addition, they are sorely needed for service provision in other languages they may speak. The manner in which accent-related issues are supported can have significant positive effects on student self-esteem, motivation, and sense of belonging within the program and university, and within the professions.

    - *Universities.* Remember that a student's skills will continue to evolve. Furthermore, as professionals, they will define a personal scope of practice.

5. Focus on the client's perception of accent.

    - *Universities.* In the end, what matters is whether clients can understand and learn from a student clinician with an accent.

- *Universities.* Carefully weigh how to ease a student into clinical practicum, by providing options to volunteer and serve as an assistant to a clinician so that performance can be initially assessed and more sound decisions can be made about clinical placement. Consider capitalizing on the student's skills, such as in knowledge of instrumentation (e.g., for a voice client), or assigning the student to a client from a similar linguistic background who may be less likely to have difficulty understanding the student's accent and may benefit from the student's skills in another language.

- *Students.* Do all the preparation and analysis needed to be ready to work with the client and to enhance the client's understanding (e.g., repeat, rephrase, vary rate/loudness control, and provide comprehension checks).

- *Universities and students.* Identify resources that the student with an accent can use with a client to minimize the potential impact on treatment outcomes. These resources may include DVDs and software that produce targeted sounds, narratives, or therapy exercises.

6. Address client concerns regarding a student's accent. A client or a client's family may indicate that they want to work only with a student with a native accent.

   - *Universities.* Include information in descriptions of the clinic's services explaining that the clinic is a training setting designed to provide required educational opportunities for all of its students while ensuring that assignments and services provided are supervised by seasoned expert personnel to ensure quality service delivery to all clients. Have a dialogue with department members about the high potential for discrimination based on national origin and provide information on the Civil Rights Act of 1964, which in Title VI bars discrimination on the grounds of race, color, or national origin under any program or activity receiving federal financial assistance, and in Title VII prohibits discrimination by covered employers on the basis of race, color, religion, sex, or national origin.

   - *Universities.* Consider developing a student-centered department policy on the issue (see San Francisco State University, 2011).

   - *Universities.* Have a conversation about why the clinic assigned the student to that client and discuss the client's/family's concerns. If there are legitimate concerns, they should be addressed. In some cases, it will be important to educate a client and his or her family about why their concerns may be unfounded.

7. Choose external placement sites with care.

   - *Universities.* Off-campus clinical supervisors should be made explicitly aware of the program's philosophy and preferred approach to helping students with accents succeed.

   - *Universities.* Consider inviting off-campus practicum or internship supervisors to relevant continuing education offerings or to have a dialogue about student-

centered and client-centered strategies for maximizing communicative effectiveness when a clinician has an accent.

- *Universities.* Choose outside placements with supervisors who are aware of and sensitive to issues related to cultural and linguistic diversity in the professions. Also, choose outside placements with appropriate caseloads given a student's current level of intelligibility.

- *Universities.* Recognize any limited potential for the student to be successful; if the placement is a poor match and the student could likely be successful elsewhere, change the student's placement.

8. Acquisition of self-awareness by students is key.

    - *Universities.* Instill in all students an understanding of ASHA's Code of Ethics and how the Code applies in clinical situations so that students seek work that is within their personal scope of practice.

    - *Students.* Understand that professionals are expected to comply with ASHA's Code of Ethics and to make a referral to a colleague when they are not qualified to work with a given client.

    - *Students.* In the final analysis, the question is not whether a student has acquired a “native-enough” accent in English. Rather, the question is whether they have enhanced their intelligibility (as substantially as needed), acquired self-awareness of their accent and its clinical impact, and have developed resources to rely upon in various situations.

    - *Students.* Carefully consider whether to continue accent modification/intelligibility enhancement after graduation as part of professional skill development to continue to build and maintain intelligibility.

    - *Universities and students.* Recognize that employers make hiring decisions based on multiple factors beyond just a prospective employee's spoken accent. Discriminating solely based on accent is a violation of federal employment law in the United States. In some instances, a student with skills in more than one language is a preferred clinician.

9. Seek outside support and guidance.

    - *Universities.* Assess established practices and systems for supporting students with accents through exit interviews of students who participated in accent modification/intelligibility enhancement. Ask students to rate the quality of the support and treatment they received during accent modification/intelligibility enhancement and generally with issues related to their accents. Ask for suggestions on improving the approach for future students.

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Recourse for Students

A collaborative approach between students and academic programs is the best approach for meeting both the student's and program's needs and obligations. Agreed-upon actions and milestones that are established early in a student's enrollment will help minimize or eliminate conflicts at the end of a student's matriculation. Students deserve to be supported to the greatest extent possible and not unfairly targeted. Faculty members should be comfortable in the decisions they make about a student's ability to provide clinical services. The best possible plan for student success will grow out of efforts to intervene early and to systematically and routinely monitor progress toward agreed-upon targets. There may, on occasion, be situations when even after an exhaustive and collaborative process and pursuit of all possible strategies, a student's desired outcomes and the capacity of his or her academic program to meet those desired outcomes may reach a stalemate. In those instances, students who feel that they are being denied an opportunity to pursue a career in our professions should consider utilizing grievance procedures in place in the universities and/or contacting the ASHA Office of Multicultural Affairs for help in objectively exploring their situation and available options. If they feel that an academic program has not been forthright in supporting them and helping to plan for their success, students should know that they also have recourse through established procedures with the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) for filing complaints against graduate education programs in the professions. Academic programs should consider making grievance procedures and related information available to students by posting them in a prominent place, reviewing the procedures as part of orientation for new students, and encouraging students to use them, if and as needed. Students should also be encouraged to report any examples of discrimination they experience or witness. Complaints levied through the CAA must relate to the *Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology* (CAA, 2011). These include issues such as ensuring that (a) students and others are treated in a nondiscriminatory manner; (b) the program makes reasonable adaptations in curriculum, policies, and procedures to accommodate differences among individual students; and (c) students are informed about the program's policies, procedures, and requirements.

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Future Research Needs and Considerations

Before we can establish more specific Association policy related to the requirements for service delivery by SLPs and audiologists, and develop academic or clinical training that would support those requirements, we need empirical answers to many questions. We need to know who will have difficulty understanding clinicians with accents, under what conditions, and how that can affect the way we provide services. We also need to know more about the impact of exposure to accents on the ability to understand accented speech. So, data are needed on whether individuals with particular types of communication disorders are more likely to have difficulty with

clinicians whose accents are different from their own than with clinicians whose accents are more similar to their own.

Additionally, we need more insight into the factors influencing intelligibility and listeners' perception. For instance, Gluszek, Newheiser, and Dovidio (2011) recently suggested that accents need to be better appreciated as key aspects of speakers' personal identities and that it is critical to educate both listeners and speakers that strong accents do not necessarily lead to communication breakdowns.

We also need to know how to more objectively measure intelligibility and how to determine acceptable levels of intelligibility for clinical practice under specific conditions. We need to further evaluate the effectiveness of the few existing assessment tools for measuring accent/intelligibility and research that will lead to the development of new, more objective measures. There is also a need for researchers to document the types of support and resources that result in greater intelligibility by speakers with accents and improved levels of clinical effectiveness by student clinicians. These data would help identify strategies with the greatest impact on clinical effectiveness and inform academic program planning and student advising. There is also a greater need for more preparation and training of clinical supervisors to develop the requisite skills for working effectively with students with accents.

In the meantime, taking as evidence-based an approach as possible is recommended for making decisions to ensure student success. That approach should be one in which faculty and students refer to extant data as well as to the perspectives of the student, faculty member, and clients. This information should be the foundation for their best judgment on how to proceed in moving students with accents to fully contributing ASHA member professionals.

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