A Review of Developmental and Applied Language Research on African American Children: From a Deficit to Difference Perspective on Dialect Differences

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The acquisition of literacy, inclusive of symbolic media such as mathematics, is dependent on the early spoken or signed language that children learn for interpersonal communication before school entry (Donlan, Cowan, Newton, & Lloyd, 2006; Nathan, Stackhouse, Goulandris, & Snowling, 2004; Snow, Tabors, & Dickinson, 2001). Professionals are apt to encounter diversity in the spoken language that children bring to school, particularly where education is compulsory and publicly funded. In the United States, children generally are expected to obtain at minimum 12 years of schooling (i.e., Grades 1–12). At least 85% of them do so in public schools (Wikipedia, 2008). In the United States, more than half of the speech-language pathologists (SLPs) and 9% of audiologists deliver professional services to children and their families in schools (American Speech-Language-Hearing Association [ASHA], 2008).

ABSTRACT: **Purpose:** The contemporary practices of delivering speech, language, and hearing services in schools reflect palpable gains in professional sensitivity to linguistic and cultural diversity. **Method:** This article reviews the dominant research themes on the oral language of African American preschoolers who contribute to such diversity in the United States. Specifically, it contrasts the historical and current frameworks that have guided studies of (a) such children's acquisition and use of English and (b) the strategies used to assess and modify their language. **Conclusion:** Research initiatives that can expand knowledge about this group are proposed.

KEY WORDS: African American preschoolers, language acquisition, assessment, intervention

African American (AA) children, who are the focus of this article, contribute to the linguistic and cultural diversity encountered in U.S. schools. As the second largest minority racial group in the country, they make up a visible percentage (~17%) of the children who are enrolled in public schools (Fry, 2007). There long has been concern about their underachievement at school. This problem has been readily attributed to the spoken English that many of them bring to school because it differs from the Standard American English (SAE) varieties that are used for instruction. This English dialect, sometimes labeled as Ebonics (i.e., Black sounds), is referred to in this article as African American English (AAE).

The presumed relationship between AAE and the educational outcomes for AA children was the focus of a special issue of *Language, Speech, and Hearing Services in Schools (LSHSS)* in 1972. It included nine papers on urban communication and language affairs ("Urban," 1972). They were chosen from papers presented on this topic at ASHA-sponsored conferences. According to Aaron Favors, ASHA's Associate Secretary for Urban and Ethnic Affairs at the time, the papers were "concerned with defining program models, providing concrete suggestions for adapting test materials and modifying existing programs to meet the speech, hearing, and language needs of the culturally different child, and assuring his success within the school environment" (Favors, 1972, p. 4).

Since that special *LSHSS* issue 38 years ago, more attention has been given to multicultural issues in the speech-language pathology and audiology professions. This is evident from the increased number of publications on the topic. Between 1970 and 2008, *LSHSS* alone published approximately 110 papers with titles focused on minority language and cultural issues inclusive of AAE. More than 80% of them were published in the past 25 years, nearly half appearing in the last 10 years. Other resources (viz., books, theses, dissertations, and videotapes) also

have had a multicultural focus. Textbooks on communication disorders now routinely over the topic. The current article highlights what we have learned from this expanding body of work that is useful to professional practices in speech-language pathology and audiology, and in particular, to the delivery of professional services to AA preschoolers. Its preschool focus on oral language is relevant to the early detection and treatment of speech-language problems, which can negatively impact children's subsequent school performance. First, I identify professional issues that SLPs and audiologists may face as a result of being unfamiliar with the culture and language of AAE speakers. Second, I identify the types of past, current, and future research themes on the language development of AA preschoolers and the types of language assessment and intervention strategies used with them as AAE speakers.[1]

PROFESSIONAL ISSUES IN SERVING AAE SPEAKERS

Historical Roots of AAE

Many AA children come to school speaking AAE as their first language. This English dialect creates professional challenges for clinical service delivery, which cannot be isolated from the historical context in which it originated and evolved in the United States. It is widely believed that AAE is the vestige of a pidgin-creole. Its patterns were influenced by African and English languages, inclusive of the early English creoles that were spoken in Africa and the African diaspora (Rickford & Rickford, 2000; Taylor, 1972; Wolfram & Schilling-Estes, 1998). AAE evolved historically in the United States as a tool of communication and cultural identity within a milieu in which AAs were denied schooling and were socially isolated from mainstream society (Rickford & Rickford, 2000). As such, there was little opportunity to transition gradually to SAE as other immigrant groups did (Baugh, 1998). Perhaps it also was difficult to view AAE as a legitimate English variety early on because no specific ancestral language could be identified to account for its differences with SAE, as could be done for English speakers of minority Native American, European, Asian, Arabic, and African languages. The variable rules of the dialect, coupled with the perception of its formerly enslaved speakers as inferior in learning ability, are likely to have contributed further to the impression that AAE was simply a poorly learned copy of SAE.

In its contemporary form, AAE is viewed as an oral dialect of English. It is debatable whether this dialect is evolving closer to or farther away from SAE (cf. Labov & Harris, 1987; Vaughn-Cooke, 1987). All AA children do not speak AAE, but many non-speakers understand it, given their familial and community ties to those who do. Despite evidence for AAE's linguistic legitimacy, the 1996 controversy over its use in the Oakland, CA schools revealed how negatively the dialect continues to be viewed by the U.S. public (Rickford & Rickford, 2000; Smitherman, 2004; Vaughn-Cooke, 2007).

AAE and Clinical Issues

Identifying AAE speakers with speech-language delays can be difficult because some of their typical dialect patterns (e.g., f/th substitution and copular verb absence) can resemble those used by typical SAE speakers who are developmentally immature or by speakers with speech-language delay. Consequently, typically developing AAE speakers, who use such patterns beyond the ages expected for SAE speakers, may be erroneously judged as delayed. This outcome is likely to occur more often when speakers exhibit a high density or rate of AAE use than when they do not, particularly in the absence of known causes of speech-language delay such as hearing loss, brain damage, and so on, as in the case of specific language impairment. Thus, the diagnostic task is complicated by the fact that young AAE child speakers may sound different for varied reasons. Atypically sounding speech may simply reflect the use of different patterns that are normal for their dialect community. AA children's speech may reflect immature use of those target dialect patterns due to a young age or to atypical or slow development of the target dialect.

Consider the following example, which illustrates the grammatical and pronunciation similarities and differences between AAE and SAE within the same utterance:

She is not fixing to ask for the hotcomb.

SAE [ʃi ɪz nat fɪksɪn tu æsk fɔr ðə _____]

AAE [ʃi na fɪnə æks fʌ də hakɔm]

One can observe that these two English varieties have the same speech sounds and most of the same words. The sounds and words also are sequenced in the same way. There are differences too, some of which can be observed among young typically developing SAE speakers and those with spoken language delay or impairment. For example, note the absence of the present tense copular verb, *is*. Pronunciation differences are shown by (a) absence of the final /-t/ sound preceding another consonant in *not* and *hotcomb*; (b) reversal of the final consonant blend in the word, *ask* [æsk] > [æks]; (c) absence of post-vocalic /r/ in *for*, and (d) substitution of the vowel /ɔ/ with /ʌ/ in *for* and the consonant /ð/ with /d/ in *the*.

Lexical differences, which are unique to AAE, show up in the use of *finna* and *hotcomb*. *Finna* (also pronounced as *fitna*) is a simplified pronunciation of *fixing to,* which codes imminent action in both AAE and SAE. This lexicalized pronunciation is likely to have resulted from the multiple sound substitutions and deletions that were allowed in AAE spontaneous speech. *Hotcomb* is an invented AAE word that differs from SAE in both form and meaning. It refers to a heatable metal instrument that is used to straighten hair and is not usually found in dictionaries. In my experience, many non-AAs are not familiar with this word, although they may use a word for a heatable instrument that curls hair. *Hotcomb* is, however, likely to be known by AAE speakers, especially girls, who are as young as 2 or 3 years of age. It is not a slang word. Compounding words is one of several ways that all speakers create new words in a language (Wolfram, 1991; also see Stockman, 1999). The same innovative process was used to create such acceptable SAE words as *hotbed, hottub, honeysuckle,* and so on. A lexical innovation like *hotcomb* was needed to symbolize a particular aspect of the AA cultural experience, namely, hair straightening. This practice reflected AAs' efforts to assimilate into U.S. mainstream society. See Smitherman (1999) for other lexical innovations in AAE, and Labov (1972), Rickford and Rickford (2000),

and Wolfram and Schilling-Estes (1998) for descriptions of other AAE patterns.

The example above represents an extreme case of AAE and SAE differences within a single sentence. It nevertheless illustrates why a non-AAE speaker may encounter multiple layers of linguistic differences in a single speech event. The more work that listeners must do to understand a speaker, the more likely is that speaker to be judged as unclear, if not communicatively impaired, by professionals who are unaccustomed to hearing AAE. One consequence of this perception is the overdiagnosis of AA children with speech-language delay. Another consequence is the underdiagnosis of AA children with such delay when any observed difference is attributed simply to normal dialect use for a speaker's age. Either misdiagnosis occurs if clinicians do not know how AAE and SAE rules differ.

Accurate diagnosis of speech-language delay among AA children is challenged further by the large numbers who live in economic poverty relative to their percentage of the U.S. population (McLoyd, 1998). Poverty can limit access to adequate health care and other resources that maximize developmental potential. Therefore, AA children may be more prone to developmental delays than the general population. Finally, it has not helped matters that historically little was known about AA children's normal speech and language development to guide clinical diagnostic decisions.

Taylor (1972) urged researchers to focus on solving the pressing practical problems of delivering speech, language, and hearing services to AA children as opposed to theoretical issues. This practical goal has been met by two types of studies that are concerned with spoken language disorders in this population. One set of studies has focused on AA children's normal acquisition and use of language. The other set has emphasized the language assessments and interventions that are used with AA children.

REVIEW OF RESEARCH ON AA PRESCHOOLERS

Past Language Research

A deficit view of normal AAE differences. Research on the *what*, *when,* and *how* of language learning has always been critical to practical work. SLPs rely on language acquisition research for the normative data used to distinguish typical and atypical language status. Despite the clinical benefit of norms, the research on AA children was not historically designed to answer basic questions about their typical language development and use. Instead, the focus was on if and how AA children differed from other groups of children, particularly White middle-class children who were regarded as the prototypical normative group in child development research (Bloom, 1992; Cole, 1986; Graham, 1992; Stockman, 2007b; Stockman & Vaughn-Cooke, 1982). This comparative focus required both groups of children to be included in a study in order to answer the question of whether their language performances differed. To minimize the effect of extraneous task variables on performance, the participants had to be compared under uniform elicitation and response conditions. Language was elicited using either an existing norm-referenced standardized test or an experimentally constructed protocol that need not have been culturally or linguistically appropriate for AA children. Observations were made in structured or semistructured school settings. The data

analyses yielded quantitative outcomes such as test scores. If age-graded data were obtained, the goal was not to describe how either group changed over time; instead, the focus was on whether group differences persisted across age. AA children's low scores on test protocols were interpreted often as a verbal or cognitive deficit and not as a source of normal variation.

In contrast to the type of language research that was done on AA children, the language research done on mostly White children in the same time period differed markedly. Scholars (e.g., Roger Brown, Lois Bloom, Melissa Bowerman, Katherine Nelson, Elizabeth Bates, and others) focused on the language of very young children (see citations in Stockman [1986, 2007b]). A few at a time were studied longitudinally using home-elicited samples of natural verbal interactions with familiar adults. Such procedures were viewed as necessary to the study of language from the developing child's perspective as opposed to the adult language user. The explanations of child behavior were motivated by Chomskian and counter-Chomskian claims about the role of biology, cognition, and social experience in developing linguistic competence. The data analyses encompassed grammatical patterns as well as the meaning and use of words and sentences. However, none of this reasoning was reflected in the language research on AA children. Scholars even had to defend these children's use of a legitimate language early on. In effect, very different frameworks were used to study the child speakers of AAE and those of SAE (Stockman, 2007b).

The practical application of the research within a deficit framework was straightforward. All differences, irrespective of whether they represented the typical language of AA children, were viewed as a problem that needed to be fixed. Entire classes of school-age children who spoke AAE could be enrolled in speech therapy to correct an f/th substitution in such words as *bath*. Preschool programs such as Head Start were created to help AA children and those in other groups compensate for their economic and cultural disadvantages before school entry (Head Start Act; U.S. Department of Health and Human Services [1981/1998]). Bereiter and Englemann's (1966) language program, which began to be applied to AA children around the same time, assumed no prior language experience.

A paradigm shift: From a deficit to a difference view of AAE. Over time, multiple factors converged to erode the deficit view of AA children's language in favor of a *difference* perspective for studying their language (Stockman, 2007b). These factors were related to (a) modification of the framework for studying language generally and children's language development in particular, (b) litigation of minority language use in schools, (c) recognition of cultural/linguistic diversity in professional practices, and (d) demographic population shifts that affected the range of culturally and linguistically different persons served by the professions.

Expanding frameworks for investigating language. First, there were shifts in the focus and method used to study language generally. That is, the social and cultural aspects of language were emphasized in the traditions of William Labov, Walt Wolfram, Shirley Brice-Heath, John Gumperz, and others (Stockman, 2007b). This genre of scholarship began to gain prominence during the 1960s amid the U.S. Civil Rights movement (Stockman, 2007b). Their research provided the empirical evidence for legitimizing AAE as a linguistic system. At the same time, the emerging field of developmental psycholinguistics focused attention on the adequacy of linguistic theories that did not show how learning a grammar

was mitigated by the meaning of sentences and their social–pragmatic contexts of real world use. Within a universal generative view of language, speakers of nonprestige languages like AAE have the same deep structure or semantic base as speakers of other languages, despite differences in their grammatical and phonological surface forms. The pragmatic contexts of language use could explain how AA children could be verbally taciturn when talking to researchers, who were unfamiliar to them in a research study at school, yet be quite verbal in familiar speaking situations (Houston, 1970). More recently, Seymour and Roeper (1999) showed how AAE could be viewed within a theory of universal grammar. Thus, the research traditions in both sociolinguistics and developmental psycholinguistics helped to shape the view that speakers of a social dialect like AAE could have a different and nondeficient language relative to speakers in other groups.

Litigation: The Ann Arbor Black English case. Second, litigation played a role in eroding a deficit view of AAE speakers. Earlier lawsuits affected the schooling of children who spoke non-English minority languages. A landmark ruling, known widely as the "Black English Case," was the first to apply the same statues to an English dialect. The case, which was heard in Michigan, involved the Martin Luther King Junior Elementary School et al. versus the Ann Arbor School District Board (Civil Action No. 7-71861; Screen & Anderson, 1994). The lawsuit, which was filed on behalf of 11 AA children, alleged that the children spoke a home language that prevented their equal participation in instructional programs at school, and that the school board had not taken action to overcome this barrier. Sociolinguistic research, which supported the legitimacy of AAE, was important to framing the legal arguments in the case. In the precedent ruling rendered on July 12, 1979, Federal District Judge Charles W. Joiner ordered the Ann Arbor School District to submit to the court within 30 days a plan that helped teachers at the King School (a) to identify children speaking "black English"…and (b) to use that knowledge in teaching such students how to read standard English.

At the time of this legal decision, there were no tools to identify child speakers of AAE (Vaughn-Cooke, 1980). The case had been litigated with research evidence on mature AAE speakers. Little information existed about the oral language of AA children before and even after school age because the research on them had not been designed to provide it. There was no research that answered such basic questions as when AA children even get their first words, sentences, and so on. Thus, this legal ruling provided another impetus to study the language of young AA children.

It is not surprising that researchers in communication disorders responded to the challenge. They were already invested in assessments for detecting impaired language. Their search for linguistically and culturally fair assessment strategies was empowered by the rising sensitivity to cultural diversity in the professional education and practices of SLPs and audiologists.

Professional recognition of language differences. A third contributor to the erosion of a deficit view of AAE speakers was the recognition of cultural diversity by the human service professions (i.e., education, medicine and the allied health professions), inclusive of those that were concerned with communication disorders. ASHA is illustrative. Its efforts to recognize linguistic and cultural diversity were fueled by the social–political changes in the United States (Screen & Anderson, 1994). At issue was if and how ASHA should respond to the new reality spawned by the quest for social justice on behalf of AAs and other minority groups, as publicly

debated by Orlando Taylor and John Michel at its 1968 national convention (American Speech and Hearing Association, 1969). This debate was among several events that led ASHA to create an office on minority and urban affairs in 1969 (a forerunner to its current Office of Multicultural Affairs). This series of events motivated the ASHA position paper on social dialects (American Speech and Hearing Association, 1983), which stated the dialect difference perspective for the professional practices of SLPs and audiologists.

Increased diversity of U.S. populations. Professional attention to multilingual and multicultural issues was sustained by the increasing diversity of the U.S. population (Battle, 2002; Taylor, 1999). In contrast to the earlier waves of immigrants who came mostly from the English Commonwealth countries and Europe, the immigrants in the latter half of the 20th century were more often of a different type of racial and ethnic background. They came from Asia, Latin America, Africa, and the Caribbean Islands (Battle, 2002). Their different languages and cultural traditions further increased the professional challenges for delivering speech, language, and hearing services to a diverse population.

Contemporary Research on AAE Speakers: Beyond the Deficit Era

Since the erosion of a deficit framework, two types of studies have dominated the language research on AA children's spoken language over the past 25 years. One set has described their typical language patterns and their variation with different demographic characteristics of AA children. The other one has stressed practical assessment and intervention issues, as separately summarized below.

Language acquisition research.

Framework issues. The evidence that AA children acquire a legitimately different variety of English reinforced the need for normative data on them. Given the value of early diagnosis and treatment of communication disorders, such data were needed especially on young children. It also was helpful for educators to know what AA children's language was like at school entry in order to take their home dialect into account when teaching them to read and write, as the Ann Arbor ruling had called for. To obtain information about AA children's language use, a new set of research questions and methods had to replace those that guided the deficit framework (Stockman & Vaughn-Cooke, 1982). Contemporary studies of AA children's language have aimed to:

- Describe the typical language patterns of AA child speakers of AAE and regard age as relevant to interpreting the observations.

- Focus on the development of the mother tongue (AAE in this case) as the principal verbal medium for early cultural transmission and socialization of many AA children.

- Focus on the meaning and use of AA children's language in addition to their linguistic forms (e.g., grammar and pronunciation).

- Use research methods that are more sensitive than before to the sociocultural contexts in which AA children learn and use language.

These investigative goals are especially useful when little is known about a group. Although new to the study of AA children, they were already being met when studying young speakers of mainstream English varieties and other languages. Below I identify

the types of studies that have been done within an expanded framework for investigating AA children's expressive language. They have varied widely in sample size, the amount and type of language sampled, and whether they were focally concerned with developmental issues. A broad range of research designs has been used. Some studies were designed to describe the language of just AA children; others were designed for group comparisons. In the post-deficit era, comparisons have been made more often between two or more AA groups of children who differed in socioeconomic status (SES), gender, or geographic location. When compared to other racial groups, AA children were matched on the critical variables associated with language differences (e.g., SES, geographic location, etc.). Observed group variation was interpreted as a difference as opposed to a deficit. Taken together, the findings from multiple studies allow a preliminary sketch of the broad developmental milestones achieved in each language domain.

Summary of developmental trends. Contrary to the deficit theory, AA children are neither nonverbal nor verbally impoverished. Their maternal caregivers use a child-directed speech register to simplify the linguistic input to young children in ways that have been described for speakers of SAE and other languages (Mills, Edwards, & Beckman, 2005).

Syntactic development. Typically developing AA children combine words by 18 months (e.g., Blake, 1993; Stockman & Vaughn-Cooke, 1986). As they get older, their utterances increase in length, grammatical complexity, and variety. The mean length of utterance (MLU) increases from 1.3 at ages 1;6 (years;months) to 2;5 to 3.39 at ages 3;0 to 4;0, and 6.61–7.42 at ages 4;0 to 6;0 (cf. Stockman, Karasinski, & Guillory, 2008; Stockman & Vaughn-Cooke, 1986; Washington & Craig, 2004). By age 3, elaborated simple sentences predominate (Stockman, 1996a) in declarative, imperative, interrogative, and negative forms (Stockman, Guillory, Siebert, & Boult, 2009). That is, most sentences include three major grammatical constituents: (a) a subject noun/pronoun, (b) a verb, and (c) a verb complement (e.g., *I catch ball; Susie eat food*), plus (d) a lexical or inflectional modifier of at least one of the three constituents (e.g., *I catch a ball*; *Susie eating food*). Complex sentences, most often of the infinitive and compound or conjoined types, also are used by 3-year-old AA children (Jackson & Roberts, 2001). At ages 4 and 5, AA children's frequency of complex sentence use increases. They also more often include relative clauses in both the subject (Oetting & Newkirk, 2008) and verb (Craig & Washington, 1994; Jackson & Roberts, 2001) phrases of sentences. AA children with the highest rate of AAE density have the most complex syntax (Craig & Washington, 1994).

Morphological development. The grammatical elaboration of sentences reflects AA children's ability to embed relational words and inflections into syntactic constructions. Here I focus just on Brown's (1973) set of 14 grammatical morphemes. It still guides early language assessments and includes many forms that differentiate AAE and SAE. At age 2, the locative words, *in* and *on* (Stockman & Vaughn-Cooke, 1991), and the present tense uncontractible copula, *is* (Steffensen, 1974), are observed. At age 3, irregular verbs (e.g., went) and the grammatical articles *a* and *the* are used regularly. Inflections are present as well. The present progressive *-ing* and the *-s* plural may be the most frequently observed inflections at this age (Stockman, 1996b). The remaining inflections in the set of 14 (e.g., *-s* possessives, *-s* third person singular, *-ed* past tense, contractible copula, and auxiliary forms) are variably absent more often at age 3 and older (Cole, 1980;

Reveron, 1978; Ross, Oetting, & Stapleton, 2004; Washington & Craig, 1994; Wyatt, 1996). Third person singular *-s* (e.g., *she eats*) is the least frequently observed (de Villiers & Johnson, 2007).

Phonological development. The number of accurately produced speech sounds by AA children increases with age. Less has been reported about vowel than consonant productions, as is the case for SAE speakers. Already by age 2, single and clustered consonants are produced in spontaneous speech. This early consonant repertoire includes 15 frequently occurring English consonants: /m/n/p/b/t/d/k/g/w/j/f/s/h/l/r/ (Bland-Stewart, 2003). Most of these consonants also comprise the minimal core of 13 to 15 word-initial consonants that are produced spontaneously by 3-year-old AA children (Stockman, 2006b, 2008). Around their third birthday, AA children also produce 8–9 word-initial consonant clusters on average (Stockman, 2006b), the obstruent plus sonorant types being used most often (Stockman, 2006a, 2008). At ages 5 and 6, the later learned fricatives such as /z/, /ʃ/ and /tʃ/ can be elicited in one or more word positions. The initial /l/ and /s/ blends targeted were elicited from 75% of AA children (Wilcox & Anderson, 1998).

AA children's word-final consonants are variably absent. Their use reflects rule-governed constraints, which are observable before age 3 (Stockman, 2006a; Wolfram, 1986). They (nasal and oral stops in particular) are deleted less often when preceding words beginning with vowels than consonants. Other simplification patterns (e.g., stopping of fricatives, fronting of velars, gliding of liquids, voicing assimilation, and so on) resemble those used by SAE speakers (Bland-Stewart, 2003; Haynes & Moran, 1989; Stockman, 2006b, 2008).

For typical speakers, the percentage of consonants correct (PCC), referenced to AAE pronunciation rules, has ranged from an average of 81–82 in spontaneous speech at ages 3;4 to 3;11 (Stockman, 2008) to a range of 95–98 for elicited single words at ages 3;7 to 6;1 (Pollock & Berni, 1997). Seymour and Seymour (1981) compared the standard articulation test responses of 80 children, ages 4–5 years, who were evenly distributed between AAE and SAE speakers. They concluded that norm-referenced criteria for English consonant productions should not differ for the two groups except for final stop omissions, which were most frequent for the AAE group.

Semantic development. The number of words used in spontaneous speech increases with age, that number varying with SES at ages 8 months to 3 years (Hart & Risley, 1995). Between ages 2 and 5 years, the average number of different words (NDW) reportedly used has varied from 75 in a 50-utterance sample (Craig & Washington, 2002) to 121 in a 100-utterance sample, as averaged across social class (Horton-Ikard & Weismer, 2007).

AA children's word combinations code categories of meaning that have been posited as language universals. Before age 3, their talk refers to object existence, actions, states, locations, recurrence, possession, and so on (Blake, 1993; Stockman & Vaughn-Cooke, 1986). Over time, these global semantic categories become further differentiated in meaning by their types of embedded words. In locative action expressions, which refer to the spatial relocation of objects, AA children add 18–20 spatial terms to their vocabulary between ages 1;6 to 3;0 (Stockman & Vaughn-Cooke, 1991). Words that code the direction of a moving object (e.g., *up, down, back,* and so on) are used earlier than those that code the resulting position to which objects move (*in, on, under, between,* etc.). The use of spatial terms emerges in the same order as that observed for SAE speakers.

Similarly, during an hour-long sample of spontaneous sentence productions, it was observed that AA children at age 4 used 109–274 different action verbs to code action relations (McWhirter, 1988). Action verbs that refer to movement and change of location or physical state (cf. *go, tear*) were used most often (60%–70%). The action verb, *go,* also appears to have a dialect-specific stative meaning. Expressions such as *there/here go the ball* are used while pointing to or looking at nonmoving objects. This use has been labeled as the "go copula" form in published reports (Cole, 1980; Stockman, 2007a). In a longitudinal study of AA children ages 18–72 months, Stockman reported that use of the go copula form proliferated between 24 and 30 months of age. Afterward, its use declined with age. Stockman argued that AA children did not need to use this early developing alternative AAE form as they got older because they, like other typically developing English speakers, most often talked about objects in past or future events and not those that can be seen or touched in the perceptual field. These results showed that contrary to earlier speculation (e.g., Cole, 1980; Stockman, 1986), some distinctive AAE grammatical forms do emerge earlier than 3 years of age.

Pragmatic and discourse development. AA children use language to accomplish basic interpersonal and intrapersonal communicative goals before age 2 (Blake, 1993). They take verbal turns and most often use words to achieve interpersonal goals such as seeking attention, identifying objects/persons in the perceptual field, and requesting objects. Less often is language used just for self-expression of internal states or social routines.

Conversational structure emerges between ages 3 and 4. There is evidence that 4-year-old AA children, who are middle class and speakers of AAE, respect conversational turn rules (Craig & Washington, 1986). For example, during their six participants' verbal interactions, Craig and Washington noted that the children took turns speaking one at a time and that most of the talk was "other-directed" as opposed to "self-directed." AA preschoolers also use verbal routines to initiate (e.g., *hi*) and terminate (e.g., *bye*) interactions (Stockman, 1996b). They make topic contingent comments, ask and answer questions, and request objects and actions (Bridgeforth, 1984; Stockman, 1996b). They elicit and respond to requests for clarification using the same types of strategies that have been documented for SAE speakers (Stockman, Karasinski, & Guillory, 2008).

AA children's conversations begin to reflect "narrative-like" talk as early as ages 2 to 3 (Sperry & Sperry, 1996). Their narratives expand over time to include a variety of forms and genre (Champion, 1998).[2] By age 4, AA children produce fictional narratives that reflect the expected structural elements of story grammars. Their narratives include more of the basic elements (e.g., introduction, endings, plot and so on) at age 5 than 4 years (Price, Roberts, & Jackson, 2006).

Typical and atypical variation. Robust evidence shows that the rate of contrastive AAE and SAE use among AA preschoolers varies with SES and gender (Washington & Craig, 1998), community type (Craig & Washington, 2004), geographic location (Hinton & Pollock, 2000), and individual differences among children in the same community and social class (Washington &

Craig, 1994). Within-group differences are not expected to affect broad developmental stages, but the age and order of acquiring specific linguistic forms might be differentially affected. The contrastive AAE and SAE patterns observed have included five commonly observed grammatical features across participant samples in different U.S. regions: zero copula/auxiliary, zero subject/verb agreement, zero past tense, multiple negation, and undifferentiated pronouns (Oetting & Pruitt, 2005). Commonly observed phonological features include interdental fricative substitutions, final single consonant deletion, and clustered consonant reduction (Stockman, 1996a).

However broadly defined the developmental patterns may be, they have differentiated the typical AA preschoolers from the atypical ones who may be diagnosed with specific language impairment (Craig & Washington, 2000; Davis, Williams, Vaughn-Cooke, & Wright-Harp, 1993; Oetting & McDonald, 2001; Oetting & Newkirk, 2008; Ross et al., 2004; Seymour, Bland-Stewart, & Green, 1998; Stockman, 1992, 1996b, 2008; Washington & Craig, 2004; Wilcox & Anderson, 1998). Also see Schraeder, Quinn, Stockman, and Miller (1999), which included AA children. Impairment reflects vulnerability in grammatical complexity (verb tense and aspect), complex sentence use, and passive sentence understanding (Craig & Washington, 2000; Oetting & McDonald, 2001; Washington & Craig, 2004).

Conclusions. The accumulated findings support the following generalizations about AA children's language development:

- Most AA children develop an oral language in the first 6 years of life without formal instruction or clinical intervention.

- Their early grammars develop in the same basic stages and in the same order as other young English speakers; some speech sounds (e.g., /r/) may be accurately produced earlier than is expected.

- Their meaningful word combinations appear by 18 months of age, predominant use of elaborated simple sentences by age 3, and complex sentences inclusive of relative clauses by age 4.

- Their sentences express basic semantic categories (e.g., action, state, location, time, etc.) before age 3; vocabulary expands over time to include a variety of word types within global semantic fields such as spatial location and action.

- Their basic pragmatic functions emerge by age 2 and are embedded in conversational discourse at ages 3–4; basic elements of fictional narrative structure develop between ages 4–5.

- Their speech sound inventories at ages 2–3 include accurate productions of more than a dozen word-initial consonant singletons (nasals, stops, glides, some fricatives) and more than a half dozen different consonant clusters (mostly of the stop + sonorant type) in word-initial position; word-final consonant singletons and clusters are variably absent, occurring more often before words that begin with vowels than other consonants.

- Their use of contrastive AAE and SAE patterns is observed at every developmental stage of morphosyntactic, phonologic, semantic, and pragmatic development—the frequency of use increasing with age and varying with SES, gender, and geographic location.

- Spoken language can be impaired in the absence of comorbidity.

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[2]The citations have been restricted to research on preschoolers. Therefore, Champion's study is not described, nor is the pragmatics research of other scholars such as Carol Westby, Eva Hester, and Sarah Michaels.

Assessment and intervention issues.

Dimensions of cultural differences. The research outcomes on AA children's language have been useful for developing more culturally sensitive clinical procedures. Best clinical practices have relied on concepts in anthropology to identify major sources of cultural differences, as shown in Table 1.

These factors, which were summarized by Stockman, Boult, and Robinson (2004), always have been relevant to the service delivery practices of SLPs and audiologists, but an implicit monocultural perspective was assumed. Cultural differences are respected in the contemporary contexts of service delivery, but groups are not likely to differ on every cultural variable. Instead, Stockman et al. proposed that groups may be distinguished more realistically by their *patterns* of similarities and differences. For example, AAE speakers may not differ from some SAE speakers on religious beliefs or the use of cultural artifacts related to food or toys but may differ in learning style. AAE speakers may be like another group of non-SAE speakers in learning style yet differ from it on aspects of social interaction, and so on.

Irrespective of how cultural differences are described, their recognition has had two consequences for professional practices. First, more options were created to assess spoken language. Second, the scope of intervention practices expanded to allow SLPs to modify the linguistic repertoire of atypical speakers with oral language disorders as well as typical speakers who need proficiency in more than one language or dialect. Below, I summarize current professional issues in each of these two areas as they pertain to AAE-speaking preschoolers.

Assessment issues. The assessment research has been concerned mainly with identifying atypical AAE speakers. To do so, clinicians have relied on traditional and nontraditional measures.

Traditional measures: Norm-referenced standardized tests. The standardized tests used to identify a language problem did not always include AA children in their normative samples. Therefore, it is understandable why such children historically scored below normative sample averages on such tests. Now that AA children are included in tests' normative samples, they have continued to obtain below-average scores on some speech and language tests. See studies of grammar (Qi, Kaiser, Milan, Yzquierdo, & Hancock, 2003; Rhyner, Kelly, Brantley, & Krueger, 1999), vocabulary (Champion, Hyter, McCabe, & Bland-Stewart, 2003; Qi, Kaiser, Milan, & Hancock, 2006; Restrepo et al., 2006), and speech sound articulation (Cole & Taylor, 1990). In contrast, other studies have not revealed significant differences between AA children's mean test scores and those of a standardization sample. See studies of

articulation (Washington & Craig, 1992) and vocabulary (Thomas-Tate, Washington, Craig, & Packard, 2006; Washington & Craig, 1999).

The observation that some AA children perform better on standardized tests than do others indicates that they are not a homogeneous group. For example, on some tests, females have scored higher than males, and middle-SES groups have scored higher than low-SES groups.

To identify AAE speakers with impaired language, clinicians need measures that help them to distinguish differences due to normal dialect use from those that are due to a spoken language impairment. Because most standardized tests were not designed to make such a distinction, research has focused on their usability for doing so.

Measures to counter negative bias in existing standardized tests. To reduce negative bias, the tendency is to modify how tests are either administered or scored so that normal dialect differences are not penalized. Some research has focused on whether test scores are elevated by disregarding failed responses to items that could be explained by a dialect difference. See a study of standardized articulation tests (Cole & Taylor, 1990). Practitioners have created their own local norms for evaluating AA children's test responses (Vaughn-Cooke, 1986). Terrell, Arensberg, and Rosa (1992) showed that articulation test responses that reflect typical and atypical language can be discriminated by comparing the performances of a child and his or her parent on the same test.

Alternative ways to use norm-referenced standardized tests were explored as yet another approach to maximizing the information gained from them. Laing (2003) showed that AA children deleted the final consonants sampled by a formal articulation test less often when the same test words were embedded in a phonetic context (in this case, vowels) that favored their use in AAE. Given that standardized tests also can be biased in the format used to elicit responses (Wyatt, 2002), Peña and Quinn (1997) showed that AA and Puerto Rican preschoolers scored significantly better on test items embedded in activity contexts that required item description as opposed to the culturally unfamiliar task of single word labeling. Fagundes, Haynes, Haak, and Moran (1998) observed that AA preschoolers improved their standardized test scores when the items were presented in thematic contexts (e.g., stories, crafts, games, etc.), which allowed them to be related in "logical and predictable ways" (p. 152). Another solution to negative test bias has focused on modifying the way that responses to a standardized test are evaluated. For example, Bleile and Wallach (1992) showed that it was possible to derive patterns of articulation test performances, which differentiated

Table 1. Sources of cultural differences.

Cultural variable	Description
Common history	Shared experiences as a member of a group with particular racial, ethnic, and national origins
Language	Formal verbal/nonverbal systems of social communication
Beliefs and values	Commonly held truths and values that shape one's view of the world and human actions
Customs	Traditional, ritualistic modes of behavior including the use of time
Material culture	Artifacts and tools, including those used in technology
Learning style	Preferred mode of acquiring new information
Social interaction style	Rules of social engagement and negotiation
Social organization	Family and local community structure

the AA children who had trouble speaking from those who did not, based on community informant judgments (in this case, Head Start teachers).

Test norms do not apply when alternative administrative procedures are used. Still, researchers have created and tested clinical strategies for obtaining more information than a standardized test provides about which AA children may have language impairments. Empirically driven solutions to the problem of negative bias have had the collective effect of showing how AA children's test outcomes are influenced by test demands.

As helpful as these solutions to negative bias may be for using existing standardized tests, they do not replace the preference for efficient use of a single standardized test that is valid for diagnosing impaired spoken language among AA children or any group. This need was met with development of the Diagnostic Evaluation of Language Variation (DELV; Seymour, Roeper, & de Villiers, 2003).

The DELV: A new norm-referenced standardized test. It is important to state that the DELV includes a pair of new norm-referenced tests that were designed to assess children who spoke AAE and those who spoke "Mainstream American English," or SAE. It was normed on both groups of children, each one including typical and atypical speakers. The 1,014 children, ages 4;0–9;11, were distributed in four U.S. regions. The DELV's unique design allows clinicians to determine first whether a child is an AAE or MAE speaker (the Dialect Screener). The criterion-referenced, diagnostic test yields a performance profile in four areas: syntax, pragmatics, semantics, and phonology. The content of these subtests reflects the findings of current research on speech/language acquisition and assessment. For example, DELV's content includes innovative items that tap fast-mapped vocabulary skills and narrative construction. The articulation of speech sounds is elicited in carefully crafted sentences that respect AAE's variable pronunciation rules. The test manual describes multiple sources of evidence for the test battery's reliability and validity.

Alternative assessments. Alternative assessment approaches have expanded the options for assessing AA children and other groups. They have taken the form of two broadly defined strategies, namely, spontaneous oral language sample analysis and procedures that tap learning potential.

Spontaneous oral language assessment. Before formal tests were readily available, SLPs relied on spontaneous speech assessments in clinical work. Even as formal tests became available, SLPs continued to use spontaneous speech assessments. Natural conversational speech makes different demands on using language than do the elicited responses to many standardized tests. Bloom and Lahey's (1978) seminal textbook revealed new ways to evaluate the multidimensional aspects of language competence in an oral language sample—some of which are not adequately measured by elicited responses to standardized tests (e.g., pragmatic behaviors). Such criterion-referenced assessments were expected to supplement, not replace, the norm-referenced, standardized tests for identifying impaired language.

In contrast, the evaluation of self-generated speech has been viewed as not only useful, but required, for diagnosing impaired language among speakers for whom suitable standardized tests do not exist, as was the case for AAE speakers (Stockman, 1996b). Spontaneous speech is readily accessible to observation. It also is implicitly sensitive to linguistic differences because speakers choose their own words and how they are said. At the same time, it is likely to offer a more authentic view of typical language use than do elicited test responses (Schraeder, Quinn, Stockman, & Miller, 1999).

Various forms of analyses can be applied. Nelson and Hyter (1990) showed how an existing procedure for analyzing early spontaneous speech (Developmental Sentence Scoring) could be adapted to take AAE grammatical patterns into account. Other protocols allow for a more comprehensive language evaluation. For example, Stockman (1996b) proposed that clinicians can observe whether 3-year-olds exhibit a minimal core of phonologic, morphosyntactic, semantic, and pragmatic performances that are noncontrastive in AAE and SAE. This empirically derived core of competencies has been shown recently to have potential diagnostic validity for AA children in two geographic locations (Stockman, 2008; Stockman, Karasinski, & Guillory, 2008).

Craig and Washington (2000) described a screening battery for older children that combined spontaneous speech measures with elicited responses to specific tasks that they developed. Their protocol included the traditional measures of sentence length and NDW as well as nontraditional measures of complex syntax and elicited responses to *wh*-questions and reversible sentences. It successfully discriminated between a group of AA children (ages 4–11 years) with language impairment and typical AA children of the same age. Washington and Craig's (2004) assessment protocol included just one spontaneous speech measure (length of communication units), which helped to differentiate typical and atypical AA child speakers.

Thus, there are intuitive and empirical reasons to view oral language sample analysis as a useful alternative to norm-referenced standardized tests when evaluating child speakers of AAE. Assessments based on spontaneous speech in natural situations have intuitive face validity. They are accessible to ordinary observations by clinicians and caregivers. They also are inherently attuned to cultural differences because children choose their own words to say. There now is empirical evidence that some measures of spontaneous speech performance can help to identify speech-language delay (Craig & Washington, 2000; Stockman, 1996b, 2008; Stockman, Karasinski, & Guillory, 2008; Washington & Craig, 2004).

Nevertheless, spontaneous speech-language assessment is not without disadvantages (Stockman, 1996b). Some clinicians may be discomforted by the amount of time needed to elicit, record, and evaluate a speech sample compared to a standardized test. It may not be practical for some clinicians to routinely elicit and evaluate a 20- to 30-min language sample in order to identify language delay, particularly those therapists with heavy screening caseloads in schools. There also is the issue of managing the individual context variation of talk in natural situations, even when the same activities are used to sample the language.

Finally, spontaneous language assessments yield a static measure of competence. Like standardized tests, they aim to describe a child's existing language status. That knowledge naturally reflects past learning. Therefore, it may not be possible to determine whether non-optimal performance is due to limitations on a child's language experiences in the environment or to a child's inadequate ability to learn from the language experiences provided. Other procedures that focus on language learning potential or modifiability have met this need.

Language learning and processing tasks. Dynamic assessment and fast-mapping strategies minimize the effect of past experiences on a current level of performance. They evaluate children's ability to learn from new linguistic input. The dynamic assessment

approach relies on a mediated test–teach–retest strategy. It was shown that both Latino and AA children's vocabulary test scores on a standardized test increased significantly from pre-to posttest after they were exposed to test-taking strategies in between (Peña, Iglesias, & Lidz, 2001). AA children were 22% of seventy-seven 4-year-olds observed. Following the short-term intervention, the typical language learners obtained significantly higher posttest scores than did the atypical ones. Such outcomes suggest that learning mechanisms were likely intact for the typical children but not for the atypical ones.

Fast-mapping assessments were inspired by observations of children's propensity for quick incidental learning of words during typical development. That is, children learn most words without deliberate instruction from caregivers, and the learning can occur with sparse input (e.g., one or so instances). Researchers have aimed to show whether group differences on standardized vocabulary tests disappear when the same children are taught novel words—a task that is expected to be less dependent on prior experience. Using fast-mapping tasks to teach novel words to 2-year-old AA children, Horton-Ikard and Weismer (2007) showed that their middle- and low-income participants did not differ significantly. However, they did differ significantly on the norm-referenced standardized tests of receptive and expressive vocabulary.

Other studies have had similar outcomes when comparing AA children to different racial/ethnic groups in processing novel linguistic stimuli (e.g., nonsense syllable repetitions) that minimize the effect of past experience on performance (Campbell, Dollaghan, Needleman, & Janosky, 1997; Rodekohr & Haynes, 2001). These studies did not include preschoolers. Therefore, they are not reviewed here.

Intervention issues. In the multicultural context of contemporary service delivery, the scope of SLP professional practices has expanded to include accent modification in addition to the remediation of impaired language. Useful concepts for delivering culturally sensitive interventions to speakers of AAE and other minority languages have been well articulated (Battle, 2002; Coleman, 2000; Kamhi, Pollock, & Harris, 1996; Taylor, 1986a, 1986b; Van Keulen, Weddington, & DeBose, 1998), but there seems to be little empirical documentation about how well they actually translate into service delivery practices for clinically remediating the impaired language of AA children or facilitating their learning of SAE as a second dialect. Less research has focused on interventions that modify AA children's impaired communicative behaviors than on the assessment and diagnosis of their language impairments. The available research seems to have targeted mostly those interventions that help typical and atypical AA children achieve literacy and general academic parity at school, as opposed to those that remediate spoken language disorders. In fact, Seymour (1986) argued that except for the clinical diagnostic process and choosing stimuli for therapy, the clinical intervention for AAE speakers with spoken language disorders should not differ from that of other groups. That is, fundamental clinical principles should prevail regardless of a child's language or dialect. Such principles are invested in therapy that is (a) multidimensional (i.e., stress language form, content, and use aspects), (b) interactive, (c) generative, (d) child centered, (e) bidialectal, (f) and diagnostic. Relative to SAE speakers, none is uniquely relevant to AAE-speaking children except for the bidialectal principle. Below, I discuss the relevance of this principle to the two interventions that are within the scope of SLP professional practices.

Remediating language impairment. The principal goal of speech-language therapy is to eradicate the client's oral language patterns that do not match the expected patterns for his or her community at a given age. When aiming to meet this goal for AAE speakers, the bidialectal principle is a sensible one to embrace. Many children are likely to come to therapy with varying levels of SAE competence. For example, AAE speakers may understand SAE even if they do not speak it (Seymour, 1986). Even within the same geographic location, AAE speakers vary in their rate of AAE use (Washington & Craig, 1994). Therapy, then, should cater to whatever a child's level of dialect use is.

AA children's level of bidialectal competence will influence their responses to therapy tasks. Therefore, dialectal issues should influence the judgments about when a targeted response is correct. Suppose, for example, that the accurate use of bound morphemes (i.e., inflectional markers) was targeted as a therapy goal. Because their use is context sensitive in AAE, a clinician should not always regard the absence of a plural marker as incorrect. For example, the absence of the plural inflection on a noun word preceded by a quantifier (e.g., two shoe instead of two shoe*s*) would not count as an error if it matches typical dialect use in a child's home. But, failure to add the plural inflection in "I have shoe*s*" may count as the error as it also does in SAE. To meet treatment goals, clinicians have been advised to first target *noncontrastive* AAE and SAE patterns instead of *contrastive* ones (Seymour et al., 1998; Stockman, 1996a). This is because AA children with and those without impairment will both use the AAE and SAE contrastive patterns that are typical of the dialect. So, group differences should be revealed most readily on the noncontrastive patterns. Despite advocacy for emphasizing noncontrastive AAE–SAE patterns in clinical applications, research has focused most often on the contrastive AAE–SAE patterns when describing AA children's typical language patterns.

It is important to point out that even when clinicians apply the same therapy programs and strategies to remediate the language of AAE and SAE speakers, outcome effectiveness may not be the same for the two groups. Intervention success for AAE speakers will be mediated by a variety of factors that extend beyond a clinician's use of culturally sensitive stimuli in therapy. There are issues of resource availability and cultural beliefs about time and disability that can affect if and how often intervention services are received. The motivation and success of learning will be influenced further by whether intervention strategies respect deeper layers of culture as related to social interaction patterns, child rearing, and caregivers' self-perceived empowerment to work collaboratively with therapists (trust issues). A disregard of one or more of these sorts of cultural factors can prevent desired therapy outcomes for AA children. They can be served by professionals who do not know enough about their culture to take it into account during intervention—a problem that can be overcome by proactive clinicians who seek such information.

Modifying accents. A bidialectal approach obviously makes sense when the intervention goal is to expand an AA child's repertoire to include an SAE variety (i.e., the recognized standard variety in a given local community) besides the AAE variety that is already spoken. The goal of accent modification should be to add, not delete, a language variety. Bidialectal competence means that children can code switch in different communicative situations. In countries with different local or home languages, one or more languages function as the official lingua franca for public discourse

in schooling, business, and government affairs. In the United States, the variety of SAE that is spoken in a given speech and school community is that language of wider communication. This practical reality means that speakers of a minority dialect like AAE are expected to learn that particular SAE variety for schooling. AA children fare better on standard tests of reading and vocabulary when they can code switch (Craig & Washington, 2004). Therefore, it is questionable whether learning SAE as a second dialect is the elective option that we claim it to be (Müeller & Guendouzi, 2006). The efficacy of interventions for learning a second language or dialect is not reviewed here because they have not focused on AA preschoolers, who were the focus of this article. Preschoolers are not expected to request such elective professional services either.

Nevertheless, one should question why SAE instruction is not promoted for preschoolers, given that learning a new language should be easiest to do at early ages. Research on simultaneous bilingual acquisition shows that young children do learn the words of more than one language at the same time and can switch between languages as situations require (Junker & Stockman, 2002; Pearson, 1998). Young monolingual English speakers also learn to vary their speech with situational context. For example, they are likely to talk differently to strangers than to family members. So learning to speak a school variety in addition to a home variety of English does not seem on its face to require a big conceptual shift in reasoning about this issue. Learning a second dialect of the same language may be viewed simply as a shift in discourse style or genre that requires no special instruction (Müeller & Guendouzi, 2006). Some AA children are likely to begin school with AAE–SAE code-switching proficiency, having learned to do so without formal instruction. Such AA preschoolers, who learn to switch codes early, are likely to have parents or caregivers at home who speak SAE and who also can provide preschool literacy experiences that increase SAE exposure. Such home experiences may be related to parent exposure to formal education (Etter-Lewis, 1985).

For AA preschoolers without adequate SAE exposure for learning to switch between dialects, professional intervention may be helpful. Such intervention now falls within the scope of professional practices for SLPs. However, SLPs may have difficulty delivering such a service to typically developing preschoolers because second dialect acquisition is regarded as an elective service, not a required one. Preschoolers are not empowered to choose it. Furthermore, SLPs are not the only professionals who may provide such a service. Other professionals (e.g., the classroom teacher or teacher of English as a second language) also may do so. There are likely to be numerous ways that educators can embed dialect awareness experiences in preschool language enrichment programs and language arts curricula, as well as in caregiver education on early development.

Unlike the goal of remediating impaired language, dialect awareness instruction, whether done by the SLP or another type of professional, should have the basic goal of expanding as opposed to replacing a child's existing language repertoire. To meet learning goals, *contrastive analysis* is expected to help with predicting the linguistic differences that occur. It allows the structural differences and similarities between two or more languages or dialects to be compared systematically (McGregor, Williams, Hearst, & Johnson, 1997). The general assumption is that some of the errors produced in a second language or dialect are due to interference from the earlier learned first language or dialect. For example, AAE contrasts with SAE in the use of the voiceless interdental fricative /θ/, which

is realized as /f/ in medial and final word positions. Consequently, the pronunciation of the words, *bathtub* and *bath* as [bæftʌb] and [bæf], respectively, can be explained by the normal dialect interference and not by impaired speech. Furthermore, Taylor's (1986b) basic principles for teaching SAE as a second dialect emphasized more than the acquisition of alternative speech pronunciation and grammatical patterns. He also advocated the building of a positive attitude toward one's own language, awareness of different languages, and the situational requirements for speaking.

Smitherman (2004) proposed further that expanding the language repertoire of AAE-speaking children should be broader than the goal of "bi-English" proficiency. Because most speakers in the world are multilingual, she advocated that AA children learn other languages besides English, a goal that also ought to be more easily achieved the younger a child is.

Future Research Outlook: New Questions

Over the past 25 years, we have learned a lot about AA children's language use and how professionals may better serve them. However, more needs to be known. Research is needed on (a) the language development of AA children and (b) the effectiveness of diagnostic and intervention procedures used with them.

AAE acquisition. We now know a lot more than before about children's use of AAE patterns that contrast with SAE varieties and the type of demographic factors that affect their rate of use. There is much to learn about the acquisition path for both those patterns that contrast and those that do not contrast with SAE (Green & Roeper, 2007). Although the evidence, which was summarized earlier in this article, suggests that AAE and SAE speakers do not differ in their early broad stages of development, they may differ in their age of achieving specific competencies within a broad stage. For example, AAE speakers may acquire some aspects of phonology (e.g., the consonant or prevocalic /r/ as in *r*at) earlier than their White, age-matched peers in the same region (Pollock & Berni, 1997). The opposite trend has been reported for phonotactic sequences (Velleman, Pearson, & Bryant, 2008). Such outcomes most likely reflect the interaction between the noncontrastive and contrastive aspects of the two dialects. It could be reasoned that AAE speakers may have more cognitive resources for learning the prevocalic /r/ because their linguistic system does not have to distribute resources to learning the vocalic and postvocalic /r/ allophones (e.g., *car* [kaɚ] > [ka]; *better* [bɛtɚ] > [bɛtə]), as is required for speakers of some SAE varieties (Stockman, 1996a).

In contrast, AAE speakers may need to allocate more resources to figuring out the variable rules for using word/syllable final consonants, which may be selectively absent. Information load in a developing linguistic system is generally relevant to understanding how learning occurs typically and how to remediate its impaired state.

Nevertheless, answering basic questions about AAE acquisition should not continue to be bound by just a focus on whether patterns do or do not contrast with SAE. Developmental studies of SAE and other languages have not been constrained in this way. Like studies of other first languages, developmental research on AAE should have the principal goal of revealing how its young speakers achieve communicative competence over time. This outlook ought to broaden knowledge about how language learning happens generally because of the kind of linguistic system that AAE happens to be (Seymour & Roeper, 1999). For example, Green and

Roeper (2007) experimentally investigated the time and order in which AA children learned the meaning of two AAE features, stress *been* and habitual *BE*, at ages 4 and 5 years. They concluded that the general assumptions of the aspect first hypothesis needs revision based on their AAE data.

At the same time, we may learn more about universal constraints on language patterns by comparing AAE speakers to those who acquire first languages other than English. For example, the French and Mandarin languages allow final consonant deletion in a broader range of phonetic contexts than does English. When these speakers learn English as a second language, they may omit final consonants like native AAE speakers. Similarities across minority language speakers ought to provide some efficiency for clinicians who deliver services to different groups.

Speech perception and production theories and methodologies have been applied to the research on speakers of English as a second language but less often to the speakers of English as a second dialect such as AAE. Research on cross-dialect perception is relevant to clinical work with AAE speakers. Most AAE speakers receive professional services from clinicians who do not speak AAE. Its perception by nonspeakers has focused primarily on their negative social view of AAE. So we know little about AAE perception in terms of the costs of processing unfamiliar speech. An important question to raise is whether AAE perception is affected by the number and type of features that differ from SAE in a given speech event (Robinson & Stockman, 2009).

Clinical applications.

Assessment. Many assessment issues could be addressed in future research. Here I consider just one issue, which is created by the fact that so many options now are available for assessing AA children and speakers of other minority languages. That issue has to do with helping clinicians to create optimal assessment paths that take advantage of the available options while simultaneously achieving efficiency in their work. A critical question to ask is whether different categories of assessments yield the same outcomes for a child insofar as identifying a normal or impaired state. Convergent outcomes allow clinicians to achieve efficiency in their assessments by choosing just one option. Nonconvergent outcomes require clinicians to use more than one option, which involves more assessment time. To determine whether two or more measures yield convergent or nonconvergent outcomes, they obviously must be given to the same child.

Stockman (2002) simultaneously compared the outcomes of a standardized test and spontaneous language sample analysis for the same child. The evaluation outcomes for the standardized test, the Preschool Language Scale—3 (Zimmerman, Steiner, & Pond, 1992), and the spontaneous speech sample were comparable for 80% ($n = 69$) of the 3-year-old AA participants in the study. This percentage included the children who passed both types of measures and those who failed both. The degree of convergence was surprising because spontaneous speech assessments were expected to yield a different, if not less negatively biased, outcome for AAE speakers than norm-referenced, standardized tests of speech and language. Still, Stockman reported that 20% ($n = 69$) of the AA children observed had mismatched outcomes (i.e., passed or failed one assessment but not the other) and thereby warranted further testing. It is the latter group for whom dynamic assessment, fast-mapping, and language processing strategies might be most useful when identifying impaired language. Future research can be helpful by demonstrating the efficacy of using such new assessment approaches

and identifying the subgroups of children who profit from them and other types of available assessments.

Intervention. Virtually no empirical evidence appears to exist on how efficacious therapy is for AA children. Thus, the need for further research is clear. Efficacy-focused research well serves the current emphasis on service accountability in the professions. It ought to be particularly crucial in this case because the same strategies for remediating language disorders are expected to be equally efficacious for SAE and AAE speakers. However, the challenge of negotiating cross-cultural differences between AAE speakers and their providers of clinical services may not be met as reliably as expected or desired. One possible consequence is less adequate therapeutic outcomes for AAE than SAE speakers.

In the area of second dialect instruction, we would profit from research on the efficacy of dialect awareness instruction for AA preschoolers, inclusive of those in kindergarten where it is available in schools. Empirical evidence for positive outcomes ought to encourage programmatic efforts to expose AAE-speaking preschoolers to the language of school instruction, which currently is unavailable to them.

Both types of professional interventions should profit from more information about the potential relationship among culture, language, and cognitive learning style. We have been encouraged to differentiate learners with a field-independent as opposed to a field-dependent learning style, the latter type associated with AA speakers (Terrell & Hale, 1992). There appears to be little direct empirical evidence for this kind of broad group characterization. Moreover, the heterogeneity among AAE and SAE speakers alike casts doubt on whether such a broad group distinction is real. Still, it is reasonable to seek evidence for cognitive style as a cultural variable for particular subgroups of speakers. There is renewed interest in linguistic relativity and Whorfian-inspired notions about the influence of cultural practices on language (Gumperz & Levinson, 1996). Some of the language assessment research also has been relevant to the claim that AA children function with a field-dependent cognitive style. For example, Fagundes et al. (1998) compared the standardized test responses of White and AA children under conditions that differed in their reliance on contextualized activities. AA children performed significantly better on the complex test items in the contextualized than in the noncontextualized condition. The same effect was not observed for most of the White children. The authors interpreted their findings in terms of possible cognitive style differences between the two groups. They called attention to the need for more research on the topic.

Other Issues: Education of SLPs and Audiologists

It is not enough to obtain research results that could guide the professional services of SLPs and audiologists. We also must create instructional opportunities for them to obtain the information. Instruction on multicultural issues is a new pedagogical frontier for the professions. Some SLPs and audiologists may lack adequate information about such issues. This can occur if their educational programs do not require them to learn about such issues or if they devote little time to them. In a national survey of accredited programs in speech-language pathology and audiology (Stockman, Boult, & Robinson, 2008), most respondents reported minimal exposure to diversity issues in their professional preparation. Their

programs most often relied on just a general infusion model of multicultural instruction. Therefore, it is reasonable to question whether clinicians are prepared to serve atypical AAE speakers or to engage in second dialect instruction for typical AAE speakers (Müeller & Guendouzi, 2006; Stockman, 1996a).

Although second accent modification is within the scope of SLP practices in the United States, it requires professionals to apply some skills in addition to those needed to manage communication disorders. For example, skills are needed for the perception of typical speech patterns that differ from their own and for using contrastive analysis to assess speaker differences. SLPs also need knowledge about cultural factors that impact situations of second dialect use (McGregor et al., 1997; Müeller & Guendouzi, 2006; Taylor, 1986b). Such knowledge is unlikely to be attained within the regular curricula of most educational programs.

SUMMARY AND CONCLUDING REMARKS

A basic premise of the current article is that written language learning inclusive of mathematics builds on the oral language foundation that children bring to school with them. This article has provided an overview of past, current, and future research issues regarding the oral language of AA preschoolers, emphasizing in particular those who learn as their first language an English dialect that differs from those sanctioned for school use. Research was reviewed on AA children's language acquisition and on the types of assessment and intervention strategies used to modify their linguistic repertoires. The significant advances in knowledge on these fronts over the past 4 decades have been enabled by scholarly contributions not only from communication disorders but also from multiple disciplines outside the field (viz., linguistics, sociolinguistics, psycholinguistics, anthropology, education, and law). The shift from a deficit to a difference view of dialect differences has allowed scholars to refute earlier claims of AAE's linguistic inadequacy as a tool of social communication for its speakers. It also has provided the impetus to study AAE acquisition by young children. The evidence so far shows that young speakers of AAE pass through the same basic stages of early development as do young SAE speakers. They develop at the same pace as SAE peers matched in age, social class, and regional location. In phonology, they may even display precocious development of some speech sounds.

The outlook for accurately identifying AAE speakers with and those without clinical language disorders is now far more promising than it used to be. A range of traditional and nontraditional strategies exist for distinguishing differences due to normal language dialect variation and those due to language impairment. This array of resources has enabled clinicians to embrace the value of using multiple sources of information to make diagnostic judgments about any child, not just an AA child.

Although the cultural factors that should be respected in service delivery practices have been identified, little research has focused on the efficacy of clinical speech and language interventions for AA preschoolers who speak any English variety. Comparatively more attention has focused on interventions that aim to optimize AA children's academic success at school. Such interventions include teaching SAE as a second dialect (e.g., accent modification), which is now within the scope of SLP practices.

However, the elective prescription for such services excludes its availability to preschoolers, who typically do not choose their own services. Yet the practical pressures to speak a mainstream English variety for schooling and other societal functions make second dialect/language instruction more of a necessity than an elective choice. Thus, although learning any new language is expected to be maximized at early ages, second dialect acquisition has not been advocated for AA preschoolers, but ought to be.

Given what is now known about the language of AA preschoolers, it is fair to say that most of them begin schooling at first grade with a rich oral language system despite the heterogeneity among them. If so, then we should be cautious about attributing underachievement at school simply to AAE use or to any one demographic factor such as social class. Middle-class AA children use AAE patterns too (Horton-Ikard & Miller, 2004). This latter group's ability to thrive or fail in school may expose a complex relationship between academic achievement and AAE use. Boult (2007) argued that it is fruitful to investigate the combined effects of social class and racial segregation on AA children's access to the language used for school instruction. Such an investigative framework exposes different subgroups of AA children that usually are not studied (cf. those with low SES in racially segregated versus nonsegregated communities and schools). This line of inquiry is among the fresh ideas that will define the research agenda on AA children's language for a new generation of scholars.

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