The Role of Mexican Immigrant Mothers' Beliefs on Parental Involvement in Speech–Language Therapy

Sharon E. Kummerer
Schwab Rehabilitation Hospital
Norma A. Lopez-Reyna
University of Illinois at Chicago

The sociocultural framework *highlights the contributions of children's cultural and linguistic contexts to early language and literacy development. To collaborate with parents in early intervention programs, including speech–language therapy, there must be a sincere commitment to the development of cultural competence. Hispanics are one of the largest and fastest growing minority groups within the United States. The goal of this study was to identify Mexican immigrant mothers' perceptions and beliefs about language development, their children's disabilities, and therapy activities. Additionally, it explored how these perceptions and beliefs inform culturally responsive speech–language therapy with families of Mexican descent.*

PARENTAL INVOLVEMENT: SOCIOCULTURAL FRAMEWORK, PUBLIC LAW, HANEN PROGRAM

Involving families in speech–language therapy is essential given that language develops through meaningful, reciprocal engagement with significant others in the child's sociocultural context (McLean & Snyder-McLean, 1999). The sociocultural model maintains that the child's interactions, social and communicative, with the important people in his environment are the most salient factors in the acquisition of language (Hulit & Howard, 2002). Consistent with the Vygotskian paradigm, both receptive and expressive language have their roots in social exchanges between the child and caregiver (Vygotsky, 1962). Within the sociolinguistic approach, the overriding motivation for language development is effective communication, and the primary context of interest is the child–mother or child–caregiver pair (Owens, 2005). One of the most significant trends in special education and related services is the construction of programs, for culturally and linguistically diverse populations, that embody the sociocultural perspective (Cruzado-Guerrero & Carta, 2006; Lopez-Reyna, 1996).

Language acquisition and growth of language and literacy occur in children's larger familial and cultural contexts (Coll & Magnuson, 2000; Kayser, 1995; Lynch & Hanson, 1998) and are based in daily parent–child conversations, interactions, and routines (Snow, 1983; Tharp & Gallimore, 1988). Learning to read is a pivotal milestone for children (Scheffner Hammer, Miccio, & Wagstaff, 2003) providing the critical foundation for subsequent academic success (Snow, Burns, & Griffin, 1998; Vernon-Feagans, Hammer, Miccio, & Manlove, 2001). Not all preschool children with language disorders will exhibit difficulties learning to read; however, research strongly suggests that preschool children with language impairments are at an increased risk for concomitant reading disabilities (Catts, Fey, Zhang, & Tomblin, 2001; Rescorla, 2002; Scarborough, 2001).

Part C of the Individuals with Disabilities Education Improvement Act of 2004 requires family-focused interventions, with collaboration among professionals and significant others during all phases of the service delivery process, through the Individualized Family Service Plan. This renewed focus on the family—their concerns, strengths, needs, and resources—entitles parents to share as equal participants in their children's educational program (Harry, Klingner, & Hart, 2005; Scheffner Hammer, 1998). It also requires that professionals reflect on their own belief systems, the beliefs and values of the families they are serving, and the impact of those beliefs on the service provision process (American Speech–Language–Hearing Association, 2005). The effectiveness of early intervention will depend to a large extent on the provision of services that are culturally desirable and/or acceptable to the families involved (Scheffner Hammer, 1998).

One approach to providing language intervention with preschool children is to teach their parents to serve as the primary intervention agents (Girolametto et al., 2002). Under the rubric of naturalistic approaches to parent training are child-oriented techniques (Fey, 1986); transactional teaching (McLean & Snyder-McLean, 1978); milieu teaching (Kaiser, Yoder, & Keetz, 1992); and the interactive model (Girolametto, Greenberg, & Manolson, 1986). Within the interactive model, the Hanen Early Language Parent Program is one of the most widely used programs for enhancing parents' responsiveness to their children's communication (Rossetti, 1996). It is largely unknown, however, whether such conversationally based parent training programs match the interaction patterns and preferences of families from diverse backgrounds (van Kleeck, 1994).

According to the American-Speech-Language Hearing Association (ASHA), approximately 10% of the general United States population has a disorder of speech, language, or hearing, with proportional distribution among members of racially and ethnically diverse groups (American Speech–Language–Hearing Association, Office of Multicultural Affairs, 1996). Recent population estimates indicated that Hispanics are one of the largest and fastest growing minority groups within the United States (U.S. Census Bureau, 2003). The largest portion of the Hispanic population within the United States (66%) is of Mexican origin. While the number of children from multicultural populations continues to grow, professionals who serve these families remain predominantly Anglo-American, middle-class, monolingual English speakers (American Speech–Language–Hearing Association, 2003). This underscores the urgency for the development and provision of culturally responsive services.

MEXICAN AMERICAN CHILDREN: MOTHER–CHILD INTERACTIONS AND PARENTAL BELIEFS

Children are introduced to language and educational opportunities through everyday interactions with significant others in their larger cultural groups (Moreno, 2002). Much of the implicit curriculum and instructional method to which young children are exposed are mediated through maternal teaching strategies (Laosa, 1978). Exploring differences in maternal teaching strategies among a sample of Mexican- and Anglo-American dyads, initial findings revealed that the Anglo mothers used inquiry and praise more frequently than the Mexican mothers, whereas the Mexican mothers used modeling, visual cues, directives, and negative physical control more frequently than the Anglo-Americans (Laosa, 1980). When the participants' level of education was held constant, however, the observed cultural group differences disappeared. In fact, later qualitative analyses confirmed that Mexican immigrant mothers considered themselves active participants and primarily responsible for their children's language and literacy development (Pease-Alvarez & Vasquez, 1994).

Previous research provides overwhelming support for the involvement of Hispanic parents in their children's education (Delgado-Gaitan, 1992; Harry, 1992; Hughes, Schumm, & Vaughn, 1999); however, there are few examples of the effective involvement of Mexican immigrant parents in their children's speech–language therapy program. Only one study to date (Mendez-Perez, 1998) provides a description of the impact of Mexican American mothers' beliefs about language acquisition and language disabilities on their response to early childhood intervention. In the Mendez-Perez (1998) study, mothers did not believe that their children had a communicative disorder, nor were they concerned about their children's language development in relation to documented milestones. Whereas parents described strategies to advance their children's language, analysis of mother–child observations revealed that they did not consistently engage in such practices during home routines. In sum, mothers' reduced understanding of the purpose of therapy activities, in combination with their belief that delays were due to maturation, resulted in the ineffective transfer of therapy routines to the home setting.

Research exploring Hispanic parental beliefs toward their children's language-based disabilities has focused on causal attributions of these disorders (Jay, 1996; Maestas & Erickson, 1992; Mardiros, 1989), primarily examining maternal attributions through the use of survey and/or questionnaire methodologies. These studies have typically presented prestated causes of disability. Collective findings from this body of work reflect beliefs that vary from biomedical, to religious, to folk explanations. In contrast, a set of qualitative studies identified intrinsic and environmental factors more often than folk beliefs (Harry, 1992; Mendez-Perez, 1998; Rodriguez & Olswang, 2003). For example, Puerto Rican parents indicated that a number of factors, in either the home or school environments, had interfered with their children's ability to read, write, and/or communicate (Harry, 1992). Similarly, Mexican American mothers attributed their children's specific language impairment to factors both intrinsic (e.g., family history or heredity, medical concerns, bilingualism, child's personality) and extrinsic (e.g.,

home environment, home–school mismatches; Rodriguez & Olswang, 2003).

The goal of the present investigation was to explore the role of maternal perceptions and interaction patterns in the construction of collaborative early language and literacy opportunities for Mexican American children. Data sources included mother interviews, speech–language documents, and informal observations of mothers verbally interacting with their children. Three questions guided this inquiry:

1. What are Mexican immigrant mothers' beliefs and perceptions toward early language development?
2. What are Mexican immigrant mothers' beliefs and perceptions about their children's speech and/or language disabilities?
3. What activities do Mexican immigrant mothers find helpful in promoting early language and literacy interactions (both at home and during therapy)?

METHOD

Qualitative Paradigm

This study had an exploratory and descriptive focus; the design was emergent and employed a purposive sample. Qualitative methods of data collection were used to capture mothers' language and behavior; the data were gathered in the natural therapy setting; and there was an emphasis on the human as instrument (i.e., the clinician). The focus on participants' meaning is of critical importance to the qualitative constructivist paradigm. Within the constructivist paradigm, the nature of reality (ontology) is socially constructed, complex, and always changing (Glesne, 1999). Qualitative research can include questions of "how" and "why" and thus is an excellent means of gathering data about culturally and linguistically diverse populations (Brice, 2002; Damico & Simmons-Mackie, 2003). The development of categories and hypotheses through the constant comparative method of analysis is the process through which the data gradually evolve into substantive theory (Glaser & Strauss, 1967). That is, the data act as a malleable body of information from multiple sources that takes the form that most coherently represents the whole (see "Establishing Trustworthiness" in the section below).

Program Description

Participants were receiving center-based services from an Early Childhood Intervention program located in the Midwestern United States where the first author has been a therapist for over 12 years. Children received individualized speech–language therapy one time per week in 45-min sessions. Therapy was provided in the child's primary or most proficient language (Spanish and/or English), with parents present. With the ex-

ception of one family whose primary language was English, therapy was conducted in Spanish. Language intervention at this site incorporated an interactive model of parent training, relying primarily on guidelines and activities inherent in the Hanen Early Language Parent Program (Girolametto et al., 1986).

For the purposes of this study, the Hanen parent prevention program *Usted Hace la Diferencia* [You Make the Difference] was selected because of its availability in Spanish and because the format utilizes a variety of figures and illustrations. There are two modules within the Hanen model of intervention. Module I, "Let your child initiate," teaches parents to observe their children's attempts to communicate, follow their children's lead, expand children's interest, and improve turn-taking abilities. Module II, "You initiate and create opportunities for language learning," advocates the use of pre-planned home activities to encourage parental interaction and promote children's language (e.g., making music, sharing books, playing games, completing art projects). In addition to language goals, the first author modeled and encouraged parental practice of literacy interactions such as reading books, explaining story content, answering questions, promoting phonemic awareness, and practicing invented spelling.

Participants

Participants were 14 Mexican immigrant mothers and their children. All mothers were born in Mexico and had been living in the United States for 4 to 21 years (with a mean of 9 years). Two of the mothers spoke both Spanish and English, and the others were monolingual Spanish-speakers. Mothers ranged in age from 26 to 38 years, with a mean of 30.5 years. The mean level of education among participants was 8 years, and 6 participants (43%) were employed outside the home. All families were of low socioeconomic background, and four of the families had participated in previous speech–language therapy programs.

The children, ages 1.5 to 3.11 years (mean age = 2.6 years), all had communication disabilities. In addition to expressive language delays, additional and/or concomitant diagnoses included receptive language delay, articulation and/or phonological disorder, developmental verbal apraxia, and/or hearing loss. Nine of the children were boys and 5 were girls. During the year, participant children received speech–language services for a duration of 7 to 12 months; 3 of the children also participated in occupational and physical therapies.

Data Sources and Procedures

Participant interviews were the primary source of data. Secondary sources of data, including therapy files and observation field notes, provided a point of comparison and validation of mothers' perceptions and practices and contributed to the construction of instrumental case studies. All data sets were collected simultaneously throughout the 12-month duration of the study.

Mother Interviews. The interview instrument used in this investigation (see Appendixes A and B) was aligned with Merriam's (2001) semistructured format and Patton's (2002) general interview guide approach. The first author interviewed mothers at the onset of intervention, and then every 5 to 8 weeks, for up to one year. The authors used the same questions for each interview to track the consistency of responses across time and to assess qualitative changes in the responses that referenced or suggested growing understanding of language development and intervention. The first author interviewed mothers in Spanish and/or English depending on their language preference, and the interviews lasted between 20 and 45 min. In total, the first author conducted 56 mother interviews over time, with each mother completing between three and six interviews during the course of the study.

Speech–Language Files. The therapy files consisted of demographic information, diagnostic reports, data toward treatment goals, progress notes, testing protocols, and parental permission forms.

Observation Field Notes. Field notes included mother–child verbalizations such as labeling objects, asking questions, expanding utterances, commenting on actions, and/or demanding language. During instances when mothers were actively participating in their children's therapy sessions, independent of the therapist, the first author recorded field notes immediately. After each therapy session, the first author incorporated these field notes into detailed descriptions of therapy activities, including the content of mother–child conversations.

Data Analysis

In alignment with the constant comparative method, analysis of mother interviews moved through a series of five phases. Phase I, Initial Transcription and Translation, involved (a) transcription of interviews, (b) recording of marginal notes, (c) review and editing with a Mexican American research assistant, and (d) initial member checks. The first author recorded and transcribed interviews verbatim in the order in which they were completed. Marginal notes consisted of brief comments on the content of transcripts, thoughts on emerging ideas and patterns, or reflective information connecting participant responses with previous research. The first author met with the Mexican American assistant after transcribing the initial set of interviews. During weekly meetings with the assistant, inconsistencies in transcripts were corrected and translations clarified. Throughout the transcription and analysis of early interviews, member checks with the participants were conducted to assure the accuracy of data and emerging conceptualizations and interpretations.

Phase II, Systematic Review and Organization, involved (a) ongoing data preparation with another bilingual speech–language pathologist (SLP) and Mexican American assistant

and (b) data organization and storage. Through informal conversations, the first and second authors and another bilingual SLP provided support for earlier patterns, considered new patterns in the data, and reviewed negative cases (i.e., those that did not fit the emerging pattern). Data management and storage consisted of systematically labeling the initial and edited transcripts and placing all data into electronic files.

Phase III, *Within-Case Summary Across Time,* involved organizing mothers' responses according to the guiding research questions and the main interview topics within each question. This consisted of a series of detailed outlines with mother quotations organized accordingly. Phase IV, *Within-Case Themes Across Time*, involved condensing further the previously displayed data to include the most prominent patterns and themes for later comparison among families.

Following the completion of the within-case summary charts and reliability check, Phase V, *Cross-Case Analysis*, was initiated. To refine and collapse final themes, we compared responses to particular questions with those of other participants (Merriam, 2001). The derived themes and/or regularities became the categories into which subsequent data were coded and sorted. Categories were created according to conceptual coherence and/or the percentage of responses within themes across time (Brinton & Fujiki, 2003; Damico & Simmons-Mackie, 2003; Huberman & Miles, 1994; Patton, 2002). Refinement of eventual theory involved comparing, contrasting, and establishing relationships among categories (Goetz & LeCompte, 1984).

We repeated the same process with data from the therapy files and field notes, and summary sheets were prepared for each family. These summary sheets included direct quotations from mother–child verbal interactions and instances of mothers facilitating their children's communication. Within-case analysis involved triangulating data from children's therapy file notes and field notes with the categories from the mother interviews. Cross-case analysis of therapy notes and field notes involved identifying and coding themes across families.

Establishing Trustworthiness

As previously stated, the main analytic tasks within qualitative methodology involve identifying regularities or patterns in the data and cross-checking to make sure the data are reliable and valid (Delamont, 1992). The criteria of *credibility*, *transferability*, *dependability*, and *confirmability* are essential in substantiating the integrity of qualitative data (Guba & Lincoln, 1989; Mertens, 1998).

Strategies to enhance credibility, or to show that findings accurately portrayed mothers' viewpoints, consisted of prolonged engagement, peer debriefing, member checks, and the triangulation of data sources (Mertens, 1998). For this study, prolonged engagement involved collecting data over a period of one year. Peer debriefing was achieved as described in

Phases I and II above. The first author conducted periodic member checks with participants to evaluate whether the data accurately reflected mothers' perceptions and experiences. Finally, the triangulation of data entailed analysis of therapy files and field notes, together with the mother interviews, to examine the consistency of evidence across sources (Guba & Lincoln, 1989).

To address the transferability of findings, we described mothers' perceptions and practices, as well as procedures used to collect, analyze, and interpret the data. Through detailed descriptions of the program site, participants, data sources, and analysis procedures, the reader is able to recognize the degree of similarity between the research site and his or her receiving context.

Dependability, or the quantitative parallel of reliability, is concerned with the results' making sense or being consistent and potentially replicable (Guba & Lincoln, 1989; Marshall & Rossman, 1999; Merriam, 2001). Measures to ensure dependability included member checks, the triangulation of data sources, and a formal reliability check in which a bilingual clinician independently reviewed and coded a subset of transcripts and summary charts, then discussed the findings in detail with the first author.

A final construct to ensure that gathered data were valid representations of families' beliefs and experiences involved assessing the confirmability of data. To ensure the logic in interpreting data were made explicit, we have included ample parental quotations in both Spanish and English to illustrate and communicate the essence of the findings.

RESULTS AND DISCUSSION

Mothers' Beliefs About Early Language Development

The majority of mothers indicated that early language development was interactive in nature and that individuals in the child's environment, especially family members, were important contributors to the process. Señora Lozano's (a pseudonym) response remained constant across time and reflected the sentiments of 12 out of the 14 mothers:

> *Yo pienso que los niños empiezan a hablar... si uno les pone mucha atención . . . O cuando les cambia uno el pañal . . . les empieza uno a hablar. O a cantar o a leerle libros porque ellos desde que están chiquitos, ellos comprenden.*
>
> *[I think that the children begin to talk…if one pays a lot of attention to them… Or when one changes their diaper…one begins to talk to them. Or to sing or to read him books because from the time they are young, they understand.] (Lozano #1–#21)*

Mothers recognized not only their role in language learning but also the central role of siblings as they interacted, argued, and played with younger children in the family. In three of her four interviews, Señora Arroyo commented on the role of Efrain's older siblings in her son's imitation of single words and requests for toys. According to her, children began to talk by "*platicándoles mucho, conversando mucho con los niños, estudiándoles libros, contándoles cuentos, y jugando con los demás niños mayores*" ["talking with them a lot, conversing a lot with the children, studying books with them, telling them stories, and playing with the older children"] (Arroyo #1–#2).

Analysis of mothers' responses concerning why children began to talk yielded four themes across therapy: (a) children learning due to nature or instinct, (b) children learning by listening to others, (c) children talking as a means of indicating necessities, and/or (d) parents dedicating time to teach their children. Describing the reasons why children begin to communicate, Señora Ramos said, "*Pues, me imagino yo que por su instinto, ¿no?, que tienen que hablar*" ["Well, I imagine that it is by instinct that they have to talk"] (Ramos #1–#40). An additional participant emphasized the role of listening and repetition in language learning: "*Porque, ellos se entusiasman cuando uno habla. Ellos repiten lo que uno dice*" ["They become animated when one talks. They repeat what one says"] (Garza #1–#20). Highlighting children's early use of utterances to indicate necessities, Señora Ayala remarked, "*para pedir lo que necesitan o para quejarse de lo que se sienten*" ["to ask for what they want or to complain about what they feel"] (Ayala #1–#50). During her final interview, Señora Mejia indicated that children learned to talk due to parental teaching: "*Como le dije anteriormente que aprenden de uno. De . . . los papas los babies.*" ["Like I said before that they learn from one. Babies learn from their parents"] (Mejia #3–#14).

Whereas mothers identified different months of age as marking the emergence of early vocalizations, all parents reported that children should begin to speak within their first year of life. Mothers also stated that although the majority of children should produce their first words at an early age, it was important to acknowledge individual differences in expressive development. In the words of Señora Arroyo, "*Muchos niños empiezan a pronunciar sus primeras palabras desde los seis meses, otros más grandes, porque no todos hablan al mismo tiempo*" ["Many children begin to pronounce their first words from six months, others much older, because all children do not talk at the same time"]. These findings highlight the variability in Mexican immigrant mothers' "theories" of language acquisition among even a small group of participants. Indeed, as previously noted by others (Harry, 1992; Roseberry-McKibbin, 2002), Hispanic parents' parameters of "normality" (in terms of language learning) seem much wider than those used by early intervention service providers.

In contrast to expressive production, mothers' conceptions of receptive language were more elusive and often defined in terms of children's ability to follow commands. These responses changed more frequently across time. For example, during her second interview, one mother stated that children should understand "from 2 years." In the third interview

(8 weeks later) she replied, "3, 4, or 5 years." At the time of her fourth and final interview (eight weeks after that), she concluded with, "5 months" (Rosas #2–#4). Through interviews and informal conversations, repeated confusion on the topic of receptive learning and children's abilities was noted. As mothers shared perceptions of comprehension, they often stated that their children understood "everything." Consistent with the above finding, Mexican American mothers of children with communication disabilities also suggested that their children demonstrated good comprehension skills (Mendez-Perez, 1998). In a related study, all but one of the African American mothers reported that their children comprehended language well (Scheffner Hammer & Weiss, 2000). It is likely that the confusion for mothers results from receptive language's being less tangible and observable than expressive production and the parents' being unfamiliar with the various skills and activities indicative of receptive capabilities.

Recommendations for Practice

Based on mothers' beliefs toward their children's language learning, we suggest use of the following practices in working with Mexican immigrant families: (a) Explore parents' theories of language acquisition. Attitudes toward language development can have an impact on parents' perceptions of their children's disabilities, effective therapy strategies, and their role in the intervention process. This is especially pertinent to the expectations on the part of families and their subsequent levels of active involvement in their children's language development. (b) Devote special attention to the area of language comprehension and the abilities that measure this construct. For instance, the clinician should note instances during therapy when the child apparently did or did not comprehend by pointing out concrete evidence. Following a shared understanding of children's difficulties, therapists and families must coconstruct receptive language goals that are meaningful to the home context (e.g., identify pictures in book and/or family album, obtain necessary items in the home, respond appropriately to parents' or teachers' questions, explain the day's events using a sequential format). When the clinician provides appropriate information about developmental milestones and children's functioning on an ongoing basis, the parent's role in facilitating language learning is tailored and made explicit (Mendez-Perez, 2000; Polmanteer & Turbiville, 2000).

Mothers' Perceptions About Their Children's Speech and/or Language Disabilities

Across therapy, four themes emerged as mothers' shared perceptions about their children's speech and/or language disorders: (a) initial identification of a delay, (b) causal attributions of the identified delay, (c) reduction in delay across time, and (d) belief that children were simply lazy or did not want to talk. During initial interviews, all of the mothers were aware that their children demonstrated some type of communication "delay," with varying levels of severity. Their descriptions were of a comparative nature, contrasting their children's difficulties in relation to the skills of siblings or same-age peers, rather than in terms of a communication delay or disorder. For the most part, mothers acknowledged expressive language delays; however, all mothers believed that their children's receptive language skills were "fine." Commenting on expressive output, mothers primarily articulated concerns about their children's pronunciation and speech intelligibility rather than gains in communicative intent, early words, or the ability to combine utterances.

While mothers were not explicitly questioned about causal attributions, during interviews and informal conversations they volunteered a variety of reasons for their children's perceived difficulties. Causal attributions were either medical (e.g., ear infections, seizures, cerebral palsy, deviation of oral musculature) or familial (e.g., lack of extended family members, family history or heredity). Only one participant made reference to a folk belief (cutting a child's hair prior to his first birthday). As time passed, 8 of the 12 mothers believed that their children's speech and/or language delay or disorder was no longer present. In fact, only 2 of these 8 children were making noticeable improvements.

Sharing perceptions of communication difficulties, mothers sometimes mentioned that their children were "lazy," were "spoiled," or "did not want to speak." When asked if she thought her daughter exhibited a speech and/or language delay, Señora Mejia replied, "*No. Retraso no . . . Yo siento como que es una niña, flojita* [*laughs*] *que no quiere hablar*" ["No. Delay, no . . . I feel that she's a girl that's a little bit lazy {*laughs*}, that she doesn't want to speak"] (Mejia #3–#117). (*Note*: We believe that the word *flojo*, translated as *lazy*, is not used in this context to denote laziness as it is typically applied when describing adolescents or adults. Rather, it is used to describe a lack of a sense of motivation or desire toward a potential outcome. At times, the term is also used to denote a lack of confidence or being timid.) Another mother denied the presence of a delay but reported that her son was spoiled: "*No, es que está muy chiquillado y por eso no habla. O sea también nosotros tenemos la culpa de que no hable. Porque todo le acercamos*" ["No, he's very spoiled, and that's why he doesn't talk. I mean we're also to blame for why he doesn't talk. Because we bring everything to him"] (Ramos #6–#92). (Note: As with *lazy* above, we felt that the use of *spoiled* implied a meaning of learned disposition on the part of the child as a result of not needing to work toward the acquisition of certain language skills. That is, his current language was sufficient to meet his needs.)

Recommendations for Practice

In consideration of mothers' perceptions of their children's communication disabilities, we have the following additional suggestions for those working with families from Mexican backgrounds: (a) Identify the perceived causes of children's com-

munication impairments. Causal attributions can affect parents' attitudes toward treatment, the type of intervention that would be most effective (Booth, 1997; Rodriguez & Olswang, 2003; Stockman, Boult, & Robinson, 2004), and the nature of parent–child communicative exchanges (Heath, 1983). A mother's acknowledgment of a child's lack of motivation or incentive needs to be noted as a context in which families can manipulate circumstances to change the child's disposition. (b) Discuss children's speech and/or language difficulties in relation to other children. Consistent with Mendez-Perez (1998), mothers in the present study easily described how their children's language acquisition had differed from that of siblings or other relatives at similar ages; however, they were not as accurate in describing their children's supposed "typical" receptive language. As in the previous section, as therapists engage parents in learning to assess their children's receptive skills, parents will also recognize the need for active, ongoing participation on their part. (c) Provide accurate labels and the appropriate terminology for parents' descriptions of their children's communication behaviors and actions. During the course of therapy, it was essential for the clinician to describe the relative importance of expressive language, articulation, and phonology and why the first was most important for the general development of language and communication.

Mothers' Views of Activities to Promote Language and Literacy Interactions

During their second and subsequent interviews, mothers were asked to provide an example of a therapy activity that they practiced with their children at home. Over time, mothers stated that they regularly engaged in such activities as reading books, labeling objects, facilitating play-based interactions, and expanding utterances. For instance, a mother whose child demonstrated a moderate expressive language delay recalled how she expanded her daughter's early words: "*Cuando andamos en la calle así que me dice, 'Mira, mira,' que le digo, 'Oh sí, mira, el árbol es grande y tiene muchas hojas,' o 'Ya no tiene,' y así. Antes eso yo no lo hacía*" ["When we are out she says to me, 'Look, look,' that I say to her, 'Oh yes, look, the tree is big and it has many leaves,' or 'It does not have any more,' and so forth. Before I never did that"] (Ayala #4–#200).

Throughout the course of therapy, mothers were additionally asked to provide an example of a home activity that was not typically practiced during therapy. Mothers reported that they sang songs and conversed with their children during daily routines (e.g., while cleaning, playing, eating, shopping, reciting prayers, cooking). For example, Señora Robles described how she introduced vocabulary, answered questions, and engaged in meaningful dialogue during cooking routines:

> *Como ayer me dice, "Mami yo quiero comer carne con elote . . ." Y le digo pues, "Vamos a ir a la tienda a traer la carne y el elote." Y ya entonces ya que comió, me dice, "¿Cómo hiciste esto tú?" . . . Lo que yo le decía, él*

> *repetía. . . . Y luego él sólito se queda a platicar, él sólito decía, "Cilantro, cebolla, cilantro, cebolla."*

> *[Like yesterday he says to me, "Mami, I want to eat meat with corn . . ." And I say to him, "Let's go to the store to bring the meat and the corn." And then after he ate, he says to me, "How did you make this?" . . . What I said to him, he repeated . . . And then he says to himself, he alone said, "Cilantro, onion, cilantro, onion."] (Robles #4–#114)*

Finally, we invited mothers to read and discuss the *Usted Hace la Diferencia* [You Make the Difference] Hanen handbook as a means of supplementing therapy practices and providing parents with concrete strategies. Sharing perceptions of Hanen materials, mothers discussed favorite chapters, techniques that validated home practices (e.g., teaching through the use of music, reading with children), and preferred stylistic aspects of the *Usted Hace la Diferencia* Hanen handbook (e.g., clear explanations, relevant examples, manageable length). Topics of particular interest included having patience with children, allowing children to take the initiative, keeping books within reach, and singing songs to advance language learning. Across time, mothers provided more descriptive examples of relevant concepts and recognized increased opportunities for implementing strategies during home routines.

Recommendations for Practice

Mothers' activity-related data made evident further implications for speech–language pathologists working with Mexican immigrant families: (a) Elicit parents' perceptions of meaningful treatment goals, and identify and expand existing home routines that support children's abilities. Across intervention, mothers often described high-quality language learning exchanges that they did not realize were particularly beneficial in advancing their children's development. (b) Clarify the relationship between children's communication goals and the clinician's play-based therapy routines. Consistent with previous research (Mendez-Perez, 1998), participants in the present study exhibited difficulty explaining the rationale behind play-based procedures or how language facilitation strategies could enhance their children's development. As previously suggested, teaching and sharing accurate labels and appropriate terminology will help to create a common ground on which to collaborate and provide a consistent program across contexts. (c) Evaluate parents' understanding about their children's communication abilities across time, and elicit feedback regarding the evolving treatment plan. Through the use of language samples, journal entries, videotapes, and Hanen materials, parents can be encouraged to share stories and provide examples of their children's communication in home contexts. Therapists, in turn, can build on families' perceptions and practices by incorporating home strategies into therapy routines and by modeling related activities to scaffold children's learning.

It is critical to highlight that several important issues emerged during discussions of home–therapy connections. Across time, mothers requested additional information about the purpose of speech–language therapy; the amount of time needed to remediate communication disabilities; and the role of parents, siblings, and extended family in supporting progress. Parents expressed concerns regarding the language of intervention and their use of Spanish in the home setting. It was imperative for the therapist to explain the necessity of conducting speech–language therapy in the child's dominant language (American Speech-Language-Hearing Association, 2004). For children dominant in the native language, intervention must be provided in the native language (Langdon & Saenz, 1996). Similarly, clinicians should encourage parents to maintain their home language through both oral and written use (Kayser, 2002; Vaughn et al., 2006). Children who develop their first language fully often make the transition to English more effectively than children who do not maintain the home language (Greene, 1998; Ramirez, Yuen, Ramey, Pasta, & Billings, 1991).

SUMMARY

As mothers shared views concerning how and why children begin to talk, responses remained consistent across time. Participants reported that language acquisition was facilitated by (a) parents' primary role (communicating, explaining, questioning, teaching, singing, reading, labeling, and playing with their children); (b) children's secondary role (hearing, listening, repeating, requesting, and paying attention to others in the environment); and (c) nature's developmental role (babbling, jargon speech, initial phonemes, and early words). Responses to when a child should begin to talk did not change much across time and were aligned with developmental milestones reported in the literature. Compared with perceptions of expressive production, mothers' reports of receptive milestones remained elusive and tentative throughout therapy. During interviews and informal conversations, all mothers acknowledged that their children exhibited some type of communication delay or were not communicating at levels comparable to those of siblings or peers. Delays, for the most part, were not attributed to folk beliefs. Across the period of the study, mothers drew connections between what the therapist did and what they could, and did, do at home.

Indeed, to increase the likelihood that families will implement suggested therapy strategies in the home environment, clinicians are encouraged to build on what parents know and already do (Garcia, Mendez-Perez, & Ortiz, 2000; Hughes, Valle-Riestra, & Arguelles, 2002). Throughout their children's therapy programs, mothers exhibited considerable difficulty discussing specific activities or strategies that could be used to augment development unless these procedures were concrete and highly relevant to their children. Mothers' difficulty articulating the purpose of therapy routines, or how clinicians embed communication goals within play-based activities, is consistent with the literature and comparable across clients

(Johnston & Wong, 2002; Madding, 1999; Mendez-Perez, 1998). The current study adds to our knowledge of Mexican immigrant parental perceptions of Hanen procedures and materials. Through reading and discussion of the *Usted Hace la Diferencia* [You Make the Difference] handbook, mothers reportedly validated existing beliefs, supplemented current learning, and identified stages in their children's development.

The sociocultural perspective reflects an appreciation for the contributions of children's cultural and linguistic contexts to early language and literacy development (Dodici, Draper, & Peterson, 2003; Garcia et al., 2000; Justice & Pullen, 2003; Moreno, 2002). Professional standards and legal mandates require the implementation of culturally responsive interventions. While there is limited research based upon which to develop such practices (Garcia et al., 2000; Kohnert & Derr, 2004; Rodriguez & Olswang, 2003), family members play a crucial role in both the identification and remediation of communication disabilities. In addition to the provision of meaningful language and literacy strategies, it is essential that clinicians model and encourage parental practice of program components. The therapist must continually seek to draw connections between the actions of parents in the home settings and their beliefs and knowledge about their children's needs. Through this lens, the therapist is poised to provide validation of parents' interventions and incorporate these actions into therapy sessions.

ABOUT THE AUTHORS

Sharon E. Kummerer is a bilingual Spanish and English speech–language pathologist and clinical supervisor at Schwab Rehabilitation Hospital. She earned her doctorate degree in special education from the University of Illinois at Chicago. Her research and clinical interests concern providing culturally responsive language and literacy interventions with Mexican American children and their families. **Norma A. Lopez-Reyna** is an associate professor of special education at the University of Illinois at Chicago. Her research interests include classroom-based assessment, effective instruction for students with disabilities who are English language learners, and parental roles in learning about and teaching children. Address: Sharon Kummerer, Schwab Rehabilitation Hospital, 1401 South California Blvd., Chicago, IL 60608.

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APPENDIX A: MOTHER INTERVIEW PROTOCOL (ENGLISH)

RESEARCH QUESTION 1: THE NATURE OF EARLY LANGUAGE DEVELOPMENT:

1 **Main Question**: Think about when your child, or when one of his or her older brothers or sisters, or a niece or nephew, was first learning to talk; how did this happen? How do children learn to talk?

Follow-up Questions (only as needed):

a. Why do you think that children start to talk? What are some of the first words that children say and why do you think they use those particular words?

b. When do you think a child should begin to understand what you are telling him or her and begin to say his or her first words?

c. How do parents and siblings help a child to talk or communicate? How might a parent or sibling find out the following information from a child who is just beginning to talk? For example, which toy or toys the child wants to play with? What the child wants to eat for breakfast? Why the child feels sad, upset, or angry?

RESEARCH QUESTION 2: THEIR CHILDREN'S CURRENT LANGUAGE ABILITIES:

2. **Main Question**: Tell me about how your child talks and understands thus far. Do you think that your child has a speech or language delay or disorder?

Follow-up Questions (only as needed):

a. How is your child learning to talk? Is it similar to or different from his or her older siblings?

b. How do you and the child's siblings help in language development? What role do family members play?

c. When does your child seem to talk or vocalize most often at home (e.g., any daily routines—mealtimes, car rides, bath-time, bedtime, etc.)?

d. Tell me about any activities or experiences that are currently useful in improving your child's language.

RESEARCH QUESTION 3: ACTIVITIES MOTHERS FIND HELPFUL IN PROMOTING EARLY LANGUAGE AND LITERACY INTERACTIONS (BOTH AT HOME AND DURING THERAPY):

You and your child have been participating in speech–language therapy for 5, 10, 15, etc. weeks now and the speech therapist has demonstrated different language and early reading activities.

3a. Main Questions:

1. Have you been able to use any of the language or literacy activities that we tried in therapy in your home? Which activities did you find most useful and which did your child particularly enjoy?

2. What is an example of an activity related to language development that we have tried in therapy that you or family members also use in your home?

3b. Main Questions:

1. Can you describe any activities that you currently perform at home, related to early language or literacy development, that we do not use during therapy? For example, an activity that your child really enjoys at home and during which he or she often attempts to communicate and/or talk with family members?

2. Please tell me of an activity that you find useful at home to help your child communicate better that I could also use here during therapy (e.g., an activity that is completed with you, with his/her siblings, or with his/her cousins in the home). (Especially those encountered during daily home routines such as mealtime, car rides, bath-time, bedtime, etc.).

(appendices continue)

APPENDIX B: PROTOCOLO DE ENTREVISTA DE LA MADRE (SPANISH)

PREGUNTA 1: ORIGEN DEL DESARROLLO DE LA INTRODUCCIÓN TEMPRANA DEL LENGUAJE:

1. **Pregunta Principal:** Recuerde cuándo su niño/a, o los hermanos mayores del mismo/a, o primos, aprendieron a hablar; ¿Cómo pasó?, ¿Cómo es que los niños aprenden a hablar? <u>Se le Harán las Siguientes Preguntas:</u> (solo si es necesario)

    a. ¿Por qué cree que los niños empiezan a hablar? ¿Cuáles son las primeras palabras que ellos dicen y por qué cree usted que ellos usan esas palabras especialmente?

    b. ¿Cuándo cree usted que un niño empieza a comprender lo que usted le está diciendo a él o a ella y que comienza a decir sus primeras palabras?

    c. ¿Cómo es que los padres o hermanos le ayudan a un niño a hablar o comunicarse? ¿Cómo podrían los padres o hermanos saber la siguiente información acerca de un niño cuando apenas comienza a hablar? Por ejemplo: ¿Con cuáles juguetes quiere el niño jugar? ¿Qué es lo que el niño quiere de comer para el desayuno? ¿Por qué el niño se siente triste o enojado?

PREGUNTA 2: LAS HABILIDADES TEMPRANAS DEL LENGUAJE:

2. **Pregunta Principal**: Hasta ahora, dígame qué tanto habla y entiende su niño. ¿Cree usted que su niño tenga un retraso o desorden del habla o del lenguaje? <u>Se le Harán las Siguientes Preguntas:</u> (solo si es necesario)

    a. ¿Cómo es que está aprendiendo a hablar su niño? ¿Es igual o diferente que al de sus hermanos mayores?

    b. ¿Cómo le ayudan usted y los hermanos del niño en el desarrollo del lenguaje? ¿Qué papel desempeñan los miembros de la familia?

    c. ¿Cuándo le parece que su niño habla más o que hace sonidos más seguidos en la casa (por ejemplo: en la rutina diaria—en la hora de la comida, en el carro, en la hora de bañarse, o en la hora de dormir, etc.)?

    d. Dígame cuales actividades o experiencias son más útiles para mejorar el lenguaje de su niño.

PREGUNTA 3: ACTIVIDADES QUE LOS PADRES ENCUENTRAN MÁS PROVECHOSOS PARA LA MOTIVACIÓN EN EL DESENVOLVIMIENTO DE LA INTRODUCCIÓN TEMPRANA DEL LENGUAJE, LECTURA Y ESCRITURA (EN AMBOS SU CASA Y DURANTE LA TERAPIA):

Usted y su niño han estado participando en las terapias del habla y lenguaje hasta ahora por 5, 10, 15, etc. semanas y la terapeuta le ha demostrado diferentes actividades de introducción temprana del lenguaje y lectura. Sin embargo, es menos con respecto a la lectura.

3a. **Pregunta Principal**:

1. ¿Ha podido desempeñar alguna de las actividades en su casa acerca de la introducción temprana del lenguaje, lectura y escritura que nosotros hemos tratado aquí en la terapia? ¿Cuáles de las actividades cree usted que fueran más eficaces y cuáles en particular le gustaron más a su niño?

2. Déme un ejemplo de una actividad con respecto al desarrollo del lenguaje que hayamos tratado aquí en la terapia que usted o sus familiares también hayan usado en la casa.

3b. **Pregunta Principal:**

1. ¿Podría describir alguna de las actividades que llevan a cabo en su casa con respecto al desarrollo de la introducción temprana del lenguaje, lectura y escritura que nosotros no usamos aquí durante la terapia? Por ejemplo, una actividad que su niño de verdad disfrute mucho en la casa y en la cual él/ella intente, ya sea, de comunicarse y/o hablar con los familiares.

2. Por favor, dígame de una actividad que le parezca más útil usar en la casa que le ayude a su niño para comunicarse mejor, la cual yo también pueda usar durante la terapia (e.g., una actividad que sea llevada a cabo en su casa ya sea por usted, los hermanos o primos). (Especialmente en la casa durante los encuentros de la rutina diaria como—en la hora de la comida, en el carro, en la hora de bañarse, o en la hora de dormir, etc.)