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MOTHERS' PERCEPTIONS OF SPEECH-LANGUAGE PATHOLOGY SERVICES: QUALITY OF LIFE ISSUES

BY

CARLA A. HANAK ©

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND
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DEGREE OF MASTER OF SCIENCE
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DEPARTMENT OF SPEECH PATHOLOGY AND AUDIOLOGY

Edmonton, Alberta
SPRING 1995

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled MOTHERS' PERCEPTIONS OF SPEECH LANGUAGE PATHOLOGY SERVICES: QUALITY OF LIFE ISSUES submitted by CARLA A. HANAK in partial fulfillment of the requirements for the degree of MASTER OF SCIENCE in SPEECH LANGUAGE PATHOLOGY.

Phyllis Schneider

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Ray Rasmussen

Marjory Sutherland

April 7, 1995

ABSTRACT

The purpose of this qualitative study was to explore mothers' perceptions of their language impaired youngsters, the speech-language pathology treatment process and the effect that this process had on the mothers' quality of life.

In total seven English speaking mothers were interviewed in depth. From the mothers' interviews six themes emerged: mothers' expectations, program impact, child temperament, obstacles to intervention, unresolved issues and agent responsible for child changes.

Results indicated that mothers' perceptions of program benefit and improvement in quality of life was linked primarily to parental expectations and to a lesser degree to improvements in the children's language skills.

Speech-language pathologists are called to reconsider how they deal with parental expectations, adult learning theories, empowerment, professional and public education and the manner in which they conduct and evaluate parent focused language training programs.

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CHAPTER I

INTRODUCTION

Personal Perspective

My reason for pursuing this topic has been shaped by my experiences as a speech-language pathologist for over ten years. Two issues that have particularly intrigued me are professional accountability and determining treatment efficacy from the client's perspective. These are the basis for this study.

Accountability

I remember the conversation well. I was having coffee with my father and the topic of discussion was my new job. I had recently obtained my first job as a speech-language pathologist and I was gushing how wonderful it was and how kind my clients were. The conversation progressed amicably until he asked me THE question. "So tell me," he said, "Do you really help anybody to get better?" I paused but for the briefest of seconds, turned to him with wide eyes and said with all the assurance and conviction of any new clinician, "Well of course!!" At the time I was miffed with him. Why on earth would he ask me such a question!? Didn't he realize how honourable my new was? To help the communicatively down trodden was a noble pursuit unto itself, far beyond this type of scrutiny. Or so I thought until I had gained some experience.

Perspective

As I journeyed as a working professional, no longer a new clinician, I sensed a growing discomfort with some of the practises of my chosen profession. I discovered that we as the professionals rarely pursued at any great length what it was that our clients truly wanted. Beyond our basic case history and assessment/ treatment plans, our clients could be dissected to the point where their communication profiles became little more than standard scores. As experts we made our "sales pitch" as to what needed to be done and gave only cursory attention to the client's wishes. This was not to say that we totally disregarded the client's concerns but to truly engage the client in a thorough and systematic way was not done.

It is by investigating the client's perspective at great length that I set about to answer the question my father asked me so long ago,"So tell me, do you really help anybody to get better?"

Specifically, in this study I have focused my attention on mothers of young language impaired children. The mothers shared their perceptions of their children, their participation in the speech-language treatment process (either parent or child language training programs) and the impact these programs had on their quality of life.

CHAPTER II

LITERATURE REVIEW

The following chapter examines literature pertinent to this study. Qualitative inquiry, the complexities of clinical accountability and treatment efficacy of parent language training programs are discussed.

Qualitative inquiry and its role in speech-language pathology research

In this section a rationale is provided for selecting this particular type of scientific research in studying mothers' perceptions. Qualitative themes central to this study are examined. The paucity of this type of research in the speech-language pathology field is also discussed.

Present day research has been criticized for a number of reasons. Three of the more significant limitations have been that present research has focused on behaviours that may not be related to what clients want or need (Bowling, 1991; Heaton, 1992; Moeller et al.,1990), that the client's perspective is conspicuously missing (Crutcher, 1993; Lomas et al., 1987,1989; Pueschel & Hopmann, 1993) and the wholeness of the individual is ignored (Fey & Cleave, 1990; Moeller et al.,1990; Schuler et al.,1990).

One way to deal effectively with these problems is to adopt a research methodology such as qualitative inquiry, which is sensitive to these issues. In his text, "Qualitative Evaluation and Research Methods," Patton (1990) discusses this type of scientific inquiry at great length. Of the conceptual issues he discusses, the following themes have great significance for this study: *naturalistic inquiry* (studying real world situations), *inductive analysis* (immersion in the details and specifics of the data to discover important categories and interrelationships), *holistic perspective* (the whole phenomenon under study is understood as a complex system; there exists numerous inter-dependencies which cannot be meaningfully reduced to a few discrete variables), *personal contact and insight*; (the researcher's insights are an important part of the inquiry) and lastly *unique case orientation* (each case is special and unique).

Although the speech act and communication process can and are often analyzed in minute detail (Fey & Cleave,1990; Hodson, 1990; Ihrig & Wolchik, 1988; and Kearns & Simmons; 1990) often the nuance of the process is lost. Communication when studied in contrived situations yields results which have little to do with the real world. Communication does not exist in a vacuum. This complex set of behaviours is best studied under those conditions suggested by Patton. One of the greatest appeals of the qualitative approach as expressed by Patton relates to unique case orientation. The more a treatment program aims at individualized outcomes the greater the appropriateness of a qualitative approach. In the field of speech-language pathology the clinician attempts to provide services that meet the client's individual needs. Documentation that permits this variation in reporting outcomes is essential in speech-language pathology. Yet this type of inquiry is seldom employed in the field.

From an extensive literature search spanning twenty years only three published studies were located that used a qualitative approach (Girolametto et al.,1993; Haynes & Oratio, 1978; and Pickering, 1976). Of these three only the Girolametto and Haynes studies related to client perceptions and clinical accountability. It is evident then that the qualitative approach is seldom used by speech-language pathology researchers nor are client perceptions and accountability jointly investigated. Yet there is a growing interest in qualitative inquiry, notably the use of consumer satisfaction questionnaires (D. Dale, personal communication, October 16, 1993; C. Fratalli, personal communication, December 2, 1994). However, these questionnaires while attempting to decipher client needs have been for the most part clinician rather than consumer generated thus the client's perspective is over shadowed.

In summary, qualitative inquiry has unique and distinct properties from quantitative research. It is an alternate method of scientific research that is seldom used in the speech-language pathology profession. Further the issue of accountability from the client's perceptions is seldom if at all addressed. How researchers have addressed the issue of clinical accountability follow.

Outcome Measurement

In order to better understand the complexities of professional accountability or outcomes/treatment efficacy as it is referred to in the speech-language pathology literature, relevant issues that affect the profession as a whole are presented.

Epstein (1990) makes reference to the outcome movement as "an era of unprecedented growth" (p.266). Siegel (1987) states that the question "Does therapy work?" is not a proper question for research since most clinicians would not accept the findings of a study that indicated otherwise. The real issue to address is not whether therapy works but rather whether the benefit of the program outweighs the cost. This type of inquiry, Siegel states, is a value question, not one that science can answer. Researchers should pose questions whose solutions will clarify basic behavioral processes instead of addressing questions that are motivated by political interests (Siegel, 1987). However, in his 1993 article in ASHA, Siegel shifts his view somewhat. He writes that treatment efficacy research is needed because it provides speech-language pathologists with a systematic way to evaluate the results of clinical procedures. He comments as well that speech-language pathologists need to know not only if a treatment is efficacious but also how it works and why it is efficacious.

Aside from philosophical issues there are a number of substantial concerns that plague efficacy research that this study will address. These concerns are discussed below.

1. **The general lack of efficacy studies.** The lack of efficacy studies in general appears to be a common lament amongst researchers. Words like "little", "lack of", "limited" and "paucity" are frequently used (Damico, 1988; Hodson & Scudder, 1990; Ingham, 1989; Kearns & Simmons, 1990; Schuler et al., 1990; Ylvisaker & Urbanczyk, 1990). This study will add to the body of knowledge on accountability from the clients' perspective.

2. **Defining the term "efficacious treatment".** Kearns and Simmons (1990) state that although there is a general agreement that investigating treatment efficacy is a worthwhile pursuit, there is considerable amount of variance in what constitutes efficacious treatment. Defining the term operationally so that professionals can agree on what is efficacious is extremely difficult (Conture & Wolk, 1990; Fey & Cleave, 1990; Hillman et al., 1990; Moeller et al., 1990; Schuler et al., 1990). An alternate method to deal with this issue is to interview clients at length to determine what they believe to be efficacious. It may be easier to reach consensus across clients than clinicians. There may be issues for clients that clinicians fail to see.

3. **The methodology employed.** Many of the problems of efficacy research relate to methodological inconsistencies and flaws (Conture & Wolk, 1990; Damico, 1988; Fey & Cleave, 1990; Hodson & Scudder, 1990; Ingham, 1989; Nicholas & Helm-Estabrooks, 1990; Salmon, 1990; Witzel, 1990; Ylvisaker & Urbanczyk, 1990). A reliance on quantitative methods has proven disappointing when dealing with patient variables and shifts in treatment paradigms. Schuler and her colleagues (1990) writing on efficacy in autism treatment stated that it was easier to document effects when operant techniques were the program of choice. Now that the treatment focus has moved to more interactional and pragmatic considerations it is harder to document efficacy. Feedback from participants and significant others may be more revealing as to the impact of treatment than merely rates and frequencies of targeted responses within therapy settings (Schuler et al. 1990). A systematic approach such as in a in depth interview better addresses these issues.

4. The types of measurement undertaken. How and what one measures as efficacious is problematic (Fey & Cleave, 1990; Ingham, 1989; Moeller et al., 1990; Schuler et al., 1990). Fey and Cleave (1990) state that when mean length of utterance (MLU) and Developmental Sentence Score (DSS) are the sole measures used to evaluate progress, researchers run the risk of miscalculating the child's overall level of communicative functioning and seriously jeopardize the validity of their study. Further they report that effectiveness is rarely measured holistically and in the real world. If this was done the authors state few studies would "pass". Moeller and her colleagues (1990) state that techniques that rely on static quantitative measures are ineffective when used alone. Moreover they state that measurement strategies that isolate the child outside the family unit and focus exclusively on hearing and language are inappropriate. Schuler and her associates (1990) reporting on efficacy studies in autism indicated that measures used to document change may not be sensitive to intervention content. Relevant gains may not be captured by selected measures. Schery and Lipsey (1983) reported that many clinical studies assess a specific clinical technique rather than a broader treatment regimen. In addition they report that a full treatment regimen may consist of many such techniques. Measuring treatment effectiveness could turn out quite differently if all aspects are considered rather than measuring the effects of one strategy in isolation. This study addresses these concerns by investigating the client's perspective for evaluating progress. Functional change, issues in global areas of development and functioning within the context of the family and home are at the crux of this study.

5. The uniqueness of the subjects studied. Researchers have expressed their concern that their particular population's characteristics are so varied and diverse that undertaking efficacy studies that can be generalized to the entire population is extremely difficult (Hodson & Scudder, 1990; Schuler et al., 1990; Ylvisaker & Urbanczyk, 1990; Witzel 1990). Heterogeneous groupings are troublesome to control. Each group of researchers mentioned above wrote as if this issue was only of concern in their disorder area. It appears that this problem is more widespread than previously thought. Qualitative approaches are better suited to address individual responses than quantitative approaches.

6. The use of anecdotal accounts of improvement as sole method for evaluation. Hillman and his co-workers (1990) in the area of voice disorders expressed concern with the scarcity of objective research to support treatment efficacy in this area. Subjective judgments maintained by clinicians and clients reporting anecdotal how therapy helped are common. Views are often based on client report and clinical observation that "the voice sounds better", is "more serviceable" or "feels better". Anecdotal reports can be found in laryngectomy research as well (Salmon,1990). Salmon (1990) stated that in many studies there have been cases of inconclusive data to support treatment efficacy. In their case study to illustrate issues related to determine efficacy of aphasia treatment, Nicholas and Helm-Eastabrooks (1990) stated that the client and his wife were pleased with the husband's treatment progress. However, the investigators did not state how they measured the couples' pleasure. It would have been particularly interesting to know how this was accomplished since the gentleman was diagnosed with global aphasia. Logemann (1990) reported that a large number of clinical descriptions and anecdotal reports of treatment efficacy are available in the swallowing disorders literature. Although they provide the clinician with important clinical insight they are not sufficient in themselves to prove efficacy. More appropriately, they should be used for stimulating more carefully designed research studies (Logemann,1990). While it appears that the use of anecdotal reports is widespread across the different disorders, there is no evidence of an in depth and systematic method in studying the consumers perceptions of that which took place. A carefully structured in depth interview will uncover more specific information about client issues than either the limited/inconsistent anecdotal reports mentioned here or the more commonly used clinician generated Likert style questionnaires which require respondents to rate their level of contentment.

7. **The lack of ecological validity in studies.** Lack of ecological validity is an issue cited by many researchers (Hodson & Scudder, 1990; Kearns & Simmons,1990; Moeller et al., 1990; Schuler et al., 1990). Hodson and Scudder (1990) indicate that for the area of phonological disorders, ecological validity is critical. By having family members/ significant others evaluate the appropriateness of our treatment goals, procedures and outcomes, social validity is promoted. Moeller and her associates (1990) advocate the use of evaluating the hearing impaired child from an ecological perspective to measure the child's skills within different situations. This requires that the child be assessed in his natural environment to observe how the systems within the environment interact to affect the child. Not to follow this approach reduces a programs' ecological validity. Associated with the concept of ecological validity is the concept of clinical significance. Fey and Cleave (1990) caution that although studies may show statistical significance what is often neglected is clinical significance. Ylvisaker and Urbanczyk (1990) also comment on this issue in traumatic brain injury.

Often statistical significance is evident but functional improvement that impacts positively on an individual's language use is not. This study promotes ecological validity by investigating at great length what mothers have to say about their children, treatment program and its impact on their life.

8. The existence of clinician bias. Damico (1988) listed five factors that contributed to the lack of efficacy in language therapy for a school-aged girl. One of the factors, clinician bias, is gaining attention in the speech-language pathology literature. Clinician bias relates to unique contributions that the speech-language pathologist brings to her clinical interactions. Fey and Cleave (1990) reported that clinician bias can occur during any point in the process and the clinician must control this by checking inter judge and/or intra judge reliability. Yet in a qualitative approach the researcher's personal experiences and insight are an important part of the inquiry (Patton, 1990). While bracketing occurs to focus attention on the data, the fact that the researcher is involved in the inquiry is expected.

9. The lack of consumer input. There has been a limited amount of research in the area of client perspectives related to treatment outcomes. One account by Haynes and Oratio (1978) studied clients' perceptions of therapeutic effectiveness. In their study, adults with communication disorders were questioned as to their perceptions regarding the treatment process. The researchers investigated clients' perceptions of their therapists' clinical skills versus personality traits. The results indicated that clinician demographics contributed least to client's perceptions of treatment effectiveness while technical and interpersonal skills were more critical. Although Haynes and Oratio (1978) clearly established how adults perceived their clinician and the treatment regime, no information was obtained about whether the individuals thought the whole therapy process was worthwhile. There was no measure of the impact of the treatment on the clients' quality of life. More recent articles have attempted to focus on clients' perspectives but how these perceptions are measured is still limited. Studies indicate that clinician perspectives do not often match that of the client and that it is necessary to take this into account when planning outcomes (Condeluci et al., 1992; Coyte, 1992; Evans & Ruff, 1992; Heaton, 1992; Lomas et al., 1989). How the client feels is more important than what the professional thinks the client ought to feel (Bowling,1991). Self report instruments are becoming increasingly popular in the Audiology profession. Instruments such as the Communication Profile for the Hearing Impaired (CPHI) (Walden et al.,1984) is one such measure that addresses this trend. Not only is hearing assessed within the confines of the clinic but clients are asked to rate their contentment with their hearing aid(s) in a variety of listening situations outside the clinic. In this way the client's needs are uniquely addressed. The Communicative Effectiveness Index (Lomas et al., 1987, 1989) is yet another tool that focuses on client/family perceptions. In their first study, Lomas and his colleagues (1987) had a group of rehabilitation clinicians and two groups of aphasic patients and/or their spouses generate a separate list of communication situations that each group felt was important in aphasics' day to day life. From this list a quality of life measurement tool was developed albeit only in the area of functional communication skills. During the development of the tool, Lomas and his co-workers revealed that aphasics/spouses focused more frequently on social needs than did clinicians. Further, clinicians overestimated the degree of patient concern about life skill situations while patients generated far more specific activities than the clinicians. Lomas and his colleagues concluded that clinician-generated items are not fully representative of patient values.

In speech-language pathology research specific to child language disorders there has been very little literature to date on family or parent perspectives. Pueschel and Hopmann (1993) indicated that there were only a few anecdotal reports that focused on parental perspectives on the speech and language abilities of children with Down's Syndrome. In their study Pueschel and Hopmann investigated parents' assessment of their children's current language skills. They also probed parents' evaluation of important contributions to their children's language learning. The authors found that parents reported themselves to be the most important in assisting their children to develop language followed by speech therapists, siblings, non handicapped classmates, television and lastly classmates with special needs. Further, the authors stated that acquiring normative data on this population is necessary and parental views are important.

In her article on parents' perspectives, Crutcher (1993) outlined what she believed was a consensus regarding parents' perspectives on the best practise in speech-language pathology treatment. She reported that she has had the opportunity to interact with "thousands of families" of children with speech and language concerns and found the current system lacking. Some of the more notable limitations that parents perceive are the lack of individualized programs for their children, time constraints for services and the speech-language pathologists' unwillingness or inability to realize that there are other important aspects of the child's /parents' lives. Some of the specific concerns of the speech program included: overemphasis on articulation, lack of carryover, neglect of social language behaviours, and lack of approaches to promote generalization within the family unit. She concluded that "the tendency of professionals to categorically view the parents' perspective as unrealistic must change." (p. 373). Family concerns are real and attending to this will assist the child in acquiring language that will support him or her in becoming a fully functioning socially capable adult (Crutcher, 1993).

10. The paucity of pragmatic research on treatment efficacy in developmental child language disorders. Much of the literature for this area deals with theoretical issues (Bain & Dollaghan, 1991: Campbell & Bain, 1991; Fey & Cleave 1990; Olswang, 1993; Olswang & Bain, 1991). Each of these researchers discuss issues related to the therapy process such as when to recommend intervention (Olswang & Bain, 1991), how long to treat (Campbell & Bain 1991), determining organismic and environmental variables in efficacy research (Olswang, 1993) and the notion of clinically significant change (Bain & Dollaghan, 1991). Fey and Cleave (1990) discuss theoretical issues such as how to conduct research. Goldstein (1990) in an ASHA report presented the argument that language scientists have not produced practical research that can be applied to individuals with language impairments. He calls for collaboration between the researcher and the clinician to promote the use of descriptive research to develop interventions and to evaluate treatment effects. Thus though the need for efficacy research has been widely discussed it remains to be done.

Treatment efficacy in parent language training programs

Since this study investigates mothers' perceptions of the impact of the treatment programs in which they participate, the literature was reviewed for articles related to this topic. Following are the results of the survey. The findings are divided into two parts: those that address efficacy from the speech-language pathologist's perspective and those which address efficacy through the client's perspective.

Speech-language pathologist's perspectives

Tannock and Girolametto (1992) critiqued the literature for studies which evaluated the efficacy of parent focused language intervention programs. They indicated although the use of parent programs is widespread there are few studies which have evaluated their effectiveness. Tannock and Girolametto (1992) refer to those parent programs which employ the use of child oriented techniques, interaction promoting and language modelling as proponents of the "Interactive model". These three components are discussed further in the third chapter under the "Treatment program" section. Suffice to say the basic premise of the interactive model is to foster parent-child interactions in a specific way that is thought to be optimum for language acquisition.

Tannock and Girolametto (1992) evaluated treatment outcomes for the parent and child in light of methodological weaknesses such as restricted sampling, pre-post test designs which don't account for maturation, and measurement problems related to a restricted focus of evaluation, narrow or few sampling points and the possible effect of the measurement situation on parents' behaviour. In total they reviewed seven studies. Their findings are divided into parent and child outcomes.

Parent Outcomes

Each study (Girolametto, 1988; Macdonald, 1989; Mahoney & Powell 1988; Seitz, 1985; Tannock, Girolametto and Siegel 1990; Weistuch & Lewis, 1985, 1986) reported positive effects in that the mothers increased the frequency in which they employed the trained treatment techniques at the end of the program. In general the mothers appeared to be more attuned to their child's abilities, more responsive to their child's communicative attempts, and less controlling of their child's activities or conversations. Yet there was so much variability in the mothers' interaction styles and how they implemented the techniques that it was difficult to meet outcome standards that were in fact set arbitrarily. Tannock and Girolametto (1992) felt that they did not really know what constituted "appropriate" levels of specific parental behaviours. Therefore parents failing to meet success criteria did not necessarily mean that their programs were ineffective.

Child Outcomes

Based on their review of the studies mentioned above, Tannock and Girolametto (1992) determined that child outcomes were minimal and were restricted to increased use of existing competencies. They could find no evidence that the parent programs they investigated facilitated acquisition of new competencies. Specifically, while the children increased in their use of existing competencies (improved participation, for instance better turn taking), no treatment effects could be determined for various measures of child language and socio-communicative abilities (Tannock & Girolametto, 1992).

Since follow up data revealed no further changes the authors suggested that any improvements in child outcomes were more likely to happen immediately after the program.

The authors conclude that their review should not be interpreted as evidence that this model cannot be effective. They suggest that this type of treatment may be more suitable as a complement to other interventions. They state:

> This approach may provide a useful adjunct to other intervention approaches in terms of enhancing children's use of newly acquired abilities. Its wholesale adoption by clinicians, however, as a primary means of facilitating communication and language development in children who have or who are at risk for having developmental delay, is premature and unwarranted at this time (p.72).

Client's perspectives

Only one study was discovered which related to client perspective in child language disorders. Girolametto, Tannock and Siegel (1993) studied the effects of an interactive model of language intervention (parent focused language training program) on mothers through analyzing subjective measures (i.e. consumer satisfaction data) and objective measures (attendance, homework completion and changes in parent-child interactions). Thirty-two mothers and their preschool children with developmental delays participated in a twelve-week "Hanen Early Language Parent Program" (Manolson, 1985). The participants were divided into two groups of 16; one group represented a low mental age and the other a high mental age.

Parent-child interactions were videotaped pre- and post-treatment and changes in applying specific intervention techniques were analyzed. Techniques that were studied were coded as either "child-oriented", "interaction-promoting" or "language modelling". A change of 10% in child-targeted communication behaviours was considered the magnitude necessary to demonstrate clinical significance. Analysis revealed that fewer than one-half of the children in each group had gains of 10% from pre to post test.

As mentioned earlier, the other outcome measure used to investigate treatment success was the consumer satisfaction survey. Through a 7- point Likert scale mothers were asked several questions. First they were asked to rate organizational and instructional aspects of the program. Next, mothers were asked to rate how they and their children had changed the way they communicated as a result of the program. Then, mothers were asked which techniques were most useful. Later at four months post-treatment mothers were sent another questionnaire asking if they still used any of the techniques, how they rated their confidence in acting as their child's communicative "educator" and what type of follow-up if any that they would prefer. Seventy-eight percent of the surveys were returned. Results revealed parental satisfaction with the quality of service, but they rated small group activities lower than individualized instruction and home visits. Also results indicated that parents noted improvements in their interactions with their children but were uncertain about improvements in the children's communication skills. Although this study is to be commended for its' thoroughness and attention to parents' perspectives, it still appeared to be driven by the speech-language pathologist in determining effectiveness. The questionnaire was clinician driven and in using a rating scale much went unexplored. No significant associations were found between subjective parent report and objective data taken pre and post. Girolametto and his co-workers (1993) concluded that consumer satisfaction surveys are insufficient as sole indicators of treatment outcome. The researchers stated that the results of the study could not be taken as evidence of the efficacy of the interactive approach. Reasons they cited included evaluation bias, lack of measurement of the psychometric properties of the questionnaire and the measurement of reports of satisfaction only. That is, there may have been a tendency for satisfied parents to return questionnaires more often than dissatisfied ones. The difficulty these researchers had in reconciling their findings may have been more a result of how they perceived effectiveness and what would be the best way to measure it. Many of the limitations that were earlier cited in the Tannock and Girolametto 1992 survey of effectiveness continued to plague these researchers. Perhaps studying the treatment/outcome phenomena from a different angle may shed new light on the situation. Studying mothers' perceptions in depth about their experiences in parent programs may provide the speech-language pathologist with additional information about how effectiveness should be defined, measured and evaluated.

In summary, undertaking sound efficacy research is a thorny and intricate process. It becomes increasingly apparent that treatment efficacy is a complex issue and not simply a matter of documenting client change in terms of pre- and post-standardized test scores (Olswang, 1990). Other measures must be included and the wholeness of the individual must be recognized.

Related trends in the outcome initiative

Little to none of the speech-language pathology literature has dealt with clinically significant change that embraces the wholeness of the client. Two trends in the medical literature which have started to address this issue are a shift from a negative concept of health and a focus on quality of life (QOL). These trends are discussed below.

There is a shift from a negative concept of health to a more positive one. Classically one list of outcome measures consists of " the five Ds " (Lohr,1988). Elinson (1987) lists these as: death, disease, disability, discomfort and dissatisfaction. However there is a move to consider more positive health measures (Bowling, 1991; Epstein, 1990; Lohr, 1988). The reason for this is that reliance on a negative definition of health provides little information about the condition of some 80 to 90 % of the general population who do not experience chronic physical limitations or substantial psychiatric impairments (Bowling, 1991). The concept of positive health implies "completeness", "full functioning" and "efficiency" of mind, body and social adjustment (Bowling, 1991). According to Kent (1989-1990), even the most exhaustive speech-language pathology battery of deficiency tests fall short of capturing client "wholeness". The implication then is that future speech-language pathology research must address client wholeness.

One other trend in the medical literature which can be applied to speech-language pathology is the use of more unconventional methods to assess outcome in relation to social health. Social health as explained by Bowling (1991) is a dimension of individual well-being distinct from physical and mental health and relates directly to interpersonal interactions and social participation. The concept of social health is one dimension of the term quality of life (QOL). Quality of life is a broader concept than personal health status and takes social health into account (Bowling,1991). There is no set definition for the term quality of life. However Bowling (1991) states that QOL encompasses: functional ability, self worth/esteem, degree and quality of social/community interactions, psychological well being, economic status, life satisfaction and health status.

On this topic only three references were extracted from twenty years of speech-language pathology research. Wertz (1984) discussed treatment for the aphasic client along a "cure-care" continuum. He stated that clinicians address the "cure stage" (usually early post onset when language may be a possible outcome) with much more frequency than the late "care stage" (when full recovery of language skills becomes less likely and quality of life becomes much more of a concern). Kent (1989-1990) alludes to QOL by when he stresses that clinicians need to be concerned with increasing the client's capacity to achieve life goals. In her article on evaluating clinical outcomes Frattali (1990-1991) examined QOL studies for audiology. There was no mention of such studies in the field of speech-language pathology. Save for the mention of quality of life in the Wertz study a literature search on this topic revealed no additional research.

When addressing client wholeness then it appears that the client's status in relation to quality of life should be examined.

CHAPTER III

In this chapter the problem, participants and procedures are described. Methods particular to qualitative research are discussed.

METHODOLOGY

Statement of Problem

A review of the literature indicates that the outcome initiative is in full swing. It is evident that service providers are becoming increasingly challenged to prove the worthiness of their treatment program. Although it is clear that the speech-language pathology profession acknowledges the importance of documenting the efficacy of the services provided, its scope has been limited primarily by methodology and focus. In scrutinizing the literature there appears to be a heavy reliance on quantitative measures evaluating treatment effectiveness through the clinician's perspective.

Purpose

This study employed the use of qualitative inquiry, namely, in depth interviews, in exploring mothers' perceptions of their young language impaired children, the speech pathology experience -- in particular the treatment process -- and the effect their programs had on the mothers' quality of life (QOL). As stated earlier Bowling (1991) states that QOL encompasses: functional ability, self worth/esteem, degree and quality of social/community interactions, psychological well being, economic status, life satisfaction and health status. In this study particular interest is paid to all of the areas discussed above except economic and health status.

Method

Participants

The agencies that were targeted in this study were Alberta Health Units. Of 12 that were solicited, four were able to provide subjects. In total seven English-speaking mothers participated. There was a possibility of nine children to be discussed (two of the mothers had twins). However one twin was excluded from final analysis because there was an insufficient amount of information to analyze. The children's ages ranged from 29 to 41 months. The children who participated in this study presented with a minimum of a mild language disorder as determined by the Developmental Language Severity Rating Scale (Alberta Health, 1993) (Appendix F). This scale is used extensively in the health units to classify the extent of an impairment and it views the client holistically. With this scale quantitative (standardized test scores) and qualitative measures (degree of functional competence) are used to determine the extent of an impairment. Table 1 summarizes the characteristics of the participants.

Table 1. Mother and child characteristics

MOTHER AND CHILD CHARACTERISTICS	
Children (total=8*)	
Chronological age (months)	Mean (range) 33.3 (29-41)
Severity rating	Mean (range) 3.1 (1-5)pre 2.8 (0-4)post
Gender Male	8
* (includes one set of twins)	1
Mother and Family characteristics (total=7)	
Maternal age (years)	Mean (range) 32 (27-38)
Years of education (mother)	Mean (range) 13.3 (11-16)
Number of "2 parent" families	6
Family size (mean number of children)	2.57 (2-3)

Treatment Program

Since mothers were studied from different health units the language training programs varied in length and format. In total there were five different programs. However in all save one the content remained essentially the same and was based on the work of various researchers such as Bruner (1983), Girolametto (1988), Goldberg (1977), MacDonald & Gillette (1988), Mahoney (1988) and Manolson (1984). Four of the programs focused on the parents' interactive style where parents were taught to modify their behaviours to facilitate their child's communication development. The basic premise was that a child learns from an active adult who acts like the child, follows her motivations and has a meaningful relationship in which "give and take" is the rule for interaction rather than one sidedness (MacDonald 1989). Specifically parents were taught how to *balance* their interactions by being reciprocal and promoting turn-taking, to *match* the child's attempts so he experiences success and can respond as well as matching progressively so the child is shown the next developmental step, to *observe and respond* more sensitively to the child so emerging skills can develop, to be *nondirective* so that the child has freedom and opportunity to initiate from his own perspective and to make interactions *mutually pleasurable* so that both the parent and child experience success with each other and can facilitate future interactions (MacDonald 1989).

As mentioned earlier there was one program which did not follow this approach but adopted a theme approach to language stimulation. Parents were involved with their children to enhance communication skills with many of the same strategies from above but to a lesser degree. Table 2 summarizes the program by focus, format, program components and philosophy.

Table 2. Program characteristics

PROGRAM	FOCUS	FORMAT	COMPONENTS	PHILOSOPHY
1	Parent	8 weekly sessions for 2.0 hours each. Alternate time between lecture and videotaping. When videotaping time was slightly shorter.	parent group, videotaping, role-playing and lecture	To give parents skills to facilitate language in the home environment and to understand more about language acquisition.
2	Parent	6 weekly sessions for 2.0 hours each. Alternate time between lecture and videotaping. When videotaping time was slightly shorter.	parent group, videotaping, role-playing and lecture	To give parents the skills to stimulate their child's language during everyday activities.
3	Parent and Child	9 weekly sessions for 2.0 hours each. Concurrent sessions for parents & children each with own S-LP. When videotaping time was slightly shorter.	parent group, videotaping, role-playing, lecture and group therapy for the child that the parent watches periodically.	To support parents in stimulating their child's language.
4	Child	8 weekly sessions for 1.5 hours each. First hour child-group & S-LP. Last half hour parent-child group & S-LP	primarily group therapy for children with some parent interaction at end of session	To develop social skills, independence and to stimulate language through a theme approach.
5	Parent and Child	6 weekly sessions. First 2 sessions 2 hour parent lectures. Next 4 sessions 1 hour child-group & S-LP with parent & S-LP observation through 2 way mirror	parent group, lecture and group therapy for the child while parent watches and discusses with S-LP	To develop in parents a responsive interactive style to use with their child within everyday conversation and activities.

Procedure

Recruiting participants

Support was solicited from 12 Alberta Health Units by providing supporting documentation detailing the rationale and proposed methodology. The Program Managers were provided with verbal and written information regarding the study's purpose and requirements including how confidentiality was addressed (Appendices A and B). Managers were encouraged to circulate the information amongst their respective Chief Executive Officers/ Medical Officers of Health and staff. In two instances, presentations were required to complete the request. Once approval was gained at the Health Unit level, speech-language pathologists were solicited for participation.

For each interested speech-language pathologist's perusal she was sent necessary documentation including a consent form with the study specifications and a prepared script to read to mothers informing them of the study and requesting their support (Appendices C and D). Once the speech-language pathologist agreed to participate, the search for eligible and willing mothers began.

Participating speech-language pathologists either telephoned prospective mothers requesting support for the study or discussed the particulars of the study on the first night of the parent program. For those who expressed an interest, a prepared letter was given with the consent form attached (Appendix E).

Epoche

Consistent with qualitative methodology it was critical for the researcher to look inward to eliminate or at least gain clarity about her preconceptions about the phenomena under study (Patton, 1990). This process is referred to as *Epoche.*

> *Epoche* is a process that the researcher engages in to remove, or at least become aware of prejudices, viewpoints or assumptions regarding the phenomenon under investigation. *Epoche* helps enable the researcher to investigate the phenomenon from a fresh and open view point without prejudgment or imposing meaning too soon (Katz, p.37).

This process is ongoing rather than a one time occurrence. During *Epoche* the researcher became aware of her particular assumptions that she held as a speech-language pathologist that might have an influence on the research participants or the manner in which the interview would be conducted. Therefore prior to each interview she reflected upon her assumptions and made a conscious effort to keep them in check so that each interview could proceed anew with a clear view without prejudgment. My assumptions were as follows.

* As a speech-language pathologist my experience with interviewing has been to seek out answers to questions that I established before hand and not to follow at great length where the interviewee wishes to explore. (I must follow the mothers' leads.)

* As an individual who has only experienced quantitative research methodology my natural tendency is hypothesize before data collection occurs and then to go out and test the hypothesis. This means that certain variables are targeted as

important and specific relationships are tested. (I must go into each interview with an open mind to see all possibilities.)

* As a speech-language pathologist I have a vested interest in finding out that speech pathology services do impact positively on people's lives. (I must follow the mother where she goes even if it means that she "finds fault" with the system.)

* As a speech-language pathologist I have developed a skill to quickly analyze situations, to classify and to make decisions based on the information at hand. (I must not make hasty decisions. I must reserve judgement until all the information is in.)

* As a health professional I have at times assumed the "expert" role with parents. (In this situation I must acknowledge the prior knowledge of the mother and learn from her experiences. If it is appropriate to give advice (that is the mother requests it) I must be tentative and release it slowly).

* As a human being I am vulnerable to all the pitfalls of human interactions. To minimize misinterpretations I must listen empathically by searching how I am like the other person, listen to my full range of inner voices (one's own personal sets of rules and beliefs about the world), to treat little of what the mothers say as superficial, to control my inferences (not to treat them as if they were reality), to control my critic (judgmental inner voice), to control any meta messages (signals that we send either consciously or unconsciously about the worth or value of what someone has to say) and to realize that in each situation there is mutual vulnerability (both the mother and I have something to risk by sharing what we have to say.) (Rasmussen, 1994).

The interview

Scheduling and formalities: Once the consent forms were received mothers were scheduled for their interviews. Interviews were held at a time and place where it was most convenient for the mother. Four interviews took place during the day in the mothers' homes while one took place in the researcher's home. In two situations the interviews were conducted over the telephone during the evening. Interruptions associated with tending to children, pets or answering the telephone were accommodated. All interviews were audio taped and brief notes were kept. The interviews took approximately one and a half hours to complete and all participants stated that they had ample time to answer each question. In order to promote reliability mothers agreed to future telephone contact if necessary to verify interview content. The mothers were also encouraged to contact the researcher by telephone if they wished to add more to their comments. All long distance telephone charges would be accepted. However as was the case no further contact was made by either the mothers or the researcher.

Guiding principles

Questions: The principles which guided the interview questions were gleaned from the efforts of McCracken (1988), Patton (1990), and Shipley (1992). Basic principles included the use of open ended questions to avoid influencing the interviewee's response, promoting clarity through the use of follow up questions, and presenting questions clearly and repeating them more than once to aid respondent comprehension.

Active listening and interactional skills: Specific strategies to enhance the researcher's active listening and interaction skills in order promote participant self-disclosure were culled from the work of Blanchard (1992), Athos & Gabarro (1988), Fontana & Frey (1994), Morley (1988) and Roethlisberger (1968). Morley (1988) writing on interpersonal skills states that "...things which look trivial to us may have immense meaning to others: may in fact touch another in a most personal and profound way" (p.471). In this study "us" refers to the researcher and "others" refers to the mothers who participated in the study. During the interviews it was essential to keep this in mind since client perceptions are at the crux of this study. Blanchard (1992) states that individuals listen, remember and evaluate selectively. Those opinions that agree with one's own beliefs are remembered more easily while those ideas that do not conform are forgotten. Messages are interpreted the way that an individual wants to understand them. Although Roethlisberger (1968) wrote on training supervisors in human relations his article entitled the same has great significance for this study. His assertions focused the researcher:

> Personal experience has a way of being very important to the person whose experience it is. Not only is each person's personal experience extremely important to him, but he is an authority on the subject. Nobody else knows more about it than he. Different people learn different lessons from experience, some times useful, sometimes not. (p.133)

Athos and Gabarro (1988), writing on listening and responding reflectively, provide some guidelines to facilitate this process. Three which were of special interest to this study include: following the speaker in her exploration rather than leading her into areas she "ought" to explore, attempt to assume the speaker's inner frame of reference rather than listening and responding from one's own frame of reference and respond with empathic understanding and acceptance rather than distance, disconcert or over identification.

Originally, interviewing in traditional techniques meant that the interviewer should avoid getting involved in a "real" conversation which she answers questions or provides personal opinions so as not to get trapped. Examples of comments include the following: "It doesn't matter what I feel. It's your opinion that's important" of feigning ignorance: "I really don't know enough about it to make a comment" (Fontana & Frey, 1994). "The interviewer's manner should be friendly, courteous, conversational and unbiased. He should be neither too grim nor too effusive, neither too talkative, nor too timid. The idea should be to put the respondent at ease so that he will talk freely and fully" (Selltiz, Jahoda Deutsch & Cook, 1965 p.576). Yet to gain trust without reciprocity in a way raises the issue of studying people for opportunistic reasons (Fontana & Frey, 1994). Using methods that view the respondent as an equal allows one to express feelings and presents a truer picture than what is gained from traditional methods (Fontana & Frey, 1994). Interviewers can show their human side and answer questions and express feelings (Fontana & Frey, 1994). These same authors state that this new approach provides a greater spectrum of responses and further insight into the respondents. Since the mothers' full range of responses was critical to understanding their experiences of the speech pathology process this strategy was adopted throughout the interview process.

The interview protocol

In order to promote flexibility and spontaneity while at the same time obtaining comprehensive data in a systematic fashion, a standardized open-ended interview guide was the instrument of choice in this study. In this way the in depth interviews could remain fairly conversational yet all topics could be discussed for all mothers thus increasing comparability of responses. The interview was divided into three parts: background information, child characteristics and mothers' perceptions (Appendix G). In the child characteristics section mothers described their child in terms of temperament, social interactions, play behaviour and communication skills. These areas were investigated in order to view the child holistically. In the mothers' perception section mothers described their involvement in the speech-language pathology process from first contact to program completion and the impact it had on their quality of life.

As the interviews proceeded it became increasingly clear that how the mothers perceived the impact of their programs could not be studied in isolation of the treatment process. Treatment outcome and process became intertwined.

CHAPTER III

DATA ANALYSIS

In this chapter data analysis specific to qualitative research methodology is discussed: what it entails, how it was specifically addressed in this study and how the results were verified.

Data Analysis in Qualitative Inquiry

In qualitative research, data analysis challenges the researcher to make sense of massive amounts of data, reduce the volume of information, identify significant patterns and construct a framework for communicating the essence of what the data reveal (Patton, 1990). Miles and Huberman (1984) define three linked sub processes to data analysis: *data reduction, data display* and *conclusions: drawing / verification*. During the *data reduction* stage the researcher reduces the data through summaries, coding, finding themes, clustering and writing stories to condense the obtained information. *Data display* involves viewing the compressed information in such a way so conclusions can be made easier. *Conclusions: drawing / verification* involves interpretation and drawing meaning from displayed data. This chapter addresses the first process and the following chapter addresses the last two processes.

Miles (1979) makes the following statement about qualitative data analysis methods: "The most serious and central difficulty in the use of qualitative data is that methods of analysis are not well formulated" (p. 590). Further Miles and Huberman (1984) state: "In short, we have few agreed-on canons for qualitative data analysis in the sense of sharing ground rules for drawing conclusions and verifying their results" (p. 16). Miles and Huberman (1984) continue that analysis methods are rarely reported in detail in published studies and: "One cannot ordinarily follow how a researcher got from 3600 pages of field notes to the final conclusions, sprinkled with vivid quotes though they may be" (p.16). Patton (1990) continues along the same vein:

> There are no formulas for determining significance. There are no ways of perfectly replicating the researcher's analytical thought processes. There are no straightforward tests for reliability and validity. In short there are no absolute rules except to do the very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study. This does not mean that there are no guidelines to assist in analyzing data. But guidelines and procedural suggestions are not rules. Applying guidelines requires judgment and creativity. Because each qualitative study is unique, the analytical approach used will be unique. Analysts have an obligation to monitor and report their own analytic procedures and processes as fully and truthfully as possible (p.372).

Analytic Procedures and Processes

The following section details the analytic procedures and processes of this study in order to fulfil the obligation as stated earlier by Patton (1990). Analysis after data collection is not an easy task as Bogdan and Biklen (1992) state: "There facing you, is all the material you have diligently collected. An empty feeling comes over you as you ask, "Now what do I do?" (p.165). In qualitative analysis metaphors and analogies can be used to communicate findings (Bogdan & Biklen, 1992; Patton, 1990). I will use a swimming analogy to explain the process of data analysis. In this study the researcher felt as if she was "drowning in the data" and had to develop a critical plan to save herself from "going down for the last count". Survival depended on a three stage plan. The first stage (fear of drowning) required that the swimmer realize it was useless to fight the waves but that she should bob along and get a feel for the dynamics of the ebb and flow. Once comfortable with the rocking motion of the waves the next stage (making for shore) required that the swimmer begin the task of heading for shore with consistent, steady and efficient strokes always with an eye on the approaching shoreline. The last stage (on firm ground) required the swimmer now safely and firmly back on dry land and wrapped warmly in a blanket to reflect on the recent events and experiences and learn for the next time.

Culled from the work of Bogdan and Biklen (1992), Burnard (1991), Colaizzi (1978), Guba (1978), Huberman and Miles (1994), Patton (1990) and Strauss and Corbin (1990) the parallel data analysis stages in this study were as follows.

Stage I: *Fear of drowning.* In the first stage each transcript was read a number of times to heighten awareness of each mothers' particular speaking styles. Transcripts were verified with the audiotapes to ensure completeness and accuracy. Intonation patterns were noted and were added to the mothers' comments. Initial researcher perceptions and attitudes were recognized at this point and noted. The researcher gave complete expression to her full range of "inner voices" in order to confront possible bias. That is the researcher engaged in *Epoche* again to eliminate personal involvement with the subject material (Patton, 1990). Towards the end of the stage questions began forming about the content of the interviews--for example, "so how do mothers..., what do they have to say about..., that comment reminds me of...." which assisted in preliminary coding.

Stage II: *Making it for shore.* In this stage coding began in earnest. *Bracketing* began at this point. During this process the researcher bracketed out the world and presuppositions to see the data in pure form untouched by extraneous intrusions (Patton, 1990). First, each mothers' transcript was read line by line for units of meaning. Those uncodable pieces of transcript which are referred to as "dross" were discarded (Field & Morse, 1985). Meaning units were marked in the transcript with different colors and were then paraphrased. Each paraphrase was written along side the mothers' statement to which they applied. Once the paraphrasing and meaning units were completed, the transcripts were reviewed again and highlighted with a yet a different color for words, phrases, ways of thinking or events that repeated or stood out. Because the mothers' transcripts began to appear dissected and disjointed it was necessary to write a story to chronicle their experiences from beginning to end in order to better understand their situations and perceptions. Once this was completed and studied again, focus turned once more to the transcript. This time the focus was on developing the coding system. The coding procedure was fashioned after the work of Guba (1978) who recommends that the researcher address the issue of "convergence" (deciding which comments fit together) and later "divergence" (deciding how to "flesh out" the categories) (Patton, 1990). This involved judging prospective categories by two criteria: "internal homogeneity" (data that dovetails together) and "external heterogeneity" (the extent to which category stand distinct from one another) (Patton, 1990). Proceeding back and forth through the data with these two dimensions in mind, the following codes emerged (Table 3). The coding process was completed when the researcher felt the coding system "fit" the data and the data had been properly "fitted into" the system (Patton, 1990). Ensuring the coding system's validity and credibility is discussed in the next section called "trustworthiness".

Table 3. Code categories and definitions

CODE	DEFINITION	TRANSCRIPT EXAMPLE
Process	Words and phrases that facilitate categorizing the sequence of events, changes over time. Included are stages, phases, passages,turning points and bench marks.	"There was a time when he turned 3 that I was spanking more than I would have liked but nothing seemed to work. He didn't seem to understand what I was getting at, but that stage has kind of passed."
Perspective	Oriented towards shared rules/norms as well as some general points of view. Usually captured in particular phrases.	"It just really opened my eyes." "It [therapy] won't hurt." "Wait and see [if he'll need it[therapy] later." "It was better than nothing."
Classification	Codes that get at the person's understanding of others and objects. Types of people is one example.	"I think he's going to be more of a sports oriented kid." "He would be a high needs baby." "Why do kids if they're stronger in other things and they start really early at it that they are delayed in other things."
Activity	Codes directed at regularly occurring kinds of behaviour either informally or formally.	"We came in, dropped the kids off and then we went in our own room." "We met very other week for two hours and that was in a group setting where we were given information, saw some videos, discussed some of our children and stuff with it."
Strategy	Strategies refer to techniques, methods and ways that people accomplish various things.	"Making them ask for what they wanted, and say the word, like 'You want juice' and getting them to say juice." "If he's using one or two words, we're trying to get him to use three."
Aspiration	Codes directed at wishes, desires, hopes, expectations. What do people want to achieve through some action.	"I expected miracles". "I was hoping that they could kind of get him talking." "I wanted him to end up not having the problem of not communicating with the other kids."
Evaluation	Codes related to the perceived value of some activity or experience.	"I wouldn't say that the program was super wonderful, but it wasn't bad either." "I found it to be a bare bones kind of program." "I know the program did have its benefits."
Affective	Codes pertaining to emotions and feelings	"I'm still frustrated." "I was feeling guilty."
Un codable (referred to as "dross")	Items which could not be coded because they could not be understood	"I know, I know, I mean... I know how it came along and everything like that."

Once coding was completed the data were organized into meaningful clusters. The clusters were then inspected and studied for what they revealed about the mothers' experiences and perceptions so their story could be told. According to

Janesick (1994, [illegible] researcher must find the most effective way to do this in order to convince her audience. This began stage three.

Stage III: *On firm ground.* The focus of this stage was on drawing conclusions and verifying results. This was accomplished by performing three major steps (Janesick 1994):

1. Look for the meaning and perspectives of the participants in the study.
2. Look for relationships regarding the structure, occurrence and distribution of the events over time.
3. Look for points of tension: What does not fit? What are the conflicting points of evidence in the case? (p. 213).

While working inductively the researcher looked for emergent patterns as described by Patton (1990). Patterns emerged in one of two ways: those perceived and articulated by the mothers and those which were in the data but were not expressively stated or perceived.

Revealing themes required the researcher to make careful considerations about what was really significant in the data and that which was not. Patton (1990) compares the errors that the qualitative researcher may make in this situation with those types of errors that face quantitative researchers: Type I and Type II errors. Therefore as with any type of research it was necessary to validate the findings. The terms that are used in qualitative research for this purpose are rigor and trustworthiness. Rigor refers to the precision or care taken in carrying out the project and trustworthiness refers to the quality of the findings (Hoffart, 1992). Before the results are presented it is critical to explain the elements of trustworthiness and to describe the processes in which it was safeguarded in each stage of data analysis.

Trustworthiness

According to Lincoln and Guba (1985), trustworthiness consists of four elements: *credibility, transferability / fittingness* (Beck, 1993), *dependability / auditability* (Beck, 1993) and *confirmability*. These terms are comparable to the terms *internal validity* (the extent to which the results correctly map the phenomenon in question) that is, is the explanation credible, *external validity* (the extent to which the results can be generalized to other settings similar to the one where the investigation occurred), *reliability* (the degree to which results can be replicated) and *objectivity* (the degree to which the results are free from bias) (Denzin & Lincoln, 1994). The validity and reliability of the qualitative data depend to a large degree on the methodological skill, awareness and integrity of the investigator (Patton, 1990).

Stage I: To promote *credibility* and *confirmability* during the first stage of the data analysis, all transcripts were studied extensively and in those situations where a mother's meanings might have been obscured provisions were made to contact her for clarification. However this need did not arise. Further to ensure that important information was not omitted from the data the researcher engaged in note taking and transcribing the audiotapes immediately upon completion. Thus there was "thick description" (Geertz, 1983) of the data. Thick descriptions have less of a chance to be biased (Hagner and Helm, 1994). To promote *confirmability* the researcher engaged in *Epoche* to become aware and to monitor her "inner voices". An individual's "inner voices" are one's values, perceptions and beliefs of how the world is and/or ought to be (Rasmussen, 1994). Further a panel of two speech-language pathologists who were familiar with qualitative research techniques reviewed the researcher's analysis of the mothers' paraphrases to limit researcher bias and selective attention (Morse, 1989) and to limit data overload by making sure the researcher did not miss mothers' comments or to keep in check those comments which were highly descriptive (Huberman and Miles, 1994).

Stage II: During this stage *credibility* was further enhanced the panel of two speech-language pathologists and by two other independent analysts. The speech-language pathologists assisted in the bracketing phase by assisting in the interpretation of a portion of the mothers' comments into tentative codes. The two analysts were able to reproduce the final coding system. Two different methods were used to verify the coding system. One analyst selected his preferred code from a closed set of four and the other selected her preferred codes freely from the complete list. Both individuals attested that the category system "fit" the data and that the data had been appropriately "fitted into" it (Patton, 1990). This process of additional analysts to verify procedures and results is referred to as triangulation by analyst (Patton, 1990).

Stage III: To further foster *credibility* Patton (1990) recommends that once the researcher has characterized the patterns, connections and logical explanations through inductive reasoning, she should examine the data for antagonistic themes. This might include arranging the data another way to see if one is led to different findings or other logical possibilities. If strong support for the alternative interpretations is not found then the researcher's original interpretations may be considered with greater confidence. One additional method employed in this study to *credibility* is the use of "discrepant case analysis" (Erickson, 1986). The researcher deliberately searches for data that does not confirm to a tentative general statement. This is somewhat analogous to testing the null hypothesis in quantitative research. Hagner and Helm (1994) point out however that disconfirming cases are not used simply to rule out the hypothesis, but to revise a generalization to fit the data better. In this study each mothers' comments were tested individually to determine if they substantiated the identified themes.

Transferability is accounted for in the detailed account of the mothers' statements and situations so that others may ascertain if the results apply to their personal circumstance. Although there were noticeable differences in the mothers' educational levels, communicative styles and programs, they shared many experiences and concerns that were judged to promote transferability.

Dependability in this study is reflected in the clear account of the methodology so that others who wish to replicate the study may do so.

In the following chapter the results of the study are discussed.

CHAPTER IV

RESULTS OF STUDY

The themes that emerged from the detailed analysis of the collected data are presented in this section. To illuminate each theme illustrations are provided in the mothers' own words of salient experiences and perceptions. Although there was the potential for eight boys to be discussed, the mother of the twins referred to her sons jointly rather than individually. She did not comment on any differences between the two except for some temperament issues which are not included in this study for any of the boys. Since it would not change the results of the study to report her sons singly, they are reported as one boy which further preserves this mother's anonymity. All names have been changed to ensure each mothers' confidentiality.

Theme 1 Expectations

A very prominent theme that emerged from the data was the expectations that the mothers placed on the programs in which they participated. The following recounts what they expected for themselves and their child. Expectations fell into one of two categories: what the mothers expected the program to be like (the treatment paradigm) or what they expected in terms of results (outcome).

Treatment paradigm: Four of the mothers made comment on what they expected when they entered the program. Comments were made about who would do the program, what would be done and how much treatment there would be.

Several mothers reported expectations that were not met. Olga thought originally that the speech-language pathologist would be working directly with her child: "I thought that I would be taking him there, and then she would be working with him." Flora thought her child would receive more therapy than he did: "At the beginning, I figured that there would be more speech therapy, whatever that meant to me at the time." Francis expected more direct therapy for her child. Francis: "I expected more of the therapist than sitting in the room with a bunch of kids. ... a little bit more direct involvement not just playing. I expected a lot more one-on-one. I don't know why." Tina believed that the parent program would be lecture style: "I knew the child was gonna not be there and it was going to be done with the parent, but I thought it was going to be lecture style and I was actually wasn't looking forward to going. You know once I got there I really liked it. It was like a support group. There was a lot of interaction."

Outcome: All mothers had expectations about the outcome of their programs. Yet there was a difference in how these were expressed. Five of the mothers had expectations of what their children would achieve from the program and two of the mothers spoke about what they expected for themselves. Child expectations ranged from improved speech and language skills to improved social interactions and reduction of frustration. However these expectations appeared to be more convoluted than at first glance. While some mothers expressed their expectations clearly and did not alter them throughout the interview, there were others who did not. They either had difficulty expressing exactly what it was that they wanted or modified their expectations during the course of the interview. For these mothers their expectations were expressed in somewhat conflicting/contradictory terms. For example for some mothers early in their interviews they said that they wanted their child to develop or strengthen emerging skills. Yet later on in the interview after much discussion they believed that their child should have demonstrated language mastery (although they did not state it as such). Thus for these mothers their reports of satisfaction were equivocal. They knew that their child had made the gains which they had originally stated but for some reason couldn't quite verbalize why they weren't totally satisfied. It appeared that they did not realize that they had two different expectations. Some mentioned that perhaps their expectations were too high but did not elaborate any further. It could be for some of the mothers that they never really had a chance to reflect on what it was that they truly wanted for their child. Below are what the mothers expected or hoped to get from their programs.

Consistent expectations for child: Tina thought that her child would be speaking at the end of the program: "I expected miracles. Like I expected that by the end he would be talking." Olga wanted to stimulate her son's communication skills so that they could understand each other. Olga: " ...get some sort of communication going...some understanding... some common ground." For Tara she hoped that the program would stimulate her son, reduce his frustration level and improve his interaction with other children.

> Tara:
> I had hoped that somehow the program might unlock whatever magical door that was closed to him that was not letting language happen for him....I hoped that for him he would get something out of it so that the frustration levels for him would go down.... that he would get back into being that happy child that I had known him to be so.... perhaps to interact with other children a little bit better so that he could enjoy the fun of them.

Sissy: "At least we knew that he would learn to properly say the words and enunciate them". For these mothers they never varied what it was that they expected. Perhaps by conventional speech-language pathology practices some of the expectations might have appeared to be lofty, but they were stated firmly and consistently. Any speech-language pathologist who came in contact with such expectations would know exactly what was expected of her and could deal with them appropriately. This would not be the case with the next set of mothers. It was difficult to determine what it was that they wanted for their child. It was only after much discussion and reflection that this became clear. When mothers were asked to describe the impact of the program it became evident that they were operating with two different sets of expectations. What they had expressed in the beginning of the interview did not match what they now stated.

Flora's, Francis' and Susan's statements are presented below. They are remarkably similar in format. First they indicate they did not know what they expected or if they expected too much, then they state an expectation that is based on emerging skills and later when asked to describe the impact of the program they speak of the program's limitations even though their original expectations were met.

Inconsistent expectations for child: Early in her interview Flora said that she thought that her son would be introduced into a social process and get his language stimulated and that she didn't expect the speech-language pathologist to "fix" her son quickly. Her son did achieve these goals but described the program as "bare-bones".

> Flora:
> I didn't know what to expect. I thought that he would get some kind of - be introduced into a social process. I just wanted another opportunity for him to maybe develop more language skills. I knew it wasn't going to be a quick fix. I knew that it was a stepping stone to what he would eventually be taking.

When asked how the program had affected her personally she stated:

> It was really good. I think there could have been more. I found it to be a 'bare bones' program. It was 'better than nothing'. My son got more socialization and more stimulation. Yah, it was really good that way. Really, I cannot say how much it's helped him. I know it did help somewhat I know it did. He progressed quite a bit. I know it helped but I don't know. Maybe it was my expectations.

On one hand Flora talks about socialization and stimulation (emerging skills) for her son which were achieved yet on the other hand she questions her expectations and wonders if they were too high. The earlier "developing more language skills" actually meant talking as normal peers would. This resulted in equivocal reports of success. Francis was in a similar frame of mind. Initially, she too was unsure what to expect. She did expect that her child would develop more speech from the program which he did (emerging skills) but felt that he should have achieved more (mastery).

> Francis:
> I don't know. He learned a lot of single words, but I think - I don't know if I expected a miracle where they were going to be walking out of there knowing everything, I don't know ....maybe my expectations were a little too high but I expected a little bit more, I don't know why.
>
> When pressed for what she wanted for her child she stated:
>
> I wanted him to end up not having the problem of not communicating with other kids. Like, not being able to go outside and play and if there is a problem they're fighting over something and I'm not knowing what's happening. Like when he comes in and tells me something I don't know if somebody's picking on him or what's happening outside. I have no idea.
>
> Susan:
> I don't know. I was hoping that they could kind of get him talking. I think they met my expectations. He's talking quite a bit more....but he's still not up to par. Maybe I was hoping that he would talk more than he is. I don't know why. I don't know. I can't pinpoint what it is. Kids born in the same month as him around my neighbourhood they put together sentences that are clearly understandable. That's what I would expect. He's improving every day but as far as kids his own age he's nowhere near the same level.

For Susan talking a bit more (emerging) really meant talking like other children his age (mastery).

With expectations like these it would be difficult for the speech-language pathologist to know what she would have to do to meet these parents' needs. It didn't appear that they meant to be misleading or switched their expectations half way through their programs. It seemed more that they really didn't have a clear definition of what "more language," "more words" or "get them talking" really meant. This issue is discussed further in the last chapter under "implications".

Only two mothers had expectations for themselves. At first glance this appeared to be interesting since six of the seven mothers were participating in what was defined as a parent program where all or part of the focus would be on them. Thus it was expected (from a speech-language pathologist's perspective) that they would have expectations for themselves. Yet this was not the case. To a parent the program could be seen as child focused because the ultimate goal is to facilitate language development in the child; thus it would not be unusual to have more child expectations. For the mothers who did have expectations for themselves they were focused on skill development. These mothers wanted to gain knowledge so that they could help their child. It will be discussed later how each mothers' expectations affected how they perceived their programs.

Expectations for mother: Tara stated that she hoped to gain tools so she could help her child: "I was looking for some tools. Something to do that would help him because I felt very useless, like everything I used didn't work. That was really only my expectation if I gained nothing else, I hope I gain some tools from this." Olga: "I just wanted some help to know which way to go-just some knowledge-just to know what to do, how to work with him or do something."

Theme 2 The impact of the program

Another very prominent theme in the data was what the mothers perceived the impact of the program was on themselves, their child and family. All of the mothers found that their programs all had some benefit. However the degree of benefit varied greatly. For some mothers the impact was more related to mother changes which were viewed as quite positive while for others the impact on themselves was seen as negligible. All mothers saw changes in their children which they viewed as positive but were impressed by these gains to varying degrees. Following are the program's impact on mother-child and family social interactions, the mothers' emotional state, their skills as language facilitators, their self worth, as well as their child's communication skills.

1. Social interactions and activities

a. Mother-child dynamics

All of the mothers commented on an improved relationship with their child. They discussed how they learned more about their child and how to challenge him more successfully by understanding his present level of ability and structuring activities accordingly. Pressures to perform were replaced with seeing the child as he was rather than where he should be. Participating in the programs opened a new world of play for the mothers and activities which were previously stressful or not of interest to the child were now seen as enjoyable and could be re-introduced to further promote language.

> Olga stated:
> I think I treat him a little better [now] too, like I was thinking he didn't talk very much, so I was treating him different, more like a baby or something. So I'm treating him like a normal three year old. He understands a lot more than what I really gave him credit for. I wouldn't ask him- O.K. you go to your room and get your socks. I would just go get it. [now] I'd say Go get your socks! and he'd just go get it. Like there's just a lot of little things that he understands that I just didn't think he did. It really opened my eyes...woke me up I guess on really what I was really doing to him and taught me what to do and what not to do.

For Tina she found that she spends more time with her son.

> Tina:
> Well he certainly got more of my attention and time. I take more time with him. I get more eye-to-eye. I get down on his level a lot more and now he demands that of me, you know he'll even pull you.

She also learned more about her son's abilities.

> Tina:
> I know it really sounds mean but you don't think they're smart because they don't speak and I was just astounded [when he could do the puzzles at the health unit] they weren't even a challenge so I know he's not stupid and so I'm trying I don't know to stretch him more in some ways. 'cause he didn't speak I was probably holding him back. I know I did way more things with my other one at this age. I think it's just 'cause they don't speak you just don't assume they understand. But he understands a lot more than I gave him credit. I ask him more detailed questions. I never used to ask him three part questions, like Go over there and pick that up and bring it here. Before I wouldn't be asking him, I would just do it. Or even now when he wants something I take time to try to get a response out of him.

Francis commented as well on the belief that if a child doesn't talk he's labelled and that she didn't realize how much she did for him. Susan's comments were similar.

> Francis:
> I never ever thought that I did a lot to cause him not to talk, like I did a lot for him, where I didn't realize how much I did for him until I had the program. Like a lot of people think oh you know the kid's stupid or something like that ...the stereotype you know how everybody [says] oh he can't talk you know there's something wrong with him.

For many of the mothers they found that they learned a lot from their programs and how to incorporate new activities or reintroduce old ones.

> Tara:
> We picked up a lot. Starting with just understanding what level he's at and where he needed to go. It [the program] also showed us how we could use play, music, books all sorts of things to try and stimulate language with him....sometimes music would get through to him better and we found that he just loves songs. Like he can sing the Flintstone song so that has really opened up some of the language so we continue to use that one a lot.

Tina and Flora also found that using music facilitated their sons' language. Tina: "Singing a short song, and going slowly... he gets it ...now on the swing he has a certain song we have to do and he sings it by himself."

> Flora:
> He was introduced to things there in the group setting that he developed an interest that I might not have been able to encourage in him. He had never sung a song before although he tried to hum things but never the words and here he

> started with the words. You know it might be every second word or every third word but he tried to carry the melody and when we went home we started that. Before that he was not very interested in singing and he became interested in singing through the program.

Francis, Flora, Sissy and Tara found reading to their sons became an activity which they could now pursue. Francis: "Book time is about the only time we sit down for ten minutes. Now he's enjoying books. Before he never could." Flora: "Before [I got into the program] I took out books but he wasn't that interested in books then. He is now. He will take up a book and, 'Read it mom.' He really likes that." Sissy: "I got from them [the speech-language pathologist] the idea of going to books...like you forget the books you have because there was a period of time that he wasn't interested. Now he will if he's in the mood. The only thing that he was interested in was taking it [the book] out and throwing it around the room, so that was a stage he went through." Tara found that her son reacted to books in much the same way. Tara: "Everything I used didn't work. He wasn't interested in books. He'd throw it away and scream. He now enjoys books. Instead of throwing them away, he loves stories. Matter of fact, if I put him down for a nap, I'm lucky if I get out of there with two or three stories. He wants more."

b. Family dynamics

Several of the mothers reported changes in their family dynamics. Family members became mobilized to help the child, and one mother regained family enjoyment.

Tara rediscovered the joy of playing with her family.

> Tara:
> We learned how to play with our kids again and have a lot of fun with them, while still being effective in helping them. It put play back into a whole new perspective again, and that it was alright to get down on the floor and just go crazy with them. So we learned how to have fun again with them instead of worrying so much about what he was doing and what he wasn't doing.

Olga also found that her program helped to take the pressure off not talking.

> Olga:
> The program showed me how to work with him. ....like she [the speech-language pathologist] says you don't even have to push the speech, it was just even the body language be more aware of it and I think that's helped with the frustration.

Reading became an event for the whole family.

> Tara:
> Now instead of us reading a bedtime story to each kid, everyone piles on one bed at night and we read a bunch of stories, and my older one is at the point where he is starting to learn to read the words and the younger one is wanting to fill in the word he knows. He can anticipate the words and he can say them and he knows what they mean. It's made bedtimes and story times a lot more of a family thing. So bedtime instead of being a fight, 'oh let's get the kids to bed' has been actually quite a fun time.

In the program Francis came to the realization that her son's language difficulties was a family affair.

> Francis:
> The problem wasn't just his [but] that it was a family problem. When you go to the program you can see what you're doing wrong that makes him think why well, he didn't need to talk, yah he gets a cookie every time someone goes 'cookie jar'. It made me feel good that 'yeah, I know I did that. That's something that I can correct.'"

Through their programs five of the mothers discovered how to incorporate other family members in their child's communication program. Siblings, grandparents and husbands all developed skills to facilitate language development.

Olga, Tina, Tara and Francis all discovered that their older siblings all had a role to play in impacting on their younger siblings' language difficulties. Olga: "I used my daughter as a tool. They play so I get her to get him to say words and she can get him to rattle them off." Tina commented on her daughter's tendency to speak for her younger sibling and how she had to teach her not to. Tina: "I've kinda had to teach my daughter too because if I stop talking to give my son a chance to respond she'll fill in. She won't give him a chance." Tara also found that her older son helped his younger brother.

> Tara:
> Even my older son has learned to talk to his brother. He has learned how to help his brother as well and he became actually one of the more effective people for him because he was much closer to his own age. There were times when the older one would spend an entire evening emptying the toy box and telling him the name of every toy and then putting them all back and doing the same thing going back. So, he gained a sense of here is a way I can play with my brother and I can help him. My son probably picked up as much from his older brother's speech as from us because it was so much closer to his own efforts.

Francis stated how her older son contributed to his younger sibling's communication difficulties by anticipating his needs: "Like his brother hands him a cookie, I hand him a cookie like he doesn't have to ask for a cookie."

Before some of the grandparents could be enlisted as language facilitators for their grandchildren, they first had to be convinced that there actually was a communication problem.

> Tara:
> My parents and in-laws didn't understand why I was making such a big deal out of something that they felt was just normal, usual. Later in the program I took my son to see my sceptic in laws and they couldn't believe the difference in his speech. Then my parents and in laws gained a better understanding that yes there was a language problem here and after they saw some of the results they were much willing to help us. They got to a point where it was,'O.K. tell us what we need to do so when he's here we can continue the same thing.'

Tina spoke about it this way:

> Tina:
> It's just you get a lot of people saying 'Oh he doesn't need that. He'll speak when he wants to'. It's more of you didn't get the support. But now with the grandparents I've kinda told her how we do things and she's really good at working with him. She can get him to say a bit more.

Francis found that her mother would follow through on what she told her. Francis: "If I said 'Oh don't give him that' or 'make him ask for it' she would do that". Olga: "I just kind of relayed to her what to do....like kinda to repeat words".

All the husbands were supportive of their children's programs and attempted to use strategies with them. Sissy: "My husband chose to go with me for the program so he knew what to do when he was with the kids." Francis: "Dad learned a lot and like the homework that we brought home to do he would follow up like "How many words did you learn this week or what did you do to make him progress farther than what he was. He tried to follow up as much as he could. Most of what he did I think was just read the book." Tara's husband attended each session with her. Tina's husband followed through on what she told him. Tina: "He's pretty good. He only knows what I've told him. I can't get him to read the book. You know "I don't read those". But what I've told him he's pretty good at." Olga:"I got my husband involved. He kinda knows how to do the one-on-one and take turn taking with him."

In summary, all the mothers spoke about the impact of their programs on their social interactions and activities. All of the mothers discovered something new about their child or themselves. They felt better knowing that there was something that they could do for their child and that the tension related to strained relations was lessened. The following section discusses more about how the mothers felt during the course of their programs.

2. Mothers' feelings

Mothers had a great deal to say about how they felt about their child's communication difficulties and how these feelings were impacted through the course of their programs. Frustration, worry, desperation, guilt, fear and confusion were emotions that the mothers experienced about their children before they entered their programs. Many of these feelings dissipated or were lessened during the course of their programs. Frustration was the most dominant emotion that the mothers experienced as they entered their program. This was later released or lessened depending on the mother.

> As Susan put it:
> Half the time everybody was getting frustrated because they couldn't communicate properly. It was really getting kind of maddening trying to be mind reader all the time, and I think it was frustrating for them too because we didn't know what they wanted, and they didn't know how to tell us. It [the program] helped with our frustration level, communicating with each other. It was encouraging to see them trying to communicate with us. It's encouraging all the time.

Sissy explained her frustration with the way her son would communicate his needs in this case requesting marshmallows:

> Sissy:
> Come here take my hand, go to the marshmallows, take the marshmallows out, put them on the counter and point to the cupboard where the little container is that they want---the cup for the marshmallows to go in so he can have a snack. He doesn't ask for it doesn't even attempt 'm' for marshmallows. He goes through all that to say 'this is what I want'...it's really frustrating for both.

The program affected Sissy greatly because she felt that she could now communicate with her son. Francis found her son's method of communicating was "nerve racking":

> Francis:
> Like you try to ignore him whining and get him to talk but he'll just sit there and it gets to be nerve racking after a while listening to him. I couldn't understand him. Like some things he'd blow me away like what do you want?

In the program she found that she learnt "how to deal with it a little better" and she felt good knowing what she did to contribute to the language problem and noticed improvement in her son when she worked at it.

> Francis:
> I felt good knowing that O.K. I did that. That's some of the problems that I can correct. I noticed a little bit more development of him when I did correct him, like he tried harder. I was pretty happy with the program for the adults.

Tara found that she and her son experienced a great deal of frustration and desperation early on. She describes her frustration with his early behaviour when she accompanied a friend and her son to the mall and began to compare the two boys.

> Tara:
> [At the mall] all of a sudden I realized that this other child would sit, would drink juice, would ask for a candy and would talk. Here's my son sitting there not doing anything. I would be up no less than ten times to chase him down and bring him back....realizing that if I said 'no' 'no' had no meaning and that there was always screaming anything he wanted was an "ah" or scream. It just got to be very frustrating all around. There was a lot of frustration and a lot of what are we doing wrong here? I was desperate for some ideas some tools something to try to bring this child along. Now [after the program] its become easier to take him and have a stop for a pop in the mall and stuff. He will sit and now understands things a lot more. He knows what I'm saying and can make choices now. Since he's become better able to convey his needs it's cut the frustration and instead of him endangering himself to get something, he'll say [what he wants]. He has gained back a lot of his happiness. The program was everything that we hoped it would be. We were very, very pleased.

Olga found that she was tired of "the screaming" and was frustrated with trying to communicate with her son.

> Olga:
> 'cause [before] I didn't know what he wanted and so I'd just kinda walk away and he'd run after me and there was screaming all the time. That's why I wanted to get doing something,'cause I was tired of the screaming. The big thing was I was frustrated. I didn't know what to do. So I think that [the program] probably helped.... the program showed me how to work with him. ...the frustration went down 'cause he doesn't scream as much. He still screams, but it's not as much. We're not as frustrated. That helps.

3. Mothers' self worth

To a lesser extent the other emotions that some of the mothers expressed early on before they started their programs focused on guilt, fear, isolation and confusion. At the end of the program these emotions either diminished or gave way to absolution, security, a sense of belonging and order. I have referred to these emotions collectively as self worth. These new emotions acted to bolster the mothers' self esteem.

Tara commented extensively that her in her program she experienced guilt release and found herself being rewarded as a mother. Tara expressed it best when she describes the turmoil that she went through and the relief she experienced from her interactions with her speech-language pathologist.

> Tara:
> Although everyone tells you 'no it's nothing that you've done,' You still sit there and there's always those feelings in the back of your mind of 'well if we hadn't been moving and we'd spent more time or if I'd taken him and had every little

> earache checked out maybe this wouldn't have happened.' So there was that kind of thought in the back of my mind a subconscious feeling that 'I've done this to my child'....so this [helping my child] really rewarded the mothering sense in you. I could [show my child] and could just sit there and say 'I told you so, I knew he could do it' and that was very rewarding because all of a sudden I knew the difference... it was I won you over. 'See he did it I did it !' The speech-language pathologist was very very sensitive to whatever concerns or hang ups that anyone in the group had. She was really really careful to help you to feel good about the fact that your child was in the program and that it wasn't a slight against something you hadn't done. You know it was kind of just that little pat on the back that you really needed. I thought that was very important because there were so many people who has an opinion and has advice out there and I felt she did a good job at dispelling those myths. Just giving you that sense of 'No you weren't a bad parent because your child ended up this way. You're excellent parents and I'm telling you you're in tune with your children and you're caring because you're here.'

In contrast Francis did leave the program feeling that she had had a part in her son's problems. Finding that she had played a role in her son's communication difficulties, but learned it was something that she could correct, Francis felt this boosted her self esteem. She had worried that there was a medical condition that had caused his difficulties and learning that there was no physical evidence for this relieved her.

> Francis:
> It was my fault as well as his and I didn't think it would partly be my fault. You know the stereotype :'oh he can't talk there's something wrong with him.' ...that helped the self esteem of the parents quite a bit. I think it took the pressure of worrying that there might be something else wrong than just delayed speech. I think it relieves a lot of pressure when you realize that part of the problem is your fault.

For Francis her self esteem was enhanced because in her mind she didn't have a handicapped child. Tina felt the same way. She was relieved to find that there wasn't a cognitive impairment.

> Tina:
> I don't know if 'security' is the word but it made me feel better that he isn't stupid; that he's just delayed and there are lots of kids like this. It made me feel good to see [she had viewed pre and post videotapes of others] that they do improve.

Sissy found that her program affirmed that she wasn't "screwing up". Sissy: "[The program] let us know that we weren't doing anything wrong, we weren't screwing up." For Olga, Tina and Tara their programs ended a sense of personal isolation. In their parent groups they found acceptance and felt a sense of belonging. Olga: "I was almost kind of sad it [the program] quit. The thing is we all had something in common. We could talk and could relate to one another. It gave you [a sense] that you're not alone. So that helped." Tina expressed similar sentiments: "It was good to have the support of the other mothers who were in the same boat. We all had that in common and we all had the same feelings and we shared them. I'm so sorry it's over. At the end we all felt kinda sad. We wanted to have a reunion." Tara found the support of the other parents good and there was a sense of "you're not alone" and there was "comradeship".

In summary most of the mothers who participated in a program that had a parent component were sustained by others like themselves and in the knowledge that there was something that they could do for their child. They felt that there was hope and that they were not alone. The skills that they developed to assist their child are described next.

4. Mothers' as language facilitators

Many of the mothers noted that they made numerous modifications in how they thought about language development/disorders and how they now communicated with their children. Overall, the mothers reported growth in three general areas. These are listed in order of how often the mothers discussed them. First all of the mothers reported that they now tended to be more "in sync" with their children's abilities. Second most stated that they were more responsive to their sons' focus and communicative attempts and would use techniques they learned to help their child, and third, some felt that they had acquired additional information on language development and disorders. These changes were consistent with the teaching objectives of the parent language training programs as specified by the participating speech-language pathologists.

In the following section the following areas are discussed: the mothers' responsiveness to her son's communicative attempts, the techniques she used, and what she reported in terms of general knowledge growth in language development and disorders. Since mothers being "in sync" with their children has been discussed in the section "social interactions: mother-child dynamics" it is not presented here.

a. Responsiveness

Overall, most mothers (Olga, Tina, Tara, Francis, Susan) reported a change in how they observed their child and now responded to him. They began to notice subtle behaviours that signalled the children had something to say. Olga found that through the program she became more aware of her son's body language which she found he used to communicate his needs. Attending to his particular style of communicating reduced the pressure to talk. A number of mothers (Olga, Tina, Francis, Susan) discovered that often they never waited for their child to initiate an interaction. Tina describes it well.

> Tina:
> That was half my problem. I never waited. I would just keep on talking. I would say 'Do you want juice? How about juice? blah-blah-blah.' I wouldn't wait and I knew what he wanted so I wouldn't wait. I wouldn't give him a chance.

Tara stated that in her program she spent a lot of time learning how to watch and listen to the children. Tara: "We spent a lot of time learning how to watch and listen to our children to know where they were and where we needed to get them to."

b. Techniques

As discussed in the second chapter under method the mothers' treatment programs did vary somewhat in format but held constant specific language facilitating techniques. Borrowing from Tannock and Girolametto's (1992) description of "the three basic principles of an interactive model of language intervention" the techniques which the mothers from this study discussed were as follows: *child oriented techniques* such as following the child's lead, organizing the environment to maximize the child's speaking opportunities, and interacting at the same physical level with the child by maintaining eye contact and face to face interactions; *interaction promoting techniques* such as taking turns, and waiting for the child to respond; and *language modelling techniques* using short simple utterances, using repetition, imitation and expanding what the child says.

While for the most part all mothers learned some techniques to facilitate language development, there was a mixed reaction to how mothers perceived and used them. Some of the mothers spoke about the techniques they used while others had nothing to comment. Further for those mothers who used techniques there was a tendency to describe more child oriented and interaction strategies than language modelling techniques. With the language modelling techniques, either descriptions were lacking or it did not appear that the mother fully knew how to implement them. Evidence of this observation will be discussed in this section and the implications of these findings will be discussed in the last chapter.

In the first part of this section the techniques that were implemented by the mothers are presented. In the last part mothers who found nothing to comment are discussed.

Mothers' reported use of language techniques

Child oriented techniques: Olga, Francis and Tina discovered letting their child "take the lead" in the program. That is they would follow what their child would like to do. Tina, Olga and Francis stated that they tried to get face to face and have eye contact with their sons when they wanted to interact with them. Tina discovered "OWLING": "I learned a lot about thinking on their level 'OWLING' which is observe what you're listening." Francis also found that she learned to use a lot of expressions or became animated with her son when she talked with him so that he could learn more. She also changed her focus on how she went through books with her son by following his lead:

> Francis:
> Like when you're reading books ...if he's stopped on one page and likes one page well you go through it and you don't have to read like if he's not interested in the story just look at the pictures and make up what he's interested in. Let him make the first move. Talk about it 'it's a book...it's a ball instead of reading the story if he's not interested.

Olga found that the practise of "sabotage" (structuring the environment to increase communicative opportunities) was not helpful for her son. "If I gave him his cup at lunch and didn't put anything in it and see what he would do, he would just go and get it for himself". However, Tina found this worked quite well for her son. "One I found is the sabotaging -helps a lot with me- forces him to communicate. I use that one a lot 'cause it does help get him going, but I would have never thought of that one on my own if someone hadn't taught us that."

Interaction promoting techniques: Olga, Francis and Tina learned how to take turns with their sons and wait for them to respond. This was most enlightening for these mothers because as was discussed in the social interactions section their relationships with their sons appeared to be one sided. As they said they didn't realize how much they did for their sons and often anticipated their needs. As Francis described it:

> Francis:
> I found a lot that we didn't wait and listen and try to make him do the response. kind of taking your time trying to figure out what he wanted. Make him take turns.

Language modelling techniques: Tara found that imitating what her son did and then commenting on it was the best way to stimulate his language. Expanding what he said was also useful.

> Tara:
> He really twigged on to imitation and that was one thing that really got him going in the program. We would play a game of banging balls. He would hit the ball so then I would hit it. So then he would hit it again and I would say 'bang'. Soon enough he would say 'bang' when he hit it and this was how we were able to incorporate the imitation and start to work language into it. We would imitate his actions and would start to add words. We then went into an expansion setting where if he would say 'bang' we would say 'bang ball' and try to get him to imitate us. If anything gave him more language it was through imitation.

For Francis she felt that her rate of speech was too fast for her son to follow and that she should use one and two word utterances instead of sentences. Francis: "Communicate at his level. Like I find I always talk so much that I think a lot of the time he misses half the things because I talk too fast..Like talk at his level say one-two words instead of sentences all the time." Tina tried to get her son to talk more during daily activities by asking him to label items. Tina: "I tried to fit it into regular normal routine type things, so when I'm changing his diaper 'cause you have to do that whether you're busy or not I would use it and try to get him to say...I'd hold it up and say 'what's this?'" She would also use repetition to try to get him to talk more. However when she referred to this technique it was not in the way that a speech-language pathologist would have used it. For her repetition was counting (repeating numbers). During her interview Tina inquired about how to progressively match her child and show him the next developmental step. She was not quite sure what to do for her son.

> Tina:
> I don't know that's one thing I should ask the speech-language pathologist. Once they [the child] have it [the language form], do you keep doing it [stimulating at the same level] ? See I can't remember 'cause I still do [do it like I did before].

In this situation Tina was unsure how to stimulate her son to produce lengthier utterances. Later in her interview she stated that she still needed to meet with the speech-language pathologist to learn more and to keep motivated.

Some of the mothers required a "warming up period" before they were convinced that the techniques were truly helpful and that they were something new something that they weren't already doing. Before they were convinced of the strategies' usefulness they needed to observe and then attempt them. Once they experienced success they were convinced of the usefulness. Tara found that practising with her child made her realize what she needed to do. "At the first session, it was a case of "well, that kind of, that's just common sense, you know, we're doing that. But then we started actually really doing it with him and being much more focused and following what he was doing much more carefully." It took Olga a while before she felt comfortable with the techniques. "It took - I don't know - half the program or so before I kinda relaxed and seen some results, like - the frustration level went down. It was once I started to know their techniques, and we practised them a bit to get the idea, then do it at home, then - then I felt better." Yet Tina was so enthralled with the techniques that she learnt that she shared them on a regular basis with a friend of hers. Tina: "Every week I had to phone her when I got back and I'd have to tell her and she's been doing it with her baby. It's been neat too that she's been using them. She thinks that they're really neat and like she would have never thought of a lot of them either....and you know they're so simple yet you wouldn't think of it. Like the sabotage thing."

Daily pressures interfered with how much time the mothers could find to follow through on the techniques and read through the manual on their own. Tina and Olga found using the techniques at times was hard because of the pressures of daily living. Olga: "When I'm in a rush I don't really give him the chance you know the one-on-one. It makes it hard because you just don't have the time to wait for that." Tina: "Sometimes it was really hard. Some days were really hectic that you just couldn't at all. I tried to fit it into regular normal routine-type things so when I'm changing his diaper I would use it and try to get him to say- I'd hold up and say "what's this?" Further none of the mothers said that they had referred to their manual since they completed their program. Again daily pressures interfered with this practise.

Mothers' reported lack of language techniques

Three of the mothers, Flora, Sissy and Susan, felt that their programs provided them with a minimal amount of techniques that lacked innovation. There was little regard for that which was presented. Sissy could not explain any of them but said she was using them. Sissy: "Some of the techniques of getting them to speak, I don't know. Basically we were using practically all of it already." Susan when asked about any strategies that she managed to learn she said, "No there weren't any techniques no not really. Just the fact of making him ask for what he wanted and say the word. That's about the only thing." For Flora she found that her program was basic. Flora: "It's not that I learnt things that I didn't know myself. I thought they were pretty basic. A lot of the things that they suggested might have been new to some of the parents but they weren't really new to me. As a remedial program it was O.K., but it just more or less seemed like a bandage." Since Flora's program was child focused it is not surprising that she did not experience much growth in this area. However it is interesting that the other two mothers seemed to either disregard what they were told or hadn't had enough exposure or opportunity to practise and use the techniques in the learning situation.

Since it was the speech-language pathologist who actually worked with the children perhaps the mothers had difficulty conceptualizing how they would work. The Eastern philosophy of learning by doing may explain why these mothers felt that they hadn't learned anything new for themselves. This area will be discussed further in the next chapter. What some mothers did learn about language development and disorders follow.

c. Knowledge growth

Through her program Olga learned that often children can say words but not know what they mean. For her she discovered that she expected her son to learn language incidentally just as her daughter had. She learned that she had to do more direct teaching through word stress, repetition and demonstration. Olga: "So that really opened my eyes...you just try to get them [children] to pick [language] up on their own. To teach something you really stress it 'hot, hot, hot' and demonstrate so they learn." Tara felt that her speech-language pathologist did a very good job at providing the parents with a rationale why certain techniques were effective and how to perpetuate the program on their own. Tara: "She was very good at giving us an understanding not just here's what you have to do but giving us an understanding of why it worked and an understanding of where to go once the program was over once she wasn't there to guide us every couple of weeks." Sissy learned that some children study and watch a great deal before they utter a word. She found her son was like this. Sissy:" He's a watcher. They [the speech-language pathologist] explained that he will watch you and watch you and watch you and then one day he will surprise you by saying something. And that's basically what happened. He watched and watched and all of a sudden five words came out."

In summary many of the mothers (Olga, Tina, Tara, and Francis) began to facilitate their child's language mostly through child oriented and interaction promoting techniques. For Susan and Sissy they gained little to no new techniques from their programs even though they had a parent component. Perhaps the format of their program did not lend itself to the adult learning process. In the other parent programs there was the use of videotaping, role playing and on going dialogue with other parents. Sissy and Susan did not have the opportunity for extensive use of these in their program and perhaps this reduced the impact of the techniques. Although not all mothers reported a gain in the use of techniques, all did report that their child made gains in their communication skills. However it will be discussed that there was a great deal of variance in how the mothers viewed their child's achievements.

5. Children's communication skills

Reason for gain: program or maturation?

On the whole all of the mothers reported that their children made some gains with their language skills during the course of the programs. Two of the mothers (Flora and Susan) were not sure to what to attribute their children's gains to: the program, coincidence or maturation. Still both of these mothers felt their programs were of benefit. Flora was equivocal about the reason for progress. "I don't know if it has that much to do with the program or just because he was ready to progress. I'm not sure but I know the program did have its benefits." Susan said it this way: "The program did help. I don't know if that was something they [the speech-language pathologist] did or whether it was just coincidence but it just it all seemed at the same time that he started to improve."

The impact of the speech-language pathologist's report on mothers' opinion for future services

Only one mother, Tara, considered that her son's present language level was near his age mates. All the others believed that their children were not at a level with which they felt comfortable and felt that additional support would be required in the future. They based their judgments on comparison to age mates or the ability to make oneself understood. Benefit and cause for concern was measured more by the mother's assessment of her son's present functional skills in how he functioned in the home, how he interacted with others and how he compared to children his own age. This was a cause for concern for all of the mothers and frustration for some. It did not appear that the speech-language pathologist telling them that their child had improved on test scores played a significant role in determining if they felt that their child would need help in the future. That is, the improved scores were fine and this made the mothers happy but that did not stop them from thinking that their child still needed help. Flora's comments speak for the mothers who were still concerned for their child.

> Flora:
> Well what they [the speech-language pathologist] told me is they were very pleased with the progress. I think he gained six or seven months that he was in the program. It made me feel a lot better. ...He has really come an awful long in the last eight months. But I think there could have been more. I found it to be a bare-bones program. I knew it was a stepping stone for what he would be eventually taking.

For Francis even though her son's test scores improved she felt that she had expected a little more for him such as being able to explain himself. She knew that her son would be reviewed in the future.

> Francis:
> He learned a lot of single words... She [the speech-language pathologist] said he improved from the first time...but I think it could have been a lot better. .... but I think I don't know if I expected a miracle ...but I expected a little bit more. If he's playing outside and comes in and tells me something I don't know if somebody's picking on him or what happened. I have no idea. I just expected a little bit more. In another year they [the speech-language pathologist] would do another follow up and see how far he's gone and if he hasn't improved put him in another program.

Improvement and the need for additional services

When improvement was mentioned it most often was in the area of vocabulary skills. Mothers made comments like "he's saying more words" or "his vocabulary has improved." Use of global terms like "getting better," "talking more", and "see a difference" was common. However they did not elaborate much further. Only Tara made comment about an improvement in combining words to make sentences. Olga felt that her son's language skills had improved somewhat during the program and she realized that it wasn't much but she was still satisfied but felt that she needed to keep monitoring it. Olga: "I'm not saying he was a miracle but for understanding each other and learning how to work with him...he's added a few words... I know it's not much but I'm still happy. But we're going to keep an eye on him and see how he's progressing...just to make sure it's not gonna be a standstill." For Tina her son's progress has been slow which frustrates her. Tina: "I'm still frustrated because it is slow moving. But he does say I would say a new word a week. But a lot of words that he used to say he still hasn't gained. Like he doesn't say 'daddy' any more or 'mommy'. I want to keep up on it though until I feel like he's on the road, 'cause he still, I think has quite a bit to go yet. And I wished as I keep comparing him to my first, at two she spoke sentences. She had a very high vocabulary." Susan also felt that there was room for improvement. Susan: "We're still not happy, I don't know you compare to other kids and he's quite behind. I think he still needs some help. He's still not up to par. He's improving every day but as far as kids his own age he's no where near the same level." For Flora, "He has really come an awful long way in the last eight months and since the program. I really enjoyed the final assessment because it was basically the same thing that they did to assess him before hand. It was interesting to see how he had progressed. I've even noticed an increase in his vocabulary. But as a remedial program itself it was O.K. but it just more or less seemed like a bandage." Sissy found that her son was speaking more and doing "really really well" and "leaps and bounds" but commented that only the family would notice the improvement. Sissy:" He is saying a lot of words....[others] know that there's a lot work to come but seeing that he has improved. Before he wasn't speaking but he's doing such leap and bounds... we can see a definite difference."

In closing there appeared to be a consensus amongst the mothers that none of the children were now communicating at the same level as their age mates. Tara's son was the closest. His mother felt that he would reach this goal within the next six months. Her perceptions matched those of his speech-language pathologist. No other mother was given any information regarding how long her son's language difficulties would persist which was worrisome for most. This forms the basis of the next theme--unresolved issues in the area of disorder etiology, educational concerns and the permanency of the disorder.

Theme 3 Mothers' unresolved issues

All of the mothers except Tara had unresolved issues concerning their child. These unanswered questions related either to what caused the delay, whether or not the child would have difficulty in school, would he grow out of the language problem, or would younger siblings have the same problem.

Tina, Flora and Francis were uncertain about the cause of their sons' problems. Tina and Francis mentioned it only once but concern filled their voices. Flora discussed it at great length. Tina expressed her uncertainty in frustration. Tina: "Like and everyone asks me, "Well why is he delayed? and we don't know why - it's frustrating." Flora expressed a great deal of concern about causation and spoke about family stressors during her pregnancy and post natal complications (severe jaundice) shortly after birth. She could not determine if any of these factors were at play for her son's problems and expressed guilt about them. She discussed these issues with her speech-language pathologist but did not seem to find the reassurance she needed. Flora: "I discussed this with the speech-language pathologist and they said you really can't tell and at first I was kind of blaming myself. I was feeling very guilty and I thought that since he was such a content baby, maybe he wasn't stimulated enough. So I really really blamed myself. I thought maybe it had something to do with me." For Francis she was unresolved about her son's difficulties with eating and wondered if his inability to eat certain food had something to do with his poor communication skills. Francis: "I always thought maybe him being lazy with the mouth was a lot of the problem, like him not eating properly and stuff. I always thought well maybe there was something wrong where he can't form the words because he's just not a good eater." She shared this with her speech-language pathologist who did notice that he did drool a lot but nothing more came of it.

Another unresolved issue for Flora and for Olga as well was the uncertainty that they faced for their sons' education. Both mothers were concerned about the impact of the boys' language difficulties on their later schooling. Flora: "I think the most challenging thing probably is my fear that he will have problems at school. I have asked different people that have assessed him and they have told me that at this point he is so young that they can't really tell what the future holds for him. they don't know if he's a late bloomer and will catch up eventually or if he will have problems throughout his schooling and that really concerns me." For Olga she too is concerned about the possible impact of language difficulties on her son's education. However she is resolved to continue monitoring to make sure that he continues to progress. Olga: "I want to keep an eye on it just to make sure that it's not gonna be a standstill because I'm concerned about the school thing... because I was thinking O.K. school's hard enough as it is and then to have to be going to therapy..."

Another concern for Tina is with her youngest child. Because her son had appeared to be developing normally and then just failed to progress any further and began to regress she worries for her baby. Tina: "Then I keep wondering about her if she's gonna talk so I'm already doing things with her, you know things that I learnt."

All of the mothers except Tara, was concerned about the persistence of their child's language disorder. In the back of their minds was a worry that the problem was still there. None asked how long will he have this problem but comments like "He still has a way to go" and "I'm going to keep an eye on it" and "Progress is so slow moving" would imply on at least some level that they were looking at more long term ramifications and were concerned.

Of all the mothers Flora had the most unresolved issues. She had many real fears which she could not settle. She stated that in her program there was no parent interaction aside from the informal chitchat that went on in the waiting room. She believed that this was a necessary component that should have been included in her program. While mothers like Tara, Olga and Tina and to a lesser degree Susan and Sissy had the opportunity at length to share their concerns with other mothers, Flora did not. It is understandable then why Flora would have more concerns in this area. However as many concerns as she had about etiology, program and future education, she had none for her sons' temperament. This again was in opposition to the other mothers. They had numerous issues about their sons' temperament which would affect how they would interact with their child. These issues are discussed next.

Theme 4 The challenge of the child

A significant theme which was culled from the data was the enormous task these mothers faced in raising their sons. Areas which posed as an extreme challenge for the mothers were the boys excessive activity levels, extreme independence, in some cases real safety hazards, reaction levels, degree of unpredictability and demand. When coupled with the children's communication difficulties this dramatically increased the parenting responsibility. In short these would not be easy children to parent. It did not appear that any one personality trait would make the parenting task any harder but the boys appeared to have a constellation of behaviours that traditionally would be termed difficult. When viewed holistically these children presented as real tests to their mothers' parenting skills and a speech-language pathologist when determining treatment plans would need to take each mothers unique needs under advisement. The entire child would have to be considered when planning how to help each mother and child.

Activity level

All the mothers except Flora find their sons to be extremely active. Not only is this very tiring for the mothers but it can pose as a safety risk. Frustration can mount when the children are taken out. Francis describes her son as "rambunctious, really active and very energetic". His activity level is so high that at times Francis has a hard time determining the extent of the injuries that befall him. "He's too active. I can't really get him to sit down and focus long enough to see if he's hurting. He's jumping all over the place, always has. He's not a sit down activity kid. He gets hurt a lot." Tina finds her son very active as well. "He likes to run around. He doesn't like to be restrained. For Sissy her son's energy level can be dangerous. "There are days when he just goes nuts, where he is pushing all the time and throwing things. It's a matter that you gotta find an outlet for him to get that - release that excess energy, without killing his brother and sister in the process." Susan finds that her son has lots of energy too. "He's just wild. One day he wanted to push a little shopping cart around K-Mart, and he was bent on doing it, no matter what anybody said, and he was just about running over people. We had to get rough with him and put him back in his stroller, but - he threw a very good temper tantrum that day. He was really screaming." Tara has had a very similar shopping experience as well and finds keeping him safe is problematic.

> Tara:
> He's a busy boy. That would be the best way to describe him. He's always been extremely active, very strong, physically very strong child." One time that I can remember [at the Mall] was when I took him for a juice and snack. He wouldn't sit, he wouldn't sit to drink anything. I would get up no less than ten times to

> chance him down in the Mall and bring him back. Trying to keep him safe with his activity level is also hard. He's just, like he can get up over a fence, he can get up on top of the refrigerator, he can climb the railings on the banisters there. He's very, very strong and he knows it and he's very quick to be able to figure out how to do something, so it takes a lot to try and - he's truly an eyes in the back of the head kid. He can be out the front door before I even - as a matter of fact that's why we moved was because he would get out the front door, and we lived on a busy street. The hardest challenge was trying to keep him safe and get him engrossed in some other activities that were not quite always so physical, because he was just on the go all the time.

Independence level

Many of the mothers indicated that their sons were extremely independent and would have no difficulty wandering off on their own or attempt something very dangerous in the home. Francis finds her son very independent and he is a safety risk.

> Francis:
> We have to put a lock on his door, because he does get up at 3:00 at night and want to pour himself his own bottle, and he knows where the knives are and he'll cut his own oranges. He's been like that for, oh, a long time. I think we've had a lock on the outside of the door for 8 months now. I find that he dreams lots, so when he does dream and he does wake up in the middle of the night, that's when he decides to get up and wants his snack, or a bottle. Once we woke up at 3:00 o'clock in the morning and found him in bed with a pickle jar, and the only reason he was in bed with us, was to wake us up because he couldn't open it.... so we lock him in his room at night, because it wouldn't take for him to turn on the stove, or take a knife and try to cut an orange or something and cut his hand off."

Susan finds her son very independent as well: "He would have no problems walking away, and going for a little walk, and saying 'see you later'. Tara finds the same thing with her son:

> Tara:
> As far as he is concerned, he can get through this world without anybody. Everything was like, 'no, me do, me do, me do'. He would rather scream and hit and throw something, than ask for help, very much. He is also the sort of child who would take off on you and explore, and never ever once stop to look back to see whether you were still around, and he could go on for a good half hour or more, without even caring where you were. He just really could live without us, as far as he's concerned. We've never had any trouble leaving his with sitters and stuff. It was like 'We're leaving'. 'Bye Mom.'

Attending and discipline

Francis said that one of the most difficult things for her to deal with is her son's listening skills which interfere with discipline.

Francis:
Like I said to my husband, 'You know, I could see why some people would want to abuse their children, because they just don't listen', like, they'd get that mad. So, he'd be one of those kids, because he laughs at you when you would give him heck, and real stubborn, you know, he just pushes you until he knows he can't push you any more.... he just keeps going. Like, when I say, 'come here', it's usually me that's going to him to get his attention. Sometimes even for him, I have to grab his face and say 'I'm talking to you', like, focus, like, make him look at me to get his attention. Yah, he's pretty hard, he's on the go so.

Tina finds that she has a hard time with getting her son to attend and do what he is told as well.

Tina:
He's very hard to get his attention off what he's involved in. I would have to take it away. Sometimes, if he's watching TV, I'd have to shut it off, or if he was playing with a toy, I might have to [illegible] it away. We had his hearing tested, because you'd say his name again and [illegible]

Generally she finds him happy but has trouble when she needs him to listen:

Tina:
He's happy, until you try to get him to do something, then he has his fits. He's a challenge. I always joke, say I had him because parenting would be too easy. He has his own mind and you can't make him do what he doesn't want to do. He does throw temper tantrums to get his own way. But if he doesn't want to do something, that's, that's. Even with just everyday things like picking up toys, or brushing your teeth, or getting dressed. He just doesn't want to be bothered. He's in that own agenda category. My way or the highway.

Tara describes her son as "very strong willed" which makes it difficult.

Tara:
If he's into it I mean, I can remove the object, he'll find the object again. It didn't matter how many times I would say no and take it away and remove him from it, he will go back to it, and he would persist for just incredible amounts of time if it was something he was really interested in, to a point where at times it became a real safety hazard with him because, if he really wanted to get to the cookies in the cupboard, he'd keep climbing up until he could get to the cookies in the cupboard. We called him 'very strong-willed'.

Both Sissy and Flora have a family history of "Attention Deficit Disorder" (A.D.D) and their sons are now starting to exhibit some of the same behaviours which leads them to believe that they do have the disorder.

Sissy:
I don't think he has enough attention span. He gets frustrated and, it's gone on to the next thing. I have a nephew that was a child A.D.D. and I have now currently two nephews who are A.D.D. as children. So the chances of my son escaping it I think are I think pretty slim.

She finds that she has to really work on getting him to focus.

> Sissy:
> When getting attention, I have to make sure I've been heard. There is a habit of tuning out. I basically have to get eye-to-eye contact. Like, even with disciplining, I disciplined him for actually pushing his sister off the back deck - it's not that far down and it goes on to grass, so it's not - no dangerous thing. But, he has to learn he can't do that. And, he was disciplined and then I needed to talk to him, and then he has the ability of turning his head and looking at things and getting distracted, so, I literally have to take him into a room where there is nothing moving, and hold his face and look at him to talk to him, which is something you do with an A.D.D. child. Then I know he's listening, otherwise he doesn't know what he's done wrong at that point, and yelling and screaming doesn't work, because, yelling and screaming, the kids learn to tune that out anyways.

Flora had no concern about activity level or general behaviour per say but others such as the speech-language pathologist mentioned that he had a hard time concentrating in his program.

> Flora:
> I have noticed though, in the program and also talking to the teachers there, the speech therapists, that he did have a problem with focus, concentration and attention. I don't know, there might be a problem with attention deficit with him. I had my two older sons checked. One of my other children, has got attention deficit, and he's having a hard time [in school]. .... so there is a possibility that he might also have attention deficit.

Adaptability and Predictability

Tina finds that her son has trouble in this area and it can make it difficult for her when she has to go out.

> Tina:
> He's not too adaptable, is very independent and very unpredictable. As Tina puts it " ...if you were at someone's house and you didn't plan on staying there more than a half an hour, he does not like to go in and out. He has to stay. That's our number one battle. He's very unpredictable. Just when I think I'm dreading going downtown because I have to go to the bank and I've got to drag him, he's gonna freak out, and he's really good, and another time when you think he's gonna be really good, he's bad.

Sissy also finds that her son is not very adaptable:

> Sissy:
> He's not as adaptable as my first child. I'll explain. We visit relatives in B.C. and travel fine is, that's not a problem. It's the change of the hour. It was - we would be there for a week, and it took most of that week to change over to an hour later, and then it took another week to change back.

In closing: from these mothers' descriptions it is clear that they are very busy dealing with their children. It behooves speech-language pathologists to consider the entire child when advising mothers how to facilitate their child's language. Some of the strategies that may be theoretically sound and "look good on paper" may be very difficult to put into practise for the mother. This topic is addressed further in the last chapter: "Discussions and Implications" under "Client perspectives".

Theme 5 Obstacles to intervention

This theme evolved out of the mothers' personal accounts of how they realized very early on in their child's life that something was wrong but for some reason, either what others said/did to them or how they felt about the situation, did not seek out immediate attention or were met with opposition along the way. There were two major obstacles that prevented the mothers from obtaining immediate help. One obstacle was a common belief that children will "grow out of their problems" or it is best to "wait and see" if services will be needed later. In this chapter the mothers' experiences will be described and in the next chapter this common practise of waiting before seeking attention will be challenged. The other obstacle that some of the mothers faced involved service issues related to program delivery or screening procedures and these will be discussed.

"Wait and See"

The "wait and see" approach involves holding back from seeking immediate attention in the hope that services in the future will not be necessary. Both Olga and Tara identified that their children were experiencing difficulties communicating at a very early age but did not get immediate attention. In Olga's case she waited before she sought help and in Tara's situation it was her doctor who counselled her to wait before seeking attention.

Olga felt that her son was developing fine and was reaching speech milestones as explained by her community health nurse at 18 months. So she didn't think much more of it until he was approaching two years and she realized that he hadn't progressed beyond the 18 month bench mark. She found that the communication wasn't there and she couldn't understand him. She didn't know what to do and was frustrated. She also noticed that he was behind his older sibling. She thought to give her son another year before she sought help but he really hadn't changed so she decided she had had enough and called the health unit speech-language pathologist. In this situation Olga felt that she needed to make sure that there was a problem before getting help.

Tara raised her concerns with her child's paediatrician. He was very receptive to her but thought she should wait and see if being around other children would stimulate him. If he did not improve after that he would refer on:

> Tara:
> He was very receptive to the things I was telling him, that I felt I wanted it looked at. I had talked to [him] to confirm his two year checkup and I had said, 'I don't think his language is where it should be', and he said, 'that 2 is a pretty

> tough age to really discern. Why don't we give it about four more months, and if you don't see things start to pick up.' He said try and get him around other kids more and see whether that stimulates it, and if that doesn't pick up, then get back to me and we will get some things under way.

"Grow out of it"

This approach implies that the child will grow out of the problems that he is experiencing and that therapy will not be necessary so there is no need to seek out assistance. Tara, Francis and Tina experienced this sentiment first hand while Sissy watched family members experience it. Susan on the other hand did not meet with resistance from others but she herself thought her son would out grow his difficulties.

Sissy saw the struggle that her relatives had with their child who did not talk but did not get help until he was in kindergarten. Sissy felt that the mother thought the child would grow out of it. "So at that point [kindergarten] they got into speech therapy. By then he was already three and a half years old almost four and where normally they would have realized it at 18 months or two years they would have put him in the program. I saw their struggle with it and everything and a lot of people said 'well - well, normally they'll learn on their own', because my aunt is a school teacher, and she was also using that a little bit, and everyone said 'don't be worried.' For her own child she sought help at once.

Tara found that her parents followed the "he'll grow out of it" theory. This made it difficult for her to convince them that her son had problems. They were opposed to her seeking assistance because they did not see the need: "The hardest part we had was trying to convince other people around us that there was a problem. They were the ones telling is 'oh, I know so-and-so who didn't speak until he was so-and-so, and now he went to Harvard, or works on wallstreet' kind of thing. They didn't understand why I was making such a big deal out of something that they felt was just normal, usual."

Tina expressed the same issue with regards to her parents. They didn't think she needed to pursue therapy. "It's just that you get a lot of people saying 'Oh, he doesn't need that. He'll speak when he wants to'. They really thought that that was a bad idea, that he really didn't need it."

When Francis spoke to her doctor about her son's lack of speech she found him equivocal about her son's development. However he did refer the child immediately.

> Francis:
> Well, what I did was go to my doctor. He says that 'some kids just don't want to talk until a certain age' 'some talk earlier and some kids don't'. ...'some kids he says, 'will deceive me.' He says, 'God knows, when they talk, they'll talk'. He said it seemed like there wasn't much of a problem with - his hearing was O.K.

> He said, 'I don't think we have anything to worry', he says, 'but if you get into the program', he said, 'it could probably take you awhile', so with the recommendation now, he said, 'he may be talking by the time you can get in. But you can - we'll put it through and see what happens'.

Susan felt that her son would "grow out of his problem as well."I figured that he would learn to talk sooner or later. It wasn't a big concern I felt that he would learn. I wasn't really too concerned about it." However once she began the program she was glad that she had because she stills sees that he is behind.

Service issues

For some mothers such as Flora and Tara it wasn't that they felt that they needed to wait before they sought attention - on the contrary, they wanted immediate attention but either could not be seen promptly as in Flora's and Tara's case or didn't know where to go (Tina's situation). This frustrated all of them.

> Flora:
> I was concerned about his speaking. He was already 2 1/2 years old and there was hardly any communication so right away I decided to go for some kind of help. I phoned the health clinic there, and I told them I had concerns. So, they sent me out some information.

However Flora felt it took a long time to get seen and this frustrated her. She saw how he was falling behind and by the time that he got into the program she was grateful.

> Flora:
> ...it took me an awful long time to get him into the health clinic and to have him assessed and then finally to get into the program. By the time he was assessed, I think it was about 8 months that I waited. I think that by the time he started the program, it was already a year. It was quite a bit, and it was a little frustrating for me. I just had to wait, and I was basically told that I would have to wait. I was told that there was a waiting list and I am very well aware of all the cutbacks and I knew I would just have to wait. I thought, well, the problem might not be as bad as I think. Perhaps I'm making too much of it, but will continue with this. Anyway, then the older he got the more I could see he was falling behind, so by the time he was assessed, I was very grateful that I had gotten in.

Tara also had to wait for services. She referred her child for an assessment at the health unit: "I phoned them up and I said that I had this child and I would like to have him assessed because I felt there was a problem." It took awhile before she was seen at the health unit. She was persistent: "It was really backed up. It was probably, I think, about six weeks before I was able to get in there, and I kept phoning every week saying has anything come open, has anything come open."

Tina's difficulties arose from not knowing where to get help. "You just don't know how to get the ball rolling". When she attended well baby clinics the focus was more developmentally based on areas such as motor skills. The nurses didn't look at speech. Following dropped articles, picking them up and ringing a bell were what Tina recalled. Tina said that she was never one to ask about speech and when she did raise the issue once or twice she was never asked if she wanted to talk to a speech-language pathologist: "And when I did bring up my concern once or twice, they never said, 'Well do you want to speak to a speech therapist?' I did that on my own."

Tina had her child assessed by a speech-language pathologist who suggested that she participate in a parent program. However at that time a program was not being offered. She did not pursue the issue any further until she took her son to their family physician for a medical complaint. She mentioned that he wasn't talking and the doctor immediately referred him for a hearing test as well as to a paediatrician: "I got him in for something else at the doctor's and I just casually said ... it's not like he talks anyways and he said, 'What he doesn't talk?' and then he got going - ... sent us to a paediatrician and then to hearing." It was the paediatrician who wanted them to see a speech therapist. If it hadn't been for her doctor Tina stated that she's not sure she would have done anything: "I just wondered if I hadn't mentioned it, 'cause he was never sick, I wasn't at the doctor's a lot if I had never mentioned that about him not talking if we would of ever done anything about it, but you just don't know how to get the ball rolling. I think that's you don't know if you have to be referred to a speech-language pathologist or if you have to - can just phone the health unit." Because of this concern Tina suggested that the speech-language pathology program and communication development should be promoted more in the health unit: " I think the program's real important and maybe they should have it more known. Like when you visit a health unit they don't talk about speech very much. Like in our health unit we have one poster on speech, and language (development) and it didn't get up until the middle of this year, and you know I think they've got so many other posters about things (they could have more). Tina also added: "When they get their last shot 18 months or something maybe ask some questions about speech development at that stage".

In closing all of the mothers except Susan and Flora experienced some form of opposition from either family or in some cases their physician that their child was normal and either didn't need help or would grow out of the problem. However in each case the exact opposite was true. Each child required attention and further would need it for at least one more term. This issue is addressed further in the next chapter in the section "Implications: improving quality of life."

Theme 6 Agent responsible for change

It became clear while pouring over the mothers' transcripts that there was a real division between who was "responsible" for effecting language improvements in the children. Although most of the mothers participated in much the same parent focused program with the exception of Flora's which was child focused, there appeared to be a split between who was responsible for the child's language change -was it the mother or the speech-language pathologist? Clearly Olga, Tina and Tara saw themselves as the agents for change in their child's life while Flora saw the speech-language pathologist in this position. For the rest (Francis, Sissy and Susan) it was a little less clear but their comments revealed that perhaps they saw it more the speech-language pathologist's responsibility. It appeared that when a speech-language pathologist became involved with the child as in Flora's, Francis', Sissy's and Susan's case, responsibility seemed to be delegated to the speech-language pathologist and a common parent reaction at the end of the program was that their child needed more speech-language pathologist one-on-one contact to make gains. The mothers' comments illustrate their positions.

Mother as person responsible for change

For Tara it was clear that she was the one who had helped her child, that she was rewarded by this and that she could continue on in the role of facilitator.

> Tara
> ... instead of me having to turn around and say 'see what the therapist has been able to do for him', I could turn around and say 'see what we've been able to do for our child, with some guidance', and there was a very much rewarding feeling to it because it was a case of 'we did this'. 'We helped him through this.' The other thing to is that you have this sense that this isn't something that ends at the end of the program. ... it's not something that only lasts for two hours once a week. It's something that last for two hours once a week, plus every moment you want to use it for the next seven days or fourteen days in between.I still have all of these tools and I can continue to use them every single day with this child, and I can keep him going right on up the ladder with them. I don't have to say, 'O.K. while we're going to put his language on hold until we get into the next program, where we see the new therapist the next time.' So that was what was the best. So, as involved as you want to get with it, will affect the outcome of it, and if you really want to help your children, or your child, you have the potential there to do wonders with it, if you want to become involved enough with it.

Tina felt much the same way but commented on how her friends would prefer a parent focus to traditional speech-language pathology services for children and how for the younger age this method was "more efficient".

Tina
And it's - and you - and they can get more of it [language training], than once a week to a speech therapist. They [parents] can do it every day, all day, if you wanted, or... I mean, the opportunity arises more often throughout a regular day, to use it ... because - you know, a lot of kids like him wouldn't go into a total stranger and get them to speak, or do what they wanted. I mean, it's hard enough for me, and that it was actually just to teach the parents to do it at home on their own time, which is more along what a lot of my friends would prefer anyways. Rather than take them in once a week to a speech therapist, shut the door, and you wait in the hall, or whatever you would do it at home when your ready- or, whenever. I think that [a parent focus] is probably - for this age group, is way more efficient. It's I think a lot of people, when they hear you're taking them to a speech program, or something, they think it's the child being taught, where it's the parent is being taught.

Olga spoke how a parent program was more effective at dealing with family frustration levels than a traditional program that was child focused.

Olga:
...and then we decided on the program for him was for her to show me the ways to work with him, because it [gains] weren't going to be immediate. You know, I'm with him, and then to show me how to work with him on a day-to-day basis, and on every activity. [With her just doing it] she could only do it once or twice a week, and then I get him home, and then - what happens there? He comes home, I'm still frustrated, he's frustrated, no one knows what to do, so were not really gaining anything.

Speech-language pathologist as person responsible for change

For Francis, Sissy and Susan it appeared that the speech-language pathologist was responsible for their child's communication skills even when they participated in a parent program. The onus appeared to be on the professional to effect change. It was no surprise however that Flora would hold the speech-language pathologist responsible for her child's gains since her son's program was child focused. Flora expressed her families belief that the speech-language pathologist is the one who "fixes" speech problems and that this can be done quite quickly.

Flora:
Everybody in my family thought that's what the problem is [articulation problem], just take him to a speech therapist and they can do miracles, you know, three or four sessions and the kid will be talking.

She was concerned about the time over the summer that her son would not be receiving any services and wanted to know what to do. She believed that a program that was more focused on direct one-on-one treatment more often would be the best route for her child.

> Flora:
> I said, 'Is there anything I can do?' My father-in-law was kind of willing to possibly pay for a speech therapist, a private one, and I got from the health clinic a sheet of all the different speech therapists. I think there could have been more [therapy]. I found it to be kind of a bare-bones program, but I understand about the different cutbacks. I think for a program like that to be more help specifically, there has to be more one-on-one probably, because I don't think there was an awful lot of one-on-one....I'm talking about one-on-one away from a group setting. It would have been nicer had it been a little longer. I would say it was a good hour, but I think it would have been a little more beneficial had it been two or three times a week, because that was a long time span between that seven days, or if had been a little bit longer, long 2 1/2 hours or 3 hours.

For Susan she thought that there could have been more therapy time as well and that individual treatment was the best choice. "I think maybe they could have done the children in the group individually. That might of helped, because they kept loosing some and they would just, kind of, go off and do their own things. It's hard to keep them all interested in the same thing. I think they should have done them separately, rather than lump them all together".

Francis felt much the same as Susan. She found her son's treatment group much too large. "I expected more than the speech-language pathologist sitting in the room with a bunch of kids. I expected a lot more one-on-one. I don't know why, but I expected a lot more work. It just seemed to me that they would get better results with the kids talking one-on-one, or two kids playing a game and trying to get them both the same."

This last theme spoke to a treatment philosophy. The mothers opinions settled into one of two beliefs: either they were the person responsible for their child's language development or the speech-language pathologist was. It became evident that those who viewed themselves as the responsible party felt that their program was acceptable and did not recommend any changes. Those who saw the speech-language pathologist in this role believed that changes needed to be made and that "more was better". Flora's quote was the most enlightening. She wanted to do more for her child so instead of getting strategies for herself she considered purchasing services from a private practise speech-language pathologist and recommended that more therapy in the future would be better. In times of fiscal restraint this perception is cause for concern for everybody involved: the child, the parent, the speech-language pathologist, the administrator and the tax payer. This issue is discussed further in the next chapter.

CHAPTER V

DISCUSSION AND IMPLICATIONS

Introduction

The purpose of this study was to explore mothers' perceptions of their language impaired youngsters, the speech-language pathology treatment process and the effect that this process had on the mothers' quality of life. There appeared to be a number of themes which emerged from this study that reflect the mothers' perceptions of their children and the program that they participated in. Specifically each mother reflected upon her child's distinct personality, what she expected from the program for herself and her child, the impact the program had on her interactions with her child and family, her feelings and self worth, her role as a language facilitator, the growth in her child's language skills, the concerns and obstacles she faced and in some situations still does, and her child's future. In this final chapter, present findings are discussed in light of other research results, implications arising from this study are presented, limitations of this study are acknowledged, and recommendations for further research are proffered.

This section is structured around the specific themes, their inter relatedness and their ties to present research.

Discussion

Expectations and program benefit

The mothers' expectations were the driving force in how they received their programs and how they perceived their benefits. Dreikurs (1971) states how expectations shape our actions.

> We all act in accordance with our expectations. They form the secret plan that guides all our actions. Expectations are our strongest and strangest motivating forces. Anyone who can alter the expectations of people can change their behaviour (p.71).

This quote is highly pertinent to this present study. The mothers' expectations appeared to be the single most important factor for measuring the success or impact of the program. For some mothers gaining tools to help her child or knowing that her child developed or strengthened emerging skills was enough for her to be satisfied. This was the case for Olga, Sissy, Tina and Tara. For Olga she wanted to get help so to know what to do and so that she could share some "common ground" with her child. In the end she realized that it "wasn't a miracle" but for gaining some understanding and having him add a few more words which she knew wasn't a lot she was "still happy". Sissy knew that she wished her son could speak "flowing sentences" but realized that this was asking for too much. She felt the program was "successful" because she "had lowered her expectations" and that "adding even one word was one word more than he had before so the program was successful." Tara had wanted to learn something "to bring her son along." She hoped the program would "unlock some door that wasn't letting language happen for him". She felt the program had done that and more. It had exceeded her expectations and she was "very, very happy."

For those mothers who initially reported that they wanted their child to develop skills or have frustration decrease in fact after further reflection wanted their child to approach normal language skills and achieving anything less was unacceptable. This was the case for Flora, Francis and Susan. They were less content with what they had received: (Flora "a bare bones program" or "like a bandaid"), were sceptical of any gains that were made (Susan: "I not sure if it's coincidence but they seemed to improve about the same time that the program started") and requested individual attention for their child from the speech-language pathologist (Francis: "I think that they could have done the kids more one-on-one. I expected more than just sitting with a bunch of kids"). All the mothers commented that they thought their expectations might have been too high but the fact of the matter is that is how they felt and accordingly that is how they judged their program. This is not to say that they did not think their programs did not have any merit at all; it was just that they didn't meet all their expectations. I feel that these mothers were unaware of their "hidden" expectations. They were truly at a loss to explain why they felt as they did: Susan: "I just can't put my finger on it."

In her article entitled "the Numerous Facets of Quality Care" Heaton (1992) shared her personal views about how quality of care is perceived by different individuals such as the client and family, the professional, the community and society. The following quote from her article has direct application to this study. She stated:

> Clients and families come to the clinic with a set of preconceived notions. They will judge the quality of the services they receive based on these notions. Notions can be modified to some extent through client and family education, which is an on-going aspect of service. However, notions are seldom eradicated, and the perceived success of outcomes will always be coloured by the initial set of expectations (p.265).

Indeed it was evident that each mother brought her own unique experiences and expectations to her program. Heaton further stated that few clients/families feel secure enough to be able to give "honest responses" to questions related to their levels of satisfaction and listed a number of reasons why this might be so. She felt that most people feel their answers should be positive and therefore mask true feelings or are constrained to express themselves freely. This may be part of the reason why it was difficult to get the mothers to talk about their less than glowing report but in meeting with the mothers and reflecting at length upon their comments, I felt that these mothers just weren't fully cognizant of all their expectations. Table 4 shows the relationship between expectation, outcome and perceived benefit. Note that high expectations were never met and how this impacted benefit.

Table 4. Relationship between mothers' expectations, outcomes and perceived benefits.

MOTHER	EXPECTATIONS STATED BY MOTHER	OUTCOMES JUDGED BY MOTHER	OVERALL BENEFITS JUDGED BY MOTHER
Olga	emerging skills for child and knowledge for mother	adequate for child and mother	good for both child and mother
Tina	mastery skills for child and knowledge for mother	less than anticipated for child but adequate for mother	fair for child and good for mother
Tara	emerging skills for child and knowledge for mother	exceeded anticipated for child and mother	excellent for both child and mother
Flora	mastery skills for child none for mother	less than anticipated for child little to none for mother	fair for child and little for mother
Francis	mastery skills for child and knowledge for mother	less than anticipated for child but adequate for mother	fair for child and good for mother
Sissy	emerging skills for child and knowledge for mother	adequate for child and mother	good for child and mother
Susan	mastery skills for child and none for mother	less than anticipated for child little to none for mother	fair for child and little for mother

Empowerment

Not only did the mothers' expectations influence how they perceived the benefits of their programs but as well influenced their thinking in who was responsible for teaching their child better language skills. When asked the question "What were your expectations of the program you participated in?" only three of the seven mothers had expectations for themselves. For Olga, Tara and Tina their primary expectation was that they hoped to learn how to help their child. For Francis, Flora, Sissy and Susan their initial response to the question was that they hoped the speech-language pathologist could "get their child talking." It was understandable that Flora would feel this way because her program was more child focused and had less direct parent involvement. Even Flora's family made comment on this issue. As Flora put it: "My family said, 'Oh just take him to a speech therapist they can do wonders you know'." While it was not difficult to see why Flora saw the speech-language pathologist as the agent for change it was less clear why the other mothers reacted the same way because Francis, Sissy and Susan had parent components just as the others did. I contend that as soon as there was a speech-language pathologist working with their child, it was the speech-language pathologist who was responsible for the child's changes. While at first glance it appeared to be the best of two worlds-- therapy for the parents to give them skills to work with their child and speech-language therapy provided by the speech-language pathologist for the child to train language skills-- introducing the speech-language pathologist may have inadvertently hindered the speech-language pathologist's ability to empower her mothers to help their children. Therefore perhaps in this situation a combined parent-child program may not be the most efficacious. This position is in direct conflict with Tannock and Girolametto (1992) who state that an interactive model of language training which is parent focused (such as Olga's, Tina's and Tara's programs) might be best used as an adjunct to other intervention approaches (as was Francis', Sissy's and Susan's). They caution about using parent programs as a primary means of facilitating communication development because from their review of the research it is not evident that children made significant language gains with parent programs alone. However in this study there was no appreciable difference in the child's outcomes in the mothers' eyes when the speech-language pathologist was involved or not. In fact Francis had the most service of all the mothers; 18 hours of a combined parent and child focused program, and she felt that there could have been more because she stated "I think [there could have been] more for the kids, they needed a little bit more work...it just seemed like they were a little bit more frustrated." Further it didn't appear that a child focused program wasn't any more successful in the mothers' eyes in helping her child than a parent focused program. Flora and Tara had the same amount of service-- 12 hours-- and it was only Tara's son who made gains that were judged acceptable by the mother and the speech-language pathologist. What were the factors that could account for this? Certainly the speech-language pathologist's skill, mother's aptitude/motivation, and child ability would certainly influence outcomes yet I propose one other ingredient to the success of the parent program-- empowerment. At the end of the treatment period each speech-language pathologist was asked about the philosophy of her program and if there was anything else that she used that she had found useful in working with parents. Tara's speech-language pathologist was the only one who specifically mentioned principles in adult learning. From Tara's comments regarding her program I was led to believe that her speech-language pathologist programmed more aggressively in this area and therefore believed it necessary to pursue this issue further.

According to Espe-Sherwindt and Kerlin (1990), there are three frameworks which one needs to operate within when addressing empowerment:

> 1. a proactive framework based on the assumption that parents are competent or are capable of becoming competent.
> 2. an enabling framework that focuses on creating opportunities for parents to exhibit competence; and
> 3. an empowering framework that creates opportunities for meeting needs in ways that promote parents' sense of control over their own lives and those of their young children (p.21).

It would appear then that there is a very delicate balance between teaching and empowering. We need to provide parents with skills to help their child and we must let them learn to "do it" so that they can carry on in our absence. However to be able to "do it" parents need to experience and savour the success of learning something that they find of use and in the end have a feeling that they are the ones who made the difference. Of the mothers in this study Olga, Tina and Tara had a sense that it was them who was helping their child but it was really only Tara who experienced the act of being empowered to the fullest extent. In her interview she talks about her ability to help her child, the reward she feels and the knowledge that she can carry on. Tara:

> So, it was 'I won you over, see I did it, he did it.' The other nice thing that was so nice about it too was that instead of me having to turn around and say 'see what the therapist has been able to do for him' I could turn around and say 'see what we've been able to do for our child with some guidance'. And there was a very much rewarding feeling to it because it was a case of 'we did this', 'we helped him through this'. The other thing too is that you have a sense that this isn't something that ends at the end of the program. I still have all of these tools and I can continue to use them every single day with my child. I don't have to say I'm going to put his language on hold until we get into the next program, where we see the new therapist the next time. So that was what was the best.

As much as Tara was empowered by her approach, Flora was constrained by hers. Of all the mothers Flora had the most unresolved issues; she worried about what had caused her son's communication difficulties, what school would be like for him, whether or not she should have sought private practise over the summer when he was between health unit and school programs; she doubted the gains that he had made and hadn't felt that she had personally gained anything from her program: "It's not that I learned things that I didn't know myself." I felt that Flora had no sense of control over her situation. There was always some concern "lurking in the shadows."

> Flora:
> My fear that he will have problems in school and they [professionals can't tell me] ...that really concerns me....I was feeling guilty...I really blamed myself that I had done something.
>
> She was equivocal about the gains that he had made:
>
> He progressed quite nicely ..he kind of took off and he started blooming and I don't know if it has that much to do with the program, or just because he was ready to progress.

She wanted to help her child but she didn't know what to do:

> I told them that I was actually really concerned about the period between the time when he finished his program and the time he goes to school ...we're going to have three or four months that are just stagnant except for what I do with him. I said is there anything I can do and my father-in-law was kind of willing to possibly pay for a speech therapist, a private one...but I wasn't encouraged by the speech-language pathologists. I'm kind of wondering maybe I should have gone that route. I really don't know at this point.

These comments are based on a very small sample and no definitive statement can be made about the appropriateness of one program over another but the comments presented raise issues that need to be addressed. What is the speech-language pathologist's role in empowering her parents regardless of the program type? With shrinking budgets, it would appear prudent to get clients to rely more on themselves as there are less resources available to meet the demand. This does not mean that clients should be left to fend for themselves but that a mechanism be put in place to foster personal growth, control and an improved quality of life.

Table 5 summarizes the relationship between program focus, loci of control, satisfaction and present need. In this study it appeared that the parent programs supported the mothers in developing enough skills that they could impact positively in their children's lives and that if they needed more help they would continue to see parent programs as viable. The inverse appeared to be true for the programs which involved the speech-language pathologist. Mothers were not as likely to feel in control, feel satisfied with what was accomplished and would request modifications in subsequent programs.

Table 5. Relationship between program focus,loci of control,satisfaction and present need.

PROGRAM FOCUS	LOCI OF CONTROL	OVERALL SATISFACTION	REQUEST FOR SUPPORT
Parent	internal (mother sees herself as agent for change)	good to excellent	similar program as before
Parent and child	external (mother sees S-LP as agent for change)	fair to good	more sessions and more S-LP involvement
Child	external (mother sees S-LP as agent for change)	poor to fair	more sessions and more S-LP involvement

Quality of life

Mothers commented on the impact of their programs on their self worth, social interactions, feelings, and their skills as a language facilitator and the communication skills of their children. These areas correspond to Bowling's (1990) quality of life components: self worth/esteem, degree and quality of social and community interactions, psychological well being and functional ability. For the mothers who participated in a program which was either parent-focused or parent-child focused (that is with the exclusion of Flora) it appeared that their programs impacted more on their own quality of life than they did on the children's language skills. The mothers experienced better social interactions with their child and within their families. Their psychological well being was improved by reducing their frustration and confusion and their self esteem was enhanced by learning what to do, that they were not alone and that they were released from guilt. This is not to say that the mothers were completely free of concern but that it had lessened.

The magnitude of life improvement had to do with how well her child did in relation to her expectations. The closer the match between expectation and actual outcome the greater the impact on quality of life. If the child's communication skills did not improve enough so that frustration related to communication difficulties declined, or that it did not match what she expected it should have, the mothers' psychological well being was still in jeopardy. Further in most parents' eyes their child is considered an extension of themselves. If the child has difficulties communicating it is a reflection on her personal self. As Shank (1987) wrote when describing what a mother of a handicapped child had to say about having a handicapped child: "Parents of handicapped children have a sense of failure as a result of producing a handicapped child "(p.18). If the child improves dramatically or expectations are met then the mothers' quality of life is enhanced remarkably. In this study this occurred for Tara.

In summary all of the mothers described some improvements in their quality of life. The magnitude of improvement in quality of life was directly influenced by the perceived change in the child's functional communication skills or the expectations she held. The mothers were not overly preoccupied with test scores. While those mothers who commented on their sons' test performances were pleased with gains, they were more impressed with functional skills and judged the impact of their program on this and what they personally gained from the program.

Expectations, empowerment and quality of life: the relationship

To be able to empower and improve an individual's quality of life, it is critical from the outset to determine the person's real expectations. Without knowing what the person truly wants it is impossible to complete the task. This position is supported by the work of Connelly and her colleagues (1993) who addressed this issue with chronically mentally ill individuals. Through a qualitative study they discovered that their clients perceived that there were four processes associated with empowerment: participating, choosing, supporting and negotiating. They stated, "From the clients' perspective empowerment meant that they participated more in the community, their choices increased, they provided support for each other and they negotiated on a more equal basis with staff". (p.297). They believed that addressing the clients' perspective was critical. "We cannot hope to be advocates for clients unless we know what they want and how they view empowerment." (p.302).

I believe that it is necessary to check and discuss expectations throughout the assessment and intervention process. Being able to tell another person what it is that you really want requires that you have developed a rapport and a trust that permits you to say whatever it is that you feel is important and not what you think is expected. Once this is established it is then possible to move into the empowerment process which will act as a catalyst to improve the individual's quality of life. Yet the relationship between empowerment and quality of life does not appear to be linear. It is more cyclic in nature and the two work to influence each other. As one is empowered her quality of life is improved. That is, as a person finds that she can and does make a difference, she becomes motivated from within and develops a greater sense that she is in control. Frustration and anxiety decrease and self esteem improves. As one's quality of life is improved she feels empowered to carry on and the cycle becomes self perpetuating. In order to be able to provide services that are sensitive to the client's needs it is essential to address the issues of expectations, empowerment and quality of life. If a speech-language pathologist does not deal with the client's expectations in a fashion that has been described here, it will be very difficult to empower her to develop a personal sense of control over the problem which will affect her quality of life and vice versa. How the speech-language pathologist may address these matters is presented in the next section.

Implications

Implications arising from this study are presented in this section and are related to current research. There are several important issues that bear discussion and relate to the client's perspective, the empowering process and quality of life.

Client's perspective

First and foremost attention must focus on the client's perspective. In this study it was the mothers. How they perceived their children, their sons' communication problems and their treatment programs were paramount in how we should define efficacious treatment. This brief section is divided between the child and the mother. I wish to draw attention to the two because I feel that there are issues that have implications for how services are provided.

About the child: As I have stated earlier I believe that we need to consider the full child and not just his communication skills when devising plans. We must observe how the child interacts with his mother. Temperament cannot be ignored. Goldberg and Marcovitch (1989) state that considering a child's temperament is useful in both assessment and formulation of treatment plans. To understand what the mother faces parenting her difficult child is a humbling experience for the professional. I believe that these children presented a certain profile which puts them at risk for continued difficulties. This opinion is bolstered by the work of Paul (1991) and Goldberg and Marcovitch (1989).

Paul (1991) compared young children with expressive language delays to normal children of comparable age and was able to develop a profile for these children in a number of areas. Two areas which are applicable to this study is what she discovered about the expressive language impaired youngster's behaviour and history of ear infections. The comments that the mothers from this study made regarding their child's temperament and hearing health were consistent with Paul's research. Both Paul's impaired children and the boys in this study were perceived as overly active and more difficult to manage by their parents. Goldberg and Marcovitch (1989) state that since difficult temperament has been associated with later behaviour problems, identification of developmental delayed children with difficult temperament may be an important part of preventative service programs. The speech-language pathologist needs to consider the impact of the child's temperament on the mother's ability to follow through on recommendations.

In terms of history of ear infections Paul (1991) found that her youngsters with slow expressive language development did not vary significantly from their age mates in the number of ear infections that they had. She concluded that ear infections were not the primary determining factor in the initial delay or persistence of the delay in her population. In this study all the mothers reported on the lack of ear infections in their sons and comments were made as to the excellent health that these children enjoyed. Tina commented how surprised her doctor was when he asked if her son had a lot of ear infections and she said he had none. In this study I too conclude that history of ear infections did not play a significant role in these children's language difficulties. So speech-language pathologists should not be quick to assume causality but to consider various possibilities.

In closing the speech-language pathologist needs to consider the child's wholeness and must be open to new possibilities regarding how best to meet the mother's needs when devising parent programs.

About the mother: It is essential that the speech-language pathologist puts herself in the place of the mother. Turnball and Turnball (1986) refer to this as "empathetic reciprocity". Adhering to this principle as defined by these authors requires that one must put herself in the place of others as fully as possible, seeing the world from the others' perspective, using their values and needs. They claim that this process is not easy because it requires us to "put our own perspectives, values and needs on the shelf" (p.106). Assessment procedures and treatment outcome measures defined and driven by the speech-language pathologist have little meaning to the client. In this study the mothers spoke about the testing situation as "playing" and test results in general terms "behind others" or "a six month delay". Also for some of the mothers like Francis and Flora, they believed there was a mismatch between what they observed in the clinic and what they saw their children do in the home. If the speech-language pathologist sees the treatment process as a means to empower parents, she must acknowledge the prior experiences of the client, see them as experts about their child and consider these observations in program planning. Discounting the mothers' reports either consciously or unconsciously puts the parent- speech-language pathologist relationship at risk even before the program commences. Telling the mother that she is wrong no matter how diplomatically still expresses to her that she is unknowledgable about her child. The speech-language pathologist may "win" the argument or prove her point but it does little to convince the mother. As quoted from Ranjan's 1992 article on "Silent Learning: Experience as a Way of Knowledge", Roger Bacon (1928) states "Arguments brings conclusions and compels one to concede but does not bring certainty nor remove doubts unless this is provided by experience" (p. 77). Thus if the mother does not see what the speech-language pathologist sees, the speech-language pathologist must consider ways to include the mother in the assessment process rather than exclude.

The empowering process

According to Evans (1992) empowerment means "different things to different people and certainly means different things in different decades" (p. 85).

There are two camps regarding this movement, those who revere it and advocate its use in every learning situation and those who feel that exercising it undercuts "best interest" for the client. My position is more moderate. I believe that the parents we engage should be empowered so that they may take as much control of the situation as they desire in order to improve their quality of life. I believe that the professional has the responsibility to assist parents in developing the knowledge, understanding, skills and attitudes to meet the communication needs of their children presently and in the future. I also firmly believe that there are people who prefer not to take part in this process and who for their own reasons would prefer in the case of communication disorders to "drop their child at the door" as Tina put it. This is more a reflection on personal preferences than quality of personal character. The speech-language pathologist must not assume which model is preferred but should discuss the merits of each position with the parent and leave the ultimate decision with the individual.

Step one: Preparation-- the planning process

Given that a parent expresses interest in a parent program that advocates empowerment what are the principles which guide it? The first step requires that the speech-language pathologist consider each individual as unique with particular views, skills and intentions. I believe this must be considered over time rather than in just one sitting.

As Bound and Walker (1992) state:

> When we are dealing with groups of learners who have widely different social, cultural and political assumptions it becomes ludicrous to imagine that facilitators can be fully effective without taking these issues into consideration when planning and structuring activities (p.166).

These same authors also speak to "intent" that which the learner brings to the situation.

> Learners bring "intent" which may or may not be articulated and which influences their approach to the event. That is, they make assumptions about the possibilities inherent in the event often with very little knowledge of what specifically they might be expected to do. This intent can be such that it entirely cuts across the purpose of those who have planned the event. The result of such mismatches of intent and purpose can be behaviour which is perceived by either party as negative, disruptive or counter productive. (Bound & Walker, 1992, p. 166)

In this study intent is tied to expectations. These authors first line is very appropriate for this study: "intent may or may not be articulated". As discussed earlier I believe that was the case for some of the mothers. Defining exactly what you want is hard work. It is possible to make global expectations but more difficult to be specific. If the parent wants their child "to talk" what does that really mean? --to who, where, about what? Perhaps it might mean just reducing her frustration in certain situations like being able to say "I'm hurt here" (For Francis this might have been very meaningful since she indicated that she can't determine when her son's hurt because of his activity level and lack of clear speech) or saying "mommy" (For Tina this would be very meaningful since this was a word which she said her son didn't say any more). It takes time to build rapport and trust so expectations may change over time as the parent becomes more comfortable with the speech-language pathologist and/or realizes on her own that maybe she needs to change them (as Sissy did). Therefore the speech-language pathologist needs to make ongoing expectation checks that are in order to get parents to be as precise as possible. Once it has been established what the learner brings to the event and what she wants from her encounters and the constraints and opportunities to meet these expectations have been discussed, the second step can commence. The second step focuses on learning strategies.

Step two: The experience-- the learning process

Giralometto, Tannock and Siegel (1993) discovered that mothers in their study of the interactive approach varied in their use of the language facilitating techniques that they used with their children. Their mothers believed that child focused strategies were the most useful. The researchers were surprised that the mothers didn't rate language modelling techniques as useful as they would have. Further the researchers didn't elaborate on this mismatch except to say that perhaps the restricted developmental levels of the children hampered their ability to examine technique appropriateness. They concluded that, "This important issue remains to be answered by future research". (p. 48)

In this study I found as well that mothers used language modelling strategies less than child oriented or interaction promoting techniques. For some of the mothers they found none of the techniques useful. However I was not surprised that they would respond differentially to the techniques because with adult learning principles one realizes that people learn and experience differently. People individualize what they learn. As Evans (1992) states, "We all have a happy knack of learning what we choose to learn whoever is trying to fill our allegedly empty minds- see how students manage to subvert the intentions of their tutors with consummate ease and pursue genuine personal learning" (p. 85). I disagree with Girolametto and his colleagues' (1993) inference that the children's restricted skills precluding examining technique appropriateness. I believe that the mothers' attitudes towards the techniques is what should be examined in far greater detail.

Further I discovered for those mothers who used the language modelling techniques they elaborated on them less than when they explained the other techniques; it appeared that they didn't know how to implement them fully, or that they adapted them in ways other than the speech-language pathologist intended. Perhaps the mothers' personal experiences were more compatible with the child focused and interaction promoting techniques which appear to be more natural and less so than with the modelling techniques which appear to be more clinically driven. This would explain why these techniques were largely missing from the mothers' accounts or were not applied as intended. As Baker (1976) pointedly commented: "Parents more often than not, assume the role of 'uninformed spectators' receiving just enough information about the methods being employed to be accepting of them" (p.694). Richards (1992) states: "The learner must have ownership of her learning" (p.156). Perhaps when language modelling techniques are taught they should be taught in greater detail with more opportunity for the parents to experience them so if adaptations take place or the mother is uncertain, the speech-language pathologist is aware and can act accordingly. For example many of the mothers indicated that they used peers as language tutors. The older siblings would act to get their younger brothers to name off words that were presented for imitation. Olga: "I used my daughter as a tool. I get her to get him to say words like, she'll say 'milk' and a whole bunch of words and she can get him to rattle them off." Tina also stated how she stimulated her son through labelling activities, "I would use it [technique]. I'd hold up [his diaper] and say 'what's this?'" McDade and

Varnedoe (1987) comment that this type of interrogation while well intended is misdirected. The parents believe that to develop the child's language more means that he should talk more and one way to do this is through the interrogation method: "Johnny, what's that?" "Say 'apple'". "No, say 'ap-ple'". "What about these? Say 'ba-na-na' (McDade and Varnedoe,1987). While this may improve vocabulary skills it violates the premises of child oriented and interaction promoting techniques and puts pressure on the child to perform an already difficult task.

One other issue with the language modelling techniques is that I feel there was some confusion over how to use them. Tina stated that she forgot what to do and I believe that this was probably more the case for the other mothers as well. In Tina's situation she was unsure how and when to expand her son's comments. Tina: "See, I can't remember, 'cause I'll still say it like [I did before]. I won't add more. I gotta start adding more." I believe that it is interesting to note that the only mother who appropriately described how to use language modelling techniques (that is, as they were intended) was also the only mother who reported significant language gains in her son--and this was Tara, who also was the most satisfied mother and who reported the most improvement in her child. I believe how we train mothers to be language facilitators and what we train them could impact more positively on the child's language skills. This area requires further investigation.

Step three: Reflection:-- the monitoring process

Once the mother has engaged in the learning process it is critical that she return to the experience, attend to her feelings and re-evaluate the experience. The role of the facilitator at this stage is to help the learner to explicitly consider two elements: 'noticing' and 'intervening' (Bound and Walker, 1992). 'Noticing' requires that the learner become more aware of what's happening in and around themselves and 'intervening' means to take action which influences the situation or themselves. For the most part the mothers in this study commented that they improved their observational skills in the area of the child oriented and interaction promoting techniques. However little was said about the language modelling techniques. Since this appeared to be a weak link in the mothers' programs perhaps more attention could be focused here. Knights (1992) stresses the importance of reflection. She states that daily pressures impinge on reflecting as deeply as we should. She urges facilitators to plan reflection implicitly into their programs and to emphasize silent and personal thought. Reflection through discussion and review of videotapes is appropriate as well but the focus should be on the personal. She finds that the use of personal journals is helpful in this manner.

In the case of parent programs perhaps the last 5 minutes could be dedicated to this endeavour. The speech-language pathologist would also engage in the activity. At the beginning of the next session the parents and speech-language pathologist could share some of the journal with the group. As well the speech-language pathologist could use the information which the parents shared to shape further activities. In a way this would provide her with ongoing feedback to the appropriateness of the activities and the particular needs of the parents. As Knights states: "Ignoring this first hand experience and rely only on other peoples' theories would be foolish" (p.173). The following questions could be used to facilitate reflection: What have I heard/seen/read? How do I feel about it? What does it mean? Knights (1992) states that in this way the presentation of facts plus individual reflection emphasizes the importance of not just knowing what to do but exploring the impact on one's own life.

In conclusion empowerment involves a genuine opportunity for advancement and growth of knowledge, respect for individual differences and a sharing of power (Powell, 1992). It is more than just telling an individual that "She can do it". It requires extensive preparation and planning. In it the individual is valued rather than devalued for what she brings to the learning situation, has control over the learning process rather than just being its subject and takes personal responsibility for further learning (Hull, 1992).

Improving quality of life

Not only is it important that we empower the individuals we work with but it is crucial that we address quality of life issues. In this way we can ensure that we have dealt with the client's perspective in as complete a form as possible. In this study there was a wide variance of improvement in quality of life (QOL). Some mothers' QOL improved more remarkably than others. The reason why some mothers' QOL was not significantly impacted was due to continued fear or concern about future or issues about the past remained unresolved. Further while frustration was noticeably reduced for many of the mothers it still persisted at a less intense level for many. The reason for this is that some mothers came to the realization that not all program expectations were met-- their child was not talking as peers were. Given that functional skills are addressed in the section on "empowering" this section is concerned with managing fears and concerns.

I believe that education can have a significant impact on fear reduction. The worry of not knowing consumes a great deal of energy and influences how one views the world. Education supports the individual. Most of the mothers expressed concern that they had identified very early on that there was something wrong with their child but for one reason or another did not seek or obtain services immediately. Arguments for not seeking or obtaining prompt attention could be attributed to a number of reasons but the two most common ones I believe were either attitudes of complacency from family/physicians, or a personal lack of knowledge/misinformation. Often mothers were told in one way or another not to worry. Expressions like "Wait and see", "He's too young to test", "He's too young to know what the future may bring" or "He'll grow out of it." were prevalent in the data. Yet I believe that telling a mother not to worry invalidates what she is feeling and does nothing to calm her fear or help her deal with the situation. In fact none of the mothers who were given this advice felt reassured or did what they were told. Mothers took what action they could and continued to worry about what they still did not know. A better approach is to acknowledge the mothers' fear and present information as it exists in current research. Giving her details may in fact reduce her anxiety and help to improve her quality of life. This means as speech-language pathologists we must keep abreast of the literature. We must read and study research so that we can feel comfortable with our clients' questions and that we can deal effectively with other professionals' issues. This is not to say that we can condemn others for their views but that we should be able to provide alternate perspectives so that more informed choices can be made, in order to alleviate worry related to not knowing or to mobilize mothers to action. I believe that as speech-language pathologists we are obligated to share our special knowledge with medical colleagues. In some fashion we must share current research findings with them.

Flora is a prime example of how being unaware of current literature did little to improve her psychological well-being in order to help improve her quality of life. Her quality of life may have been significantly impacted if her concerns for the future could have been addressed more definitively. She was extremely worried about whether her child would have problems in school and she was told it was hard to tell. According to Lockwood (1994) those children who come from a family with a history of speech problems or learning disabilities are at risk for communication difficulties. Further Tallal (1988) submits that many children who are diagnosed as language impaired in the preschool years frequently are re-diagnosed later as "learning disabled" when they reach school age. For Flora then, she has reason to be doubly concerned yet nobody was willing or perhaps knew of the research to share with her. True we can't be expected to know everything but when a concern like Flora's is expressed I believe it behooves us to review the literature in order to provide more than a safe answer. With today's demand to see more clients and do more treatment the speech-language pathologist may find that she does not have time for such pursuits and that which she learned in her training would be all that she could reflect upon. I believe this to be a dangerous practise as it jeopardizes the psychological well-being of the client. We must do all we can to protect it.

The following table displays the contradiction between advice provided to the mothers in this study by well meaning family and physicians and what researchers could tell them. On the left side of the table are paraphrases that were culled from the data which reflect beliefs commonly held by either the mother, her family, physician or other professional she came in contact with. On the right is what some researchers have discovered and believe to be true. This is not intended to be a definitive review of the literature on the topic of early identification of language disorders and intervention but is meant to illustrate the mismatch between the views commonly expressed by the public and those expressed by researchers.

Table 6. Comparison of the public's and researchers' opinions.

FAMILIES' AND PRACTITIONERS' OPINION	RESEARCHER'S OPINION
It is very difficult to determine a language disorder at an early age.	"Children who fail to produce 50 words and two-word combinations at 24 months can be considered delayed in expressive language development" (Paul, 1991, p.2).
One should wait and see about a child's language problem instead of getting help right away because they get better on their own.	Spontaneous improvement does occur for some children (Whitehurst et al., 1991) but "there are other 2 year olds for whom early expressive delays presage long term difficulty in language and school achievement" (Paul, 1991, p.1).
It is very difficult to predict if a child with a language problem at an early age will have trouble when he gets to school.	"Children who have difficulty acquiring speech and language are at high risk for learning problems when they reach school age" (Lockwood, 1994, p.43).

As can be seen from the table most of the comments made by family and professionals vary greatly from the current research. Although Whitehurst's comment is presented in the table it is heatedly debated in the speech-language pathology community and would not be seen as a view widely held. It is open to discussion and presented here to illustrate that mothers need to hear several opinions, not just those the speech-language pathologist feels is important to share.

One final obligation that I believe the speech-language pathologist has is to her medical colleagues. In some fashion she must share current research findings with them. Programs may be cutting back public and professional education services because of budgetary constraints but as Tina put it:

> Tina:
> Well I think the program's real important and maybe they [the speech-language pathologists] should have it more known. Like our health unit has one poster on speech and language and it wasn't put up until the middle of this year....and maybe the nurses should ask some questions about speech development at the 18 month needle when they get their last shot. ...They should look maybe look for that more, ask more questions.

In this discussion I have presented the inter-relatedness of the mothers' themes. Specifically I have argued how expectations impact on the perceived benefit of a program and how empowerment and attending to quality of life issues can impact on expectations. In the implications section I have contended that as speech-language pathologists we should consider the client's perspective when providing services and strive to empower those we serve so that we can impact their quality of life. I have illustrations through the mothers' personal accounts of how this may be accomplished. In the last part of this chapter I acknowledge the limitations of this study, and suggest areas for further study.

Limitations

The limitations of this study are acknowledged on two levels, those that were known prior to conducting the study that relate more to philosophy and those that became evident as the study unfolded.

Limitations known "in advance"

In qualitative methods sampling approaches vary greatly from quantitative methods (Patton, 1990). According to Patton, quantitative methods depend on a larger sample randomly selected while qualitative methods focus in depth on relatively small samples selected purposefully. According to Patton, 1990:

> Patton:
> The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling (p.169)

In this study *maximum variation sampling* was selected (Patton, 1990). The purpose of this strategy is to look for information that elucidates programmatic variation and significant common patterns within the variation but does not attempt to generalize findings to all people or all groups (Patton, 1990). There is no attempt to generalize the findings of this study beyond the setting in which it occurred. Issues for consideration are specific to the set of activities (how parent programs are conducted) for a specific group of people (mothers). Although it may be possible to see how the concepts of empowerment and quality of life might be pertinent to the spouses of those with traumatic brain injury for example, the nature of their experiences and perceptions will be different and therefore would need to be examined on their own merit.

Limitations known "after the fact"

It became clear as the interviews were conducted that although the mothers were as truthful as they could be about what they received in their programs and how they felt about it (in essence their perceptions) there was only their word to go on. There was no real in depth verification through other sources. Although the participating speech-language pathologists were contacted for follow up information regarding the programs they provided they were not canvassed nearly as deeply as the mothers. Other methods of inquiry such as on-site observation, in depth interview with program staff and document review would have been useful. It is important to note that in no way does this invalidate the mothers' perceptions or the "truthfulness" of this study. According to Patton (1990) it is better rather than to try to convince others that ones' findings are true that one do the best job in describing the patterns that appear to her to be present in the data and that she present these patterns as her perspective on the issue at hand based on her analysis and interpretation of the data that she had collected. Thus others would understand that what she had presented was no more than a perspective on the outcomes and readers would judge this perspective by their own understandings of the program and how it would fit into their own personal world view.

Recommendations

This study has raised a number of issues related to clients' perceptions of the treatment process and what they perceive to see as its benefits. To serve our clients better by providing them with programs that are more tailored to their needs we must move towards their perspective.

The quantitative research path which we have been travelling upon I believe is too narrow. We have no room to negotiate. We can't see the next bend in the road so to speak. We are constrained by our methodology. The richness of communication and human interaction is lost when treatment outcomes are seen as separate independent variables that can be quantified and their relationships to dependent variables best portrayed statistically (Patton & Westby, 1992). It is time to consider widening the path with qualitative bricks. Qualitative approaches acknowledge holistic settings and impacts. There is greater attention to nuance, inter-dependencies, complexities and idiosyncrasies (Patton & Westby, 1992). One should not replace one methodology with another but each should be used when it is appropriate. Westby and Erickson (1992) state:

> Quantitative methodologies focus on hypothesis testing while qualitative methodologies focus on hypothesis building. Quantitative approaches are appropriate when the questions that should be asked are known. In contrast with unfamiliar areas researchers and professionals do not have the necessary knowledge to ask the right question. In these situations qualitative methodologies provide a mechanism for gathering information that will enable the researcher to ask the right question, collect meaningful data, build relevant hypothesis for future quantitative analysis. (vi)

For example, in their study of the interactive approach with mothers and their developmentally delayed children Giralometto, Tannock and Siegel (1993) asked a number of research questions. The ones that are more pertinent to this discussion were "Do parents report use of the interactive techniques when they are not being observed (videotaped)?" "Do all parents rate program format favourably and adopt all interactive techniques, irrespective of their child's level at entry?" Although it appeared that the intent was to obtain qualitative responses in fact quantitative replies were culled from the data. The use of "do" precludes one to either a yes or no response which will then quantified in some manner. Girolametto and his colleagues (1993) were limi[illegible]d to what they could say about their findings: "Yes" mothers reported that they used the techniques and "No" not all parents adopted all techniques. In this study questions were more related to: "What do mothers have to say about the language facilitating techniques that they were exposed to?" ar [illegible] y used them, "How did they explain them?" In this way I was able t [illegible] scription from the mothers about their perceptions of the quali [illegible] ther than the quantity. In this situation then the use of in d [illegible] a mechanism for gathering information regarding technique [illegible] hich at a later date would enable me to ask more quantitat [illegible] additional training on techniques do mothers use language [illegible] ore often"? Future research needs to consider focusing more in th [illegible] we are to better understand the needs of those we serve.

Conclusions

In conclusion, based on the mothers' perceptions, there are ramifications for how parent language training programs should be conducted and evaluated. The views expressed below are a result of my in depth analysis of the data and my personal beliefs.

According to Patton (1990) it is better rather than to try to convince others that ones' findings are true that a researcher describes to the best of her ability the patterns that appear to her to be present in the data and that she present these patterns as her perspective. Her perspective then is then based on her analysis and interpretation of the data that she had collected. Thus others will understand that what she has presented is no more than a perspective on the outcomes. Readers will then judge this perspective by their own understandings of the programs and how this fits into their own personal world view. My perspective follows.

Enhancing Parent Programs

Expectations

Given that the mothers' expectations were pivotal in determining the successful outcome of a program and that often these expectations are not fully realized by the mothers, speech-language pathologists should consider focusing on this area throughout the treatment process. Parental expectations should be explored in depth in order to determine what it is that they see as a need and what they expect from their involvement. Speech-language pathologists should expect that these expectations may vary and may shift over time. It is not possible to deal effectively with expectations if they are addressed only during the first session of a parent program. Clinicians must be prepared to take time to address this issue and ask parents not only what it is that they desire for their children but for themselves as well.

Language training components

Speech-language pathologists should reconsider how they teach *language modelling* strategies to parents. Given that there was a discrepancy in how the mothers in this study viewed language facilitating techniques, greater focus is needed in this area. The speech-language pathologist should consider that for the most part language modelling strategies are not as easily acquired as *child oriented* and *interaction promoting* techniques. The strategies may make perfect sense to a speech-language pathologist who is trained in this area but may have little relevance from the parents' perspective. The speech-language pathologist must be cognizant of the parents' perspective. Further the speech-language pathologist needs to understand that each person will personalize her own learning so parent goals need to be individualized. I believe that of all the language training components it is language modelling that facilitates language development the most. I base this belief on my personal observations. The only mother who spoke as a "speech-language pathologist" regarding the strategies that she used with her child had the only child that made significant gains as viewed by the mother and speech-language pathologist. Although more research is needed in this area to test this observation I believe that parents should be given more support to be able to use language modelling strategies more effectively. Further at the end of the program I believe that the speech-language pathologist schedule monthly maintenance meetings with her parents in order to address issues that may arise in the future once the program is complete.

Professional development

From studying the mothers' transcripts at length I believe that there are three areas that speech-language pathologists should consider for on-going professional development in order to provide quality service. These include counselling, adult learning theories and advances in the speech-language pathology profession itself. Many of the mothers had unresolved issues regarding their child and their feelings that perhaps required more extensive counselling. Some of these concerns could be best addressed by sharing recent research findings with the mothers. Because the demand today pressures clinicians to see more clients for treatment, often there isn't sufficient time or resources available to engage in professional development. Yet it is here that I believe the mothers' quality of life may have been more significantly impacted. As well awareness of adult learning theories may impact more powerfully on the outcomes of parent programs. Since the primary client in this type of program is the parent, strategies must be employed that enable the individual to "own" her learning to enhance empowerment. I believe this will enhance the power of the programs we provide. Table seven summarizes these issues.

Table 7. Researcher's perspective on "best practises" for parent focused language training programs.

FORMAT	COMPONENTS	EMPHASIS	PHILOSOPHY
INITIAL PROGRAM: 10 weekly sessions for 2.0 hours each. Alternate time between lecture and videotaping (in the clinic and the home.) **FOLLOWUP PROGRAM:** 3 monthly meetings 1.5 hours each to address parent issues that arise.	Include the following: parent group, videotaping, role-playing and S-LP lecture and demonstration.	1. Ongoing investigation of parental expectations. 2. Maximum use of counselling techniques. 3. Maximum use of adult learning strategies. 4. Focus on parental empowerment through three stages: preparation, the learning process and reflection/monitoring. 5. Ongoing dissemination of current and pertinent advances in the field based on the parents' need. 6. Re-structuring language promoting techniques to increase the emphasis on parent need, the wholeness of the child and the use of language modelling techniques.	1. To improve parents' quality of life by: a. reducing frustration and worry, b. enhancing self-esteem, c. improving family social interactions, d. increasing parent skills to facilitate language growth in the child presently and in the future. 2. To improve the child's quality of life by: a. reducing frustration, b. improving social interactions, c. providing parents with the means to expose the child to new varied play learning opportunities to stimulate language skills, and d. improving functional communication skills determined by the S-LP and the parent.

Evaluating Parent Programs

Not only is it important that speech-language pathologists reconsider how they conduct parent language training programs but as well they need to reassess how such programs are evaluated. Earlier in the thesis I discussed the work of Giralometto, Tannock and Seigel (1993) and how they evaluated their parent language training programs through the use of questionnaires. They based much of their evaluation tool on Baker (1988). The approach that I recommend to evaluate parent programs varies somewhat from Giralometto, Tannock and Seigel's (1993) interpretation. The following table is my adaptation from Baker (1988).

Table 8. Program evaluation criteria for parent focused language training programs

CRITERIA FOR EVALUATING PARENT FOCUSED LANGUAGE TRAINING PROGRAMS		
ISSUE	**QUESTION**	**METHOD**
SOCIAL VALIDITY	How do parents view the program's philosophy, goals, procedures and effects prior to and following services?	Schedule intake interviews with parents prior to the program to determine their perspective. Interview again at the end of the program.
CONSUMER SATISFACTION	What do parents have to say about the program?	Interview parents at the end of the program to determine their level of satisfaction.
PARENT PROFICIENCY	What do parents learn from the program?	Interview parents to determine what they believed they learned from the program and analyze videotapes pre during and post therapy to measure levels of parent responsiveness, use of techniques and improvements in knowledge growth.
CHILD GAINS	What do children gain from the program?	Evaluate the wholeness of the child: play skills, functional communication skills, and temperament through various commercially available tests pre and post program.
FAMILY QUALITY OF LIFE	What is the impact of the program on the family's social interactions and activities, attitudes and feelings such as frustration, guilt and worry?	Discuss with parents what they believe the impact of the program has been on their lives. Investigate family leisure issues. As well administer commercially available questionnaires of parenting stress indexes pre and post treatment.
EMPOWERMENT	Do parents feel the program has met their needs in ways that promote their sense of control over their particular situation and that they can maintain what they learned?	Discuss with parents how they feel about their ability to function as their child's primary language facilitator. Develop a program specific checklist to determine how well parents reflect on the learning process.

It can be seen from the table the primary method of evaluation is through the use of interviews and that the areas to be investigated are broader and attempt to be less fragmented. Although this model is proposed for the evaluation of parent focused language training programs, it could be used for any program that involves the parent as the primary facilitator.

Evaluation method

It is important to note that several programs make use of questionnaires to evaluate that which they do but I believe that a great deal of information is lost this way. Program evaluation from the client's perspective is relatively new. Evaluators must take the time to analyze that which the client feels is important before developing questionnaires. Questionnaires that have not been developed through in depth interviews with the party who the researcher is interested in learning from are in fact just a variation on quantitative measures perceived by the professional. Our view of program evaluation may be skewed if we do not interview in depth at first to determine important issues. Once we believe that we have addressed these issues, the results then may be pooled to develop tools that can quantify our findings. As discussed earlier this perspective is supported by Westby and Erickson (1992).

Evaluation content

As discussed above this model attempts to be less fragmented and sees the client more holistically and from the client's perspective. It is equally important to evaluate a program for its social validity as for improvements in test scores. Further research is needed in this area.

It would not be fitting to close without answering the question that my father asked me so long ago. In response to his question I have to answer from the findings of this study that "Yes we do help others to get better" but the response is conditional. It all depends on who is defining "better", and how they define "better". If "better" is defined by the mother that the child would be "cured" or "fixed" as was in the minds of some of the mothers in this study then the answer would be "no". If however "better" means the mother now experiences improved social interactions as well as enhanced psychological well-being and self-esteem (that is an improved quality of life) and she says that the program was of benefit I would say "yes". Degrees of being "better" were found to be dependent upon the mothers' expectations for herself and her child.

Accountability in our profession should be measured by how well we enhance our client's perception of quality of life and the proficiency we demonstrate in empowering them. Our impact on our clients' lives should be dramatic and when all is said and done our clients should feel strong enough to carry on without us.

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Appendix A -- Director's request

Dear Jane:

Re: Formal requests for a University of Alberta Thesis Project.

Thank you for considering my thesis proposal. As promised, I am following up our conversation of March the 20th with a formal letter outlining the purpose and requirements of my study.

As we are all aware, the issues of relevance, practicality and utility are becoming increasingly important in the evaluation of our programs. There is a renewed sense of fiscal responsibility and a greater demand to objectively document the impacts of the services we provide. Failure to do so can have injurious effects on funding. In this study I propose to investigate what mothers feel are the effects of language therapy on their preschool children.

Purpose:

The purpose of this study is to investigate at the provincial level mothers' perceptions of a parent language treatment program. The ultimate goal is to define efficacy through mothers' Quality of Life (QOL) issues. Quality of life is a multidimensional concept that encompasses social, cognitive, affective and physical domains.

Study Requirements:

My study will require the cooperation of health unit directors as well as speech-language pathologists to identify prospective subjects as described below.

Requests of Directors:

1. The Director should discuss this study with applicable individuals (i.e. M.O.H / C.E.O. or research committee) in order to comply with any health unit policy or procedures regarding research completed by outside agencies. If any additional information is required, Directors are requested to contact me in order that I may comply.

2. Directors should then discuss the study with staff to solicit support.

3. Following this Directors should contact me with the names of prospective SLPs and an approximate number of prospective mothers.

4. Lastly, Directors are asked to sign the attached consent form and return it in the self addressed envelope.

Requests of speech-language pathologists:

For this study I require willing speech-language pathologists with at least two years of experience with the preschool population to:

1. Sign a consent form.

2. Review files for suitable candidates (children between the ages of two years five months and three years five months and are identified as language impaired (at least a severity rating of 1).
(Note: I am not asking clinicians to change any client's status on the treatment waiting list).

3. Contact clients on my behalf and read the mothers a prepared script.

4. Give interested mothers an invitation/consent form.

5. Ask the mothers to read, sign and return the invitation/consent form to the speech-language pathologist. (Extra copies will be provided for the mothers to keep).

6.Return the clinician's and mother's consent forms to me in the provided self addressed envelope within one week of completion.

7. Provide scores of the Preschool Language Scale Three (PLS-3) pre and post or the REEL. (Whatever is administered, please ensure it is the same tool pre and post).

8. Complete a severity rating scale for language (as per Alberta Health requirements) pre and post.

9. Provide the parent training language program (as per health unit specifications).

10. Submit the necessary documentation (language severity rating and test scores) in a timely fashion (i.e. data submitted within three weeks of collection).

Thank you so much!

If you need any additional information please call me at 473 - 4910.

Sincerely,

Carla A. Hanak B. Sc.
Master of Science Candidate

Enclosures

Appendix B -- Director's consent form

Director's Consent Form

I have read the description of the thesis proposal " Formal requests for a University of Alberta Thesis Project" to be conducted by Carla Hanak.

I fully endorse this study.

On her behalf, I will seek out members of my speech-language pathology team who would like to participate and give them her letter of invitation.

I will contact her with the results of my inquiry within three weeks of receiving her packet of information by providing clinicians' names and an approximate number of prospective mothers willing to participate.

I understand that she will treat my clients and speech-language pathologists with utmost respect and keep all records confidential.

I will be informed of the results of the study once the thesis has been defended.

______________________________ _______________

[Director's signature] Date

Appendix C -- Clinician's invitation/consent form

TITLE OF STUDY: Quality of life approach to outcome measures in speech-language pathology INVESTIGATORS: Principal Investigator: Carla Hanak-- 473-4910

Co-Investigator: Dr. P. Schneider--Department of Speech Pathology and Audiology, Corbett Hall, University of Alberta.

Information:

I am a speech-language pathologist presently studying at the University of Alberta. I am conducting a research study on treatment outcomes in the area of child language. I want to measure mothers' perceptions about what they feel the effects of speech therapy has on quality of life.

For this study I require willing speech-language pathologists with at least two years of experience with the preschool population to:

1. Sign a consent form.

2. Review files for suitable candidates (children between the ages of two years five months and three years five months and are identified as language impaired (at least a severity rating of 1).
(Note: I am not asking clinicians to change any client's status on the treatment waiting list).

3. Contact clients on my behalf and read the mothers a prepared script.

4. Give interested mothers an invitation/consent form.

5. Ask the mothers to read, sign and return the invitation/consent form to the speech-language pathologist. (Extra copies will be provided for the mothers to keep).

6.Return the clinician's and mother's consent forms to me in the provided self addressed envelope within one week of completion.

7. Provide scores of the Preschool Language Scale Three (PLS-3) pre and post or the REEL. (Whatever is administered, please ensure it is the same tool pre and post).

8. Complete a severity rating scale for language (as per Alberta Health requirements) pre and post.

9. Provide the parent language training program weekly (as per health unit specifications).

10. Submit the necessary documentation (language severity rating and test scores) in a timely fashion (i.e. data submitted within three weeks of collection).

Confidentiality:

Your identity during and after completion of this study will remain confidential. The recorded data will be stored on computer disks, coded and grouped together so that you will remain anonymous. The computer disks will be erased after the study is completed and the results have been published.

Should you have any questions, please call me, Carla Hanak at 473- 4910.

……

Consent: I have read the above description of the research project research project entitled "Quality of life approach to outcome measures in speech-language pathology" to be conducted by Carla Hanak. I agree to participate.
I understand that all information will be kept confidential.
My participation in this study is completely voluntary. I may withdraw from the study at any time.
I have received a copy of this letter.

Speech-language pathologist   Date

Carla Hanak (Investigator)   Date

Appendix D -- Mother's information summary to be read by the slp

This script should be read before treatment commences or during the first sessions of the program.

I have been contacted by a speech-language pathologist from the University of Alberta in Edmonton who is working on her Masters' Degree. For her thesis she is looking at what mothers feel the effects that parent training programs have on their young children.

Could I read a brief description to you about her study and see what you think?

She would like to interview mothers after they finish their parent language training program. The interview will last at least one hour but she will take as much time as you need to answer the questions. She'd like to ask you questions about your child such as what he/she likes/dislikes to do, how he/she interacts with other people and about your child's listening and speaking skills. She'd also like to talk to you about the program you participated in. She'd really like to know what you have to say about these areas.

Your participation is completely voluntary and you can withdraw at any time without jeopardy. She will be audio taping the session but your identity during and after the completion of her study will remain confidential.

If you are interested in participating would you like more information? I have an invitation /consent form for you to read and sign. Please give it back to me after you sign it so that I can mail it to her. She will then call you to arrange your interview.

If after you read the letter you have questions, she asks that you call her.

Thank you for your time.

Appendix E -- Mother's invitation/consent form

TITLE OF STUDY: Quality of life approach to outcome measures in speech-language pathology
INVESTIGATORS: Principal Investigator: Carla Hanak-- 473-4910
Co-Investigator: Dr. P. Schneider--Department of Speech Pathology and Audiology, Corbett Hall, University of Alberta in Edmonton.

Information:

I am a speech-language pathologist presently studying at the University of Alberta in Edmonton. I am conducting a province wide study on how mothers feel a parent language training program affects them and their children. The information that will be gathered during this study will help speech-language pathologists better understand mother and child needs. This information would have the potential to help speech-language pathologists further refine their programs to meet family needs.

I would like to interview mothers after they and their children have completed the program. The interview will take place where it is most convenient for you. The interview will last for at least one hour but we will take as much time as you feel you need to answer the questions.

Requests:

1. In the interview you will be asked about your child. I will ask about his/her play activities, interactions with others, temperament, behaviour and speaking and listening skills. As well you will be asked for your opinions. I will ask about your concerns, expectations, what you thought of the program and your perceptions of the programs' impact.

2. I will be tape recording our conversation so that I don't miss anything you say. However, if necessary I would phone you after the interview to clarify any of your comments that I have questions about.

3. As well I ask that you give me permission to receive the test results that I am asking your child's speech-language pathologist to complete for this study.

Confidentiality:

Your family's identity throughout this study will remain confidential. All recorded information (conversation and test results) will be coded and grouped together so that you both remain anonymous. All data will be erased after the study is completed and the results have been published.

Participation:

Your participation is completely voluntary and you are free to withdraw at any time without jeopardy.

If you are interested in participating please sign the consent at the bottom of this page and return it to your child's speech-language pathologist. She will then send it to me and I will then contact you to arrange our interview. We will meet after you have completed your program.

Should you have any questions whatsoever about this study please call me, Carla Hanak at 473-4910 in Edmonton. If you are calling long distance please call collect.

I look forward to hearing from you!

Consent:

I have read the above description of the research project entitled " Quality of life approach to outcome measures in speech-language pathology " to be led by Carla Hanak. I agree to be interviewed after completing the program.

As well I give my permission to have my child's test results sent to Carla Hanak.

I understand that our privacy will be ensured. No information will be released or printed that will disclose our personal identity.

My participation in this study is completely voluntary. I may withdraw from the study at any time without jeopardy.

I have received a copy of this letter.

Mother's Signature ______________________ Date ______________

Carla Hanak (Investigator) ______________________ Date ______________

Appendix F -- Severity rating scale for language disorders

DEVELOPMENTAL LANGUAGE SEVERITY RATING SCALE

DESCRIPTION	0	MILD (1)	2	MODERATE (3)	4	SEVERE (5)
Degree of functional communicative competence within the client's appropriate modality		Level of competence detracts from normal communicative interaction		Level of competence limits normal communicative interaction		Level of competence severely restricts normal communicative interaction
Extent of language impairment considering both receptive and expressive skills (semantics, syntax and pragmatics)		minimal disruption		several areas of deficit		pervasive throughout all language areas: reading, writing, speaking, listening, pragmatics, semantics, syntax and phonology
Test Score Analysis						
Standard Deviation		Between -1.0 & - 1.5		Between - 1.5 & - 2.0		Greater than - 2.0
Standard Scores		77 - 84		70 - 76		69 and below
Percentile Rank		7 - 15		2 - 6		< 2 Percentile
Mean Length of Utterance						

(Alberta Health, 1993)

Appendix G -- Interview Protocol

INTERVIEW QUESTIONS

Introduction: This interview is being conducted to help me get insight into what you feel about your child's speaking and listening skills, his play activities, relationships, emotions, temperament and behaviour. This gives me a chance to see your child through your eyes and to understand your concerns, expectations, what you thought of the program and its impact.
I hope to better understand what mothers have to say about their children and the impact that therapy has had.

I thank you again for participating in this study and want you to know that what you have to say with provide very useful information about mothers' and their children's needs.

Please remember that your comments will be kept anonymous.

As well if you are unsure as to why I am asking any of the questions please feel free to ask. Also I would like to ask you that if after our interview when I go through your transcript if there is anything that I am unclear of if I may contact you so I am clarify what you said.

I would like to ask you some questions about yourself and your family before we get started so that I have some background information about all the mothers who participated in my study.

I. DEMOGRAPHICS

1. Please tell me: How many people live in your home?
   - How many children and their ages.
   - How many adults and their relationship to the children.

2. How old are you?

3. How many years of schooling have you had?

4. Do you work outside the home? If so what is your occupation?

5. (If mother answers that there is a husband in the household ask) what is his occupation?

Thank you for this information.

I'd like to start our interview now.

II. CHILD CHARACTERISTICS

1. I'd like us to begin by having you tell me about your child. I want to get to know him.

Please tell me what he's like. What is he interested in?
Tell me the most challenging thing about raising him.
(**explore** all areas of development: communication, cognition, motor, social interaction, independence, affect (temperament). **Targeting** Quality of Life Issues as well as the "wholeness" of the individual.)

Temperament probes will study the following:

1. Describe your child's ability to sit still during different activities. (activity level),
2. Describe your child's daily activities. Does he do much the same day after day or are they variable? (rhythmicity)
3. Describe how your child approaches something new such as new toys or people. (withdraw - approach)
4. Describe when if your child is in a bad mood how easily he can be "joked" out of it. (adaptability)
5. Describe your child's general mood. (mood)
6. Describe what your child does when he's doing something and he's interrupted. (distractibility)
7. Describe your child's ability to stick to a task. (attention span and persistence)
8. When you want your child's attention what do you have to do to get a response out of him? (response level)
9. Describe how intense your child reacts to having a toy taken away. (reaction)

III. MOTHERS' PERCEPTIONS

2. Some parents have difficulty in deciding if they should get help while others make the decision fairly easily. What kind of decision process did you go through in thinking about whether to put your child in therapy?
   What particular things concerned you? OR What particular things made it easier?

3. What kind of testing was done?

4. What were your expectations about the therapy program?
   What did you hope to get out of the experience?
   What did you hope your child would get out of the experience?

4. During the therapy sessions you were with other parents and/or children.
   What was it like? What kinds of things did you do? Is there anything that you will continue to use at home? What changes if any would you make?

5. How did the program affect you personally?
   What would you say that you got out of the experience?
   What would you say your child got out of the experience?
   What would you say that others (family/friends got out of the experience)?

6. If you were to tell a friend who had a child with similar difficulties about this program what would you tell him or her?

7. This is my last question. Are there any other feelings or thoughts you'd like to share to help me understand your child, the therapy or any difference it has made for you or in your child's life?

Thanks so much for your time. I've really enjoyed our time together.