Toward a “Thick Description” of Families: Using Ethnography to Overcome the Obstacles to Providing Family-Centered Early Intervention Services

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Family-centered services have been mandated through legislation addressing early intervention services for a decade. During this time, a wealth of articles and books have discussed what constitutes family-centered services and how to implement them. (See for example, Bailey & Simeonsson, 1988; Dunst, Trivette, & Deal, 1988). Despite this, “the family-centered intent of IDEA (Individuals with Disabilities Education Act) has not been fully realized” (Boone, Moore, & Coulter, 1995, p. 400). Although most speech-language pathologists and early interventionists are in agreement with the philosophy of family-centered services (Crais & Wilson, 1996), a discrepancy exists between what is considered ideal practice and what commonly is happening in early intervention programs. In particular, many aspects of assessment procedures, the decision-making process, and Individualized Family Service Plans (IFSPs) continue to be driven by the professional rather than the family (Bailey, Buysee, Edmondson, & Smith, 1992; Boone et al., 1995; Crais & Wilson, 1996; Mahoney, Sullivan, & Dennebaum, 1990; Roush, Harrison, & Palsha, 1991).

When professionals were asked to identify barriers to delivering services that were more family centered, interventionists commonly reported that the families themselves were obstacles to providing such services. Nearly 50% of Crais and Wilson’s (1996) respondents, half of whom were speech-language pathologists, felt that a lack of interest by the parents-impeded service delivery, and 40% indicated that a lack of parental education was a barrier to establishing a closer relationship with parents. Close to 30% believed that language and cultural factors also interfered with the services they provided. Roush et al. (1991) found that for early interventionists, “single-parent families, families in which English is a second language, low-income families, and others with difficult life situations often present formidable challenges to family-centered intervention, even when personnel are available and well trained” (p. 363). In other words, if parents are not as prepared as a two-parent family from the mainstream culture provide professionals with challenges.

The literature has demonstrated that efforts are needed to make services more family centered. To do this, however, two questions must be addressed: (a) What has prevented services from becoming fully family centered? and (b) what specifically can speech-language pathologists do to tailor their services to the individual families they serve?

In response to the first question, I believe the reason professionals fall short of providing family-centered services is not because they lack the desire to do so or are poorly trained. Instead, it is my contention that services are not family centered to the extent intended by the law because there is a mismatch between the theories in which speech-language pathologists were trained and the theories that underlie the provision of family-centered services. Speech-language pathologists have been schooled in the experience-oriented, scientific tradition in which conclusions are reached by an objective observer who tests hypotheses to determine cause and effect relationships (Cortin & Chabon, 1988; Goldberg, 1993; Hegde, 1985; Kamhi, 1984). However, the origins of family-centered practices are found in family systems and ecological theories that developed, to a large extent, in reaction to the experimental tradition. When speech-language pathologists use the assumptions of experimental methods to deliver family-centered services, they fall short of delivering the “ideal” service. As stressed by Johnston (1983), speech-language pathologists cannot deliver intervention services without regard to the theory on which the therapeutic approaches they employ are based.

The answer to the second question is twofold. First, to make services more family centered, speech-language pathologists must become knowledgeable about the theories that underlie a family-centered philosophy to service delivery. Second, a method for serving families that shares a similar set of assumptions with those of the theories behind the family-centered philosophy needs to be employed.
The purpose of this article is to address these needs.

In the first section of the article, the underlying assumptions of the theories on which family-centered philosophy is based are explored and the components of children’s environments as defined by these theories are discussed. In the second section, an approach to serving families from different cultures is presented that is based on ethnographic research methods. This approach provides clinicians with the ability to develop a “thick” description of the families with whom they work. The phrase **thick description** refers to a description that unfolds from observations made of a family in context and is told from the family’s perspective (Geertz, 1983). As it will be demonstrated, because ethnographic methods are built on assumptions that complement those of the theories underlying family-centered services, the use of the sensibilities of ethnographers are highly appropriate when providing services to families.

**The Underlying Theories of Family-Centered Services**

**Family Systems Theories**

The family-centered philosophy of service provision arose out of family-systems theories and ecological theories of child development. Family-systems theories developed in the field of social work and family therapy in reaction to traditional psychological therapies that serve as the foundation for therapeutic methods in speech-language pathology (e.g., Rogerian, behaviorism, and individual psychology) (Becvar & Becvar, 1988). Some major assumptions of these theories are discussed in this section and summarized in Table 1.

As implied by the name **family systems**, the first major assumption held by family systems theorists is that the individual is part of a family system that consists of members that are interdependent. An individual can only be understood in context because of the complex relationships that exist between that individual and the members of his or her system (Minuchin, 1985). Therefore, the family, as opposed to the child, is viewed as the recipient of services, and the larger context in which behaviors occur becomes the focus of therapy (Becvar & Becvar, 1988).

A second assumption of family systems theories is that “patterns (of behaviors) in a system are circular rather than linear” (Minuchin, 1985, p. 290). Direct cause and effect relationships do not exist. Because an individual is part of an “organized whole,” the behaviors of that individual are seen as influencing and being influenced by others within the family system. In therapy, this translates to family systems therapists asking what is happening so they can describe a family’s behaviors rather than investigating why a particular behavior occurs to determine a cause and effect relationship (Becvar & Becvar, 1988).

Third, change and development are inherent in family systems. Families go through life-cycle changes as members enter the system through birth or marriage, as members grow older, and as members exit the system through death or divorce (Carter & McGoldrick, 1989; Minuchin, 1985). This assumption, which has implications for learning about the family system, is discussed later in greater detail.

The final assumption consists of three basic principles: (a) “One cannot not behave,” (b) “One cannot not communicate,” and (c) “The meaning of a given behavior is not the true meaning of the behavior; it is, however, the personal truth for the person who has given it a particular meaning” (Becvar & Becvar, 1988, p. 69). In other words, communicating, behaving, and failing to act or communicate are in themselves forms of communication, and although a person may ascribe meaning to another person’s behavior, that meaning may only be true for the person doing the ascribing. For example, a family that does not come to therapy is sending a message. The therapist may assume that a family is not interested in therapy, whereas the family may believe that therapy is

<table>
<thead>
<tr>
<th>Family Systems Theories</th>
<th>Experimental Method</th>
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<tbody>
<tr>
<td>Focuses on the family</td>
<td>Focuses on the individual</td>
</tr>
<tr>
<td>Causality is circular</td>
<td>Cause and effect relationships are linear</td>
</tr>
<tr>
<td>Asks what is happening</td>
<td>Asks why a behavior occurs</td>
</tr>
<tr>
<td>Families and their members develop and change</td>
<td>Individuals develop and change</td>
</tr>
<tr>
<td>Meaning is interpreted by the individual</td>
<td>Meaning is determined by an objective observer</td>
</tr>
<tr>
<td>Subjectivity is inevitable</td>
<td>Objectivity must be maintained</td>
</tr>
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</table>
not meeting its needs and has chosen to miss its appointments.

This assumption of multiple perspectives has significant implications for therapy. Because different people may have different views of the same situation, subjectivity is recognized as being inevitable. People’s perspectives, as opposed to the therapist’s “objective” assessment of the situation, serve as a starting point for change and the basis for the goals set in therapy.

**Ecological Theory**

Family-centered services also arose from ecological theory. Ecological theory was developed by Bronfenbrenner (1979), who criticized developmental psychologists for studying "development out-of-context" (p. 21). Referring to Piaget and other well-known psychologists of the time, Bronfenbrenner stated:

> These established models typically employ a scientific lens that restricts, darkens, and even blinds the researcher’s vision of environmental obstacles and opportunities and of the remarkable potential of human beings to respond constructively to an ecologically compatible milieu once it is made available. As a result, human capacities and strengths tend to be underestimated. (p. 7)

Similar to family systems theories, Bronfenbrenner’s theory stressed the importance of exploring the context in which behaviors occur, looking beyond the “immediate setting” when attempting to understand development, and ascertaining the perceptions of developmental behaviors rather than determining how they “may exist in ‘objective reality’” (p. 4).

**Components of the Child’s Environment**

Both family systems theorists and ecological theorists envision a child as being a part of a complex, interdependent environment. Because of their slightly different approaches to defining the system, each approach is discussed separately.

**The Dynamic Family System**

Family systems theorists view the family system as consisting of several layers (Carter & McGoldrick, 1989). At the center is the child who is surrounded by the nuclear family, which makes up the first layer. The second layer consists of the extended family, whose involvement with the child may be more or less direct, depending on the family and the role that extended family members play.

Family friends, parents’ colleagues from work, and professionals who serve the family make up the third level. Thus, speech-language pathologists are distal members of the system who must strive to fit into that system. The outermost layer consists of social and cultural factors that influence families’ behaviors and views of the world (Carter & McGoldrick, 1989).

This system, with its many members and levels, progresses through developmental stages or life-cycle transitions. As a family moves from stage to stage, it experiences what Carter and McGoldrick (1989) label as horizontal stressors, both predictable and unpredictable, and vertical stressors. Predictable horizontal stressors occur, for example, when a child is born. The parents must incorporate the child into their relationship and determine how to meet the additional financial and household responsibilities incurred (Carter & McGoldrick, 1989). Unpredictable horizontal stressors are added when the newborn child has special needs. At this time, parents face added issues such as finding an accurate diagnosis and appropriate services as well as informing other children and relatives (Barber, Turnbull, Behr, & Kerns, 1988).

As the family develops over time, vertical stressors also have an impact on the family. These are defined as:

> patterns of relating and functioning that are transmitted down the generations of a family primarily through the mechanisms of emotional triangling. It includes all the family attitudes, taboos, expectations, labels and loaded issues which we grow up. (Carter & McGoldrick, 1989, p. 8)

In other words, families have long-standing patterns of behavior that parents may be expected to follow. Added to the family patterns are cultural patterns of behavior that also influence the family’s behaviors as it moves through stages of the life cycle (Carter & McGoldrick, 1989).

Thus, family systems theorists place a great emphasis on the influence and involvement of the members of the system that have regular, personal contact with the child and the family. Ecological theorists extend the system to include society’s participation to a greater degree.

**The Environment of the Child**

The environment in which children develop, as defined by Bronfenbrenner (1979), consists
of four interrelated systems. The first system encompasses the immediate settings in which children develop. It includes activities and relationships that children experience with individuals with whom they interact regularly, such as parents, siblings, relatives, day-care workers, and speech-language pathologists who are providing direct services.

The second system consists of the relationships among the settings of which children are a part (e.g., their home, day care, hospital, early intervention program). According to Bronfenbrenner, the richness of this second system is determined by the number and the quality of connections between one setting and another in which the children participate. For example, the more links that connect a family and professionals providing early intervention services, the more beneficial the services will be to the child and family (Garbarino, 1990).

The third layer includes settings in which children have no direct involvement, but that can aid or hinder their development (Bronfenbrenner, 1979). The parent’s workplace, community agencies, and interagency coordinating councils are examples of places that can have a significant impact on children’s development without direct involvement of the children with the agency or group.

The final and broadest system involves the social-cultural environment in which the children are reared. It consists of “broad ideological, demographic and institutional patterns of a particular culture or subculture” (Garbarino, 1990, p. 83) and serves as a blueprint for how events should occur and people should behave in a society.

The conceptualizations of the children’s environment and family system that ecological and family systems theorists have developed have direct applicability for working with families from various cultures. Both frameworks provide speech-language pathologists with a guide for viewing children within a broader cultural and social context and highlight components of the children’s family system and environment that speech-language pathologists need to explore when serving families with children with special needs.

The efforts that clinicians make to learn about a family often consist of asking families a preset list of interview questions, requesting that families fill out questionnaires (see for example Bailey & Simeonsson, 1988; Dunst et al., 1988), or using lists of potential strengths of families as a guide for gathering information from them (one possible source is suggested by Turbiville, Lee, Turnbull, & Murphy, 1993). The problem with these approaches to assessment is that they are based on the mainstream culture’s view of what a family should be and can lead a clinician to form assumptions about how a family should behave, regardless of its culture. As a result, the clinician may target mainstream behaviors in therapy that family members did not display during the assessment. Because the behaviors may not complement the family’s cultural style, the family may not follow the clinician’s suggestions, may inconsistently attend early intervention services, or in more extreme instances, may not come to therapy at all. As a result, the family becomes a “challenge” to the clinician. The problem, however, is not the family, The problem is that the traditional assessment approaches did not assist the clinician in developing a full understanding of the family’s views about their child, patterns of interaction, and goals for services.

Therefore, I propose that to better understand a family’s system and to make services more family centered, professionals need to learn about a given family using methods (a) that have underlying theoretical assumptions that complement those of the theories on which family-centered philosophy of service delivery is based and (b) that allow speech-language pathologists to work from the perspective of the families they are serving. As will be demonstrated, ethnographic research methods fit these qualifications.

The Assumptions of Ethnography

Like family systems and ecological theorists, ethnographers developed methods in reaction to the experimental approach in science. According to ethnographers, the experimental tradition leads researchers to seek facts that are deduced from the data, to identify causes, to attempt to explain behaviors from an objective framework, and to separate the behaviors of individuals from the context in which they occur. Instead, ethnographers make observations of individuals’ behaviors in the contexts in which they occur and develop conclusions that arise from the data (Mischler, 1979). They assume that there can be many perspectives about a given event, recognizing that subjectivity is inevitable (Clifford, 1986; Taylor & Bogdan, 1984).
In keeping with the view that individuals' perspectives are the key, ethnographers seek to explain behaviors from the point of view of those they are studying. To do this, ethnographers strive to set aside their own conceptions and to view the experiences of those being studied from the individuals' behavioral framework (Geertz, 1983). Their aim is to "represent otherness in such a way that "we," who are outside the relevant situation can imagine what it is like to be in it" (Shwed, 1996, p. 18). In other words, ethnographers go beyond merely trying to understand the other and instead work to assume the perspective of those they are researching.

Because family systems theories, ecological theories, and ethnographic methods share many of the same underlying assumptions, ethnographic methods are particularly well suited to learning about children and their families who are from different cultural groups. Table 2 outlines the overlapping assumptions.

Additionally, ethnographic methods allow speech-language pathologists who ascribe to a family-centered philosophy to meet one of the major goals of service delivery, which is to understand a family’s values, priorities, interpretation of events, and decision-making process (Dunst, 1990; Jones, Garlow, Turnbull, & Barber, 1994; McGonigel, Kaufman, & Johnson, 1991). In fact, ethnographic methods allow speech-language pathologists to take this one step further by enabling speech-language pathologists to develop the perspective of the family, rather than achieving a mere understanding. As pointed out by McGonigel et al. (1991), "...the values, structures, and interaction patterns of families are part of their very being [which] help define who they are as a family" (p. 34). These values are not negotiable (McGonigel et al., 1991). Given this assertion, it is argued that to be effective in working with families, speech-language pathologists need to start from the perspective of the family. Ethnographic methods will enable them to do this.

It is recognized, however, that ethnographic research techniques are time intensive and require study to implement. Therefore, they may not be carried out in full in all clinical situations. However, it is possible for speech-language pathologists to employ the sensibilities of ethnographers as they work with families. In doing so, clinicians will gather information about the children and families with whom they work from many of the sources of data they use when employing traditional assessment strategies. The key is that by employing the sensibilities of ethnographers, clinicians will be able to reframe how they approach the assessment process. No longer will their goal be to document information or objective facts about the family. Instead, their goal will be to see the children’s family systems and early intervention services through the eyes of the families they serve, which in turn will enable them to deliver truly family-centered services.

**Applying Ethnographic Sensibilities When Learning About Families**

Having no preset hypotheses to prove or disprove, ethnographers “triangulate” data from multiple sources to develop an understanding of the culture they are researching (Patton, 1990). For speech-language pathologists, triangulation of data can include combining information from reading the literature on cultures, reviewing written documents such as medical and therapy reports and documents from community agencies, interviewing community leaders and other service providers as well as the family, observing interactions within the family’s community and between the child and significant individuals in his or her life, and administering questionnaires (see Table 3 for examples of each type). The following sections demonstrate how speech-language pathologists can employ the sensibilities of ethnographers when gathering information from these sources to learn about the families they serve.

Before discussing each of the potential sources of data, it should be pointed out that the review of the literature and documents about community organizations, interviews with community leaders and service providers, and observations within a family’s community are designed to supply speech-language pathologists with necessary background information if they are unfamiliar with the family’s culture and community resources. These components do not have to be conducted if the clinician has sufficient knowledge in these areas. The primary sources of information about the family’s

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**TABLE 2. Assumptions shared by family systems theories, ecological theories, and ethnographic methods.**

<table>
<thead>
<tr>
<th>Shared Assumptions</th>
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<tbody>
<tr>
<td>Behaviors are examined within their context.</td>
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<tr>
<td>Descriptions of behaviors are made.</td>
</tr>
<tr>
<td>Multiple perspectives are recognized.</td>
</tr>
<tr>
<td>Subjective realities are sought out and seen as valuable.</td>
</tr>
<tr>
<td>Complete objectivity is viewed as neither possible nor desirable.</td>
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<tr>
<td>Work begins from the point of view of those studied.</td>
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</tbody>
</table>
### TABLE 3. Sources of data about families.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Where Data Are Obtained</th>
<th>Data Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature reviews</td>
<td>Books &amp; articles</td>
<td>Social-cultural environment including:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural values and beliefs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child rearing practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Roles family members assume</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication styles</td>
</tr>
<tr>
<td>Written documents</td>
<td>Medical &amp; treatment reports</td>
<td>Child’s medical &amp; therapeutic history</td>
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<tr>
<td></td>
<td></td>
<td>Nuclear and extended family’s experiences with health professionals</td>
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<tr>
<td></td>
<td>Newspaper articles/agency brochures</td>
<td>Support for families in the community and nationally</td>
</tr>
<tr>
<td>Interviews</td>
<td>Discussions with community leaders and service providers</td>
<td>Social-cultural environment Strategies for being successful working with families from a particular culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conversations with family members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Members of the nuclear/extended family and their roles, the child’s development and abilities, parenting beliefs, family perceptions and goals, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family’s experiences with and perceptions of the medical and treatment community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agencies with whom the family is involved</td>
</tr>
<tr>
<td>Observations</td>
<td>Conducted in the community</td>
<td>Social-cultural environment by: attending</td>
</tr>
<tr>
<td></td>
<td></td>
<td>social, cultural, &amp; religious events; observing interactions in parks, restaurants, stores in the family’s community</td>
</tr>
<tr>
<td></td>
<td>Conducted of the child with significant individuals in his/her life</td>
<td>Child’s communicative abilities, child’s interactants, activities engaged in, etc. (See table 4)</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Completed by the family</td>
<td>Information about the nuclear family (e.g., names, ages of siblings)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community agencies with whom the family is involved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information about the parents' employment, sources of insurance</td>
</tr>
</tbody>
</table>

System and the child’s communication abilities come from the clinician’s review of medical and therapeutic reports, interviews with the family, observations of the child’s communication skills, and a questionnaire.

**Literature Reviews.** For ethnographers, literature reviews are a source of background information that has been written on the subject the researchers are studying (Bernard, 1988; Marshall & Rossman, 1995). For speech-language pathologists, the purpose of the review is to gather broad, background information about a particular family’s culture. This information then can be used as a guide for learning about the family. One must be careful not to automatically assume that the family shares some or all of the values and beliefs of their culture that the literature depicts. Families will differ on the basis of their “access to societal institutions, degree of acculturation, and how sources of oppression undermine or override these traditional values and practices” (Coll, Meyer, & Brillon, 1995, p. 199).

Textbooks, ethnographic studies, and works of fiction can be used to acquire much background information about a family’s culture. These might include *Ethnicity and Family Therapy* (McGoldrick, Pearce, & Giordano, 1982), *Developing Cross-Cultural Competence* (Lynch & Hanson, 1992), *Counseling Across Cultures* (Pedersen, Draguns, Lonner, & Trimble, 1996), *All Our Kin* (Stack, 1974), *Hustling and Other Hard Work* (Valentine, 1978), *Mama Might Be Better Off Dead* (Abraham, 1993), and *The Joy Luck Club* (Tan, 1989).

To understand the cultural environment of the families one serves, one can gather information about their culture’s views and beliefs, their child-rearing practices, the roles family members assume, and their communication styles (Cheng & Hammer, 1992). Knowledge of a family’s cultural views and beliefs is necessary.
for having a basic understanding of the family’s culture and as a basis for understanding its parenting behaviors and parenting decisions. Parents from various cultures have differing views as to:

...the definition and roles of the family; parental beliefs about the determinants of development, including what, how, and who may foster or hinder a child’s development; as well as what aspects of a child’s development are most important (i.e., discipline vs. intelligence) and what the definition of competence is in each of these areas. (Coll et al., 1995, p. 190)

In addition, information about the individual consulted for medical advice, the beliefs about disabilities, and the views about individuals with disabilities can provide valuable insights into how families perceive the services being offered to them and their role in those services. For example, if women are traditionally the caregivers and responsible for all aspects of the children’s daily lives and men are seen as the decision makers and income generators, it is highly probable that the fathers may not assume an active role in intervention services but may be making decisions about their children’s participation in services behind the scenes. If folk healers are commonly seen for the treatment of a disability, therapeutic services may not be viewed as a viable option for families.

Similarly, if disabilities are believed to be the result of fate or a gift from God, as in many Asian, Pacific Island, and Hispanic cultures (Cheng, 1990; Randall-David, 1989), the family may not be interested in services because its culture believes that a child’s fate cannot be changed (Cheng & Hammer, 1992). Moreover, if the family’s culture assumes that individuals with disabilities are not capable of being contributing members to their society, interest in services may be minimal.

A review of the literature can also be helpful in gaining knowledge about the communication and interaction styles of the family’s culture, as culture and language are inextricably linked. As Schwartz (1981) states: “Language is a part of culture so essential to the specification of human nature that it both pervades the rest of culture and is most readily taken as its controlling metonymic analogy” (p. 7). For example, because of interest in consensus and avoidance of conflict in order to save face, the word yes can mean no in many Asian and Pacific Island cultures (Cheng, 1989; Hammer, 1994). This terminology can have significant implications for interactions between speech-language pathologists and families seeking services. A family may say “yes” to a professional to acknowledge her statement without intending agreement. As a result, the clinician may be surprised when the family does not return for the next appointment that she thought the family had agreed to, but in actuality did not (Hammer, 1994).

The literature review is one source of written information through which speech-language pathologists can gather basic information about the cultures of the families they serve. As discussed in the next section, written documents are another source through which more specific background information about particular children and families can be obtained.

**Written Documents.** Ethnographers use written documents, such as official reports, correspondence, files, agency documents, and evaluation forms, to gather information as well as to “lend insight into organizational processes and the perspectives of the people who write and use them and to alert the researcher to fruitful lines of inquiry” (Taylor & Bogdan, 1984, p. 68. See also Marshall & Rossman, 1995). For speech-language pathologists providing early intervention services, written documents can help them learn about families’ interactions with health care professionals. The documents to be examined include medical reports and reports from other professionals and programs with whom the child and family have been involved.

Although the review of medical and therapeutic reports is not a new concept, the way in which reports are read is different. By employing ethnographic sensitivities, speech-language pathologists read the reports not only to obtain factual information about a child’s medical and therapeutic histories but also to understand the family’s experiences and the impact those experiences might have had on the family. For example, when reviewing a child’s medical history that includes several extended hospitalizations due to complications associated with a preterm birth, one can appreciate the emotional and physical toll this may have had on the family.

In addition, the family’s treatment by the medical community can affect a family’s relationships with professionals. Mistrust can easily be established if a family is not given respect. For instance, some professionals hold preconceived notions about families from different cultures. As a result, they may treat families as unreliable informants and may disregard their opinions. When examining written documents about a child, a professional may detect through their tone evidence of a mistrust that has developed between a professional and a family.

Through the reports, clinicians will not be able to completely understand the family’s experiences or know how trusting of professionals they may be. However, they can ask the
family questions and listen for statements
family members make about the medical community that will be useful in determining the family’s perspectives about these early experiences and their impact on the family.

Written documents can also be used to obtain information about the practices and policies of public and private organizations offering services to families. Newspaper articles provide data about public policies that either serve or fail to support families with children with special needs or families that depend on public and private agencies to support them in raising their children. Reports and pamphlets from agencies that list policies and eligibility criteria are another source of information.

By reading documents with the sensitivity of ethnographers, speech-language pathologists have an opportunity to better understand how communities support or fail to support families raising young children. It may also help them better to see that certain behaviors of families are not their choice but are the result of community programs or policies. For example, in Micronesia, many families need to pick up their monthly checks at the welfare office, where they have to stand in line for indeterminate amounts of time. Trips to the welfare office could cause families to be away from the homes when the homes visits were scheduled, but they would not necessarily inform the home visitor of the potential conflict (possibly due to embarrassment about the situation). The problem was largely the result of a system that required that the checks be picked up in person. The solution was very simple—the speech-language pathologist needed to find out the days checks were delivered and schedule visits for an alternate day.

**Interviews.** Ethnographers commonly interview informants who are knowledgeable about the culture or organization they are studying. Similarly, interviews can serve as a major source of information about the families that are seeking early intervention services.

**Interviews of Community Leaders and Service Providers.** If the speech-language pathologist is not familiar with the family’s culture, interviews can be conducted to gather information about the family’s social-cultural environment before the initial meeting with the family takes place. This information can supplement and expand the knowledge acquired through the literature review. Interviews with leaders and elders within the family’s neighborhood community can be helpful in broadening knowledge of the values, beliefs, and behaviors of the family’s culture (Randall-David, 1989). Because cultural understanding is automatic for members of a given culture and therefore may be difficult to explain to an outsider, it may be beneficial to present the leaders and elders with specific scenarios and ask them to comment on each one or to answer questions, rather than request a description of the culture (LeVine, 1984; Rubin & Rubin, 1995).

When conducting semistructured interviews with families, it is helpful to keep in mind the following recommendations based on suggestions provided by Bernard (1988), Hammer and Wildavsky (1989), Rubin and Rubin (1995), Taylor and Bogdan (1984), and Westby (1990). Before the interview, the interviewer develops “guide questions” that cover topics that the speech-language pathologist foresees discussing with the family. Such questions may tap information about the child’s birth and medical history, the family’s understanding of the child’s diagnosis, who the family members see for medical care, important members of the family’s system, and the like. These questions are then
used to “guide” the interview. Questions are presented one at a time, and follow-up questions are asked to explore a topic thoroughly. Succeeding questions logically follow from the information the individual has shared (Hammer & Wildavsky, 1989; Rubin & Rubin, 1995).

Specifically, guide questions are open-ended questions that are designed to assist the interviewer in learning about “what a family considers important in their world and how they perceive their world” (Westby, 1990, p. 106). Questions may be “grand tour questions” (e.g., “Tell me about your child’s day”) or experience questions (e.g., “Tell me about your experiences in the hospital when your child was born”) that target major experiences and events in the family’s life. They also may be used to target specific information when asked in the form of “minute questions” (e.g., “Tell me about mealtime with your child”). Additionally, questions may be used to follow up on information a parent shares when responding to broader questions. Types of follow-up questions include “example questions” (e.g., “You said that your child is selfish. Give me an example of when he is being selfish”) and “native-language questions” (questions designed to explore the family’s meaning of a particular term) (Westby, 1990). Examples of guide questions that might be used at various points in the assessment and IFSP process are listed in the appendix.

Guide questions may be asked about the child or the family directly. However, in addition to soliciting specific information from the family, questions are also designed to obtain the family’s perspectives on the child and the members’ experiences with their child. For example, the statement “Tell me about your child’s experience in the hospital” appears to be asking for information about the child. However, it is also providing the parent with the opportunity to relate what kind of impact this experience had on him or her and on the rest of the family. Similarly, conversations about the child’s daily routine can provide insights into the roles various family members and friends play in the child’s and family’s lives. These discussions can reveal who helps with caregiving responsibilities, who serves as a playmate (and what activities are engaged in during these playtimes), who are the income generators, and who are the decision makers.

Having developed a list of guide questions, the speech-language pathologist begins the first meeting by attempting to put the family at ease (Rubin & Rubin, 1995). The purpose of the interview is reiterated (Westby, 1990), and time is taken to explain the assessment and IFSP process to the family. The initial questions posed during the interview are nonthreatening. Therefore, the interview might begin with a question such as, “Tell me a little bit about your child [or family]” as opposed to “Tell me about your child’s birth.” The question about the child’s birth might touch on feelings that are too personal or emotional for the family to share with an individual with whom they have little contact.

Digressions on the part of the interviewee are permitted and even welcomed because it is at these times when a parent may be sharing something that the interviewer did not think to ask (Thompson, personal communication, April 1993). On the opposite end of the continuum, the interviewer should allow the parents to disclose the information they wish to share and permit them to withhold information that they want to keep private (McGonigel et al., 1991). This aids the clinician in keeping the information-gathering process more like a conversation than an interview (Bailey & Blasco, 1990; Summers et al., 1990). Although obtaining information is important, it is not as essential as establishing a trust between the family and the interviewer. If a strong rapport is built in the beginning, important information and the family’s perspectives on the services being provided will more likely be shared as the partnership between the speech-language pathologist and the family continues.

Additionally, it is imperative that the interviewer exhibit a nonjudgmental attitude toward the family and the information that is shared (Zeanah & McDonough, 1989). Although this caution may appear obvious, it can be difficult to do when families come from cultures other than one’s own because people naturally tend to interpret behaviors and statements through their own cultural framework (Harwood, Miller, & Irizarry, 1995). When employing the sensitivities of an ethnographer, a speech-language pathologist’s ability to withhold judgment and suspend his or her views on a particular behavior is tested (Shweder, 1996). To work from the family’s perspective, however, it is important that a clinician understand how families view and interpret events (McGonigel et al., 1991).

When working in Micronesia, I frequently was in situations in which my views and cultural practices were different from those of the families I was serving. For example, families commonly missed home visits due to commitments to their family (e.g., funerals which lasted 7 days or preparation for fiestas) (Hammer, 1994). In keeping with the spirit of an ethnographer, I worked from the perspective of the families and understood that services could be a lower priority for families over other family responsibilities. I decided not to verbally address the issue of missed appointments.
with the families because they would have interpreted my comments from their cultural viewpoint as a confrontational act, which would have resulted in many families withdrawing from services. Instead, my goal was to strengthen my relationship with the families and their trust in the services I provided, which I hoped would increase the value of my services to them. To do this, I accepted the families’ behaviors and conveyed a genuine interest in the families and in assisting them in meeting the goals that they had identified.

All the information gathered during the interviews can be supplemented with observations of the family’s community and of the child when interacting with important individuals in their lives. As is discussed in the next section, information obtained in this manner can be used to assess the child’s communication skills and to assist with the planning of intervention services.

**Participant Observations.** As participant observers, ethnographers enter the field they plan to study with no hypotheses to test, looking for the salient aspects of the behaviors that occur in the environment (Patton, 1990; Taylor & Bogdan, 1984). To assist them in learning about the families with whom they are working, speech-language pathologists may make two types of observations: observations in the family’s community and observations of children interacting with significant individuals in their lives.

**Observations of the Family’s Community.** If a given family is not from the speech-language pathologist’s culture, observations may be made in the family’s community to learn more general information about the culture. For example, grocery shopping or eating at restaurants in the family’s neighborhood can be informative experiences. They are activities that most speech-language pathologists engage in as part of their routine and thus, do not require much additional time. Visits to other businesses, trips to the park with one’s child or with a friend’s child, and attendance at social, cultural, and religious activities in the family’s community are additional sources of information. When visiting these places, observations of parent-child interactions, spouse-to-spouse interactions, or adult-to-adult interactions can yield information about parenting behaviors as well as styles of communication. Speech-language pathologists of the majority culture may feel uncomfortable going to places in which they are in the minority, which is understandable; however, this experience can also yield valuable information that may lead to insights about how minority families may feel when entering communities and places of business, including early intervention programs, in which they are not in the majority.

**Observations of the Child and Family.** Observations can also be made as part of the assessment of the child, as is typically done during a more traditional evaluation. When employing ethnographic sensitivities during an assessment, the speech-language pathologist makes observations while he or she is interacting with the child as well as when the key individuals in the child’s life, who had been identified during the interview process, are interacting with the child. For the purpose of completing an assessment in a reasonable amount of time, observations may be initially made of the mother or father interacting with the child during common events. However, as services progress, additional observations can be made of the engagement in a wider range of activities with a parent or parents as well as with other individuals important in the child’s life.

The purpose of these observations is twofold. The first is to provide the speech-language pathologist with naturalistic data about the child’s ability to communicate in settings in which he or she is commonly a member. The second is to learn about who interacts with the child and the activities in which those people engage with the child. This makes it possible to develop practical intervention suggestions on the basis of what the individuals are already doing (Andrews & Andrews, 1990). When making these observations, “it is necessary to enter such observations free of already existing taxonomies of behavior because they may have been derived from and be limited to certain cultural patterns of communicative interaction” (Crago & Cole, 1991, p. 117).

To maximize the observations made of the child interacting with others, many aspects of the interactions are to be observed (see Table 4). When observing in a family’s home, it is important to note who interacts with the child and what types of activities those individuals engage in with the child. This is illustrated by the following example that came from my work with African American mothers with infants.

During the observations of one of the mothers at play with her child, it was discovered that she enjoyed reading books to her child and that her interactions with her child typically did not involve toys. However, it was learned that her teenage daughter “taught” and played with her youngest child in the context of “school.” This information has significant implications for developing intervention plans. Suggesting activities that were centered around toys to this mother would have been inappropriate. However, developing activities and sharing suggestions on ways to enhance her child’s language..."
<table>
<thead>
<tr>
<th>Observation</th>
<th>Possible Behaviors that Occur Within the Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who interacts with the child?</td>
<td>Mother, father, sibling, multiparty</td>
</tr>
<tr>
<td>What are the topics of the interaction?</td>
<td>Toys, mealtimes, book reading</td>
</tr>
<tr>
<td>Who initiates the interaction?</td>
<td>Child, sibling, parent</td>
</tr>
<tr>
<td>Who directs the interaction?</td>
<td>Child, parent, sibling</td>
</tr>
<tr>
<td>What mode of communication is used by each member of the interaction?</td>
<td>Vocal, verbal, nonverbal</td>
</tr>
<tr>
<td>What communicative acts are used by the interactants?</td>
<td>Assertives, responsive, conversational or directive style</td>
</tr>
<tr>
<td>What is the adult’s agenda when interacting with the child?</td>
<td>Instructional games—adult as teacher</td>
</tr>
<tr>
<td></td>
<td>Social games—Adult engages in songs, routines</td>
</tr>
<tr>
<td></td>
<td>Larger life lessons—Adult teases, teaches sharing or coping with events</td>
</tr>
<tr>
<td>What is the adult’s teaching style in relation to how the adult views how children learn to talk?</td>
<td>Child talks to learn—adult teaches and directs</td>
</tr>
<tr>
<td></td>
<td>Child learns to talk—adult models and encourages repetition</td>
</tr>
<tr>
<td></td>
<td>Child listens and learns to talk—child is the observer of interactions</td>
</tr>
<tr>
<td>What is the child’s role in the interaction?</td>
<td>To perform—answer requests and questions.</td>
</tr>
<tr>
<td></td>
<td>To be obedient and quiet—learn by observing the adult or older child</td>
</tr>
<tr>
<td>Who adapts to whom in the interaction?</td>
<td>Adult and child are co-conversations</td>
</tr>
<tr>
<td></td>
<td>Parent believes play is for children and does not view herself as a “playmate.”</td>
</tr>
<tr>
<td>Who is responsible for understanding the child?</td>
<td>Child is viewed as not talking unless the words are clear</td>
</tr>
<tr>
<td></td>
<td>Child’s vocalizations are interpreted as being communicative</td>
</tr>
</tbody>
</table>

When reading books would be more appropriate for this mother-child dyad.

Within adult-child and child-child interactions, observations are made to determine which partner typically assumes the responsibility for initiating the interaction and which partner leads the interaction. Although researchers who study parent-child interactions in the white, middle-class culture support the adult allowing the child to initiate the interaction and the adult following the child’s lead, cultural differences as well as variations in individual behaviors will be found (van Kleek, 1994). For example, the African American mothers and infants I studied used a wide range of communication styles (Hammer, 1996). Many mothers shared the responsibility for beginning interactions and leading the play with their children, others typically followed their children’s lead, and still another subgroup assumed the sole responsibility for leading most of the interactions. Such information on a dyad’s communicative style can be useful when developing intervention plans with families that build on and enhance their natural interaction styles.

Needless to say, observations also include noting the communicative acts and modes of communication used. In terms of the specific acts produced, communicative act taxonomies such as the one by Fey (1986) can be used to note the purposes for which language is used and for identifying maternal styles of interaction. However, as is the case with the initiation and leading of play, one should also be open to the range of possible maternal styles that may be observed. Traditionally, a conversational style has been preferred over a directive style (McDonald & Pien, 1982; Nelson, 1973; Newport, Gleitman, & Gleitman, 1977). This conclusion, however, has been questioned. Pine (1992) suggests that this preference for a conversational style is culturally biased, as the mainstream culture values language-oriented maternal interactions over behavior-oriented interactions. The findings of ethnographic studies of interactions between parents and their typically developing children of various...
cultures support this argument. For example, because of the importance placed on children to understand and obey what is said to them. Inuit adults of northern America primarily use language to direct children (Crago, 1990). A similar pattern has been observed in the Lao and Basotho tribes in Africa (Blount, 1972; Demuth, 1986). In other words, cultures value different parental styles, and one should expect that mothers will employ interactional styles that reflect their parenting beliefs (van Kleek, 1994).

Additionally, parents and other caregivers may vary in their communicative style because parents adjust their behaviors to their children’s strengths, needs, and personalities. As stressed in transactional models of development, children’s behaviors are affected by those in their environment, and children, in turn, affect the behaviors of others. For example, a mother’s anxiety about her child’s development after a complicated birth and her child’s subsequent language delay may result in her employing a more directive style of interaction in an effort to foster her child’s communication skills (Sameroff & Fiese, 1990).

When noting the communicative acts produced, it is important to note what mode of communication the parent or child uses to express his or her message. Although speech-language pathologists are trained in observing vocal and verbal communication and in observing some nonverbal gestures, they may have more difficulty noting the gestures and nonverbal forms of communication used in other cultures, in particular in cultures where context is a significant component of communication. For example, in Micronesia, a quick raise of the eyebrows can be used to greet, to affirm a speaker’s statement, or to respond to a question. The meaning of the gesture depends on the context and must be recognized by the conversational partner as being a communicative gesture (Hammer, 1994).

In addition, observations are made of the adult’s expectations for the interaction(s) and of her teaching style. For example, one adult may view children as learning through imitation and, therefore, may model words for her child to imitate. That adult may believe that children learn to talk through listening and may expect a child to observe interactions rather than to participate in them (Quinn & Iglesias, 1989). Other adults may view their children as conversational partners only when they have something new to contribute to the conversation and will not ask them questions (e.g., What’s this?) if the adult knows the answer (Heath, 1983). Each of these views affects the role children assume in interactions.

Additionally, it is important for speech-language pathologists to note who adapts to whom in the interaction. For example, mothers from the mainstream culture often interpret most of their infants’ behaviors as meaningful. As stated by Brazelton, Koslowski, and Main (1974):

Most mothers...are unwilling or unable to deal with neonatal behavior, as though they are meaningless or unintentional. Instead they endow the smallest movements (of the infant) with highly personal meaning and react to them affectionally. (p. 68)

Mothers from the mainstream culture attribute words to their children’s vocalizations when they approach 1 year of age. This is not true for all cultures, however. In the Kaluli culture of Papua New Guinea, children are not viewed as talking until a child uses the Kaluli words for mother and breast (Ochs & Schieffelin, 1984).

Related to this, it is also necessary to ascertain who is responsible for understanding the child. Do adults attribute meaning to children’s vocalizations or word approximations, or is it the children’s responsibility to make themselves understood? Using the Kaluli culture as an example once again, adults do not attribute meaning to children’s vocalizations because it is believed that “one cannot know what another thinks or feels” (Schieffelin & Ochs, 1983, p. 123).

Because of the strong relationship between culture and adults’ child-rearing and interactional styles, participant observation can yield important information that would not be gained through traditional assessment methods that are typically based on what the mainstream culture views as important features of a parent-child interaction. By being open to a variety of communicative behaviors displayed by the children and significant individuals in their lives, speech-language pathologists can gain a wealth of information through participant observations that can be triangulated with the data gathered through literature reviews, written documents, and interviews as well as questionnaires, which are discussed in the next section.

**Questionnaires.** Questionnaires that ethnographers use to survey people on their behaviors (Bernard, 1988) are another potential source of information through which to gain an understanding and knowledge of families. Traditionally, speech-language pathologists have used questionnaires to gather personal information from the family. Often, they are sent to the family before they have met the early intervention team or after the initial visit. However, in
an ethnographic, family-centered assessment, I suggest that the questionnaires be given to families personally after at least one meeting has occurred with the speech-language pathologist. This way a rapport is established with the family before personal information is requested.

Questionnaires can be a less intrusive way of asking for necessary information about the family such as the following: (a) employment information, (b) parents’ and siblings’ ages, (c) information about health insurance, and (d) the family’s participation in public agencies like Women, Infants and Children (WIC) and Aid to Families with Dependent Children (AFDC).

When asking a family member to complete a questionnaire, I suggest giving the option of completing it alone, with other family members, with the speech-language pathologist, or with the speech-language pathologist and one or more other family members. These options provide a family member who cannot read the opportunity to complete the questionnaire without having to reveal that she is illiterate, which may be embarrassing to some individuals. In addition, when the questionnaire is filled out in the presence of the speech-language pathologist, the family member may verbally share information that comes to mind when answering a particular item (Thompson, personal communication, April 1993). Regardless of how family members choose to complete the questionnaire, the clinician should always inform them that they may keep private whatever information they do not want to reveal and share whatever information they wish to.

Recording the Data. Ethnographers rely primarily on field notes to record the events and thoughts others share during the process of data collection. Audio and video recordings may also be used, depending on the situation and in the absence of logistical problems.

The taking of notes is common practice of speech-language pathologists as well; however, when using the sensitivities of an ethnographer, notes are recorded in a different manner. Typically, speech-language pathologists take notes during the assessment and the interview with the family. However, one must achieve a balance between establishing a rapport and the accurate recording of data (Taylor & Bogdan, 1984). Therefore, it is suggested that the clinician refrain from taking notes or take minimal notes to record information that may be forgotten. Emerson, Fretz, and Shaw (1995) propose that ethnographers write only one or two words that capture the key components of conversations and behaviors observed to aid their memory, or take no notes at all.

After the interview or observation, the observer writes notes that describe his or her experiences and observations. Taylor and Bogdan (1984) provide several suggestions for recalling information when writing field notes. First, if no notes were taken, remember key words in people’s comments. Second, focus on the first and last comments in conversations. Because conversations generally follow an orderly sequence, remembering how a conversation started will assist one in recalling what was said. Third, visualize events that were observed and play back remarks that were made to assist one’s memory. Fourth, record one’s notes as soon as possible after the interview or observation. Because it is not always possible for speech-language pathologists to do this, given all of the appointments they have in a day, I have found it helpful to use a cassette recorder to record my notes while I am in the car going to my next appointment or returning to my office.

It is possible to use audio and video recordings to record data, but one must remember that these devices draw attention to the observer and may cause individuals to be cautious about what they say or do (Rubin & Rubin, 1995). Clinicians may find it helpful, however, to make video recordings of specific interactions. When this is done, the speech-language pathologist must explain to the family the specific purpose for the recording (e.g., to take a closer look at a child’s communication abilities in a particular context) and obtain permission before bringing the equipment to the family’s home.

Analysis of the Data. Having collected data from several sources over a period of time, the speech-language pathologist can begin the process of analyzing the data to provide a thick description of the subject of study (Geertz, 1983). Ethnographers concurrently collect, code, and analyze their data and decide what data need to be collected next (Glaser & Strauss, 1967; Strauss, 1987). Therefore, as the data are gathered and field notes written, ethnographers assign codes to the behaviors they observed and the meanings the individuals they are studying. The coded data are sorted into categories that represent or explain the behaviors and ideas found. Once sufficient data have been collected and categories explaining the patterns observed are finalized, ethnographers identify themes that link the categories and develop theories that explain what has been learned so that they can describe the individuals they have studied from the perspective of those individuals (Glaser & Strauss, 1967; Miles & Huberman, 1994).

Similarly, when employing the sensibilities of ethnographers, the speech-language pathologist can gather data about the family over a period of time, beginning with the assessment and continuing through the provision of intervention services. Through the analysis of the
speech-language pathologist’s notes, patterns are identified that assist that individual in determining the family’s values, beliefs, and styles of interaction. As additional discussions occur with the family and observations are made of the child, more information can be integrated into the speech-language pathologist’s working knowledge of the child and his or her family.

This process enables a speech-language pathologist to work from the family’s perspective when collaboratively developing intervention plans. The example discussed in the next section is designed to illustrate this point.

**Beginning From the Perspective of the Family**

The following example involves Anita, an African American mother of two preschool boys, ages 17 and 36 months. Anita was a single mother with some college education who was employed as a secretary. Triangulation of information from interviews and observations of this dyad revealed that Anita did not view herself as a playmate for her children as many mothers from the mainstream culture do. As a result, she did not set aside specific times to teach her children (Rogoff, Mistry, Goncu, & Moser, 1993). Instead, Anita’s preschool children were allowed to play by themselves and determine their activities for the evening (within limits for preschool children). During this time, Anita monitored their behaviors and was available to assist them when they approached her for help. She interacted with her children and taught them as opportunities arose in the context of ongoing activities in the household with one exception, book reading. Each night Anita read to her children before bed, assuming the role of a teacher.

Knowing that Anita’s children assumed the responsibility for structuring their own activities greatly assisted me in interpreting the interactions I observed of Anita with her children. Because I understood these general patterns, it became apparent why Anita sat off to one side of the room while her children played. It was not that she was disinterested, which had been my impression before I integrated the information from the interview with my observations. Rather, she did so because she did not view herself as needing to be an active participant in her children’s play. As a result, her children initiated, led, and terminated most of the play. They typically established what was played with and when they and their mother would interact. When not with his older brother, her younger child often played by himself for a minute or more and then would approach his mother, with whom he would interact. After completing the interaction or receiving the assistance that he desired, he would return to the other side of the room and play.

It must be pointed out that these conclusions were not stated by the mother. Rather, by setting aside my own culture’s conceptions of mother-child interactions, I was able to uncover the patterns of Anita’s behaviors. This understanding might not have been achieved through traditional assessment strategies. Admittedly, it is likely that a speech-language pathologist who used a traditional approach to assessment would have been able to determine that Anita did not play with her children. However, it is asserted that without employing the sensitivities of an ethnographer, a speech-language pathologist would have either (a) identified mainstream interactive behaviors to be targeted in therapy (such as setting aside time to play with one’s children) or (b) refrained from suggesting that structured play activities be engaged in because they were not observed, not because the speech-language pathologist was working from the mother’s views about child rearing. A clinician who does not assume the mother’s perspective is limited in her ability to offer suggestions about facilitating language development that complement the mother’s views and beliefs about interacting with children.

Regarding language development, Anita believed that children learned to talk by imitating others and by listening to music. Music, she explained, provides children with a beat that attracts their attention and helps them learn as they imitate the songs they hear. She believed this because her children would sing parts of the songs they sang at day care.

When talking with her younger child, Anita employed several different teaching strategies. She imitated her child’s word approximations, provided him with the names of objects, and frequently responded to vocalizations and word approximations with short sentences as though he was engaging her in a conversation. When her son approached her to play, Anita frequently used directives to assist her child or teach him how to manipulate a toy.

Anita assumed an active role in structuring her son’s book-reading experiences. She typically read the text sentence by sentence, commenting on pictures when her child lost interest in what she was reading.

By employing the sensitivities of an ethnographer when collaboratively developing an intervention plan, a speech-language pathologist could support Anita’s interaction style by encouraging Anita to continue to interact with her children as opportunities naturally arose and suggesting strategies that built on Anita’s views of language development. For example, Anita could be reinforced for imitating her
child’s vocalizations and words approximations and for providing him with the names of objects in his environment that he could repeat. In keeping with her view that children learned to talk through music, a suggestion could be made that involved Anita singing songs with her child that either consisted of or were broken into short phrases that her child could imitate. Also, efforts could build on her interest in reading books to her child. Suggestions that Anita paraphrase the sentences in the books she read to her child, thus reducing her sentence length, and pause occasionally to allow her child the opportunity to imitate her or to comment on the pictures would be in keeping with her view of children’s language development (Whitehurst et al., 1988). Also, the speech-language pathologist could discuss with Anita the possibility of commenting on pictures more frequently, rather than commenting on pictures solely when her child lost interest in the book he was reading. This would provide her child with additional opportunities to imitate her.

The Benefits of Working From the Perspective of Families

The primary goal for speech-language pathologists who assume the sensibilities of ethnographers is to build from the perspective of the family. To do this, speech-language pathologists assess children’s language abilities and attempt to learn about their families’ systems using multiple sources of information. An ethnographic assessment requires speech-language pathologists to reframe their approach to assessment by striving to describe the families from the families’ point of view and ascertaining the families’ beliefs about their children, family systems, and goals for intervention. This assessment, in turn, results in speech-language pathologists going beyond developing an understanding of the families to achieving the families’ perspectives.

By working from the families’ perspectives, families will not become challenges or obstacles to clinicians, because clinicians and the families begin intervention from the same point of view. This does not mean that speech-language pathologists give up their responsibilities for sharing their professional views on various issues (McGonigel et al., 1991). After establishing a positive rapport with the family, speech-language pathologists have an ethical obligation to express concerns and professional opinions to family members. However, a philosophy based on a family-centered approach to service delivery requires that the decision-making process remain in the control of the parents, not the therapists (Jones et al., 1994). Speech-language pathologists providing family-centered services must remember that families strive to do the best for their children and are in the best position to determine what the service outcomes and the means for achieving those outcomes should be (Jones et al., 1994).

Because use of the sensibilities of ethnographers is a relatively new concept to service delivery, no studies have formally explored the benefits to this approach. However, it is hypothesized that the benefits of early intervention services will be maximized when service delivery plans are developed with both the speech-language pathologists and families working from the families’ perspectives. By building upon the parents’ or other caregivers’ belief systems, members of the children’s family systems will be more comfortable and more successful implementing suggestions. Families, in turn, will view services as better meeting their needs, which can lead to increased participation in collaboratively developed intervention plans and follow through of those plans (Andrews & Andrews, 1990; van Kleek, 1994). Thus, the obstacles to providing to family-centered services are overcome.

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References


Appendix

Sample Guide Questions

**General Questions**

Tell me about your child/family.

Tell me about a typical day for you and your child.
- What does the child’s father (significant others) and your child do together?
- What do your other children and your child do?
- What are your child’s favorite activities to do during the day?

Who helps you take care of your child?
- Do they ever make suggestions about raising or taking care of your child?
- What suggestions have been helpful?

Tell me about your child’s birth/experiences in the hospital.

What doctors or people have you consulted about your child?

What have the doctors or others told you about your child?

What do you think caused your child’s disability?

What is the most rewarding aspect of raising your child?

What is the most challenging aspect of raising your child?

What do you hope to gain from the assessment?

What are your goals for your child?

How do you think our program can best assist you?

**Communication**

How does your child let you know what s/he wants?

Give me examples of sentences and directions your child understands.

Can you understand everything your child says to you? Can others?

What do you and/or your child do when you cannot understand him/her?

How do you think children learn to talk?

Have you tried anything to help your child learn to talk?