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LANGUAGE AND LANGUAGE DISABILITIES:

ABORIGINAL AND NON-ABORIGINAL PERSPECTIVES

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ABSTRACT

This ethnographic study combines qualitative and quantitative research methods to examine the relationship between culture and language disability. Nine Cree and nine non-Cree couples, all parents of a language-disabled child, were interviewed. The parental responses from the two cultural groups were compared. Comparisons of interest included language socialization patterns, the influence of culture on the concept of language disability and perceptions of speech-language pathology service delivery. Few crosscultural differences in parental responses about caregiver-child interaction and about language disability were identified. It is hypothesized that a process of cultural blending may account for these findings. However, differences relating to the perception of speech-language pathology service delivery were found. While both groups described poor access to services, long waiting periods for intervention and insufficient quantity of service, there were differences in degree reported between the Cree and non-Cree families. The clinical implications of these findings are discussed.

RÉSUMÉ

Cette étude ethnographique combine des méthodes de recherches qualitative et quantitative dans le but d'examiner la relation entre la culture et les difficultés linguistiques. Des entrevues ont été faites avec des parents d'enfants avec des difficultés d'apprentissage reliées à la langue. Neuf des couples étaient d'origine crie et neuf ne l'étaient pas. Les réactions des parents des deux groupes culturels ont été comparées. Les comparaisons les plus intéressantes comprenaient les patrons de socialisation de la langue, l'influence de la culture sur les idées par rapport aux difficultés linguistiques, et enfin, les perceptions des gens à l'égard de la distribution des services orthophoniques. En comparant les deux groupes, peu de différences ont été révélées concernant les attitudes face aux troubles linguistiques ou à l'égard des interactions parent-enfant. Il est supposé qu'un processus de mélange culturel soit responsable pour ces trouvailles. Par contre, des résultats d'importance reliés à la distribution des services orthophoniques ont été identifiés. Les deux groupes ont décrit un abord difficile aux services, des longues périodes d'attentes pour des interventions et un manque de quantité de services. Cependant, il y avait des degrés de différences entre les familles cries et non-cries. Les implications cliniques sont discutées.

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Chapter 1

INTRODUCTION

This thesis examines the relationship between culture and language disability using a combination of qualitative and quantitative methodological approaches. The motivation for this study derived from the author's clinical work as a speech-language pathologist in the rural, remote community of Timmins in northern Ontario. This position with the Porcupine Health Unit involved delivery of service to a huge geographic area known as the Cochrane District. This area includes a number of small, rural communities inhabited by people from a variety of cultural backgrounds, including Cree, Anglo-Canadian, Franco-Canadian and Europeans. The Cree reserve of Moose Factory and the city of Timmins are within this area and were chosen as communities of comparison for this study.

Speech-language pathologists working in this district are faced with issues relating to delivery of service to non-mainstream cultural groups, such as Cree families living on the James Bay coast. After working in this geographical area for a period of four years, this author found herself repeatedly questioning her clinical practice in the following ways. How appropriate are standard speech-language pathology methods of assessment and intervention for Cree children? How do the parents of these children feel about their child's speech and language difficulty? Do they perceive their child to be "language disabled" or "learning disabled" in their own cultural context? If they do perceive their child to be language disabled, how do parents receive speech-language pathology services?

The search for answers to these questions provided the inspiration and rationale for the present study. The objectives of this project were to elicit responses from Cree and non-Cree parents about three main issues: their language socialization practices, their feelings about language disability and their perceptions of speech-language pathology service delivery. A face-to-face interview survey with open- and closed-ended questions was chosen as the data collection tool.

More specifically, the rationale for this study evolved from a previous survey conducted by this author while working for the Porcupine Health Unit in Timmins, 1991 (Saville, 1991). The findings of this survey will be briefly described, to provide background information to the present study.

During the early 1990s, administrators from the Porcupine Health Unit made a decision to reduce speech-language pathology services throughout the district, owing to funding and staffing limitations. This action prompted the Moose Factory Island District School Area Board to request continued service provision, claiming that their need for speech-language pathology services was particularly great. They believed that the prevalence of speech-language disability was higher in Moose Factory than in Timmins. This claim provoked the Porcupine Health Unit to carry out a small study investigating the prevalence of speech-language problems in children aged 0-9 years in various communities in the Cochrane District (Saville, 1991).

The communities of Timmins, Matheson, Iroquois Falls, Cochrane and Moose Factory were chosen for the survey. The numbers of children in these communities, who were on the Porcupine Health Unit's active and waiting caseloads, were totaled. Then, these numbers were converted to percentages using the total number of children in the 0-9 age group in each community. Comparisons were made between the communities

of Timmins and Moose Factory. Surprisingly, fewer than the estimated average of 10% (Ministry of Health, Ontario, 1996) were identified as needing service in Timmins (5.8%), whereas an amazing 32.2% (nearly a third) of the children in Moose Factory were identified as having some kind of speech-language problem.

It was difficult to determine exactly why such a huge discrepancy should exist. However, the author suggested two possible explanations. First, communication problems may be over-identified in Moose Factory (owing to measurement of a child's language ability using mainstream norms) and/or under-identified in Timmins (due to lack of public awareness and education regarding child language development). Second, children from Moose Factory may be inaccurately or inappropriately diagnosed as language disabled (e.g. children learning English as a second language). The author also recognized the possibility of a higher prevalence of speech-language disability in Moose Factory, as claimed by the Moose Factory Island District School Area Board.

The recommendations from this report were to investigate public health factors relating to the etiology of language disorders (e.g. otitis media) and to conduct further research into language socialization practices of Cree families living in Moose Factory. This needs survey therefore provided clinical motivation for the present study, which examines the second of these recommendations.

Only a few studies have previously examined language socialization patterns in Native Canadian or Native American families. This study builds on research by Crago (1990a&b, 1992a&b), who observed caregiver-child interaction in Inuit families. Language socialization patterns in some American Indian cultures have been studied (Guilmet, 1979), although caregiver-child interaction patterns in Canadian Indian cultures, such as the Cree, have not been previously examined. The language

socialization body of literature includes studies of crosscultural differences in caregiver-child interaction from around the world. These studies attempted to document those aspects of the interaction which appear to be similar across cultures (universals) and those aspects which seem to be culture-specific (Lieven, 1994). It is hoped that this study will be theoretically significant by enhancing this body of research through the addition of Cree language socialization practices and by providing an opportunity for making comparisons between cultural groups native to Canada.

The literature available on the influence of culture on the concept of disability is very broad. This thesis particularly addresses the work of McDermott (1993), who maintained that the concept of disability is culturally or socially constructed. In addition, he claimed that the paradigm of disability upheld by a particular society will affect all children from mainstream as well as non-mainstream cultural groups. This thesis compares the paradigms of disability inherent in the cultural values expressed by people from Timmins and Moose Factory.

Very few studies have previously examined speech-language pathology service delivery and consumer satisfaction. However, this study is similar in nature to work by Ilott, Holdgrafer and Sutter (1991) who examined consumers' satisfaction with different aspects of speech-language pathology service delivery. No previous research of this nature has been attempted with Aboriginal populations, so this study, by examining the perceptions of Cree parents, is the first of its kind in this regard.

In accordance with the three main sections of this thesis, there are three main hypotheses. First, it is hypothesized that Cree children develop language differently from mainstream children, owing to different patterns of language socialization. The second hypothesis maintains that the concept of language disability is construed in

different ways by Cree and non-Cree families. This will result in differing attitudes toward a child with a language or learning disability. The third hypothesis relates to speech-language pathology service delivery. It is predicted that there will be differing levels of satisfaction with speech-language pathology services between the Cree and non-Cree groups, particularly relating to issues of cultural sensitivity or appropriateness.

The following literature review is divided into three main sections: language socialization, the concept of disability and speech-language pathology service delivery. Next, the details of the methodology employed, including background information on the communities and the participants will be presented, followed by the findings of this project. Finally, the relationship of the results to previous research will be discussed, concluding with a discussion of the clinical implications of this study and suggestions for future research.

Chapter 2

BACKGROUND LITERATURE

This chapter is divided into three main sections: The first focuses on the theory of language socialization, which suggests that aspects of child development, specifically how language is used with the child, are influenced by social and cultural phenomena. Language socialization in Native American and Canadian cultural groups is examined, particularly as it occurs in the Canadian Cree, who are represented in this study. The second section of the chapter examines the social and cultural construction of disability. It is suggested that the concept of disability is socially and culturally linked. Language and learning disability in particular will be the focus of the discussion, with specific reference to the concept of language disability in Native Canadian cultures. Crosscultural differences in language socialization and in the concept of language disability present issues for the practice of speech-language pathologists and other language interventionists. The third section of the chapter discusses some of these issues for Native Canadians and provides a rationale for the present study.

Language Socialization

Like many aspects of cultural knowledge, language is socially and culturally influenced. The study of language socialization focuses on "socialization through language and socialization to use language" (Schieffelin & Ochs, 1986b, p.3). It is grounded in ethnographic studies of language use and caregiver-child interaction and

assumes that children acquire cultural knowledge, such as values, social relationships, and principles of learning, as part of the process of language acquisition.

In this section, a brief historical overview is presented of the social interactionist model of language development, a precursor to the study of language socialization. Child-directed speech in white, middle-class families is described, followed by illustrations of crosscultural variation in caregiver language input. More specifically, language socialization practices and issues pertaining to cultural variation and change within the Native American/Canadian culture are discussed.

The Social Interactionists' Perspective On Language Acquisition

The nature of input to language-learning children has been considered by many to be central to developing theories of language acquisition (Brown, 1973; Brown & Bellugi, 1964; Gallaway & Richards, 1994; Newport, Gleitman & Gleitman, 1977; Snow, 1972; Snow & Ferguson, 1977). Owing to the poverty and degeneracy of input, Chomsky claimed that the presence of an innate Language Acquisition Device (LAD) was essential for a child to develop language, (Chomsky, 1965). Since this claim, certain researchers have become interested in Baby Talk or Child Directed Speech (CDS), and many have attempted to show that language input, parent-child interaction, and the child's participation in social settings are also important ingredients for language acquisition, (Bruner, 1981; Furrow, Nelson & Benedict, 1979; Newport, et al., 1977; Snow, 1972). In addition, Bruner (1981, 1983) suggested that a Language Acquisition Support System (LASS), with elements such as "scaffolding" and "fine tuning", is an important catalyst for the LAD. In other words, some researchers believed that caregivers had an important role to play in facilitating their child's language acquisition.

Research into CDS began with Brown and Bellugi in 1964 and expanded enormously during the 1970s and 1980s. During this time, researchers began to relate the study of the social context of language acquisition to caregiver input and this became known as the "Social Interactionist" model of language development (Snow, 1994).

Child-Directed Speech

Charles Ferguson (1964) played a leading role in the study of "baby talk", which he described as a simplified register containing short, well-formed utterances, fewer hesitations, fewer complex sentences and fewer subordinate clauses (Snow, 1972; Phillips, 1973). At this time, the focus was on description rather than explanation. However, researchers soon began to question the extent to which maternal speech modifications were responsible for facilitating the child's language growth. A debate began, which centred around the correlation between the syntactic simplicity of maternal speech and measures of language progress (Furrow et al., 1979; Newport et al., 1977). It became increasingly clear that there was no simple correlation between child directed speech (CDS) and the process of language acquisition. The discussion began to move away from the facilitative effects of CDS per se toward the kinds of processes which children use in the analysis of caregiver input, (see Julian Pine,1994, for review). During the last 20 years, the scope of research on input and acquisition has broadened to include, among other things, discourse analysis (e.g. the relationship of the adult's utterance to the child's preceding utterance: Cross, 1977) and the mapping of pragmatic functions and forms (Ninio, 1992), as well as continued study of registers (Conti-Ramsden, 1985).

In addition to the controversy surrounding the facilitative effects of simplified caregiver input on language development, there has been an ongoing debate about the universality of child-directed speech. Research into CDS was originally based on studies conducted in the United States or Great Britain, involving white, educated, middle- or upper-class families (Brown, 1973; Sachs & Devin 1976). Child-directed speech in these studies is described as "syntactically simpler, more limited in vocabulary and in propositional complexity, more correct and more fluent." (Snow, in Fletcher & MacWhinney, 1995, p.180). This led to the false assumption that the language used with young children is simplified in uniform ways across different cultural groups. Some researchers began to realize that theories of language acquisition needed to be tested in other cultural settings (Ochs & Schieffelin, 1984) and with languages other than English (Slobin, 1985). Thus began the development of language socialization research and the cross-linguistic study of language acquisition. This thesis investigates certain aspects of language socialization.

Crosscultural Variations Of CDS

Children learn language in a social/interactional and cultural context. Through the caregivers' use of language, children learn to become competent participants in social activities and events within the cultural framework of their community (Crago, 1988; Crago, 1992b; Heath, 1983; Rogoff, Mistry, Goncu & Mosier, 1993; Schieffelin, 1986; Watson-Gegeo & Gegeo, 1986). They acquire cultural knowledge through language, such as information about social relationships and cultural values (Schieffelin, 1990). The theory of language socialization contains the notion that the kind of input and social interaction that children are exposed to is culture-specific, rather than universal (Lieven, 1994). Some cultures are child-centred, some are situation-centred

and many have patterns of caregiver-child interaction which differ from those documented in white, middle-class society (Schieffelin, 1986). For example, Shirley Brice Heath (1983) studied caregiver-child interaction in the rural, African-American community of Trackton, and found that people there believe that children should be encouraged to discover things in the world as their own. The following quote from Heath's book illustrates Trackton people's feelings about language development: "He gotta learn to know 'bout dis world, can't nobody tell 'im", (Heath, 1983, p.84). Conversely, the child's presence in the social environment did seem to be important for language-learning in this community, as children were noted to imitate speech echoically, selecting elements from the conversations going on around them (Heath, 1983). By contrast, the Kaluli believe that once the child has acquired the two critical words of "mother" and "breast", he or she needs to be shown how to speak (Schieffelin, 1986).

Crago, Allen and Hough-Eyamie (1997) demonstrated that the elements of a Language Acquisition Support System (Bruner, 1981) need not take the form of scaffolding or fine-tuning found in studies of white, middle-class British and American families. In their study of Inuit families, they found that Inuit caregivers did provide a socio-pragmatic framework for their children, although this framework differed in form from that found in the white, middle-class studies (Crago, Allen & Hough-Eyamie, 1997).

Other differences in language socialization practices noted by researchers include the role of siblings in child-rearing (Schieffelin, 1986); dyadic versus polyadic language learning environments (Heath, 1983; Schieffelin, 1986); the absence of baby talk to prelinguistic infants (Ochs, 1982; Pye, 1986; Schieffelin, 1986); teasing and

shaming routines (Crago, 1988; Heath, 1983; Schieffelin, 1986) and variation in use of elicited imitation (Crago, 1988; Demuth, 1986; Watson-Gegeo & Gegeo, 1986).

Cultural change and variation. Although crosscultural differences in caregiver-child interaction and in child-rearing have been identified, not all individuals within a cultural community will share the same values, attitudes and beliefs and there will be change over time.

It has been suggested that variation over time may be related to the amount of contact cultural group members have with the dominant culture (Crago, Annahatak & Ningiuruvik, 1993; Duranti & Ochs, 1996; Duranti, Ochs & Ta'ase, 1995; Hough-Eyamie & Crago, 1996).

Duranti and Ochs (1996) studied multicultural effects in Samoan American families and found that English was being used fluently in some instances. However, the *way* it was used was consistent with the socialization practices typical in traditional learning environments in Samoa, thus providing cultural continuity. The dominant language was therefore seen as being used "at the level of the communicative code rather than at the level of communicative conduct" (Duranti & Ochs 1996, p. 12). This concept of cultural blending has been termed "syncretism" by these authors. In their previous study (Duranti, Ochs & Ta'ase, 1995), they found that the Samoan literacy tool, the Pi Tautau, had become a symbol of tradition and cultural identity for the children of Samoan descent attending religious school classes in Southern California. The Pi Tautau is a large poster displaying the Samoan alphabet and Roman numerals. It serves to instruct literacy in Western Samoa, whereas in Southern California it is used to teach children how to speak as well as how to read Samoan. This study illustrated that,

for many Samoan Americans, "home" is both Samoa and the United States - there is cultural blending or syncretism.

Hough-Eyamie and Crago (1996) illustrated cultural variation between two Aboriginal mothers from two different Native groups (Mohawk and Inuit) and the dominant Canadian culture. They found similarities between the Mohawk and Inuit mothers on some measures but variation on others. They suggested that varying amounts of contact and blending with white Canadian culture were responsible for the differences between the two Aboriginal mothers. The Inuit mother was from a remote community on the Arctic Tundra of Northern Quebec. This community was only settled within the last thirty years and Inuktitut is still the majority language. By contrast, the Mohawk mother lived on a reserve on the outskirts of Montreal, with much heavier influence from mainstream Canadian culture. For example, most people in this community no longer speak their native language, as English has become the primary language within the community. The authors concluded that language interaction patterns across Aboriginal groups are strongly influenced by varying degrees of syncretism with the dominant culture.

In summary, child-directed speech varies between and within cultural groups, and there is change over time. The amount of variation and change depends on the degree of influence from the dominant culture.

Native American and Canadian issues. Any discussion of Native American/Canadian language socialization practices has to be placed in the context of their overall ways of living and factors that have impacted or continue to impact on Aboriginal life. These include geographical, political, economic, educational, linguistic and public health factors.

Many American and Canadian Indians continue to live on reserves, which tend to be geographically remote or, at least, physically separate from non-Aboriginal communities. In the United States, fifty percent of American Indians reside on reservations, with limited access to general services, (Harris, 1986).

Politically, most native communities have undergone several changes in how and by whom they have been governed (Harris, 1986). Some Aboriginal communities continue to have reserve status and function as discrete cultural groups, whereas others have adapted to influence from mainstream society. The changes have, in part, been economically motivated. Some Native people continue to "live off the land", but many have sought jobs in urban centres and have a lifestyle somewhat comparable to non-Native Americans and Canadians (Joe, 1980; Shorten, 1991).

In most Indian communities across Canada and in the United States, there is a history of children being sent away to residential schools for their education and it is only fairly recently that Native children have been able to attend schools in their own communities, and be taught in their first language in culturally congruent ways, (Crago, 1992a; Hodge & Edmonds, 1988; Joe, 1980; Shorten, 1991). Although there is considerable variation across North America, most Native children are educated in the language of the dominant culture (usually English), which is often their second language (Crago, 1990a; Taylor, 1990). Tharp (1989) also documented that psychocultural variables, or learning styles, vary from culture to culture. He stated that verbal or analytic problem-solving is emphasized in mainstream North American schools, but many other cultures adopt more global or visuospatial approaches. These psychocultural variables may put non-mainstream children at a disadvantage in the North American educational system.

Finally, there are many public health issues that impact on how children are raised in Native communities. Many reserves, because of their remoteness and rural location, do not have potable water for drinking, have limited access to medical facilities for immunization and medical treatment and many children are prone to otitis media with effusion (Harris, 1986; Stewart, 1983). The prevalence of otitis media in Native children has implications for speech, language and hearing development in these children (Anderson & Anderson, 1983; Harris, 1986; Stewart, 1983; Todd, 1986).

In summary, the language socialization practices of Native American and Canadian families are likely to be influenced by the geographical location, the political, economic, linguistic and educational history, and the general health services available within their communities.

Language Socialization In Native American And Canadian Cultures

There is a paucity of language socialization studies conducted within Native American/Canadian culture and even fewer within the Cree culture. Of those that have been conducted, studies have been done with Canadian Inuit families (Crago, 1990a, 1992a&b; Crago & Eriks-Brophy, 1994), Canadian Athabaskan families (Scollon & Scollon, 1981) and American Navajo families (Freedman, 1979;Guilmet, 1979; Joe, 1980).

Crago (1990a, 1992a) found that the communicative interactions between Inuit caregivers and their children differed in many ways from patterns observed in white, North American families. She found that the older Inuit women felt that it was more important for children to understand, follow directions and learn to do "socially useful things" (Crago 1990a, p.78) than for them to talk. Thus, Inuit children are socialized to look and listen. Communication without talk seems to be more common than in

mainstream North American families. Like Heath's study (1983), Crago found that Inuit children were not expected to participate in adult conversations, and, if the children asked questions during this time, they were ignored. They were, however, *exposed* to a great deal of adult conversation (Crago, 1992a). When talk *is* addressed to children, the ways in which Inuit caregivers interact with young children differ from child directed speech in mainstream North American homes. For example, nonverbal modeling and demonstration is commonly used as a teaching strategy by Inuit parents, rather than verbal explanation, which is more typical in non-Aboriginal homes (Crago & Eriks-Brophy, 1994). Young Inuit children are also encouraged to model verbalizations on those of older siblings, in repetition routines and it is not uncommon for older mothers to interact in silence with their children (Crago & Eriks-Brophy, 1994).

With regard to other Native North American cultures, it has been documented that Navajo mothers view talkative children as discourteous and undisciplined, in contrast to the mainstream society view that verbosity is an indication of intelligence (Freedman, 1979; Guilmet, 1979). Similarly, Northern Canadian Athabaskans do not expect their children to develop verbal language until the age of five and children speaking very much prior to this age are viewed as abnormal (Scollon & Scollon, 1981).

Joe and Miller (1987) have identified some of the general differences between American Indian and Anglo-American cultural values. They reported that the American Indian culture emphasizes how people *behave*, in contrast to mainstream culture, where the focus is on how people *think* or *feel*. Other characteristics of Native American culture include respect for group life, non-family supportive networking, a pragmatic approach to tasks and a quest for harmony. By contrast, Anglo-Americans were described as having a tendency to focus on the individual, rather than the group, to keep

family and friends separate, to adopt a "fix-it" approach to tasks and to have a quest for progress. Much of Joe's work has been conducted with Navajo populations on reservations in the south-west United States. She identified that, unlike mainstream American families, but like Inuit families, older siblings and extended family members play a large part in the role of caregiving for young children within the family (Joe, 1980), which is likely to affect the way a young child learns language and cultural values.

Anderson and Anderson (1983) identified cultural values in the behaviour of Native American children, such as valuing co-operation over competition and responding to authority figures by looking down or away. These characterizations of behaviour give some insight into family values and child-rearing practices within the American Indian culture.

Unfortunately, information regarding the Cree culture and their language socialization practices has not been previously documented. However, as mentioned above, issues such as remote geographical location, political, educational and economic history, second language learning and public health factors influence cultural practices and beliefs. It is therefore anticipated that differences in cultural values, beliefs, attitudes and child-rearing practices will be found between Cree communities and mainstream Canadian groups.

Summary

The study of language socialization has developed out of the social interactionist model of language acquisition. Researchers in this field have shown that aspects of child development, such as language development are influenced by social and cultural phenomena. These language socialization practices vary between and within cultural communities and there is change over time. The amount of change depends on the

extent of influence from the dominant culture on the non-dominant culture (syncretism). The limited research that has been carried out with Native Canadian communities has shown that there are cultural differences in child-rearing and language socialization practices, but there is some blending with mainstream Canadian culture for those communities that have more contact with or influence from it. Other issues impacting on lifestyle, socialization practices and variation over time include geographical location of the community, the historical and current political, economic and educational situation and the public health status of the community and access to medical services.

The Social And Cultural Construction Of Disability

Like language socialization, the concept of disability is socially and culturally linked. Culture has been described as shaping an individual's experience of disability, affecting the person's role in society (McKellin, 1994). This has implications for the way language disability in particular is viewed, both in mainstream North American society and in minority cultures.

In this section, models of disability as paradigms for health care delivery in the United States and Canada are discussed. The widespread use of a "deficit model" has influenced how disability is construed in different cultural settings (McDermott, 1993). Specifically, sociocultural issues pertaining to the delivery of health care for Native Canadians will be addressed in the context of their attitudes and beliefs and how these may be changing over time, as influence from mainstream Canadian society increases.

Models Of Disability

The biomedical, or disease model of disabilities, has been in use by health professionals since the mid-nineteenth century (Scheer & Groce, 1988). The underlying assumptions of the medical model are characteristic of the theory of functionalism, which suggests that individuals are allocated to their place in society according to their abilities. This categorization process involves two components: labeling and segregation. According to the medical model, individuals are labeled as diseased and segregated on the basis of their diagnosis (Peters, 1993). Individuals then receive specialized treatment for their category of disorder and are either rehabilitated or cured, or must accommodate their role in society according to their disability (McCormick, Pichora-Fuller, Paccioretti & Lamb, 1994; McKellin, 1994).

The scope of the biomedical model has been extended to psychoeducational settings and the same principles are used in mainstream North American schools. The educational system in North America, for example, involves assessment of students, using normative tests and then categorization of them on the basis of their performance on these tests. The skills which are measured by these tests and considered important for students to acquire are arbitrarily set by society (McDermott, 1993). McDermott called this phenomenon "culture as disability". For example, McDermott and Varenne described a case study of a child with a learning disability (Adam). They emphasized that Adam's learning problems would not have been so devastating to his interpersonal relationships, if the North American culture did not focus so relentlessly on individual success and failure (McDermott & Varenne, 1995). McDermott referred to this as the degradation or deficit account of disability (McDermott, 1993). The term "deficit model" will be used throughout this thesis to describe a paradigm which focuses on the

individual and their inherent impairment, while disregarding any environmental or cultural influence (McCormick et al., 1994; McKellin, 1994; Peters, 1993). In an attempt to standardize diagnosis of disorders and treatment for them, this model has remained popular with physicians and other health professionals (including speech-language pathologists) until the present day (McKellin, 1994; Peters, 1993).

The World Health Organization (1980) recognized the limitations of the medical model (from which McDermott's deficit model developed) and redefined the concepts of impairment, disability and handicap. In the International Classification of Impairments, Disabilities and Handicaps (WHO, 1980), impairment is defined as "any loss or abnormality of psychological, physiological or anatomical structure or function", representing some deviation from the norm in an individual's *biomedical status*. Disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". Thus, disability represents a departure from the norm in terms of *performance*, a functional limitation in aspects of daily living. Finally, handicap is defined as "a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex and social and cultural factors) for that individual". Notice here that the valuation is dependent on *cultural norms*, so that a person may be handicapped in one group but not in another. Existing societal and cultural values are important, because individuals are judged as being handicapped relative to other members of society.

In spite of the World Health Organization's attempt to redefine the above terms, the modern health care system still tends to operate at the impairment end of the continuum, using normative tests to identify disorders and categorize individuals

(McKellin, 1994). McKellin (1994) proposed that clinicians need to focus more on the cultural context of the impairment, which he described as an anthropological approach to service delivery. By doing so, issues such as the impact of the impairment on lifestyle (i.e. disability) and the social consequences of disability (i.e. handicap) can begin to be addressed. McKellin's anthropological framework was the focus of discussion at a symposium with the title "The psycho-social impact of hearing loss in everyday life: An anthropological view", which took place at the 1994 Annual Conference of the Canadian Anthropology Society (CASCA) and involved the Institute for Hearing Accessibility Research (IHEAR), as well as audiologists and other professionals. The anthropological framework is based on the belief that handicap is not an individual characteristic and has to be measured in context (Pichora-Fuller, 1994). Although applied to the hard-of-hearing population in this instance, this anthropological framework could be used as a paradigm for any disability or handicap.

For many speech-language pathologists and other health care practitioners, recent health care reform has resulted in a demand for evidence that intervention leads to beneficial outcomes for clients or consumers (Boston, 1994; Pietranton & Baum, 1995). This focus on functional outcome measures means that speech-language pathologists need to demonstrate that intervention makes a difference to the client in their everyday communication abilities, with focus on the disability/handicap end of the WHO continuum (Boston, 1994; Pietranton & Baum, 1995). Thus, an anthropological or sociocultural approach would enable clinicians to assess the appropriateness and effectiveness of their intervention by measuring the ability of their clients to communicate in everyday situations in their own communities (McKellin, 1994).

Culture And Disability

Culture, a term which generally describes shared meanings between individuals in a community (Hannerz, 1992), has been described as shaping an individual's experience of disability (McKellin, 1994). Cultural values affect a disabled person's role and the extent to which they are integrated into society. They are also responsible for negative consequences such as non-acceptance or stigmatization.

In mainstream and minority cultural groups, families and communities adapt or accommodate to people with disabilities, forming "ecocultural niches" (Gallimore, Weisner, Bernheimer, Guthrie & Nihira,1989). Gallimore's study of American families with children with developmental delays illustrated that the adaptations made depends on many factors, including ecological constraints or resources and cultural beliefs and customs. An example of this can be found in Martha's Vineyard, where the incidence of congenital deafness is so high that deaf people are completely integrated into the community and there is no exclusion or stigmatization. In fact, the community is organized so that it is difficult to discriminate the deaf from the hearing people (McDermott, 1993, 1995).

The Martha's Vineyard example illustrates that disabilities are not inherent characteristics of individuals, as the medical model suggests, but rather manifestations of cultural focus. The term disability is used to denote inability to perform tasks which are arbitrarily chosen from the array of daily life activities and marked as significant for that culture or community, (McDermott & Varenne, 1995). In the United States in the 1960s, many minority students failed in school, because of the cultural deprivation argument that these children were from impoverished homes and did not have experience of tasks considered to be important in North American culture, (McDermott &

Varenne, 1995). Despite the attempt by some pedagogical and health care professionals to rectify this cultural bias, there is still a tendency to evaluate minority students using normative tests developed and standardized using North American subjects, with underlying mainstream cultural values (Crago, 1990a&b, 1990b; Darou, 1992; Taylor & Payne, 1983; Van Kleeck, 1994).

Stewart (1983) states that the American Indian culture generally is more accepting of deviance than society at large. However, although cultural groups may have different values about disability and handicap, these beliefs and attitudes may change over time, (Duranti & Ochs, 1996; Duranti, Ochs & Ta'ase, 1995). In certain non-mainstream communities, the purveying of the deficit model and its inherent assumptions may also influence cultural norms and values and people may begin to adjust their conceptualizations of disability, attitudes and behavioural patterns in favour of mainstream values. This blending process may happen unconsciously, in the same way that language socialization and other behavioural patterns are affected by syncretism.

Social And Cultural Issues In The Health Care For Native Canadians

Some of the issues pertaining to Native Canadians have been mentioned in the previous section; namely, remoteness of community, political, educational and economic background, linguistic factors and public health issues. Examining health care specifically, remote, rural communities will likely have limited access to medical facilities (Harris, 1986). Remoteness and amount of cultural blending occurring in the community will likely determine the extent of traditional medicine practice; for example, the use of Indian healers. Very little research has examined the state of traditional medicine in countries that have very strong biomedical systems, such as Canada. Waldram (1990)

found that traditional medicine remains fairly strong on Canadian Indian reserves and even urban Natives (living in Saskatoon) still retain traditional health and illness beliefs.

As mentioned previously, sociocultural issues often give rise to public health problems which are difficult to address. The incidence of otitis media is extremely high in Native American and Native Canadian children: Various studies have shown that about 75% of children in Inuit and Canadian Indian communities have experienced one or more episodes of otitis media by the age of two (Stewart, 1983). Stewart (1983) also reports findings from studies looking at the consequences of middle ear problems on language development in Aboriginal children, and states that development of auditory processing skills is delayed. He suggests however that this may also be due to other sociocultural problems such as malnutrition. Although somewhat controversial, other risk factors for language delay/disorder in Native children include fetal alcohol syndrome, passive smoking and water pollution (Harris, 1986; Todd, 1986).

Of particular relevance to this study, is the recent government initiative to enhance preschool speech and language services throughout Ontario through collaboration with local District Health Councils and planning groups (Ministry of Health, 1996). In May, 1996, the Ontario Ministries of Health, Community and Social Services and Education and Training announced that $10 million would be allocated annually for preschool children with speech and language needs. The purpose of this project was to reduce disparities in availability of speech-language pathology services for young children. Local planning groups were established, coordinated by the local District Health Council, to determine the specific needs of each district and amount of funding needed to fulfill the goals of the plan. A planning group was established in the Cochrane District and a plan was submitted to the Ministry in June, 1997 (Cochrane District Health

Council, 1997). This paper identified specific high risk factors for children living in communities on the James Bay coast including the high prevalence of middle ear problems and prenatal maternal alcohol consumption, compounded by the remoteness of the communities and subsequent infrequency of professional visits (Cochrane District Health Council, 1997).

Attitudes And Beliefs Of Native Canadians And Americans. Several authors have compared Anglo-American and Native American cultural values (Joe & Miller, 1980; McCubbin, Thompson, Thompson, McCubbin & Kaston, 1993) and these general differences in beliefs have implications for attitude toward disability. The Anglo-American family is traditionally nuclear; life is oriented toward the individual; spiritual beliefs are compartmentalized, in that God is other-worldly; the environment is to be owned and controlled by humans and time is structured and future-oriented. By contrast, Native Americans have an extended family structure; emphasis is on the needs of the group above that of the individual; the Great Spirit is in all and spirituality is part of the world; the environment should be respected and time is present-oriented and cyclical (Joe & Miller, 1980; McCubbin et al., 1993).

Few studies have examined the beliefs of Aboriginal groups surrounding the concept of disability. Morse, Young & Swartz (1991) compared Cree Indian healing practices to Western health care methods and identified incongruities that the Cree may encounter as follows. They found that Cree people were accustomed to identifying their own state of health and illness and thus adopted a passive, rather than participatory role in healing. The notions of preventative medicine and "silent" diseases were incomprehensible to the Cree, and they did not relate to the role specialization of health practitioners, such as the social worker's role in counseling. Finally, they found that the

concept of "holism" was lacking in the Western medical system. In traditional Cree medicine, the sweat lodge ceremony is central to their beliefs about health and healing. Here, counseling and instruction are provided explicitly, unlike other skills in Cree life, which are learned by apprenticeship, (Morse, Young & Swartz, 1991).

Change And Variation With Cultural Contact. As mentioned in previous sections, cultural change occurs when a non-mainstream community has contact with mainstream society and this affects general lifestyle patterns, language use, behaviour and language socialization practices. It also influences other behavioural patterns which are socially and culturally determined, such as the beliefs, attitudes and values surrounding the concept of disability.

In Native communities where there is access to Western health care systems, Aboriginal people may still adhere to some their traditional beliefs about disability. Minde and Minde (1995) studied psychiatric symptomatology in Cree children on the Quebec side of James Bay. The community studied had relatively little contact with mainstream culture (for example, nearly everybody speaks Cree at home), although a psychiatrist traveled there from Montreal to provide sporadic service. These authors found adherence to traditional values, such as a philosophy of interconnectedness, a belief in emotional restraint, absence of confrontation and the right to silence. They felt that the Cree people's concept of disability was still founded on these values and therefore it was difficult for them deliver psychiatric services using mainstream models (Minde & Minde, 1995).

Janzen, Skakum and Lightning (1994) studied professional services in a Cree community in Alberta and found a continuum of adherence to traditional ways. They describe "culture" as "something that's being lived today in terms of lifestyle among our

people" (Janzen et al., 1994, p.88), whereas "tradition" involves "incorporating indigenous thought into daily living, practising century-old customs in terms of the ideals, the principles, the values and beliefs of their ancestors" (Janzen et al., 1994, p.88). The continuum these authors describe has four groups: Firstly, "traditional practitioner" at one end of the continuum, who practises according to the above quote; secondly, "cultural practitioner", who ignores parts of the ancestral tradition, but still believes strongly in maintaining Cree cultural practices; thirdly, a group combining traditionalists and culturalists, with varying degrees of adherence to Cree customs and values and lastly, a group whose members embrace assimilation and do not live according to traditional ways, even though they still consider themselves members of the Indigenous Nation (Janzen, Skakum & Lightning, 1994).

Summary

The concept of disability is socially and culturally influenced and some authors even believe it to be culturally constructed (McDermott, 1993). The deficit model has been shown to be culturally-insensitive for the delivery of health care services and the need for a sociocultural or anthropological model of disability has been raised (McCormick et al., 1994; McDermott & Varenne, 1995; McKellin, 1994; Peters, 1993). Values, attitudes and beliefs surrounding the concept of disability vary between and within cultures. However, the fostering of the deficit model in Aboriginal communities may have influenced the local people's attitudes and behavioural patterns, in terms of language socialization practices and conceptualization of disability. These issues have implications for the practice of speech-language pathologists, who deliver service to remote, Aboriginal communities, such as Moose Factory.

Sociocultural Issues For The Practice Of Speech-Language Pathologists

This section examines some of the sociocultural issues for the practice of speech-language pathologists. These issues include service delivery in remote communities, culturally sensitive approaches to assessment and intervention and disadvantages in service delivery for Native Canadians. Consumer satisfaction and efficacy will also be examined.

Speech-Language Pathology Models Of Service Delivery

Various approaches to delivery of speech-language pathology services have developed in the past 10 years. As alternatives to the clinician-directed model of service delivery, child- and parent-centred approaches and use of supportive personnel have also become popular, as well as hybrid models (Ilott, Holdgrafer & Sutter, 1991; Paul, 1995). Use of supportive personnel, such as speech assistants and Special Education Resource Teachers and use of interactive models involving parent training have become especially popular in remote and underserviced areas (Crago, Hurteau & Ayukawa, 1990). A particularly popular method of intervention with young children is parent-focused, interactive, language intervention programs, such as the Hanen Early Language Parent Program or HELPP (Manolson, 1985). Such programs are widely used throughout Canada and the United States, because they increase parental involvement in intervention, allow for early intervention (where a more direct approach might not be as effective) and are more efficient than a direct approach, because parents are seen in groups. However, the HELPP program and other parent education programs are grounded in research on parent-child interaction in white, middle-class

families and the goals, therefore, reflect beliefs about language teaching that are not shared by all cultural groups, (Van Kleeck, 1994).

Cultural bias may also be reflected in the overall paradigm inherent to speech-language pathology practices. The deficit or medical model of disability, as described in the previous section, is frequently used by speech-language pathologists in health and educational settings. Speech-language pathologists, in general, still assess children through use of some standardized tests, make a diagnosis (assign a label for the disorder) and treat (provide therapy specified for that disorder) according to the diagnosis made, which ideally leads to remediation (Crago & Cole, 1991; Harris, 1986; Taylor & Payne, 1983). This deficit model may not only be inappropriate because of its underlying philosophy, but may be particularly damaging for non-mainstream children, because it does not correct for cultural bias (McDermott, 1993; McKellin, 1994).

Sociocultural Issues

The ways in which speech-language pathologists provide services and make use of the deficit model, in particular, presents various sociocultural issues.

Firstly, use of a deficit paradigm can result in cultural insensitivity, owing to focus on the individual, rather than cultural context (McKellin, 1994).

Secondly, the use of standardized, norm-referenced tests may be culturally and linguistically invalid, due to various sources of bias (Darou, 1992; Taylor & Payne, 1983). Types of bias, as described by Taylor and Payne, include *situational bias* (culturally-specific rules of communication may be present during the test situation); *bias in directions or format* (the testing framework may not be consistent with home routines); *value bias* (the test may present culturally specific values or ethics) and *linguistic bias* (the student may not be familiar with the language used). These sources of bias are

likely to be present in many assessments that have been standardized on white, middle-class children from the United States or Great Britain (Crago & Cole, 1991).

Thirdly, providing services for children whose first language is not English is difficult, even with the use of interpreters. The difficulty lies in distinguishing a language problem from difficulty learning English as a second language (Taylor & Payne, 1983). This distinction may be blurred by using a model which assumes English to be the language of operation.

Lastly, parents may have attitudes and beliefs that differ from the mainstream culture. For example, Navajo parents interviewed in Joe's study viewed learning disability as a school problem and felt, therefore, that intervention was the responsibility of the school, rather than of the parents (Joe, 1980).

Remote Areas And Service Delivery

Remote, Native communities have limited access to services such as speech-language pathology and often have no choice in the type of intervention they receive (Harris, 1986). In the Aboriginal community where this study takes place, indirect models of service are used, as in other remote parts of Canada with non-Aboriginal populations. The problem of service delivery to remote areas is compounded by difficulty with recruitment and retention of speech-language pathologists in positions in northern Ontario. Historically, the Ministry of Health has provided incentive grants to speech-language pathologists through the Underserviced Area Program to work in communities such as Timmins. Unfortunately, although this has helped recruit staff, it has not retained them in northern posts. Consequently, staff turn over has meant that

problems with service delivery to outlying regions, such as Moose Factory, have been identified but never addressed (Saville, 1991, Cochrane District Health Council, 1997)

Barriers To Service Delivery For Native Canadians

In addition to the aforementioned general barriers to service delivery related to sociocultural issues, there are a few specific to speech-language pathology. For instance, although places in training programs for speech-language pathologists are reserved for Native students, very few Aboriginal people train to be speech-language pathologists and many speech-language pathologists report that they had no specific training in dealing with multilingual and multicultural populations (Crago, 1990a&b; Shewan & Malm, 1989). This is disturbing, when population forecasts predict that, within the next few years, as much as one third of speech-language pathology caseloads will be children from black, Hispanic, Asian and Native North American cultures (ASHA, 1988). Some professionals have tried to circumvent this cultural barrier by training local Native people to deliver services, using culturally appropriate methods (Crago, Hurteau & Ayukawa, 1990; Kuehne & Pence, 1993). This strategy has not been widely adopted, possibly due to inconsistency in service provision and difficulty retaining staff, as mentioned previously.

A second problem for speech-language pathologists in Canada is the unavailability of cultural norms for Native Canadian children, due to the limited research published in this area (Crago & Cole, 1991). This means that speech-language pathologists continue to use materials developed on (and only appropriate for) white, middle-class children (Tharp, 1989; Van Kleeck, 1994; Westby, 1995).

Lastly, the remoteness of Native communities is a barrier in itself to access to speech-language pathology services. Not only do speech-language pathologists travel

to these remote communities infrequently, but it is difficult to attract professionals to these localities or enable Native families to travel south to access services (Cochrane District Health Council, 1997).

Consumer Satisfaction And Efficacy

Consumer satisfaction studies relating to the profession of speech-language pathology are generally few in number and there are no previous satisfaction or efficacy studies that exist with Aboriginal populations. This study is, therefore, the first of its kind in this regard.

Ilott, Holdgrafer & Sutter (1991) examined consumers' satisfaction with different models of speech-language pathology service delivery (such as direct versus indirect intervention), different forms of service (such as speech-language pathologist versus speech aide delivery of the program) and quantity of service (such as low, moderate or high frequency of contact with the professional). They found that consumers (parents, teachers and school principals) were as satisfied with indirect as they were with direct service delivery, providing that the frequency of contact was moderate or high. However, they also found that providing a speech-language pathologist (rather than a speech aide) and increasing the quantity of service produced the most satisfaction overall.

Girolametto, Tannock and Siegel (1993) studied parental satisfaction with interactive language intervention (the Hanen Early Language Parent Program). Their results indicated that parents were very satisfied with this type of intervention, but equivocal about improvements in their children's language skills. That is, the parents felt that their interactions with their children improved, but there appeared to be no association between the parental reports and objective measures of change (videotaped

interactions). These authors concluded that satisfaction measures cannot be used as sole tools of outcome measurement.

Summary

There are a number of sociocultural issues for the current practice of speech-language pathologists. Firstly, an appropriate and efficient model for service delivery in remote. Aboriginal communities is lacking. Secondly, no culturally-sensitive tools for assessment and intervention are available. Thirdly, there is a dearth of Native professionals, especially speech-language pathologists. And finally, no consumer satisfaction or efficacy research has been done with Native families.

Conclusion

Many aspects of individuals' lives are socially or culturally influenced. The process of socialization through language and socialization to use language (Schieffelin & Ochs, 1986a), termed language socialization, is one of those aspects. In a similar way, the concept of disability is diversely constructed and there are varying attitudes, values and beliefs surrounding this concept. Therefore, each culture or society have different expectations about language development in their children and different beliefs and values about the concept of a learning or language disability.

Health care services, including speech-language pathology, limited in accessibility for remote, Native Canadian communities, may not be culturally appropriate for a number of reasons, despite blending of values and attitudes with the dominant culture. These reasons include culturally biased methods of intervention, culturally-insensitive models of service delivery, and sociocultural issues related to educational, linguistic and public health factors. Native families have little or no choice in what should

be done for their child and no studies of consumer satisfaction have been done with Native people. These issues have implications for the practice of speech-language pathologists in remote, Aboriginal communities and provide the motivation for this study.

Rationale For The Study

As a speech-language pathologist working in the northern Ontario community of Timmins and providing service twice a year to Moose Factory (a remote, Cree reserve), this author has had first-hand experience of the difficulties faced by clinicians and by families in providing culturally appropriate speech and language services. My professional experience provided the impetus for this study.

The aim of the study is to examine the attitudes and beliefs of Cree families in Moose Factory and non-Aboriginal families in Timmins toward language socialization and language disability and address consumer satisfaction with existing speech-language pathology services. In particular, three specific questions are asked. Firstly, what are the language socialization and child-rearing practices of Cree parents in Moose Factory and do they differ from those of non-Aboriginal parents in Timmins? Secondly, what are some of the attitudes of Cree people toward language and learning disability and do they differ from those of non-Aboriginal people in Timmins? Thirdly, how satisfied are Cree parents with the speech-language pathology services available and the models of service delivery and are they more or less satisfied than non-Aboriginal parents living in Timmins?

As this study was clinically motivated, it was hoped not only that a theoretical gap might be filled, in terms of expanding knowledge about language socialization and concepts of disability in the Cree culture, but also that some useful suggestions might emerge for clinicians working with Aboriginal people in remote, Canadian communities.

Chapter 3

METHOD

This chapter outlines the research methodology, including profiles of the communities where this study takes place (Moose Factory and Timmins) and the speech-language pathology services available to these communities. The subjects (i.e. parents of a child with a language or learning disability) are also described, including how they were selected, as well as the method and type of data collection and the interview structure employed with them.

The Communities[1]

Rationale For Community Selection

The communities of Timmins and Moose Factory, both in remote areas of northern Ontario (see Figure 1 below), were chosen for two main reasons. Firstly, the community of Moose Factory comprises a Cree reserve, which, owing to the author's personal connections, was a readily accessible source of Aboriginal participants for the study. Timmins was chosen as the community from which to select non-Aboriginal participants for the same reason: The author has worked as a speech-language pathologist in both communities (for the Porcupine Health Unit) and therefore was able to recruit participants more easily by using connections with former co-workers at various agencies in Timmins. As Moose Factory inhabitants continue to follow certain

[1] In addition to conventional literature searches (such as was available from the Ojibway-Cree Cultural Centre in Timmins), oral histories of the communities involved in this project and details of speech-language pathology service provision, were obtained from a number of sources. Historical information about Ministik school (Moose Factory) and services to the island was provided by Lil West, Special Education Coordinator at the school. Information about the agencies in Timmins providing speech-language pathology services to Timmins and to Moose Factory, was obtained directly from staff employed by those agencies. These people are members of the local chapter of the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) and members of a Private Practice Professional Interest Group (PPPIG). Information was also obtained from Claudette Lamontagne (Executive Director for the Integrated Services for Northern Children Program) through personal communication.

cultural traditions and have a lifestyle which differs in various ways from families in Timmins, an opportunity to examine the language socialization patterns of families in these disparate communities presented itself.

Secondly, the District of Cochrane has been classified as an "underserviced area" by the Ministry of Health for many years. Until recent years, health professionals, particularly speech-language pathologists, have been difficult to recruit and retain in northern positions. A history of long waiting lists, rapid staff turnover and gaps in service exist, and these problems continue to present as issues for the delivery of services to Timmins and Moose Factory. It was therefore possible to examine speech-language pathology service delivery to these communities through the eyes of the consumers and make comparisons between the non-Aboriginal and Aboriginal group perspectives.

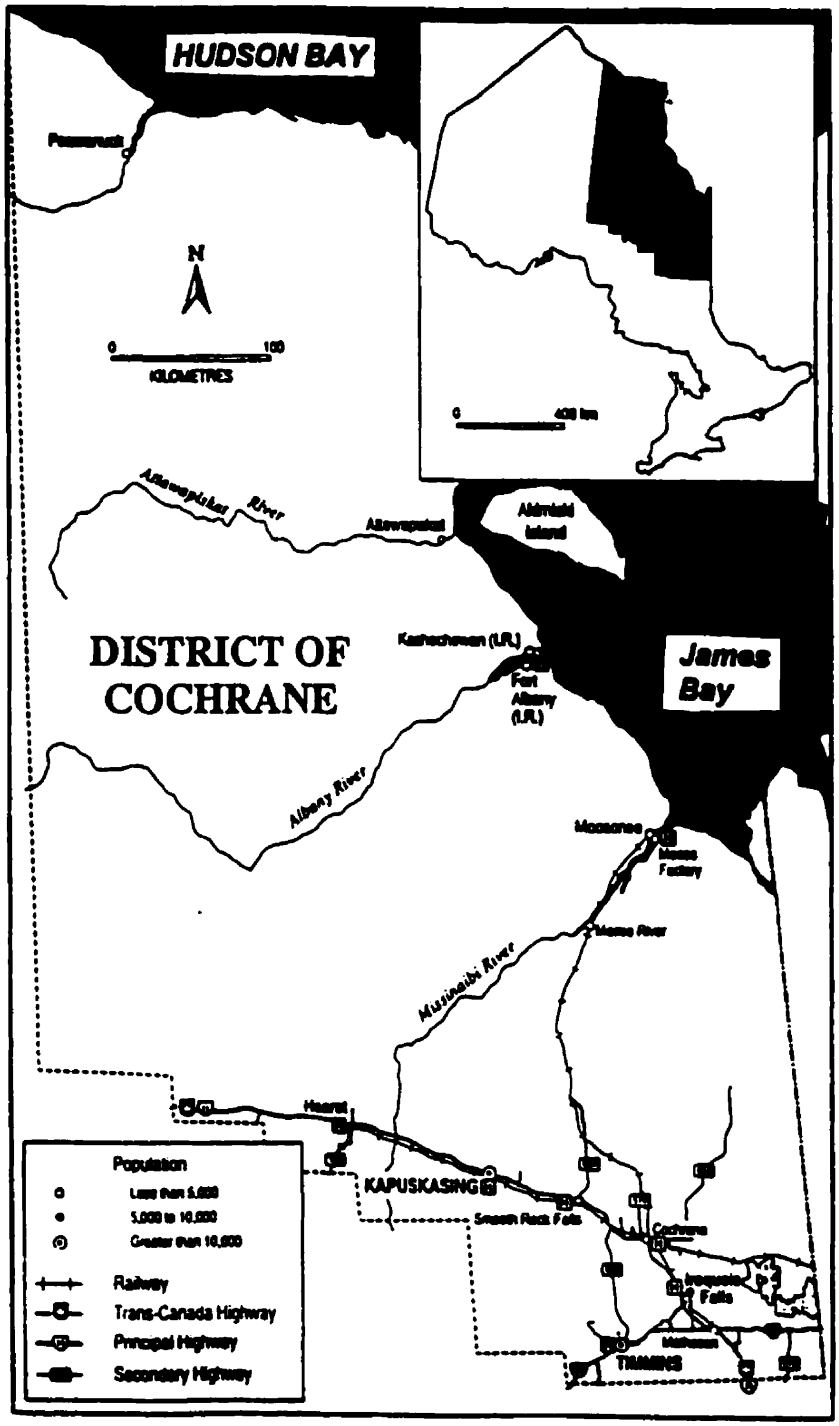
Moose Factory

Moose Factory, a Cree reserve on an island off the James Bay coast, has a population of about 1200. It neighbours Moosonee, a Cree community with non-reserve status across the Moose river. As there are no roads into these towns, they are quite isolated from Timmins and other larger communities in northern Ontario. Public transportation into the area is possible only by train or air.

The Cree inhabitants of Moose Factory descended from nomadic, hunting and trapping people, whose origins in the area can be traced back to the seventeenth century. Historically, there were two major outside influences on the community of Moose Factory. The first was the founding of the Hudson's Bay Company in 1671. This company brought English and French fur traders into the community from Europe and a mutually beneficial relationship began to grow between the local Native people and the

Figure 1

Map showing the location of the communities of Timmins and Moose Factory within the District of Cochrane



From: Cochrane District Health Council Plan for the Development of a Speech and Language Services System for Preschool Children (Cochrane District Health Council, 1997).

Europeans. The Cree provided the company with furs from their traplines in exchange for goods from Europe. The company also provided the Cree trappers with housing and food (Barnes, 1988; Cheechoo, 1991).

The second influence was the arrival of Wesleyan-Methodist missionaries in 1840 and Anglican missionaries in 1864. These missionaries settled in the community and eventually interbreeding took place between the local Cree women and the English, French and Scottish men associated with the churches or with the Hudson's Bay Company. By the early 19th century, children were born from these mixed relationships and their generation and future generations became known as Métis, meaning "mixed blood" (Barnes, 1988).

The Cree depended on a lifestyle of trapping and hunting for many years and a few still do today. This meant they would abandon the reserve for months at a time to trap and hunt, returning to the fur-trading post for food, medical care, and rest. Many sent their children away to residential schools in southern Ontario, which were operated by the federal Ministry of Indian Affairs, or to Bishop Horden residential school in Moose Factory (Barnes, 1988). This continued until 1984, when Ministik school in Moose Factory was opened. This school continues to provide education for children up to grade eight and a new high school is in the process of construction on the island. The language of instruction at Ministik school is English, but most children participate in a Cree class, which focuses not only on teaching the Cree language, but also some of the cultural traditions, such as trapping skills or building snow shelters for survival. Some traditions still live on in Moose Factory, such as the great goose hunt. To enable the children to accompany their parents on this outing, Ministik school closes for a week in the fall (Information provided by Ministik school, 1997).

No highways were ever constructed to connect Moosonee and Moose Factory with the south. Instead, the Temiskaming and Northern Ontario Railway and the Polar Bear Express were very important to the development of both Moosonee and Moose Factory. Tourism began to appear as an alternative means of employment to traditional trapping and the train brought in supplies to the communities, as well as providing a means of transportation (Barnes, 1988).

In 1949, the Moose Factory General Hospital began operating, which meant greater access to medical services of all kinds. The hospital provides acute medical care and serves as a base for special clinics by visiting physicians and other medical professionals. The Porcupine Health Unit (based in Timmins, with a satellite office in Moosonee) and an interdisciplinary team from the Child Development Centre in Kingston began to provide services for families in Moosonee and Moose Factory in the 1980s (see below).

Timmins

The city of Timmins, with a population of about 50,000, lies in the region known as Porcupine and within the District of Cochrane. It is the largest city in North America by area, however it is quite remote. The nearest city of Sudbury is 350 km away.

For thousands of years, the area was inhabited by Aboriginal peoples from Cree and Ojibwa bands. Three thousand Native people continue to live in Timmins and the surrounding area, but many have adopted an urban lifestyle and have relinquished Aboriginal traditions such as hunting, trapping and sweat-lodge ceremonies. Many have relocated to Timmins from James Bay seeking employment or education (Timmins Chamber of Commerce, 1995).

At the turn of the century, gold prospectors settled in the Porcupine area and many mines were founded. Mining of gold and other metals, such as zinc, copper, silver, tin and cadmium, continues to be the main industry of the area. In fact, Porcupine has become recognized as the largest gold-producing area in the Western hemisphere. The second major industry in the Cochrane District is forestry (Timmins Chamber of Commerce, 1995).

Educational options for children in the Timmins area consist of the Timmins Public Board of Education (mostly English language schools) and the Roman Catholic Separate School Board (mostly French language schools). Secondary education facilities include the community colleges of Northern College, Collège Universitaire de Hearst and Collège Boréal; the nearest university is Laurentian University in Sudbury (Timmins Chamber of Commerce, 1995).

Although much bigger in size and population than Moose Factory, Timmins and the District of Cochrane have been classified as "underserviced areas" by the Ontario government for many years (Cochrane District Health Council, 1997). Until recent years, health professionals from all disciplines have been difficult to recruit and retain in northern positions. There is a history of long waiting lists, gaps in service and rapid staff turnover, particularly in speech-language pathology. More recently, a broader range of services and more consistent delivery of service has become available. Services to preschool and school-aged children in Timmins with speech/language difficulties are described below. Comments are also made on the availability and unavailability of these services to children in Moose Factory.

Speech-Language Pathology Services

Porcupine Health Unit

Porcupine Health Unit provides speech-language pathology services to children from 0-5 years as part of the public health service to the Cochrane District (which includes Moose Factory and other James Bay communities), and to children in grade one and above as part of school support services, funded by the Community Care Access Centre (formerly Home Care). The latter service involves assessment and intervention to school-aged children with exclusively non-language-based difficulties, namely phonological, articulatory, fluency or voice problems. Children with "mixed" disorders, such as phonological *and* language problems combined, sometimes qualify for service. Since 1980, children with language-based learning difficulties have been considered to be the responsibility of the School Boards (by the government) for the provision of speech-language pathology services. Unfortunately, the Public Board of Education has not recruited a speech-language pathologist for many years, thus leaving an enormous gap in service for this population.

The Health Unit continues to provide a range of public health services to the community of Moose Factory, such as immunization, water treatment, dental care and developmental health checks for children including speech-language pathology services. By 1985, a model was established for delivery of speech-language pathology services. Twice a year, the speech-language pathologists (usually two people) would fly into the area and stay for a few nights, apportioning their work time between three elementary schools (two in Moosonee and one in Moose Factory). Their time was spent formally assessing as many as twelve children per day, due to the long list identified by the teachers as needing speech-language therapy. This evaluation was followed by

individualized therapeutic programs, left by the visiting speech-language pathologists, to be carried out by the special education resource teachers at the school. There was often very little time to discuss options with the teachers and rarely did the speech-language pathologist meet with the parents, although an invitation to attend the appointment was sent out by the school (OSLA Chapter, personal communication, April 23, 1997; West, L., personal communication, February 28, 1997).

Child Development Centre Team (CDC)

The Child Development Centre Team (CDC), based at Hotel Dieu Hospital in Kingston, Ontario, (over 1200 km away from Moose Factory) originally began providing satellite services to Moose Factory in 1984. At that time, services throughout Northern Ontario were very limited and Timmins, the nearest centre for services, had only one sole-charge speech-language pathologist, providing scanty services to the whole Cochrane District. The CDC team comprised a range of professionals, including a developmental pediatrician, psychometrist, speech-language pathologist and occupational therapist. Their mandate was primarily to provide a diagnostic service for preschool children in Moose Factory. Like the Porcupine Health Unit, this team would travel bi-annually to Moose Factory and would mainly see children in pre-Kindergarten, Kindergarten and grade one. Services were exclusively diagnostic; standardized tests were administered and a report was produced, which provided the results of the normative testing and some general recommendations, but few specific suggestions for intervention (West, L., personal communication, February 28, 1997).

Cochrane Temiskaming Resource Centre (CTRC)

CTRC provides services to children of all ages and adults with developmental challenges. Although they do provide service to children in Moose Factory, the service

is limited to a few visits per year and the population that they serve do not have specific language and learning difficulties (OSLA Chapter, personal communication, April 23, 1997).

The Porcupine Health Unit, the Child Development Centre Team and the Cochrane Temiskaming Resource Centre are the only agencies providing regular speech-language pathology services to Moose Factory, and, as mentioned above, visits are infrequent. Thus, the people of Moose Factory have become accustomed to an itinerant delivery of speech-language pathology services. They have never had a speech-language pathologist living locally and no professionals with an Aboriginal background have ever been recruited to service the area.

The Children's Treatment Centre (CTC)

The CTC provides speech-language pathology services in Timmins to children aged 0-19 years with primarily physical challenges. Services for children in grade one and above with language problems are limited to those who have multiple educational problems. Services for preschool children often are limited to those with some physical basis for their speech and language difficulty, such as cleft lip or palate and sensorineural hearing loss. The Children's Treatment Centre employs 1.5 full-time equivalent speech-language pathologists. Owing to a heavy caseload and the goal of eliminating travel time, services have been restricted to the outlying communities, including Moose Factory and other James Bay towns. Services are thus only provided to families living in Timmins or who can travel to Timmins (OSLA Chapter, personal communication, April 23, 1997).

Timmins Roman Catholic Separate School Board (TRCSSB)

Whereas the public board of education has no speech-language pathologist on staff, the TRCSSB has one full-time equivalent for the whole board of elementary and high schools in Timmins. The speech-language pathologist providing these services is therefore restricted to mostly collaborative and indirect methods of service delivery to language- and learning disabled children, most of whom are francophone. Services are not offered to other school boards outside of Timmins, including Moose Factory (OSLA Chapter, personal communication, April 23, 1997).

Integrated Services for Northern Children (ISNC)

Services in the rural communities surrounding Timmins are available through Integrated Services for Northern Children, a government program, funded by the Ministries of Health, Education and Community and Social Services. Services are restricted to children in the outlying towns only and to those with a multiplicity of learning needs. ISNC does not provide services to Aboriginal children living on reserves, such as Moose Factory, for several reasons. Political discussions at a ministerial level with First Nations' leaders have focused on services for Aboriginal children for several years. Although ISNC has voiced a willingness to provide service to children on reserves, the Aboriginal communities have been unable to come to an agreement of how services should be delivered. Issues centred around cultural sensitivity of services and hiring of Aboriginal professional staff, for example, have been unresolved between some of the Native communities and their political leaders. ISNC services are therefore not available to children in Moose Factory, (Lamontagne, C., personal communication, May 15, 1997).

Private Practitioners

Due to long waiting lists at public agencies, some speech-language pathologists in Timmins have started to offer private services. Most private practitioners in the town combine private work with employment at a government agency. Therefore, services are usually available only in the evening and on weekends, with the exception of one private practice speech-language pathologist who runs a part-time clinic during the day. Rates vary among the clinicians, but most are in the region of $90 per hour. Some employers in Timmins offer private (extended) health insurance as part of their employees' benefits package, and these provide some coverage for speech-language pathology services. However, most insurance ceilings are in the region of $300 per year, which is quickly exhausted, if regular speech-language pathology sessions are required. Although some private speech-language pathologists are prepared to travel short distances (less than 100 km) to provide services to communities neighbouring Timmins, none travel to the James Bay coast, so private services are not yet available to Moose Factory (Private Practice Professional Interest Group, personal communication, June 19, 1996).

Despite an improvement in some areas of service delivery, there is still a need for more speech-language pathologists, as waiting lists are long and amount of service is limited. There are currently nine full-time equivalent speech-language pathologists within the Cochrane District providing services to preschool and school-aged children. Census data from 1991 indicated that 7115 children in Timmins (5.5 %) and 270 in Moose Factory (32.2%) were identified by parents and professionals as needing speech-language pathology services (Saville, 1991). It was difficult to account for the huge discrepancy between the percentages, although a number of speculative reasons were

suggested. These included over-identification of children with speech-language problems in Moose Factory (for example, second language learners), and under-identification of children in Timmins (due to lack of public education), and an insufficiency of staffing resources, given the geographical area with widespread, rural communities. Given that the speech-language pathologists have to provide service to the preschool and school-aged populations of the District (145,618 square kilometres) and that they travel to small communities (70-260 km, not including James Bay), this presents an enormous service delivery challenge to clinicians. Creative ways of providing efficient service have been explored by all agencies, including group therapy, consultative approaches and parent training programs, such as the Hanen Early Language Parent Program. Indirect methods of service delivery are routinely used to maximize professional time (such as those suggested by Ilott et al., 1991, and Paul, 1995). Nevertheless, long waiting lists still exist.

Nature Of The Study

This study takes the form of an interview survey (Briggs, 1986; McCracken, 1988). It is both qualitative and quantitative in its approach.

Subject Selection

Nine Aboriginal families from Moose Factory and nine non-Aboriginal families from Timmins were recruited for the study. They were identified through special education resource teachers or speech-language pathologists in the area. All families had a child with a severe speech and/or language disorder, and, in most cases, the child's learning ability was also affected.

Subject Characteristics

The characteristics of the Aboriginal and non-Aboriginal respondents are shown in Tables 2 and 3. There were 18 respondents in total, or 9 couples; there were no single-parent families. However, owing to subjects' working schedules, it was only possible to interview both parents for three of the Aboriginal and six of the non-Aboriginal families. The single interviewees were able to provide some information about their absent partners.

All parents were educated in English (as the language of instruction) although for many of the Cree parents, English was their second language. The respondents' perceptions of their own current language proficiency for Cree, English and French are illustrated in Table 4. All interviews were conducted in English without need of an interpreter.

Cultural background. The Aboriginal group were also asked about their cultural background and whether they felt their immediate and their extended family held "strongly to traditional ways", whether they were "more modern in their ways" or whether they were "both modern and traditional". The percentages of responses in each of these three groups are shown in Table 1.

Table 1

Percentages of Aboriginal parents reporting various degrees of traditionality

Category	Immediate Family (n=17)	Extended Family (n=17)
Hold strongly to traditional ways	0%	12%
Are more modern in their ways	59%	29%
Are both modern and traditional	41%	59%

Table 2

Subject characteristics: Aboriginal group.

Aboriginal Parents	Age	Own Home	Income[2]	Highest Level of Ed.	Never lived South	Lived in Moose Factory... >10 yrs	<10 yrs	All life
Family 1A	43	No	>$50	Coll	Yes		Yes	
B	40			Gr 8	Yes	Yes		Yes
Family 2A	37	Yes	>$50	Gr 13	Yes	Yes		Yes
B	44			Coll	Yes		Yes	
Family 3A	25	No	$20-30	Gr 13	No	Yes		
B	28			Coll	Yes	Yes		Yes
Family 4A	47	Yes	$15-20	Gr 8	Yes	Yes		
B	50			Gr 13	Yes	Yes		
Family 5A	30	No	$30-40	Gr 13	Yes	Yes		
B	35			Coll	Yes	Yes		
Family 6A	37	No	$15-20	Gr 13	Yes	Yes		
B	41			Gr 13	No	Yes		
Family 7A	36	Yes	>$50	Coll	Yes	Yes		Yes
B	43			Gr 13	Yes	Yes		Yes
Family 8A	35	No	$20-30	Coll	No	Yes		
B	36			Coll	No	Yes		
Family 9A	38	Yes	>$50	Uni	Yes	Yes		Yes
B	37			Coll	Yes	Yes		Yes
	Mean: 38	**Yes: 44%**	**Mean: $30-40**		**Yes: 78%**	**Yes: 88%**	**Yes: 12%**	**Yes: 22%**

Note: A = Mother; B = Father. Ed. = Education. Coll = College. Uni = University. Gr = Grade. Never lived south = parent never lived in Southern Canada. Yrs = years.

[2] Income is in thousands of dollars (Canadian)

Table 3

Subject characteristics: Non-Aboriginal group.

Non-Aboriginal Parents	Age	Own Home	Income[3]	Highest Level of Ed.	Never lived South	Lived in Timmins ... >10 yrs	<10 yrs	All life
Family 1A	35	Yes	$40-50	Coll	Yes	Yes		Yes
B	33			Coll	Yes	Yes		Yes
Family 2A	35	No	$15-20	Uni	No		Yes	
B	37			Coll	No		Yes	
Family 3A	29	Yes	>$50	Coll	Yes	Yes		Yes
B	31			Uni	Yes	Yes		Yes
Family 4A	31	Yes	$40-50	Gr 13	Yes	Yes		
B	28			Gr 13	Yes	Yes		Yes
Family 5A	38	Yes	$40-50	Gr 13	Yes	Yes		Yes
B	41			Gr 13	Yes	Yes		
Family 6A	42	Yes	>$50	Gr 13	Yes	Yes		Yes
B	46			Coll	Yes	Yes		Yes
Family 7A	37	No	$20-30	Gr 13	Yes		Yes	
B	33			Gr 13	Yes	Yes		
Family 8A	31	Yes	>$50	Coll	No	Yes		Yes
B	34			Coll	No	Yes		
Family 9A	36	Yes	$40-50	Coll	Yes	Yes		Yes
B	39			Coll	Yes	Yes		Yes
	Mean: 35	**Yes: 67%**	**Mean: $40-50**		**Yes: 83%**	**Yes: 83%**	**Yes: 17%**	**Yes: 61%**

Note: A = Mother; B = Father. Ed. = Education. Coll = College. Uni = University. Gr = Grade. Never lived south = parent never lived in Southern Canada. Yrs = years.

[3] Income is in thousands of dollars (Canadian)

A larger percentage of extended families (particularly grandparents or elders) maintain traditions and fewer of these are more modern in their lifestyle, whereas immediate families were mostly described as more modern in their ways (59%) and none was described as holding strongly to traditional ways. As participants referred to extended families as consisting mainly of grandparents, one could speculate that the younger generations (immediate families tended to include the younger family members) are adapting to cultural change and adopting mainstream lifestyles. Non-Aboriginal families were not asked about their adherence to cultural traditions because they all came from mainstream cultural backgrounds (i.e. Anglo-Canadian and Franco-Canadian), and their degree of traditionality was considered to be irrelevant to their language socialization behaviours.

Although all Aboriginal respondents were comfortable with the labels "Native" and "Aboriginal", the term "Cree" was difficult for them to define and some were not comfortable with this identification. Several respondents commented that they could not be defined as "Cree" because of inadequate Cree-language skills and varying adherence to Cree cultural traditions such as drumming, participation in sweatlodges and spring hunting. However, as the cultural heritage of the geographical area of Moose Factory in general is Cree, the Aboriginal group are still denoted as Cree for the purposes of this study.

Language proficiency. Respondents were questioned about their language proficiency in English, French and in Cree and asked to rate their level of proficiency. The results are shown in Table 4.

Table 4

Percentages of parents reporting various levels of language proficiency in English, French and Cree within categories on a scale.

Scale of Proficiency	English		French		Cree	
	Ab	Non-Ab	Ab	Non-Ab	Ab	Non-Ab
	(n=18)	(n=18)	(n=18)	(n=18)	(n=18)	(n=18)
Very Well	100%	100%	0%	17%	39%	0%
Well			0%	22%		0%
Average			0%	11%	11%	6%
Poor			22%	44%	33%	
Not at all			78%	6%	17%	94%

Note. Ab = Aboriginal. Non-Ab = Non-Aboriginal.

Language use in the home. The language use characteristics of the Aboriginal and non-Aboriginal groups are shown in Tables 5 and 6, respectively. None of the Aboriginal families reported Cree to be the focal child's first language (see Table 5), although 67% of parents grew up in Cree-speaking families and 61% of respondents reported some ability to speak Cree (although were reluctant to describe themselves as "bilingual"). Three non-Aboriginal families reported a bilingual home environment, where the focal child was exposed to both French and English (see Table 6).

Table 5

Percentages of language use variables in the Aboriginal homes

Description	% (n=18)
Family background is Cree-speaking[4]	67
Family background is not Cree-speaking	33
Parents' language in education was English	100
Parents speak Cree very well	39
Parents speak Cree average-poorly	44
Parents do not speak any Cree	17
Cree is sometimes spoken in the home	33
English only is spoken in the home	67

Table 6

Percentages of language use variables in the non-Aboriginal homes

Description	% (n=18)
Family background is anglophone	50
Family background is francophone	11
Family background is mixed (A/F)	39
Parental language in education was English	67
Parental language in education was French	33
Respondents able to speak some Cree	6
Language used in the home is English only	67
Language used in the home is French only	0
Both French and English are used in the home	33

Note. A/F = one parent was anglophone and one parent was francophone.

[4] Parents stated that at least one of their parents was Cree-speaking.

Data Collection

This study takes the form of a survey, using a face-to-face interview with the parents of a child with a speech/language difficulty. The Aboriginal parents were interviewed either in their home or at Ministik school in Moose Factory, depending on their preference. As mentioned above, both parents were interviewed in only three out the nine families; in the other six interviews, only the mother was present and in one case, the mother was accompanied by one of her older daughters. The non-Aboriginal families were all interviewed in their own home, as this was their preference. Both parents were present for six out of nine interviews. The Aboriginal families were interviewed between February 24 and 28, 1997. The non-Native families were interviewed between March 25 and June 23, 1997. The interviews ranged from one hour and fifteen minutes to three hours in length.

The Interview

A written questionnaire was used to guide the interview (see Appendix). The original questionnaire was adapted owing to situational constraints. For example, most respondents were not willing to commit more than one hour of their time to answering questions. Questions which were always asked are asterisked on the questionnaire. The other non-asterisked items were asked according to the situation or as they were deemed appropriate.

The initial part of the interview contained short answer or closed questions pertaining to lifestyle and language background (sections A and B, respectively). These sections were not audiotaped. Questions pertaining to language socialization and disability/service delivery (sections C and D respectively) were audiotaped in all families, with the exception of one Aboriginal family, who consented to participate only if the

interview was not recorded. These questions were either more open-ended or required rated responses. Written notes were kept during all the interviews and recorded on the questionnaire.

Data Analysis

The interviews were transcribed by the researcher, so that the greatest possible level of accuracy in transcription was achieved. McCracken (1988) discourages researchers from transcribing their own data, claiming that becoming too familiar with the data during transcription will affect the analysis. However, owing to the poor recording quality and lack of funding to hire a typist, this option was not feasible.

Quantitative Analysis

Regarding responses to the scaled questions, the limitation in taking the mean of ordinal data is acknowledged. However, it was believed to be revealing, nonetheless, to examine the data from a quantitative perspective, so an equal interval scale was assumed. Since not all parents were available for an interview, a mean response for each family (the average of both parents' responses, in cases where both parents *were* interviewed) was determined to establish equal sample sizes (n=9 in each group).

Differences between the Aboriginal and non-Aboriginal groups in three main areas - language socialization, concept of disability and service delivery - were examined using t-tests on mean responses to each scaled question. Questions were asked about developmental language milestones and child-directed speech (language socialization), parental attitudes toward language and learning disabilities (concept of disability), accessibility of services and appropriateness of speech-language pathology services and mainstream education for Aboriginal families (service delivery).

Categorical data were analyzed by calculating the percentage of response to each category and then comparing the differences in percentages between the Aboriginal and non-Aboriginal groups. (No statistical analyses were performed on these data). Data were compared in this way for each of the three perspectives. Topics addressed include language use variables; parental concern for their child's difficulty; non-oral communication; diagnosis; parental attitudes toward assessment and intervention, and consumer satisfaction with the speech-language pathologist's assessment and proposed intervention.

Qualitative Analysis

A qualitative analysis of the data was made by comparing the respondents' comments in the Aboriginal and non-Aboriginal groups. These comments were either responses to statements or questions posed by the researcher or spontaneous comments. The transcripts from the interviews were grouped according to different questions or issues for the Aboriginal and non-Aboriginal respondents. This enabled the researcher to find patterns of similarities and differences in attitudes within and between the two groups.

In addition to this, two independent raters, with no prior knowledge of Aboriginal culture, were asked to read transcript segments with all identifying information (i.e. group identity) removed. The raters were then asked to rank the interviewees' responses, (based on their interpretation of the interviewee's transcript segment) by placing them on the same nine-point scale used by the respondent during the interview (e.g. Strongly Agree to Strongly Disagree). The raters' rankings and the interviewees' responses were then compared and comparisons were also made between the rankings of the two raters. The purpose of this analysis was to examine the extent of agreement between

the scaled responses of the interviewees (quantitative data) with their comments (qualitative data) to identify any discrepancies or contradictions.

Chapter 4

RESULTS

This chapter examines the results of the data analyses from three perspectives. First, comparisons are made between the Aboriginal and non-Aboriginal groups in terms of child-directed speech, language socialization patterns and non-oral language in both communities. Then, the concept of language and learning disability is examined with reference to Aboriginal and mainstream culture. The value of learning and literacy in each community is also discussed. Finally, speech-language pathology service delivery issues are addressed, including consumer satisfaction, accessibility and adequacy of services and cultural appropriateness and sensitivity. Within each section, the phenomena of cultural change and cultural blending are considered.

Language Socialization

In this section, developmental language milestones and parental concern regarding the attainment of these milestones are compared between the Aboriginal and non-Aboriginal groups. Then, patterns of language socialization are examined. For the purposes of this study, language socialization patterns consisted of aspects of child-directed speech, such as use of direct questioning, modeling, and labeling, as well as the rate and complexity of parental speech. Parental attitudes towards oral language production, the notion of "baby talk" and non-oral communication, such as use of eye contact and silence, were also examined. These practices in the Aboriginal and non-Aboriginal groups were compared.

Developmental Language Milestones

Parents were asked at what age they expected normally-developing children to attain certain linguistic milestones (see Table 7). Table 7 indicates that there were no significant differences between the Aboriginal and Non-Aboriginal groups in terms of their expectations regarding when their children combined words, when they were understood by strangers or when they were able to recognize their printed name.

Table 7

Aboriginal and Non-Aboriginal Parental Estimations of Age at which Children Develop Certain Language Milestones

Question: At what age do/are children usually...	**Ab Group** (n=9)			**Non-Ab Group** (n=9)			
	Mean	**R**	**SD**	**Mean**	**R**	**SD**	**t**
...say their first words?	1.61[5]	1	0.49	1.22	1	0.44	1.78
...combine words?	1.67	2	0.71	1.67	2	0.71	0.00
...understood by strangers?	1.83	2	0.61	2.06	1	0.30	0.98
...recognize their name written?	1.44	1	0.53	1.72	1	0.44	1.21
...write their name?	1.67	1	0.5	2.11	1	0.33	*2.22

Note: Ab = Aboriginal group; Non-Ab = Non-Aboriginal group. R = range.
*$p < 0.05$.

A significant difference [$t(16) = 2.22$, $p < 0.05$] between the groups was found in terms of when parents expected their children to be able to write their own names. Aboriginal parents generally expected their children to write their names *at a later age* than non-Aboriginal parents. One Cree mother suggested an explanation for this,

[5] See Appendix (Questionnaire) section C1(a)-C1(e), for the scale of age ranges provided for respondents.

reporting that literacy has only recently become important for Aboriginal families, since their traditional mode of communication was oral:

> SW: There's no access to those things, that you have in school, like er ..because ours is more like an oral tradition. (Aboriginal mother).

A difference between the parental expectations for the age at which a child would be expected to say their first words reached significance at $p = 0.09$.

Language milestones in bilingual homes. In light of the fact that two languages are used in some of the homes in both the Aboriginal and non-Aboriginal groups (see Tables 5 and 6), parents were asked whether language milestones would be the same for children learning two languages. The non-Aboriginal group (n=10) was split approximately equally into those that responded affirmatively (47%) and those that responded negatively (53%). By contrast, more Aboriginal parents (n=15) felt that language milestones would be the same for a child learning two languages (80% responded Yes; 20% responded No). The following quote supports this notion:

> LW: Well Cree kids really pick it up fast, I think. It would help them pick it faster .....and then they started speaking Cree faster, than with the English. (Aboriginal).

Parental concern for child's language difficulty. Parents were asked when they were first concerned about their child's language and when they were first given a professional opinion about their concerns, either from a physician, teacher, speech-language pathologist or other health professional. As can be seen from Table 8, non-Aboriginal parents seemed to be concerned about their child's language at a younger age. All non-Aboriginal parents were worried about their child's language development

before the age of four (100%), whereas over half (55.5%) of Aboriginal parents were not concerned about their child's language or learning abilities until they were five or above. A similar pattern was noticed with professional identification of language difficulty: 89% of the non-Aboriginal parents had received a professional opinion about their child by four years of age or younger, whereas 55% of Aboriginal parents did not consult with a professional until the child was five years or above (see Table 8).

Table 8

Percentages of children identified in different age-groups as language-delayed by parents and professionals

Child's Age	**Aboriginal** (n=9)		**Non-Aboriginal** (n=9)	
	Parents	**Professional**	**Parents**	**Professional**
<2-2 years	33.5%	0%	78%	33%
3-4	11%	45%	22%	56%
5-7	22%	33%	0%	11%
>7 or >G2	33.5%	22%	0%	0%

Note: Professional = physician, teacher or speech-language pathologist; G = grade.

In an attempt to explain this discrepancy between the groups, the reported language problems of the Aboriginal children were examined more closely, particularly for the four children who were identified as having communication difficulties relatively late. The mother of one of these four children reported that she was never concerned, even though two of her children had severe articulation disorders and unintelligible speech. Their oral language abilities, however, were within the normal range, so one possible reason for her lack of concern is perhaps that the children's language

competency was more important to this mother than the clarity of their speech. The other three children, who were identified late, all had subtle language and learning difficulties, such as social use of language (pragmatics), understanding humour, figurative language and verbal reasoning abilities, as well as reading and writing problems. These types of difficulties may be harder to identify in general.

The Aboriginal parents who were not concerned until later were also those who identified themselves as "more traditional" or "both modern and traditional" in their ways. As will be discussed later, parents in Moose Factory have only recently become involved in their child's schooling and may have limited experience of learning difficulties. By contrast, the non-Aboriginal children all presented with more obvious speech, language and learning difficulties and their parents were very involved in their schooling. In addition, the non-Aboriginal parents had better access to public educational material about early intervention and learning problems.

Respondents were questioned about their present and past level of concern. In their open-ended responses, parents in both Aboriginal and non-Aboriginal groups expressed similar feelings. Some parents in each group expressed *less* concern as the child began to show progress and *growing* concern regarding lack of services and cuts in funding for special educational resources and speech-language pathology services, for example. Parents in both groups were usually the first to identify that their child had a problem with speech and/or language (see Table 8) and noticed stark differences between the language-disabled child and siblings, with the exception of families with more than one language-disabled child. This was the case for two Aboriginal families and two non-Aboriginal families. These parents in both groups felt more concern for the

younger child, because of diminishing services such as speech-language pathology and increased waiting times for intervention:

INT[6]: S. (=older child) did have speech therapy, but was there a time lag there?

DP: We weren't on the waiting list or nothing. You got us in right away.

INT: And then K. (=younger child), you don't know if he'll be given help right away?

DP: Yes, we have to wait till after the assessment there. (non-Aboriginal).

KT: Yeah, like I really felt like...I wished I could have access to...or a support group. Or to have speech-language therapy on a regular basis over a short time given for it to work with him...(Aboriginal).

These quotes foreshadow the parents' frustration over long waiting lists, lack of access to speech-language pathology services and lack of support or guidance, which is more fully expressed in other parts of the interview described later in this chapter.

Child Directed Speech (CDS)

Parents were presented with different statements about their verbal interactions with their children and were asked to rate their agreement with the statement on a nine-point scale ranging from Strongly Agree to Strongly Disagree (see Table 9). They were also asked about direct questioning and labeling, and to rate on a nine-point scale (ranging from Very Often to Never) how often they felt they used these techniques.

Oral language and CDS. In this section, each of the child-directed speech characteristics are addressed in turn and quantitative and qualitative differences

[6] INT = Interviewer

Table 9

Parental Rankings of Extent of Agreement with Statements about CDS

Statement/Question	Ab Group (n=9)			Non-Ab Group (n=9)			t
	Mean	R	SD	Mean	R	SD	
(1) A young child should be encouraged to use talking to communicate his needs/thoughts	1.66	4	1.41	1.00	0	0	1.41
(2) Adults usually speak differently to a young child than they do to older children or adults	1.77	6	2.11	2.11	2	0.93	0.43
(3) If a child is going to talk, he'll learn to do it, no matter what adults do	4.44	8	3.17	6.17	8	2.96	1.19
(4) Children need to be "shown how to speak" by being told to copy the adult	2.88	6	2.03	4.77	8	2.91	1.60
(5) Some parents frequently ask their children questions like: What's this called? and some don't. How often do/did you do this?	2.55	4	1.67	2.77	5	2.33	0.82
(6) Some parents like to label things for their child, e.g. That's a horse. How often do/did you do that?	1.55	2	1.13	2.11	3	1.36	1.25

Note. R=Range. The scales provided for responses to statements 1-4 ranged from 1=Strongly Agree to 9=Strongly Disagree. The scales for questions 5 and 6 ranged from 1=Very Often to 9=Never.

*$p < 0.05$.

between groups are discussed. Specifically, the importance of oral language, baby talk, modeling, use of direct questions, use of labeling, and reducing the rate and complexity of child-directed speech are compared between the Aboriginal and non-Aboriginal groups.

Regarding the statement: *"A young child should be encouraged to use words/sentences to communicate his needs and thoughts,"* (Table 9, #1), no differences between groups for the scaled responses were observed. Both groups felt that their children should be encouraged to verbalize their needs as soon as they are able, as these quotes illustrate:

> AW: ...when they point...when they're younger, I think it's okay, but when they get older, they point, but you get them to say what they want. (Aboriginal).
>
> CP: J.'s 21 months now and I try to make her at least say part of the word before I give it to her. (non-Aboriginal)

However, parents in both groups felt that a child (especially one with a speech or language problem) should not be pressured to talk:

> LW: You can't push a child, right? (she demonstrated that modeling would be preferable). (Aboriginal).
>
> RL: I say to X [=child developing language normally] "Use your words". I would have never done that with Y [=language delayed child]. (Non-Aboriginal).

Regarding the statement: *"If a child is going to talk, he'll learn to do it, no matter what adults do,"* (Table 9, #3), there was a considerable amount of disagreement within both groups (standard deviations for the Aboriginal and non-Aboriginal groups were 3.17 and 2.96 respectively), although there was no significant difference between the groups. Parents in both groups generally felt that if a child was exposed to language in a social

setting, but language was *not* directed to the child, he would learn, but the rate of language development would be slower. The following quotes from Aboriginal and non-Aboriginal parents illustrate the similarity of their perceptions:

AW: The child will talk, but they'll probably be slow, because they're not really being included. (Aboriginal)

SW: There would probably be some kind of delay I would think...I would suspect. You're not nurturing the child. They'd be limited, I guess, in some way. (Aboriginal)

LG: I think a child would develop a lot faster if speech was directed at them and if the child is listening too. (non-Aboriginal).

Baby Talk. No significant difference between groups was noted in the parents' agreement with the statement *"Adults usually speak differently to a young child than they do to older children or adults,"* (see Table 9, #2). However, there was a relatively large amount of variance within the Aboriginal group (SD=2.11, compared to 0.93 for the non-Aboriginal group). A possible explanation is that Cree people might not have traditionally adapted their speech to children in the same ways as mainstream Canadians. Perhaps some maintain these traditions even today.

In addition to rating their agreement with each statement, they were also invited to add comments and discuss the reasoning behind their ratings. In response to the above statement, both groups inferred that the term Baby Talk referred to parental use of diminutives and of their child's protowords, as this quote from a non-Aboriginal parent illustrates:

RL: I'd just say "Do you wanna bubble?" [=child's word for 'bottle'] and then I'd catch myself and I'd think "she's growing up now, I should say 'bottle' now". (non-Aboriginal).

Parents felt that this habit would have a negative influence on the child's language development if used in the long term, but that such "baby talk" would not be detrimental if used in the early stages of language development. Parents from both groups expressed this opinion, as these quotes exemplify:

KT: Well, I mean I do it, I don't feel guilty, like people do it. (Aboriginal)

JD: Like that baby stuff is hard to break. (Non-Aboriginal).

In spite of their view of "baby talk" (as use of diminutives and protowords), as an inappropriate practice, parents in both groups had ideas of how speech can be positively adapted for a young child. The strategies they mentioned included modeling, use of direct questions, labeling, slowing rate of speech and reducing complexity of language. Each of these strategies are addressed in turn.

Modeling, direct questioning and labeling. No quantitative differences were found between parents' scaled responses to the statement *"Children need to be "shown how to speak" by being told to copy the adult"* (see Table 9, #4). Both groups, in general, felt that there should not be too much pressure on children to "speak correctly", especially children with speech and language problems. Indirect modeling was suggested as a strategy by several parents in both groups:

LW: It's better if they pronounce their own way first and then eventually like getting them to do it over again, not pushing them, but kind of correcting them in a slow way. (Aboriginal).

CP: I prefer to, if the child says it wrong, then repeat it back to them saying it properly, but not coming right out and saying "That's not how you say it, say it like this". I notice now with J., I've been trying to correct some of his grammar. He still says "Him do it" and I'll say "*He* does it" and he will repeat it. I don't try to overdo it, but I do think some correction has to be put in there sometimes. (non-Aboriginal).

As illustrated in the above quotes, some parents feel that they should make an effort to "correct" their child's speech/language and a few parents in both groups, who have children with speech (articulation) problems, did feel that demonstration of articulatory placement was also important for their children:

KT: ...with J., we would try and get him to repeat a sound by the mouth and show him how the mouth..trying to overexaggerate...(Aboriginal)

JD: I think it's more important for children that has speech problems, than it is for children that don't... but when it comes to a child that has a problem speaking and the way your tongue is going. (non-Aboriginal).

Parents were asked how frequently they presented their child with questions, such as "What's this called?". No significant quantitative difference between groups was found (see Table 9, #5). Parents in both groups felt that use of direct questions was a helpful strategy in advancing the expressive language of their child. Aboriginal and non-Aboriginal parents reported that they used this strategy more with their second or third child than their first, reporting that their skill as facilitators of language improved as they became more experienced:

ES: I think I did that more often with my girls than my boys. I would say "Occasionally" with my boys and with my girls I did it "Very Often".

DS: Is that because they were quicker at picking those things up or..?

ES: I think I was more ready for my kids by then. My boys, like I wasn't really ready for my boys when they were born. (Aboriginal).

CP: I use it more with my younger child, now that I know better... (non-Aboriginal)

In addition, both groups reported using direct questioning with the child having difficulty more often than with language-normal siblings:

RI: We used it more with D., because of his problem (Aboriginal)

AL: ...after we realized M. had a problem (non-Aboriginal).

Parents were asked *"Some parents like to label things for their child, for example "That's a dog". How often did/do you do this?"* As with direct questioning, no significant differences were noted between groups, neither quantitatively (see Table 9, #6) nor qualitatively. One Cree mother commented that she would often use labeling in English and in Cree, to teach her child Cree vocabulary:

EW ...like when we go hunting with her... "this is a moose". And then we'd tell her..."that's an owl". We'd tell her in Cree too. Like "beaver", like we'd tell her the same in Cree too. She's pretty good at it. (Aboriginal).

They all reported that they used labeling more with their language-delayed children and parents in both groups felt that labeling was not needed with children who were not having any problem developing language. One non-Aboriginal parent said "he didn't seem to need it", when referring to their language-normal child and one Aboriginal parent said they used labeling "..only with D." (language-delayed child).

Rate and complexity of child-directed speech. Although parents were not asked to respond to a statement or question about rate of speech, several parents

made incidental comments about their rate of speech in their open-ended responses. Parents from both groups felt that it was helpful to use a slower rate of speech with all children, but particularly with a child having difficulty developing language, as indicated by this quote:

> AW: They're being left out, so.. so they won't really talk, because it's fast when you... like if I were to talk to my husband, it's fast talk, like fast, and when you talk to a child, you've gotta slow down, so I think if a child hears you, when you're talking fast, then it's not, they can't... (Aboriginal).

Parents from both groups felt that the complexity of language addressed to the child needs to be reduced to facilitate child language development. Comments about complexity were often made in response to the question "How do you think a child learns language?" or to the statement "Adults usually speak differently to a young child than to older children or adults". One Aboriginal family, who had been given information from the Hanen Early Language Parent Program (HELPP), suggested using simpler vocabulary, talking at the child's level and establishing eye contact:

> KT: To talk more at their level, to try and use easier words. Not to talk down to them, but to talk at their level.
>
> JT: The Hanen approach.
>
> KT: They taught you to look at them and with my little boy, with J., he really wanted to look away... "J., look at mummy" and he still doesn't...and I'll say "Look at me". I really think it builds up the vocabulary or whatever...then it helps him to concentrate (Aboriginal).

In a similar way, non-Aboriginal parents demonstrated using shorter sentences with simpler grammar:

LG: To M. [=LG's spouse] I might say "Do you want a glass of water?" or "Do you want something to drink?" whereas to a child you might say "want water?" (non-Aboriginal).

In summary, the results showed that characteristics of child-directed speech found in mainstream Canadian families, such as use of direct questions, labeling, modeling, reduced rate of speech and reduced complexity of language seemed to be present in many Cree families, to varying extents. In the next section, aspects of non-oral communication are compared between the groups.

Non-Oral Communication

Silence. The main difference between the groups, as shown in Table 10, seems to be that the Cree parents appeared to be more comfortable with silence than the non-Cree parents, but there seems to be no difference in terms of the parents' expectations of their children regarding silence.

As the following transcript extracts illustrate, there were discrepancies *within* the Aboriginal group regarding comfort levels with silence. These discrepancies could be accounted for by varying degrees of adherence to traditional ways of being. Some Cree families seemed to value silence and recognized that the more traditional Native families have more silences in their interactions:

INT: Is silence something that's valued?

AW: In a lot of families, yeah. My husband's family is kinda quiet. They talk, but ..you have to read after their facial expressions (Aboriginal).

INT: Do you think the Cree people have more silences in their interaction?

JT: I think so (Aboriginal).

By contrast, some Cree families responded in a similar way to non-Aboriginal families, in that they found silences awkward:

WS: It's uncomfortable when no-one is talking. (Aboriginal).

EL: Yeah. Say maybe all of a sudden there's a lull there for two minutes or something, I feel like I have to think of another subject so to bring up conversation again. But it's just me, y'know. (Non-Aboriginal).

CP: No. I find it very awkward. There's nothing worse than traveling in a car with somebody and not talking. It's like the elevator. I think most people feel awkward. Everybody stays really quiet. Nobody wants to talk. (Non-Aboriginal).

Eye contact. No significant differences in attitude toward eye gaze appeared to exist between the groups (see Table 11), except perhaps that Aboriginal parents tended to respond as "unsure" rather than with categorical yes/no answers.

Some Cree parents indicated that those who are "more traditional" in their ways, tend to have less eye contact:

EW: .. sometimes and I, like me eh, and others look away. I'm quite shy [laughs]. That's what I notice about most Indian women. I have white friends too, eh. They're not the same as the Native women. (Aboriginal).

ES: I would say most of the elders are kind of shy in their own way, but when you hear them talking and they've known each other for so many years and...but when my dad would talk to us or fixing up something and doing something with his hands and y'know, he'd be busy with something but he'd be talking to us. I find a lot of elders would do that, but I've never seen them sit there and really look at each other. It was just casual talking... (Aboriginal).

Table 10

Percentages of Aboriginal and Non-Aboriginal Responses to Questions about Silence

Question	Aboriginal			Non-Aboriginal		
	Yes	No	n	Yes	No	n
Are children expected to be quiet at certain times or in certain situations?	70%	30%	10	80%	20%	15
Are your children quiet when you expect them to be?	67%	33%	6	44%	56%	9
Can people be together comfortably without talking?	91%	9%	11	54%	46%	13

Table 11

Percentages of Aboriginal and Non-Aboriginal Responses to Questions About Eye Contact

Question	Aboriginal (n=12)			Non-Aboriginal (n=13)		
	Yes	No	Unsure	Yes	No	Unsure
Is it usual for adults to look each other in the eye during conversation?	75%	8%	17%	69%	23%	8%
Is it usual for children to look adults in the eye during conversation?	75%	8%	17%	77%	23%	0%

One Cree mother suggested that some traditional Aboriginal people tend to use physical contact in lieu of eye contact or verbal exchange:

INT: In those very traditional families, when the child wants to get the adult's attention, d'you know of any ways that they do that..?

SW: I think they use physical contact.

INT: They touch?

SW: Yeah. They tap you on your hand... (Aboriginal).

Some of the non-Aboriginal respondents also found direct eye contact uncomfortable:

EL: I don't (=make eye contact). I do and then I kind of look away, it's like...I think it just depends on the individual. (non-Aboriginal).

In general, Cree and non-Aboriginal parents felt that eye-contact between adults and children is normal: 75% of the Aboriginal group and 75% of the non-Aboriginal group thought that it was "usual for children to look adults in the eye during conversation" (see Table 11). In fact, several parents felt that it was necessary for development of language skills:

WS: With children, you need to get down to their level to make eye contact[7]. Making eye contact with children is not disrespectful. (Aboriginal).

CP: Children...yeah, I think they do, except when they're not telling the truth [laughs]. Then they tend to look the other way, but I think adults do that too. Because when they're asking questions, they certainly look you, no, I'm thinking of J. He certainly does... (non-Aboriginal).

In conclusion, few differences were noted between the Aboriginal and non-Aboriginal groups in terms of eye-contact and silence. This was especially true of the

[7] "Getting down to the child's level" and making eye contact with them is a strategy suggested in the Hanen Early Language Parent Program, which was taken by this parent.

parents in the Aboriginal group who described themselves as "modernizing" (see quote, p. 85). Some made reference to more traditional Cree people (elders), who they felt made less direct eye contact and who were more comfortable with silence in interaction with other adults. Both groups of parents felt eye contact with children was important for holding their attention and improving communication with them.

Cultural change

As previously mentioned, most Aboriginal families indicated that their culture is changing, reporting that they live according to mainstream ways, while retaining some traditional practices, as this quote illustrates:

> INT: Do you notice any difference with the really traditional native people?
>
> LW: No, I guess they feel they need to change their children..
>
> INT: Because times are changing?
>
> LW: Yeah. Like some families they'll really.. like something happened to them. Y'know the children actually see that and they don't wanna pass it on to their children. (Aboriginal).

As this Cree mother indicated, parents appeared aware that there is potential for their culture to change and they seemed to want to instill this feeling in their children, so that they may be able to adapt to mainstream culture.

There also appeared to be geographical variation in maintaining traditions within the Cree culture of northern Ontario:

> LW: I think up the coast [=further north along James Bay] it's much more Cree than here (Aboriginal).

and Cree respondents alluded to cultural variation over time:

> SW: Our culture is different, but ways are changing. (Aboriginal).

GR: Our extended family is more modern now, but they do go spring hunting. (Aboriginal).

In summary, although some Cree families seemed to retain an awareness of traditional Cree behaviour patterns, such as valuing silence, avoidance of direct eye contact and maintaining some traditions, there was also an awareness of and aspiration to cultural change.

This section has examined child-directed speech and language socialization patterns in the Aboriginal and non-Aboriginal groups and found few significant differences, with the exception of beliefs regarding some of the language milestones. The within-group variance (comparatively larger standard deviations) in parental responses to some of the scaled questions suggests that attitudes about some aspects of child-directed speech may not be culturally discrete. The next section will address this notion of cultural distinctiveness and cultural blending in terms of the concept of language disability.

Concept Of Disability

In this section, the results are examined in light of potential differences in the way the concept of disability is constructed in different cultural settings. Parental attitudes regarding the diagnosis their child received, the intervention offered, the influence of the present model of service delivery and the value of literacy are issues to be discussed.

The Nature Of The Disability

Parents were asked: "*Do you think your child has a language or a learning disability?*" Of the Aboriginal group, 78% responded 'Yes' to this question, compared to 56% of the non-Aboriginal group, although there were some differences between and

within groups in the way the terms "language disability" and "learning disability" were interpreted.

Firstly, the children of the Aboriginal parents tended to be older; consequently, the parents were more comfortable labeling them as "learning disabled". By contrast, the non-Aboriginal parents, in general, preferred the term "language delayed", as they considered their children too young to be diagnosed as learning disabled.

Secondly, the children in the Aboriginal group all had some kind of language difficulty, even if reading and writing abilities were more affected than oral language. Conversely, only two families in the non-Aboriginal group were comfortable with the term learning disability for their child. Four of the non-Aboriginal parents preferred the label "language delay", owing to the age of their child, three had a child with early language difficulties, that resolved to a purely speech difficulty and two were comfortable with the learning disability label, as their children were older.

Parents were then asked who was the first professional to identify or diagnose their child. Their responses are tabulated in Table 12.

Because the school provides most support and services for the families living in Moose Factory, it is not surprising that they were usually the first to identify local children as having difficulty with language (67% of the children in the Aboriginal group). The others were either taken to the family physician, due to parental concern during preschool years or assessed by members of the Child Development Team[8].

Non-Aboriginal parents also tended to take their children to the family doctor first, when they had concerns. However, some parents indicated that, although the

[8] Child Development Team = Traveling assessment team from the Child Development Centre, Kingston. For more information, see Methods chapter.

Table 12

Percentages of Diagnoses by Professional for Focal Children in the Aboriginal and Non-Aboriginal Groups

Professional	Aboriginal (n=9)	Non-Aboriginal (n=9)
School/Teacher	67%	11%
Speech-Language Pathologist	0%	33%
Audiologist	11%	0%
Physician	11%	56%
Child Development Team	11%	0%

physicians often referred the family to speech-language pathology services, they often erroneously reassured parents that the child would "probably grow out of it". For example, one angry parent reported that the doctor said "Give it more time, it'll come," and this resulted in the child being diagnosed later with a significant language problem. This delay led to a longer wait for intervention.

Parents were asked whether they agreed with the diagnosis. Some differences in the interpretation of the term learning disability were found between the groups. One Aboriginal parent agreed to a certain extent with the diagnosis of learning disability, but preferred to describe her son as "slow":

> ES: ..the first words that would come out if they asked me about him would be that he's a slow learner, that he's capable enough to learn, but it will take him a while. (Aboriginal).

This parent, like others on Moose Factory island, seemed very grateful for the support and guidance they received from Ministik school. In fact, some Cree parents appeared

to give the responsibility of dealing with the problem to the school. The above mother expressed this in terms of her low academic expectations for her son, which changed after his participation in a special educational program:

> ES: ...we used to think he would go nowhere, eh. ..It's improved and he's looking forward to..want to graduate high school, you know. He never used to talk like that. He used to say "I'll never do that, I don't think I'll ever do that". Now it's changed quite a bit, because of this program (=special education program). (Aboriginal).

As mentioned previously, non-Aboriginal parents of younger children had reservations about use of the term "learning disability" but most (87%) agreed with the "diagnosis" or what they were told by the professional. Other satisfaction issues, such as parental agreement with the diagnosis and intervention, will be discussed in the final section of this chapter.

Disability and Culture

During the discussions with families from both groups, no obvious crosscultural differences regarding conceptualization of language disability were apparent. Although Aboriginal parents tended to be concerned later than non-Aboriginal parents (see Table 8), this could have been due to lack of services, especially information on early intervention. As mentioned in the first section of this chapter, the Cree children had more subtle language differences, which could have accounted for later identification. In addition, Cree parents tended to be concerned about the same behaviours as non-Cree families, such as having difficulty communicating with their child:

> ES: I knew they were having problems because I couldn't even understand him too and they were at that age when like a neighbour's child would come up

to me and talk to me and ask me something and my child couldn't even do that. (Aboriginal).

The Aboriginal group was asked to rate their agreement with the statement *"The services offered were appropriate for your family's culture,"* and to provide comments[9]. The mean response to this statement was 1.44 (1=Strongly Agree, 2=Agree, etc.), indicating that most Aboriginal respondents agreed with this statement (see Table 13). Three general views were apparent in the parents' open-ended responses: Firstly, there is an awareness that the community is changing and values are becoming more aligned to mainstream values:

WS: I think it [=Hanen Early Language Parent Program] would be useful for all people, Native and non-Native. (Aboriginal).

LW: They're modernizing. (Aboriginal).

In fact, 83% of the Cree parents questioned about cultural sensitivity (n=6) felt that services were culturally appropriate.

Secondly, parents felt that the services in general were appropriate, because it was the local school that provided them and the teachers were attuned to the ways of the community:

ES: Well, what they offered there, what they offered at the school was the only.. it was on the island, so it was okay.. (Aboriginal).

Thirdly, the professionals that visited were somewhat aware of cultural issues:

GR: ...the reports indicated that they weren't specifically for a Cree child... (Aboriginal).

[9] The assumption was made that the professionals providing services in these communities and the respondents in the non-Aboriginal group all came from mainstream cultural backgrounds. Therefore, this statement was not presented to the non-Aboriginal group.

In fact, speech-language pathologists providing service to Moose Factory often inserted the following disclaimer in their reports: "As this child is from an Aboriginal background, the test results should be interpreted with caution" (OSLA Chapter, personal communication, April 23, 1997). Thus, the professionals used assessments developed on mainstream populations, but showed insight into the potential inappropriateness of this by stating that the child came from a different cultural background and therefore might have performed differently on the test. Nevertheless, many speech-language pathologists have no experience of life in Aboriginal communities, or even life in Northern Ontario, and this was reflected in parents' comments:

> KT: Um...I think it would be a more appropriate if it were people from the north or people who know more about the north and the culture. Like these people, they come from Kingston.. But the animal pictures that they showed him...
>
> JT: Yeah, they were more appropriate for kids down South.
>
> KT: ...like camels and stuff like that, no moose or beaver...There are no zoo animals around here. We've been fortunate enough to go to the zoo.. (Aboriginal).

Just as the concept of disability appears to be changing in Moose Factory, so does the attitude toward education. Residential schools used to be the norm for Aboriginal children in many communities and Moose Factory was no exception, until about fourteen years ago.

> EW: We used to go trapping a lot. I didn't go to school. I just didn't wanna go to school. Our parents never forced us to go to school, not like right now....and then the reason I think I never talked to my kids in Cree, I wanted them to learn more about English, so when they go to school... (Aboriginal).

CR: I wanted him to adapt to a better chance in life and get a good education. (Aboriginal).

As education has become available locally for children in Moose Factory, the value of education seems to have increased, as the above quotes indicate.

Language Competency And The Value Of Literacy

Although many families in Moose Factory are changing in their attitudes and values, some still maintain that their linguistic tradition is an oral one, and visual and oral ways of instruction are still valued in the community. Some families continue to adhere to traditions such as these. Consequently, children from these backgrounds may not have had much exposure to reading and writing. Parents may not be as oriented to literacy and hence not recognize or accept the diagnosis of a learning disability as easily. The following quotes from Cree mothers, who described themselves as "both modern and traditional in their ways", illustrate these points:

SW: It's so hard, because what if a child is brought up in the Cree tradition? There's no access to those things, that you have in school, like er ..because ours is more like an oral tradition. But they know this, because it's like they don't have the material. It could be more er..like he could probably survive over there [=in the outdoors] like whereas another child, y'know.... Like he would know how to.. it's hard..Like our tradition has always been oral, being out. (Aboriginal).

ES: I think putting the child into a .. the best way to describe it is.. to learn how to cook, the best place to be is in the kitchen, for them to learn. Instead of just sitting down at the table to learn all these things, it should be more..like a ..right now they're learning the outdoor education..outdoor ed. They go out into the bush and they learn all that. Like they go right into the things that has to be

Table 13

Parental Responses to Statements and Questions About Language Disability, Learning and Culture

Statement/Question	Ab Group (n=9)			Non-Ab Group (n=9)			t
	Mean	R	SD	Mean	R	SD	
The services offered were appropriate for your family's culture	1.44	4	1.33	N/A	N/A	N/A	
How well a preschool child talks will determine how successful he/she will be at school	4.00	7	2.69	3.22	8	3.49	0.53
A child's success at school is measured by *how quickly they learn to read and write*	2.44	4	1.51	2.00	5	1.73	0.58
A child's success at school is measured by *how much they participate in class discussion*	2.77	6	2.11	2.55	3	1.01	0.28
A child's success at school is measured by *how much they listen in class*	2.33	4	1.41	1.22	2	0.67	*2.13
In our school system, too much emphasis is placed on learning to read and write	5.22	6	2.53	6.22	8	2.82	0.79

Note. Ab = Aboriginal. Non-Ab = Non-Aboriginal. R = range. Responses were given on a nine-point scale from 1=Strongly Agree to 9=Strongly Disagree.

*$p < 0.05$

done, instead of staying in class where ..well sometimes they would bring..I remember they used to bring.. like they would teach us how to skin a beaver and they brought the beaver in class and they showed us. I think that's where the concepts and the understanding and something when it's ...that atmosphere. (Aboriginal).

Aboriginal parents interviewed indicated that the local children in Moose Factory have appropriate educational resources available because the teachers are able to custom design programs for local children. However, the parents felt that the "level of learning" is lower in Moose Factory than further south, say, in Timmins or North Bay:

GR: Um...It depends on the level of learning they come from. It tends to be higher when you go further south.

INT: It's lower up here?

GR: It's probably higher when you go further south. (Aboriginal).

This lower level of learning was felt to put Aboriginal children at a disadvantage, if they were to relocate to a community further south.

Parents were presented with the statement *"How well a preschool child talks will determine how successful he/she will be at school,"* to examine the relationship of oral language to literacy (see Table 13). There was no significant difference between the scaled responses of the groups to this statement and open-ended responses were disparate within both groups. Standard deviations were 2.69 (Aboriginal group) and 3.49 (non-Aboriginal group) indicating considerable variance. Some felt that oral language proficiency is a good predictor of acquisition of literacy skills, whereas others felt that having a language delay did not put their child at a disadvantage in school.

KT: It kind of bothers me, because his speech will pick up, but I kind of wonder about his learning, because he does have difficulty with other things and I'm more or less thinking that he probably will....(Aboriginal)

LW: Yeah. I guess. Well there is a connection. He was slower and then he was slower at reading. I guess yeah because my daughter K. was talking very well and in school she's doing very well. (Aboriginal)

RL: Language is a sign of intelligence. (non-Aboriginal)

JD: Well, all the kids have their problems. The reason why he's having the problems is because of his speech there. (non-Aboriginal)

In general, more non-Aboriginal parents than Aboriginal parents agreed that early verbal skills can forecast academic success or difficulty. However, some parents in both groups disagreed with this statement ("How well a preschool child talks will determine how successful he/she will be at school"):

CR: I remember R., he was a very verbal child, as a preschooler, then didn't do that well in school. (Aboriginal)

SF: No. I strongly disagree with that. Only because some of them talk very well and...(non-Aboriginal).

Parents were asked to rate their agreement with three ways a school might measure a child's academic success (see Table 13). Firstly, all the non-Aboriginal parents agreed that a child's success at school is measured by how quickly they learn to read and write and all but one Cree parent agreed, who rated her agreement as neutral:

LW: Yeah, that's what schools do. That's too bad. [Indicating that schools put undue emphasis on literacy]. (Aboriginal)

The second measure of school success rated was how much children participate (verbally) in class. Parents in both groups felt that this was the weakest measure, because shy children may choose not to participate verbally, but would still be able to answer test questions, if called upon by the teacher:

EW: But sometimes N. likes to ask things, but then again I find her shy. (Aboriginal).

WL: Yeah, some kids are smart as a whip, but they're just shy. (non-Aboriginal).

EL: A child could be sitting there and basically know the answers, like I was that way in school, I never spoke in class, I never participated, but I mean you still come out basically learning something. If you're put on the spot, they say "what's the answer to this?" you can do it. (non-Aboriginal).

The third measure of school success rated was how much children listen in class. There was a significant difference between groups [$t(16) = 2.13$, $p < 0.05$], although most parents in both groups agreed that listening was highly valued in classrooms: 89% of the Aboriginal group and 100% of the non-Aboriginal group rated Agree or Strongly Agree on the scale. Aboriginal parents therefore stated their agreement with the statement less strongly than the non-Aboriginal parents. There was no obvious reason for this discrepancy.

In light of the fact that the Cree traditionally had an oral style of learning (see quotes, p. 87), parents were asked to rate their agreement with the statement: *"In our school system, too much emphasis is placed on learning to read and write."* (see Table 13). Two families in each group agreed with this statement. However, in general, most

parents in both groups appeared to disagree with the statement and expressed similar reasoning:

KT: Not here. Too many children leave school unable to read and write.. (Aboriginal).

RI: Disagree. We need to get back to basics. There's too much play in school. Need to use standardized tests, because too many children leave school unable to read and write. Too far away from the core curriculum. (Aboriginal)

PL: I agree that it is very important to learn to read and write. We need to catch the kids that don't learn easily. The government and Canada as a whole value literacy. (non-Aboriginal)

CP: I don't agree with that, because they also emphasize other physical activities and things like that, so that it's more rounded. Reading and writing is important, but so it mathematics and everything else. (non-Aboriginal).

However, some parents in both groups felt that schools *do* seem to emphasize reading and writing too much:

JD: They expect too much out of the kids today. Like right away they're expecting too much. I mean when I was going to school, I remember this in grade five and they're learning this in grade two or three. (non-Aboriginal).

In conclusion, parents in both Aboriginal and non-Aboriginal groups appeared to value literacy and had similar concerns and aspirations for their child's learning. Some Cree parents felt that, although their culture is changing, they still maintain oral traditions and value learning in functional contexts (see quote by ES, p.87). These respondents may still be in the process of adapting to a mainstream schooling system. Although

there were differences between the groups in terms of interpretation of terminology and in the roles of the speech-language pathologist versus the school, the Cree parents seemed to have accepted the way services are delivered, including the assignment of a diagnosis and provision of special education sessions, for example. On the other hand, some parents in both groups expressed disregard for how educational and speech-language pathology services are delivered. In the next section, aspects of service delivery and consumer satisfaction are discussed in more depth.

Service Delivery Issues

Consumer Satisfaction

Consumer satisfaction was addressed in a number of ways. Parents were questioned about the accessibility and adequacy of speech-language pathology assessments and intervention, length of waiting time, amount of help given, choice of services available and their agreement with the diagnosis and intervention.

Accessibility And Adequacy Of Services. Both groups felt that speech-language pathology services were not easily accessible. Referring to Table 14, it can be seen that, although the Aboriginal and non-Aboriginal families had similar types of intervention, Ministik school in Moose Factory took primary responsibility for delivering remedial language services for local children (89%), whereas speech-language pathology services were more directly accessible for non-Aboriginal families in Timmins. In fact, there was a striking contrast between the availability of regular speech-language pathology services for the two groups. *All* the non-Aboriginal families had access to regular speech-language pathology sessions, whereas *no* regular services were provided for families in Moose Factory. Cree parents expressed a desire to have access to the same services available in southern cities:

KT: I really felt like I wished I could have speech-language therapy on a regular basis...I often wished I was living somewhere else. I never really felt there was help up here...there was a place, that there was help available, but it wasn't here. (Aboriginal).

Aboriginal parents also indicated a feeling of disempowerment with the system, in that someone else took the responsibility of contacting a professional and scheduling an appointment:

WS: You couldn't contact them (speech-language pathologists/SLPs). The hospital would to it and there was a long waiting list. (Aboriginal).

CR: Everything was done through Ministik school. (Aboriginal).

ES: It takes a while to get those things (=SLP appointment) going. (Aboriginal).

On the other hand, most non-Aboriginal families had some degree of choice and services were more available to them, in spite of long waiting lists for assessment and intervention. One non-Aboriginal family had to travel to Sudbury (300 km) to access services when they were first concerned (1990); one couple waited two years before receiving an assessment for their son and five families had to wait varying lengths of time for intervention. Those who were able to access an assessment quickly did so two to three years ago, indicating an increase in waiting time over the last few years.

In addition, there was a significant difference in length of waiting time for assessment and therapy between the groups. All the Aboriginal parents had to wait longer than 3 months for an assessment by a speech-language pathologist or for commencement of therapy, whereas some non-Aboriginal families had access to an assessment (22%) and therapeutic intervention (44%) within three months.

Table 14

Percentages of Agreement with Questions Concerning Diagnosis and Intervention for the Language Disability

Question	Aboriginal Group			Non-Aboriginal Group		
	Yes	No	n	Yes	No	n
Parents agreed with the terms language or learning disability	78%	22%	12	56%	44%	15
Parents agreed with the diagnosis	64%	36%	11	87%	13%	15
Parents were offered help for the child's problem	78%	22%	12	78%	22%	15
Parents were offered regular SLP services	0%	100%	9	100%	0%	9
Parents waited *more than* three months for SLP assessment	100%	0%	9	78%	22%	9
Parents waited *more than* three months for SLP intervention	100%	0%	9	56%	44%	9
Child given special education programming including a language component	89%	11%	9	56%	44%	9
Family given information from the HELPP	22%	78%	9	22%	78%	9
Parents were given a choice of what should be done	33%	67%	12	67%	33%	15

Note. SLP=speech-language pathology. HELPP=Hanen Early Language Parent Program.

Finally, there was also a difference between the groups in terms of the choices available. Two-thirds of the Aboriginal group felt that there was no choice of intervention available, whereas only one-third of the non-Aboriginal group felt this way. In their open-ended responses, the non-Aboriginal parents remarked that they had a choice of which agency to contact, whether to have therapy at a health facility or at school and whether to receive services in English or French. By contrast, the Aboriginal group could only receive services at the school, and, even though the first language of the focal children was English, services were not available in Cree.

Parents were asked *"Did you agree with what was suggested for your child?"* All Cree families agreed with the intervention, but some felt that it wasn't enough:

RI: It was okay, but it wasn't enough. Some of it was okay, but I still feel like I'm in the dark. (Aboriginal father).

WS: I think it would've been good to have a speech therapist here. (Aboriginal mother).

All non-Aboriginal families agreed with the speech-language pathologist's suggestions for their child, except for one family, who were referred for an Ear, Nose, Throat Specialist consult for palatal abnormality, and then had to wait to receive therapy. In fact, with the exception of this family, the non-Aboriginal families were very satisfied with the type of intervention offered, but in general felt they had to wait too long and that it was not frequent or intensive enough.

Aboriginal parents' responses indicated an acceptance of the speech-language pathologists' ways of working and the materials and types of intervention suggested:

INT: The really traditional Aboriginal families, do you think the speech pathology materials and reports are appropriate for them?

LW: They're probably about the same. They're modernizing. (Aboriginal).

Non-Aboriginal parents perceived some negative aspects in the way speech-language pathologists and teachers functioned, particularly the way the health and education systems focused on labeling the child, creating stigmatization:

> RL: You see, if a child is labeled and that label gets in the education system, that teacher treats that child with that label. What does that do to the children and the relationship they have with their peers? I mean, it really interferes. What does it do to the morale of that child? But their labeling her interrupted her education. Because they didn't think she was able to do those things, they didn't include her to be able to do it. (non-Aboriginal).

Cree parents felt that the local school provided the most assistance in terms of accessing a professional to assess their child and providing ongoing resources such as special education (e.g. one-on-one teaching). One Cree parent, who had lived in Timmins for a short while, preferred the service given in Moose Factory. She described it as more accessible and more culturally appropriate, in that the school in Timmins assumed it was a second language learning problem, even though the child did not speak any Cree:

> LW: Well we didn't come to the school here. In Timmins they didn't do very much. Up here, it was more...because I wanted to do it there. And their classes are so big, they can't recognize what's going on, but here they would... (Aboriginal).

The comments from the Cree parents indicated that they feel isolated from services, because of their geographical location, and that the services provided by traveling professionals from the south were not adequate to meet their needs:

KT: It wasn't any good, when they first saw him eh. When they first assessed him, they didn't really give...they didn't have any answers..So that was the first time. I didn't feel.. I never really thought that I'd had the answers I wanted. I never really felt that I'd had good..support or...good care. Never did I feel like there was enough help there for us, as parents in dealing with this. Because there's a lot of stress....I agreed with it, but I wasn't satisfied. We had lots of handouts and we didn't have time to read them. Also I'd prefer to have someone show us, or have some kind of personal interaction, like maybe a video, so they wouldn't have to be there necessarily, but nobody took the time to say, this is like... (Aboriginal).

RI: Well I mean...that was okay I guess, but..it wasn't enough. Some of it was okay, but I still feel like I'm in the dark...letters...couldn't call somebody. The team didn't really stay here... (Aboriginal).

By contrast, the non-Aboriginal families indicated that they knew the services were available, but felt that they weren't really accessible, due to long waiting lists and too few speech-language pathologists:

JD: No, but what I find is that there's not enough speech therapists to go around. And they don't have the funds for it and stuff like that, which it shouldn't be denied, especially for kids who need it. He was on a waiting list, and I feel they should've turned around and informed the parents more and like I just feel there should've been more done. More follow-ups done, like there was no follow-ups done whatsoever. (non-Aboriginal).

SF: Easy to find yes, but they were hard to access. Because I worked at the daycare, that R. did get in when he did. Otherwise there was an extensive

waiting list and I know a lot of people that say ...like how long the children have to wait. (non-Aboriginal).

CP: It was frustrating, yeah. It was too long to wait. Because actually he didn't start getting regular therapy until just this January, so he had already turned five. (non-Aboriginal).

CP: Well, it depends if "talk with" means to, y'know, sit down and ask for, well what can be done and no, that wasn't very easy to do [laughs]. I'd say disagree.

INT: so, accessing was difficult.

CP: Yeah, it was difficult. I'd keep to see how he..er...how the waiting list was coming along and there might be the odd little recommendation of what you could do, but it certainly wasn't enough. (non-Aboriginal).

RT: Well, he was on a waiting list for a couple of years for sure. (non-Aboriginal).

Some families tried to "fast-track" their child through the waiting list, by asking a physician to advocate for their need, but often this was in vain:

DP: I even went to the specialist, like a specialist who had the hearing done beforehand and she was supposed to help me to contact the Health Unit and stuff. But it didn't help either. (non-Aboriginal)

JGP: It was supposed to speed it up and it didn't work. (non-Aboriginal).

Although most of the non-Aboriginal families had to wait from 9 months to 2 years for an assessment for their child, two families with now older children recalled *not* having to wait at all for an appointment (1992-93). One of these families now has a second child on the waiting list for assessment, for which they have already waited a year. This

suggests an increasing demand for speech-language pathology services and diminishing availability of services.

In summary, both Aboriginal and non-Aboriginal families generally felt that the speech-language pathology services were inadequate and inaccessible. However, the groups tended to deal with this problem in different ways. The Aboriginal parents looked to the local school for support, access to diagnostic services and provision of therapeutic programming for their child. The non-Aboriginal parents, on the other hand, tended to comply with the system of waiting lists. They compensated for this by shopping around at different agencies or putting pressure on speech-language pathologists to speed up the process, by making phone calls themselves or by asking teachers or physicians to advocate for them. Some of the non-Cree families resorted to accessing private speech-language pathology services, but these were available in Timmins only and were often prohibitively expensive for families.

Cultural Appropriateness And Sensitivity. The present model of speech-language pathology service delivery and programs such as Hanen Early Language Parent Program appeared to be well accepted by families in Moose Factory. In general, parents had the same aspirations and goals for their children as the non-Aboriginal parents and cultural insensitivity did not appear to be a major issue.

Aboriginal parents in Moose Factory felt that children that attend the local school (Ministik) were not at a disadvantage, but if children were transferred to schools in Timmins or further south, they would be. Their reasons for this attitude have to do with culture and with "level of learning", as mentioned in the Concept of Disability section. Non-Aboriginal families in general felt that children from cultural backgrounds other than

mainstream Canadian are disadvantaged in school and expressed these views in their open-ended responses:

AL: They've been bought off is basically that part. In their own Native land, when they're at home, they probably do well. This atmosphere here, it's such a change over, I don't think they can accept it. I don't think they adjust to it. I think there's too many influences of... (non-Aboriginal).

CP: Well, I guess they would have to be at some disadvantage, because the parents probably aren't fluent with the language. But whether hearing it at the school is enough...Well, I can remember some..having Native children in my class, when I was in school and they were always outcasted. Nobody ever played with them and they were always...the ones that I can remember were always very quiet and kept to themselves. That's gotta be a disadvantage to their learning. It's hard to say, but my instincts tend to say they probably haven't changed. I think there tends to be a fair bit of discrimination towards the Native people. I mean if we see it in adults, it's gotta carry down to the children. (non-Aboriginal).

Some non-Aboriginal parents expressed feelings about the Cree children having to attend school in Timmins, either because their family had relocated to the city, or because the children were boarding in Timmins to attend school. One parent felt that Cree children would be at a disadvantage because they are withdrawn from mainstream classrooms to attend special "Cree" classes and then probably feel disconnected from the lesson when they return:

DP: Yeah, because see, from what I learned from the teachers, they're out of the class when they're doing the Cree, like their language like that and they go

back in the class and they say like there's all of a sudden new work and..We have Cree down the road here. (non-Aboriginal).

To summarize, both Aboriginal and non-Aboriginal parents felt that children from non-mainstream cultural backgrounds, such as Cree children, were disadvantaged in mainstream school settings. However, Cree children attending school in their local community would not be considered disadvantaged, as the Cree students form the majority.

Conclusion

In terms of speech-language pathology service delivery, both groups felt that services were inaccessible and inadequate. Aboriginal families, in general, were satisfied with the resources available at the school, but found the traveling speech-language pathology service inadequate and sometimes inappropriate. Non-Aboriginal families were generally satisfied with the speech-language pathology services they received, but felt that waiting lists were too long and the quantity of service lacking. In comparing the two groups, neither situation was ideal. The non-Aboriginal groups had limited access to a limited quantity of service, as compared to the Aboriginal group, who had no regular speech-language pathology service and even greater limitations to access.

Chapter 5

DISCUSSION AND CONCLUSIONS

The purpose of this study was to examine and compare language socialization patterns, the concept of language disability and speech-language pathology service delivery in Aboriginal (Cree) and non-Aboriginal families. Three hypotheses were made, which predicted that: (a) language socialization patterns in Cree families would differ from those in mainstream Canadian families; (b) the concept of language disability would be construed in different ways by Cree and non-Cree families and (c) consumer satisfaction with speech-language pathology services would differ between Cree and non-Cree groups.

Summary Of Results

Aspects of child-directed speech and language socialization practices were found to be very similar in the Cree and non-Cree families, who participated in this study. Oral and written language appeared to be valued in both groups and characteristics of CDS, such as use of direct questions, labeling, modeling and reduced rate and complexity of speech were reported by both Cree and non-Cree parents to be present in their verbal interactions with their children. However, some differences between the Aboriginal and non-Aboriginal groups were seen in non-oral communication behaviours, such as eye contact and silence. This was especially true of the parents who described themselves as "more traditional", suggesting a range of adherence to traditional patterns of behaviour. Disparity was also observed in some of the language milestones and in

the onset of parental concern and time of professional diagnosis. It was suggested that this may also indicate cultural variation within the Aboriginal group.

No significant differences were found between the Aboriginal and non-Aboriginal parents' conceptualizations of language and learning disability or in their educational goals for their children. However, a pattern of cultural blending (of the Cree culture with mainstream culture) seemed to be in process, perhaps changing the parents' ways of interacting with their children, their values toward learning and communication and their ways of dealing with a speech- or language-impaired child.

Finally, speech-language pathology resources were found to be severely limited for both groups. The Aboriginal families had no consistent service provision and survived with infrequent diagnostic resources and special teaching provided by the school. For any regular therapy or indepth assessment, the family had to travel to southern centres (such as Timmins, Kingston or Toronto) which was not usually feasible for reasons such as travel costs and time away from their home community. By contrast, the non-Aboriginal families had access to both diagnostic and therapeutic services in Timmins, but were faced with long waiting lists and insufficient staffing resources. Although some services were available, these families were frustrated with complicated access procedures and lack of information while waiting for service.

Cultural Blending

The Aboriginal parents interviewed in this study indicated that, in Moose Factory, adherence to traditional values and practices ranges from those who see themselves as "traditional" (referred to as "elders" by respondents), to a blend of both "modern and traditional", to those who see themselves as mostly "modern". This finding supports the work of Janzen et al. (1994) who identified a continuum of traditionality. In addition,

syncretism or cultural blending seemed to be occurring in Moose Factory, in similar ways to those observed by Duranti & Ochs (1996). Local people appeared to be integrating some aspects of mainstream culture into their own traditional ways of living, such as watching television or encouraging their children to read, while maintaining some traditions, such as spring hunting. Respondents suggested that cultural blending is more noticeable in Moose Factory than in Aboriginal communities further north along James Bay (see quote, p. 89), perhaps because of its closer proximity to the mainstream cultural community of Timmins. This bears similarity to the findings of Hough-Eyamie & Crago (1996), who found that Mohawk communities on the outskirts of Montreal had incorporated aspects of mainstream culture into their lifestyles to a greater extent than Inuit communities further from Montreal. These "blended" ways of being impacted on the three areas of interest examined by this research project, namely language socialization, the concept of disability and speech-language pathology service delivery.

Language Socialization

In review, language socialization involves the imparting of cultural knowledge and the social rules of language use, by caregivers to children, during the process of language acquisition (Schieffelin & Ochs, 1986a, 1986b). Although few studies have examined Cree language socialization patterns, Crago (1990) discovered that Inuit caregivers interacted with their children in very different ways to those observed in white, middle-class families in North America and Great Britain. Conversely, the caregivers in this study seemed to adopt mostly mainstream patterns of interaction with their children. Cree children were encouraged to verbalize their needs, make eye contact with their parents and read books. This was in contrast to Crago's study (1990a, 1992a), which

showed that caregivers placed much less emphasis on the child's verbalizations and much more emphasis on following directions and learning to do "socially useful tasks" (Crago, 1992a, p.493). Cree parents felt that children should be included in conversation for them to learn to talk. Although many of the crosscultural studies in the literature showed that children are explicitly taught what to say in interaction with others (Crago, 1990a; Demuth, 1986; Heath, 1983; Schieffelin, 1986), the child's own topics are rarely responded to in a conversation-type way. For example, in Heath's study of black working-class families in Trackton, children were expected to learn about the world for themselves and from other children (Heath, 1983). Similarly, Crago found that Inuit children were socialized to learn by looking and listening and were discouraged from talking while adults were conversing or during class (Crago, 1990a, 1992a). The Cree parents in this study, on the other hand, showed concern for a less talkative child and encouraged their children to interact with them in similar ways to the non-Aboriginal parents.

The Aboriginal respondents in this study also felt that they should teach a young child by labeling and modeling, asking direct questions, reducing the rate and complexity of their speech and making eye contact with their child. These patterns of interaction differ sharply from those described in all other studies of Aboriginal North American cultures (Crago, 1990a&b; 1992a&b; Crago & Eriks-Brophy, 1994; Freedman, 1979; Scollon & Scollon, 1981). These studies all identified much more use of nonverbal modeling and situation-centred rather than child-centred styles (Schieffelin & Ochs, 1986b).

Of particular interest is the similarity between the Aboriginal and non-Aboriginal parents in their use of questions. Heath (1982) pointed out that children in white, middle-

class homes were trained to become "question answerers". That is, caregivers asked their children questions to which they knew the answer. Parents from both groups in this study reported that they asked their children these types of "test" questions. This pattern was not found in a number of studies of other cultures. Ochs (1982), Heath (1982) and Crago (1990a) found that the caregivers in their studies did not tend to question children in this way. Some questions were asked by caregivers, however these questions frequently had no right answer.

Therefore, the findings of this study suggest that many families in Moose Factory are adapting to mainstream ways of child-rearing. Although a few Cree families seemed retain some of their traditional language socialization patterns, most families in this study reported that their culture is changing, supposedly due to influence from mainstream culture. The community of Moose Factory is vulnerable to this influence via television and other media and via non-Aboriginal people entering the community, either to live and work on the island or to provide itinerant professional services.

One striking difference between the Aboriginal and non-Aboriginal parents in this study was the onset of their concern for their child's speech and language development. In general, the Cree parents became concerned about their child's language problems much later than the non-Cree parents. This pattern bears resemblance to the findings of Scollon and Scollon (1981), who observed that Athabaskan children tended not to develop verbal language much before five years of age and, consequently, parents were more likely to become concerned about their preschool children if they were highly *verbal* than *nonverbal*. Although many of the Cree parents seemed to be adapting to mainstream attitudes toward child language development, perhaps some of the more traditional parents do not place such high value on language skills in a young child. This

more traditional pattern, if it exists in Cree culture, resembles the attitudes of Inuit parents and teachers studied by Crago (1990a). Crago, like Scollon and Scollon, found that Inuit parents and teachers were much more likely to become concerned about highly verbal children and would consider these children lower in intelligence or even learning disabled (Crago, 1990a).

Cree parents felt that special care should be taken with a child with speech and language problems, not to put pressure on them to talk, but to encourage them through use of indirect modeling. For a child with articulation problems, however, the respondents felt that parents should use more direct modeling, by demonstrating articulatory placement for the child. The non-Cree families from Timmins expressed similar feelings about encouraging verbalization in a child with language difficulty and more direct input with speech-impaired children. They also described using similar interactional strategies with their children to facilitate communication, such as labeling, indirect modeling and use of questions.

The findings of this study do not support many of the crosscultural studies reported in the literature. In particular, one might have expected to find similarities between language socialization patterns in Inuit and Cree families, since both are Aboriginal groups native to Canada. However, this was not the case, possibly because this study was reliant on the respondents' reports, rather than on direct observations. Although an interview study of this kind provides valuable insight into parental beliefs about their language socialization practices, the validity of the survey data is reduced without direct observation to support their testimonies.

It is also hypothesized that cultural blending may account for the mainstream patterns of language socialization found in this study. Various authors have suggested

that cultural change over time is related to the amount of contact the non-dominant culture has with the dominant culture (Crago, Annahatak & Ningiuruvik, 1993; Duranti & Ochs, 1996; Hough-Eyamie & Crago, 1996). This phenomenon was also observed in this study. As previously mentioned, Moose Factory has been influenced by mainstream culture for many years. Indeed, Cree respondents indicated that their community has had more contact with Timmins and mainstream culture than some of communities further north on James Bay, such as Kashechewan and Attawapiskat. Thus, there appears to be geographical variation in maintenance of traditions within the Cree culture of northern Ontario, as well as cultural variation over time. Several of the Aboriginal group reported diminishing numbers of Cree people who take part in drumming and sweat-lodge ceremonies, which they regarded as very traditional customs (Cheechoo, 1991), although they continue to engage in spring hunting, which is also considered to be a traditional activity. Because of this variation in traditional activity participation, most respondents were reluctant to describe themselves as "traditional" and preferred to describe themselves as "both modern and traditional".

In summary, differences in language socialization patterns between Cree and non-Cree families were not identified in this study, in contrast to other crosscultural studies. However, this project relied on respondents' reports, based on their perceptions of their behaviour, rather than actual observations of parent-child interaction, and a process of cultural blending appeared to be occurring. These factors may account for the discrepancies between the findings of this study and the literature on language socialization.

Models Of Disability

The deficit model, as described by McDermott (1993), appears to be routinely adopted by speech-language pathologists and other language interventionists in schools and health care facilities within the communities of Timmins and Moose Factory. This model emphasizes labeling of individuals, who are then segregated to receive special instruction or therapy (McDermott, 1993; McDermott & Varenne, 1995; Peters, 1993). McDermott (1993) maintains that use of the deficit model negatively affects all children who lack certain abilities, which are arbitrarily determined to be important by society. Support for this belief was found in the open-ended responses of parents from both the Aboriginal and non-Aboriginal groups. In particular, one non-Aboriginal parent felt that labeling a child would be detrimental to them in the educational system, in that the attitude of the teachers toward that child would be affected, which would in turn affect the academic performance of her child (see quote by RL, p. 97).

Although the deficit-based model negatively affects *all* children who differ from the norm, it is also prone to cultural bias and thus is more detrimental to children from non-mainstream cultural backgrounds. Evidence of types of cultural bias documented by Taylor and Payne (1983), such as value bias, was found in this study. One Cree parent reported that the speech-language pathologist used materials which were inappropriate for children from a Cree background, namely toy animals which were not representative of animals indigenous to northern Ontario, and therefore unfamiliar to most children living in Moose Factory. Owing to time constraints, speech-language pathologists servicing Moose Factory tended to use tests that were standardized and norm-referenced on white, middle-class North American children (OSLA Chapter, personal communication, April 23, 1997). These tests are particularly prone to value

and linguistic biases (Crago & Cole, 1991; Taylor & Payne, 1983) and reinforce the negative principles of the deficit model (e.g. labeling and categorization).

In spite of evidence of mainstream influence in Moose Factory and the adoption of some mainstream cultural values and practices, the cultural variation present within and between the two participant groups suggests that a culturally-sensitive and flexible model of disability is needed. Appropriate suggestions have been made by various authors as follows.

Clinicians working in health-care settings are influenced by the deficit or medical model under the guise of World Health Organization (WHO) terminology, in that "impairment" denotes "deviation from the norm". McKellin (1994) suggested adopting an anthropological approach which would help clinicians focus more on the impact of impairment on lifestyle (i.e. disability) and the social consequences of disability (i.e. handicap). This suggestion is in accordance with a general trend in health sciences to develop client outcome measures which are functionally based and oriented toward the disability/handicap end of the WHO continuum, rather than the impairment end (McKellin, 1994). Other authors, such as Crago and Cole (1991), Peters (1993), McDermott (1993), and McDermott and Varenne (1995) all proposed similar, culturally sensitive models, albeit using terminology more appropriate for educational settings. Collectively, they advocated a pluralistic, rather than deficit-based paradigm, focusing on the cultural context, rather than the individual.

Service Delivery

The findings of this study were very informative in terms of the Aboriginal and non-Aboriginal groups' reception of speech-language pathology services. This project added to our understanding of the literature in a number of ways.

First, problems with service delivery and a lack of consumer satisfaction were reported by respondents from both groups. There is a paucity of consumer satisfaction studies in the field of speech-language pathology in general and no consumer satisfaction studies have been done with Native populations. Consumer satisfaction research done with mainstream groups have tended to address satisfaction with methods of service delivery. Examples include Girolametto et al. (1993), who looked at consumer satisfaction with a parent-focused language intervention program and by Ilott et al. (1991), who examined different forms of service delivery (direct/indirect), quantity of service (frequency of contact with the speech-language pathologist) and modes of service delivery (speech-language pathologist versus speech aide). Ilott et al. found that consumers did not object to indirect over direct service delivery (speech-language pathologist or speech aide worked directly with the child), but were more satisfied when the frequency of contact with the clinician was "moderate" or "high". "Moderate" denoted more than one day per month but less than two full days a week, whereas "high" denoted two full days or more per week.

Owing to the remoteness of the community and the subsequent infrequency of the speech-language pathology service to Moose Factory, indirect models of service delivery have been routinely employed, as suggested by Paul (1995) and Ilott, Holdgrafer & Sutter (1991). Indirect methods have also been employed in Timmins, due to long waiting lists for service and too few professional staff. These indirect approaches include use of supportive personnel (for example, special education resource teachers), use of "home programs" (i.e. therapy programs designed by the speech-language pathologist, but carried out by parents or teachers), as well as parent- and caregiver-training programs (e.g. HELPP).

The parental reports in this study agreed with the findings of Ilott et al., in that indirect methods of service delivery (such as the HELPP or use of therapeutic programs carried out by special education resource teachers) were well received by respondents in both groups. Ilott et al. added the caveat that an indirect service was well accepted providing that *the frequency of contact was high*. Similarly, in this study, parents had more complaints about the low frequency of contact with the speech-language pathologist than they did about the method of intervention.

Secondly, respondents complained about the difficulty in accessing services. Both Cree and non-Cree parents described their frustration at not knowing whom to call for help or how to speed up the referral process. Similar barriers to service delivery for Native Americans (such as geographical remoteness, lack of professional staff to provide service, and cultural diversity) were described by Harris (1986). However, no studies have previously documented consumer satisfaction with Native Canadians and few have examined speech-language pathology service delivery to mainstream cultural groups. Some of the barriers mentioned by Harris (1986) are also applicable to non-Aboriginal communities in areas like northern Ontario, such as a paucity of speech-language pathologists and fragmented delivery of service.

Public health issues described by several authors impacted on children in Moose Factory in the same way. In particular, otitis media with effusion is prevalent in Cree children in this community (it was often mentioned by parents when they discussed the onset of their concern) as in other Native American and Canadian groups (Anderson and Anderson, 1983; Harris, 1986; Stewart, 1983; Todd, 1986). Middle ear problems place children at a higher risk for speech and language problems, especially if access to

medical treatment for ear infections is restricted by geographical location and lack of public education (Cochrane District Health Council, 1997).

Thirdly, it was assumed that the type of services provided to non-Aboriginal families in Timmins was culturally appropriate, since all families in this group identified themselves as coming from mainstream cultural backgrounds. No comments were made by any of the participants regarding the cultural appropriateness of the speech-language pathology services, with the exception of the one Aboriginal respondent previously mentioned, concerning the materials used in testing. Although this was a complaint from an Aboriginal parent, non-Aboriginal children from northern Ontario could also be subject to this kind of bias, in that their culture (i.e. their physical, psychological and social context) differs from the culture of the children on whom the standardized tests were developed. This is reminiscent of McDermott's idea of "culture as disability". That is, when arbitrary testing measures are chosen to represent significant aspects of the dominant culture, poor performance on those measures merely signifies deviance from the norm, so that the child is disabled by the culture, rather than by an inherent deficit (McDermott, 1993). Several respondents reported that they did not observe the speech-language pathologists' sessions, so it was difficult for them to comment on the cultural sensitivity of the clinician. They did mention, however, that the speech-language pathologists documented their awareness of the potential for cultural bias in their reports.

In summary, the respondents in this study did not provide negative feedback regarding the cultural appropriateness of mainstream speech-language pathology services for Cree families in Moose Factory. In fact, they provided positive feedback on some parent training programs, such as the Hanen Early Language Parent Program

(Manolson, 1982), for example. This is contrary to the work of Van Kleeck (1994), who advised clinicians that the HELPP, and other parent training programs, may reflect cultural beliefs about how children learn language, that are based on parent-child interaction in white, middle-class families, thus rendering them inappropriate for parents from non-dominant cultures. However, Cree parents in Moose Factory, who received HELPP training, felt that the strategies suggested *were* appropriate for them, perhaps because of cultural change and blending with mainstream practices. In fact, the facilitative techniques suggested in the HELPP, such as "getting down to your child's level", labeling, modeling and expanding, were equally reported as helpful by Aboriginal and non-Aboriginal parents.

That is not to say, however, that the HELPP and similar programs, would necessarily be appropriate for *all* Cree families in *all* Cree communities. As stated above, the degree of blending with mainstream culture can vary markedly between and within nondominant cultures and it is important that speech-language pathologists routinely adopt a culturally-sensitive approach (Van Kleeck, 1994). Some of the suggestions by authors include ethnographic interviewing of the parents about communication patterns and interaction with their child, by "adopting an ecological framework that considers children's functioning within the broader aspects of their environment" (Westby, 1990, p.101). Other ideas include adapting programs to incorporate cultural differences or custom designing programs according to the family's needs (Van Kleeck, 1994) and obtaining naturalistic data on children and reviewing the sociocultural features of communication in a particular cultural community before giving a diagnosis or providing intervention (Crago & Cole, 1991). Use of standardized, norm-referenced tests is not recommended by several authors, since the normative group

does not represent the target group (Darou, 1992; Taylor & Payne, 1983). This study supports this view, especially if tests of this kind are used exclusively. Given the respondents complaints of lack of support and therapeutic direction from professionals, speech-language pathologists providing service to Moose Factory would perhaps make better use of their time (at least for families with children under five) by interviewing the parents, discussing their concerns and making informal observations of the child's communicative behaviours and parent-child interaction (as suggested by Crago & Cole, 1991 and Westby, 1990).

Clinical Implications

One obvious issue affecting both Cree and non-Cree families is the lack of accessible and adequate speech-language pathology services for children within northern Ontario. As mentioned earlier, census data indicated that 5.5 % of children in Timmins and 32.2% of children in Moose Factory were identified by parents and professionals as needing speech-language pathology services (Saville, 1991). Although these data do not account for difficulties in accurate identification of children, due to lack of public education, for example, they do indicate a very high prevalence of speech-language problems in Moose Factory, and an insufficiency of staffing resources, given the geographical area with widespread, rural communities (Cochrane District Health Council, 1997). Given that nine speech-language pathologists have to provide service to the preschool and school-aged populations of the District and that they have to travel to small communities (up to 500 km, including James Bay), this presents an enormous service delivery challenge to clinicians. Indirect methods of service delivery are routinely used to maximize professional time (such as those suggested by Ilott et al., 1991, and Paul, 1995). Nevertheless, long waiting lists still exist. There is pressure from the

Ontario government to employ these indirect service delivery methods further, as they perceive these to be time-efficient and cost-effective ways of providing service (Ministry of Health, 1996).

A recurring theme affecting Cree and non-Cree parents seems to be the lack of public or parental education regarding language milestones (when they should be concerned about their child's language) and whom to contact for help. With the degree of cultural blending and Cree parents' expectations for their child's learning, information of this kind should be more readily available to families in Moose Factory and throughout the Cochrane District. This suggestion concurs with the work of Harris (1986), Joe (1980) and the Cochrane District Preschool Speech and Language Planning Group (1997), who identified a need for improved health education for Aboriginal families.

However, without increasing the number of speech-language pathology positions in northern Ontario, waiting lists are expected to lengthen and adequacy of service to decrease further. In seems unreasonable to expect parents of children with severe language problems to wait two years for an assessment, drive three hours to see a professional or receive a visit from a speech-language pathologist only once a year. Again, this supports the findings and suggestions of Harris (1986) and Joe (1980), who felt that lack of professional resources presented a major barrier to service delivery for Native families. However, little investigation has been done into the provision of speech-language pathology in northern Ontario, until the recent Ministry of Health initiative for developing speech and language services for children aged 0-4 years in Ontario (1995). A sum of ten million dollars was allotted annually to this project and local planning groups were established to suggest how services might be improved at a local level. A team of professionals, in collaboration with the Cochrane District Health Council,

developed a plan, which consisted of a proposal for enhancement of speech and language services to preschoolers in the Cochrane District. This proposal (Cochrane District Health Council, 1997) stated a number of objectives. These included increasing the number of speech-language pathologists and communicative disorders assistants (CDAs) within the District; improving access to services by having a central registry of identified children and a common intake process for all agencies, and improving early identification of children through improved public education and increased number of HELPP courses offered each year within the District (Cochrane District Health Council, 1997).

Providing services to diverse cultural communities is an issue which has captured centre-stage within the domain of speech-language pathology in the last ten years (Crago, 1990b; ASHA, 1988, Van Kleeck, 1994; Westby, 1995). One suggestion for addressing these concerns was to evaluate and improve the training of speech-language pathologists to provide culturally-sensitive and culturally-appropriate services to people from a wide range of cultural backgrounds. A second, but not mutually exclusive, suggestion for dealing with this problem was the recruitment of Aboriginal students to speech-language pathology training programs. Although places for Native students have been reserved on several Canadians Masters' Programs, few of these have ever been filled. A specific objective of the Cochrane District Health Council Plan (1997) was to recruit an Aboriginal Communicative Disorders Assistant specifically for James Bay. It would seem that more innovative and proactive recruitment strategies like this need to be employed to improve service to Native communities.

Future Research

One of the major challenges in completing this research project was the attempt to combine qualitative and quantitative analyses. Several flaws were inherent in the attempt to analyze the data quantitatively, such as the small sample sizes, taking means from a scale which is ordinal, rather than equal-interval, in nature, and averaging responses of couples to arrive at equal sample sizes. Thus, one must be cautious about interpreting the failure to find statistically significant group differences as truly reflecting similar patterns of performances. In fact, the qualitative data appeared to provide more insight into the important issues for the families and also suggested group differences. Methodologically, future studies may be improved in a number of ways.

For example, several respondents suggested that there would probably be less cultural blending in some of the more remote, isolated Cree communities, such as Kashechewan and Attawapiskat. It may therefore be theoretically and clinically advantageous to replicate this interview study in one or more of these communities. If traditional Cree values and attitudes are preserved in more culturally isolated communities, this would enable researchers to detect differences in language socialization patterns and conceptualizations of language disability, if they exist. One could also examine the extent to which mainstream speech-language pathology services would be culturally appropriate for families in these communities.

Another possibility would be to enhance both the quantitative and qualitative analyses. For example, a larger sample could be gathered and a different tool could be employed (one not based on an ordinal scale) to better facilitate the quantitative analyses of the data. The study could also be broadened qualitatively by making direct observations of the subjects, as well as collecting their reports, to enable triangulation of

the data. Interview or survey data reflect respondents' attitudes and views, which may differ significantly from their behaviour. In other words, this study gained information on parents' *ideas* about their language socialization practices, rather than their *actual* practices. One means of corroborating the Cree parents' ways of interacting with their children would be to directly observe parent-child interaction in Cree and non-Cree homes using videotaped samples and analyzing the tapes for particular interactional behaviours and aspects of child-directed speech.

A final suggestion for improvement would be to make a comparison between Aboriginal and non-Aboriginal parents within the community of Moose Factory. Although there are only a small number of non-Aboriginal families living on the island, it would be interesting to compare this group with a group of Cree families, all from Moose Factory, in order to eliminate community differences, which may have confounded the results.

More research is needed to address issues of service delivery in speech-language pathology and particularly to examine consumers' perceptions of services. Since 1994, a Task Force from the American Speech-Language-Hearing Association has been doing research into outcome measures and cost effectiveness. Administrators of schools and health care facilities are demanding that speech-language pathologists be accountable for the outcomes of their intervention and prove that they make a difference (Boston, 1994; Pietranton & Baum, 1995). The perspective of the consumer (e.g. parents of a language disabled child) has become important in measuring outcomes and consumer satisfaction surveys are increasingly employed as measurement tools. This study has provided valuable information from Aboriginal and non-Aboriginal consumers of speech-language pathology services, which could prove useful in service delivery planning. As consumer-driven services are coming to the fore,

more research of this kind will be needed to examine consumers' needs and preferences.

Conclusion

This study has demonstrated that cultural communities existing in isolated pockets of Canada have cultural practices which are not easy to define. The people of Moose Factory appear to be in a state of change, realigning their values and beliefs about their culture to mainstream values and beliefs, however unconsciously this occurs. Many aspects of mainstream culture have been integrated into their lives, while preserving some traditional practices, making it very difficult to make generalizations about their lifestyles and anticipate their needs regarding professional services, such as speech-language pathology. The degree of cultural change and cultural variation in northern Ontario has indicated that a culturally sensitive model of service delivery should be adopted.

The overall need for an anthropological approach (as suggested by McKellin, 1994) by speech-language pathologists fits very well with the current political mandate, which is to provide intervention that has measurable and functional outcomes for clients. This could be achieved in Moose Factory, Timmins and in other communities by supporting any use of norm-referenced tests with information gathered from parents and teachers, and direct observations of the child in naturalistic environments. This would enable the clinician to evaluate the child's performance in his/her physical, psychological and social context. Following this, functional and culturally relevant goals of intervention could be collaboratively set by the clinician, parent and teacher. This study has not only shown that Cree people in Moose Factory have specific needs regarding services, but also that non-Aboriginal families living in Timmins also have a great need for improved

service delivery. Employment of an anthropological model, which focuses on functional outcomes and adopts efficient ways of delivering service, would be one step toward ameliorating the service delivery problem in the Cochrane District.

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APPENDIX

CULTURE AND LANGUAGE DISABILITY STUDY

FAMILY INTERVIEW QUESTIONNAIRE[10]

Date of Interview_____

People present at interview_____

_____

_____

Does a child in your family have a difficulty with language or learning? ☐ Yes ☐ No

Child's name_____ Date of Birth _____

Person interviewed_____Relationship to child_____

A: Family Lifestyle

***1. Parental Information**

Mother's Name		Father's Name	
Age		Age	
Ethnicity		Ethnicity	
Marital Status		Marital Status	
Job		Job	

***2. Type of family housing:**

apartment ☐ Own? ☐ Rent? ☐

house ☐

mobile home ☐

motel/hotel ☐

other ☐

***3. Source of family income:** Wages☐ WCB☐ Long-term disability☐

Unemployment ☐ Welfare ☐ Spousal support ☐

Pension ☐ Other ☐

[10] This questionnaire was used to guide the interview. For scaled items, respondents indicated their responses on a separate scale and the interviewer marked the response on the questionnarie, along with any pertinent notes.

***4. Family Income**

Less than $15,000		$40,000-$50,000	
$15,000 - $20,000		More than $50,000	
$20,000 - $30,000			
$30,000 - $40,000			

***5. Parents' Living Situation**

In Moose Factory/Timmins	***Mother***	***Father***
Never		
Less than 2 years		
2-5 years		
5-10 years		
More than 10 years		
All your life		
In Another Northern Community	***Mother***	***Father***
Never		
Less than 2 years		
2-5 years		
5-10 years		
More than 10 years		
All your life		
In Southern Canada	***Mother***	***Father***
Never lived South		
Less than 2 years		
2-5 years		
5-10 years		
More than 10 years		
All your life		

*6. *Where were you born?* Mother_____
Father_____

7[11]. *Would you say your (immediate) family... (husband, wife and children)* hold strongly to traditional ways? ☐
are more modern in their ways? ☐
are both modern and traditional? ☐

[11] This question and #8 were asked only of the Aboriginal respondents, as the issue of traditionality was considered irrelevant to the non-Aboriginal group

8. *Is this the same for your extended family?* yes ☐ no ☐, they...
hold strongly to traditional ways? ☐
are more modern in their ways? ☐
are both modern and traditional? ☐

B: Language Use in the Home

*1. *What language(s) did the parents learn at home, before starting school?*

	Mother	Father
From mother?		
From father?		
From grandparents?		
From others?		

*2. *What language did you use in school?* (circle appropriate word)

Mother				***Father***		
Cree	English	French	***Kindergn***	Cree	English	French
Cree	English	French	***Gr 1-3***	Cree	English	French
Cree	English	French	***Gr 4-8***	Cree	English	French
Cree	English	French	***Gr 9-13***	Cree	English	French
Cree	English	French	***College***	Cree	English	French
Cree	English	French	***Univ/Other***	Cree	English	French

*3. *Parents' language proficiency: How well do you speak these languages?*

Mother:

Language	Very well	Well	Average	Poor	Not at all
Cree	5	4	3	2	1
English	5	4	3	2	1
French	5	4	3	2	1
Other:	5	4	3	2	1

Father:

Language	Very well	Well	Average	Poor	Not at all
Cree	5	4	3	2	1
English	5	4	3	2	1
French	5	4	3	2	1
Other:	5	4	3	2	1

*4. *What language(s) do the parents use with each other?*

Mother —> Father:_____
Father —> Mother:_____

*5. *How many children live in the home?*

Name	Age	Sex

*6. *What language is used with _____?*
(focal child)

Mother	**Always <----------> Never**				
Cree	5	4	3	2	1
English	5	4	3	2	1
French	5	4	3	2	1
Other	5	4	3	2	1

Father	**Always <----------> Never**				
Cree	5	4	3	2	1
English	5	4	3	2	1
French	5	4	3	2	1
Other	5	4	3	2	1

*7. *Is the same language used with all the children in the family?* yes ☐ no☐

*8. *If no, is a different language used with the focal child?* yes ☐ no☐

*9. *If yes, which language and why?*_____
_____
_____

C: Language socialization and development

*1. *At what age do you think children usually....*

• say their first word(s)?	<12 m	12-18m	18-24m	24m+
• combine words?	12-18m	18-24m	24-30m	30m+
• are understood by strangers?	By 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +
• recognize their name written?	3-4 yrs	4-5 yrs	5-6 yrs	6 yrs +
• write their name?	< 4 yrs	4-5 yrs	5-6 yrs	6 yrs +

2. *Is it the same for children learning two languages?*_____

_____

_____

*3. *At what age did _____(focal child)...*

• say his/her first word?	<12 m	12-18m	18-24m	24m+
• combine words?	12-18m	18-24m	24-30m	30m+
• be understood by strangers?	By 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +
• recognize his/her name written?	3-4 yrs	4-5 yrs	5-6 yrs	6 yrs +
• write his/her name?	< 4 yrs	4-5 yrs	5-6 yrs	6 yrs +

*4. *Which language is referred to for question 3?*_____

*5. *If discrepancy between 1 and 3... Why do you think your child's language development is different?*

_____

_____

*6. *How do you feel about your child's language development?*

Very Content		Somewhat Content		Undecided		Somewhat anxious		Very anxious
1	2	3	4	5	6	7	8	9

*7. *How much of a problem is it for your child?*_____

_____

_____

*8. *How much of a problem is it for you?*_____

_____

_____

9. *How does_____'s (focal child's) language development compare with his/her brothers and sisters or other children you know?*

Very well		Well		Fair		Poorly		Very poorly
1	2	3	4	5	6	7	8	9

*Please try to describe these differences*_____

_____

_____

*10. *When, if at all, did you become concerned about* _____*(research child)?*

_____

*11. Why?

_____

_____

Circle the extent to which you agree/disagree with the following statements:

*12. *A young child should be encouraged to use verbal language (words/sentences) to communicate his/her needs and thoughts.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

13. *Adults usually speak differently to a young child than to older children or adults.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

14. *Asking a young child direct questions (e.g. what's this called?) will help them learn to talk.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

15. *Children learn mainly by watching and listening to others talking.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

16. *If a child is going to talk, he/she will learn to do it, no matter what adults do.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

17. *How do you know when a child has learned language?*_____

_____

_____

*18. *Children need to be "shown how to speak" by being told to copy the adult.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

19. *How do you think a child learns language?*_____

_____

_____

_____

20. *Are children expected to be quiet in certain situations or at certain times?*

☐ yes ☐ no ☐ no opinion

Comments:_____

_____

_____

21. *If yes, do they do it?*_____

_____

22. *Can people be together comfortably without talking?* ☐ yes ☐ no ☐ not sure

23. *If yes, under what circumstances?*_____

_____

_____

24. *Is it usual for **adults** to look **each other** in the eye during conversations?*

yes ☐ no ☐ unsure ☐

25. *Is it usual for **children** to look **adults** in the eye during conversations?*
yes ☐ no ☐ unsure ☐

26. *Some parents frequently ask their children questions like:* **"What is this called?" "What colour is this?"** *and some parents don't ask this type of question. How often do you do this?*

Very often		Often		Occasionally		Rarely		Never
1	2	3	4	5	6	7	8	9

27. *Some parents frequently tell their child to do things. How often do you do this?*

Very often		Often		Occasionally		Rarely		Never
1	2	3	4	5	6	7	8	9

28. *Some parents like to label things for their child. e.g. That's a horse. How often do you do this?*

Very often		Often		Occasionally		Rarely		Never
1	2	3	4	5	6	7	8	9

29. *Some parents like to tease their children or joke with them. How often do you do this?*

Very often		Often		Occasionally		Rarely		Never
1	2	3	4	5	6	7	8	9

D: Language, Learning and Disability

*1. *Do you think your child has a language or learning disability?* yes ☐ no ☐

*2. *If so, how would you describe your child's problem?*_____

_____

_____

*3. *Who first identified your child as having "a problem"?*_____

_____

*4. *What did they think the problem was?*_____

_____

*5. *Did you agree with that?* yes ☐ no ☐

*6. *Why or why not?*_____

_____

*7. *Were you offered help for your child's problem?* yes ☐ no ☐

*8. *What kind of help was offered?*_____

_____

_____

*9. *Were you given a choice of what should be done?* yes ☐ no ☐

10. *Was there a discussion of which language would be used in treating your child?*
yes ☐ no ☐

11. *How did that go?*_____
_____

*12. *Did you agree with what was suggested for your child?*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

What was your opinion?_____
_____
_____

To what extent you agree/disagree with the following statements?:

13. *The health/education services offered were easy to find and the professionals were easy to contact or talk with..*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____
_____
_____

14[12]. *The services offered were appropriate for your family's culture.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____
_____
_____

15. *Does your child like to go to the sessions/lessons?* yes ☐ no ☐

Comments_____
_____
_____

[12] This question was not addressed to the non-Aboriginal respondents, as it was deemed irrelevant and inappropriate.

16. *The services offered (e.g. place, time of appointment...) were convenient for you.*

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments_____

_____

_____

17. *Is your child happy in school?* _____

_____

To what extent do you agree with the following statements:

18. *How well a preschool child talks will determine how successful he/she will be at school.*

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

*19. *A child's success at school is measured by ...*

(a) how quickly they learn to read and write.

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

(b) how much children talk/participate in class.

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

(c) How much children listen in class.

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

_____

_____

20. *In our school system, too much emphasis is placed on learning to read and write.*

Strongly Agree								Strongly Disagree
1	2	3	4	5	6	7	8	9

Comments:_____

21. *Does going to school change the way a child talks to adults?* yes ☐ no ☐
Comments:_____

*22. *Children who are not from anglo- or franco-Canadian families are at a disadvantage in the Canadian school system.*

Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree
1	2	3	4	5	6	7	8	9

*Why? Why not?*_____

*This ends our interview. Is there anything else you think might be helpful?*_____

Interviewer's
Comments:_____