What Pediatricians Should Know About Normal Language Development:

Ensuring Cultural Differences Are Not Diagnosed as

The cultural and linguistic characteristics of patients in the United States have changed as the population has experienced significant shifts in demographics during the past 20 years. Along with cultural differences come differences in the belief systems that govern family reactions to disability and disorder. Both pediatricians and speech-language pathologists must be cognizant of these differences if they are to provide the most appropriate treatment for young children.

This article offers guidelines to help practicing pediatricians make decisions about referring children and their families to speech-language pathologists in light of changing demographics in the United States.

EFFECTS OF CHANGING DEMOGRAPHICS

Until recently, most, if not all, of the information about normal language development available to speech-language pathologists and pediatricians had been collected from white, middle-class families for whom English was the first language. A problem is that the United States population from which the speech-language pathologist’s caseload is drawn is much more diverse than the current corpus of normative data. Normative data that do not match the population to which they are compared are relatively useless; at the very least, the data are suspect, and at the very worst, they are dangerous because they can lead to misdiagnosis of a disorder when no disorder is present.

Data reported by the US Census Bureau indicate a steady increase in the proportion of nonwhite minorities in the United States and a decline in the numbers of citizens who consider themselves white of non-Hispanic origin. For example, from 1980 to 2000, the percentage of persons in the United States who identified themselves as Hispanic rose from 6.4% to 12.5%. From 1990 to 2000, the percentage of Spanish-speaking households in the United States rose from 7.5% to 10.7%. It has been estimated that by the middle of this century, if current birth rates and immigration patterns continue, white Americans of European descent will be the largest minority in the United States.

Surveys conducted by the American Speech-Language-Hearing Association showed that in 2000, racial and ethnic minorities comprised one-third of the typical speech-language pathologist’s caseload. According to the National Health Interview Survey, racial and ethnic minorities demonstrate a higher prevalence of speech and hearing disorders than do whites. This may be the result of the greater propensity for minorities to have lower socioeconomic status and consequently less access to adequate health care and other life essentials such as adequate housing, sufficient and healthy food, and clothing. This higher prevalence of communication disorders in minority populations also may be the result of inaccurate diagnoses that occur when assessment tools are used to evaluate populations on which they were never standardized.

EDUCATIONAL OBJECTIVES

1. Describe the effects the changing demographics of the United States are having on the scope of practice of speech-language pathologists.

2. Define the difference between "language disorders" and "language differences."

3. Delineate the differences between cultural patterns of language learning and how these may be mistaken for disordered language development.

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Disorders

At the same time, the American Speech-Language-Hearing Association Omnibus Survey indicates more than 90% of certified speech-language pathologists are monolingual (English speaking), white, and come from middle-class backgrounds. Although these characteristics are not necessarily incompatible with the ability to provide unbiased service, there is an obvious mismatch between the cultural and linguistic backgrounds of most experts in the field of language disorders in children and a large proportion of their clientele.

To deal with this mismatch, the American Speech-Language-Hearing Association is dedicated to the recruitment and retention of minority students in professional training programs, the encouragement of graduate programs to train bilingual speech-language pathologists, and the provision of continuing education opportunities to enhance multicultural literacy. Many of these efforts are coordinated by the Association’s office of minority affairs.

LANGUAGE DIFFERENCES VERSUS LANGUAGE DISORDERS

As the population of the United States grows more diverse, it is critical to recognize, as Cole admonished, that the “melting pot” mentality from the
turn of the 20th century, characterized by the Latin phrase “e pluribus unum” (“out of many, one”) has been replaced by a desire to maintain cultural and linguistic heritage, or “e pluribus pluribus” (“out of many, many”). American culture is more heterogeneous today not only because there are greater proportions of non-European Americans living in the United States but also because those who identify themselves as members of minority groups want to maintain their identities.

At the beginning of the 20th century, assimilation into the mainstream was the goal of most new immigrants to the United States; today, maintaining one’s native culture is a more common pat-

Los Angeles County School District serve a population of children from homes in which more than 70 different languages are spoken.\(^8\)

The issue of dialect differences has been unnecessarily contentious for speech-language pathologists, as evidenced by the controversies surrounding the use of African-American English, a nonstandard dialect of English used by some African Americans\(^3\) as well as some whites who live in inner cities.

Historically, linguists have had no trouble recognizing that nonstandard dialects are viable, normal language varieties with many more similarities than differences.\(^7\) Unfortunately, the learning curve of many speech-language pathologists has been somewhat flatter. There is evidence that many speech-language pathologists and classroom educators have considered nonstandard English dialects, of which African-American English is only one example, to be incorrect attempts to speak English. As a result, children who speak African-American English have been diagnosed inaccurately as demonstrating a language disorder, when in fact they were using a different language system. Inappropriate recommendations for speech-language therapy may have followed; in the worst possible scenarios, referrals for special education services have been made.\(^2\)

In an attempt to remedy this situation, the American Speech-Language-Hearing Association developed several position statements to describe best practices. Specifically, these have compared language disorders to language differences; provided guidelines concerning when children using nonstandard dialects can appropriately avail themselves of the services of a speech-language pathologist;\(^9\) and specified the appropriate role for monolingual speech-language pathologists when providing services for children who have limited English proficiency.\(^10\) In the latter situation, the difference is not one of nonstandard versus standard dialect, but one of a child who is learning English as a second language.

The speech-language pathologist’s role in dealing with dialect differences must focus on teaching the speaker the standard dialect not as a replacement for the nonstandard dialect but rather as an alternate to be used in specific contexts. Thus, speech-language pathologists may contrast specific syntactic constructions produced in the child’s “home” or nonstandard dialect (eg, “two shoe”) to the “school” or standard dialect (eg, “two shoes”). The “home” dialect construction is not characterized as wrong but as not preferred for use in contexts such as classroom conversations with teachers, formal speeches, and (later in life) job interviews, cases when standard American English may be expected.

When providing evaluation services to children learning English as a second language, speech-language pathologists must determine whether a child’s English proficiency is sufficient for the testing of language skills in English. If language dominance testing reveals the child’s dominant language is not English, then it is unethical to assess the child’s language skills using English tests, without appropriate support from a translator or interpreter.

For example, think of how you might feel as the parent of a normally developing 8-year-old who accompanied you to Germany for a year. Your child does not speak more than rudimentary German and yet he is given a battery of IQ tests in
German to determine grade placement in
his new school. You are both baffled and
appalled to learn that as the result of these
tests, your child has been recommended
for a special education classroom for a
severe language and cognitive deficit. In
a circumstance such as this one, it is
somewhat easier to see the foolishness of
interpreting language failure using inap-
propriately selected tests.

Unfortunately, when English is the
language of focus, and dialect rather than
language differences are at issue, this con-
found is sometimes less easily recog-
nized. As Wolfram7 pointed out, it is a
mistake to think that everyone else speaks
the same dialect. Dialects can differ, but
as long as the pattern of dialect or lan-
guage use is systematic, rule-governed,
and conforms to socially shared norms, it
serves the purpose of all languages and
dialects: it enables communication.

**CULTURAL DIFFERENCES
AND LANGUAGE LEARNING**

Speech-language pathologists, as
well as pediatricians, focus their therapy
on the child and the child’s family. A
family-centered approach, dictated for
speech-language pathologists by federal
legislation governing public education,11
is considered best practice for service
delivery because children’s communica-
tion difficulties are affected by and in
turn have the potential to affect every-
one in the child’s family.

For therapy to be successful, it is
important for the family to be part of
 treatment planning as well as involved
in the process of carrying over the ther-
apy goals into the home environment.
This scenario for incorporating families
into the therapy program is both logical
and inclusive in its approach.

Family-centered therapy programs
attempt to empower families by acknowl-
edging the essential role they play in their
child’s treatment. However, depending
on the service provider’s knowledge of
cultural differences, family-centered pro-
grams can be fraught with a number of
cultural assumptions that do not match a
family’s home culture and may sabotage
the therapy plan as well as the credibility
of the professional service provider. A
delineation of these particular cultural
assumptions includes12:

- how credibility as a professional is
  established;
- the status of relationships that govern
  conversation partners;
- the value placed on children’s early
  talking;
- the place of routines in child care;
- perspectives on caregivers’ roles in
  language learning; and
- inclusion of family members in ther-
  apy planning.

**Professional Credibility**

In middle-class, mainstream Ameri-
can culture, it is assumed that profes-
sionals with degrees appearing after
their names, indicating their educational
expertise, are knowledgeable in their
area of expertise. For most, the degrees
bring instant credibility to their relation-
ship with their patients.

In nonmainstream cultures, espe-
cially those that represent an Eastern
perspective or a lower socioeconomic
status, faith in a practitioner’s expertise
is earned differently. A person viewed
in the community as a healer, a family
elder, or a mainstream practitioner who
has already established credibility in
the family’s community is much more
likely to be viewed as knowledgeable
than the stranger with impressive edu-
cational credentials. This professional
may wrongly assume that his or her
expertise is automatically accepted. If
practitioners are not aware of this dif-
ference in achieving credibility and do
not make attempts to gain the confi-
dence of the nonmainstream family,
their recommendations may be dis-
missed as valueless.

**Conversation Partners**

Middle-class families generally act
as if their language-learning children are
appropriate conversation partners. Whether the child speaks at all or very
little, these families tolerate the child’s
immature contributions to conversations
as well as the child’s initiation of con-
versations with adults. Thus, when
speech-language pathologists encourage
these families to spend more time talk-
ing to their children and engaging them
in conversation, this recommendation
appears plausible.

However, in some other cultures,
children are expected not to speak until
spoken to, and until they use real words,
children are not viewed as being able to
contribute to a conversation. For these
families, a similar recommendation by
the professional to include the child in
conversations, especially if the child is
nonverbal, appears odd. Such recom-
endations are not likely to be carried
out, and speech-language pathologists
may view the family as noncompliant.

If practitioners are unaware of this
assumption in their care delivery arsenal,
they probably will not spend time
explaining to families that engaging a
child in conversation can provide him or
her with opportunities to practice what
has been learned in the therapy setting.

**Early Talking**

In the mainstream, caregivers are
often able to give a great deal of infor-
mation about the specifics of their chil-
dren’s first words. Speech-language
pathologists attempt to collect pertinent
developmental data from family mem-
bers to compare with available norma-
tive data. Precocious language learning
is valued and thought to be closely relat-
ed to intellect. That is, the earlier the
child begins to use words and put words
together, the more intelligent the child is
believed to be.

In other cultures, precocious language
use is not necessarily viewed as a positive characteristic. Instead, the child who uses language early on may reflect badly on the parents, especially mothers whose job it is to anticipate their children’s every need, making it unnecessary for them to use words to request. Because of the marked status differences between children and adults, rather than appearing accomplished and “cute,” early talkers may be perceived as rude.

If speech-language pathologists are not aware of this mainstream assumption, they may conclude children from nonmainstream families are delayed in language learning when in actuality these children have not been encouraged to speak at a very young age. In addition, information about early language milestones may not be available perhaps because it was not viewed as important or was an embarrassment to the family.

Some nonmainstream cultures negatively view persons of lesser status (i.e., young children) making eye contact with those of greater status (i.e., adults); rather than a sign of disrespect, not looking directly at an adult when spoken to is a sign of respect. Unfortunately, lack of eye contact during conversation often is viewed in the mainstream as an indication of an inability to maintain attention or as a lack of respect.

**Child Care Routines**

Another frequent assumption of speech-language pathologists working with families in the mainstream is that routine is an essential part of all families’ daily schedules. These practitioners believe the child is incorporated into a predictable dinertime routine, a predictable bathtime routine, and a getting-ready-for-bed routine at a set time. These routines contain their own sets of vocabulary and roles for the participants. Thus, routines are used as the basis for language learning. When involved in predictable routines, children can spend more resources thinking about how words and phrases can be mapped onto the activities that occur each time.  

However, in nonmainstream families, routines are less common. For example, the child from a lower socioeconomic family may be part of a close-knit, extended family, and bedtime can mean sleeping at any one of a number of relatives’ or friends’ homes. Similarly, there may be no set bedtime; children often fall asleep when they are tired, which may be much later than in the middle-class household where bedtime often is prescribed. In such settings, a recommendation by a speech-language pathologist that the family read a book together every night before the child goes to bed not only makes little sense but also cannot easily be carried out.

**Language Learning**

Families can differ greatly in terms of how language learning is viewed. In the mainstream, parents assume caregivers recognize that they serve an important role in facilitating their child’s language learning by providing language models, exposure to written text, and opportunities for conversation practice.

However, not all families share this belief. When asked about their views of how parents can assist in language learning, almost all of the mothers classified as belonging to a lower socioeconomic group on the basis of their education and income stated they did not believe there was anything that they, or any parent, could do to help children learn language. They viewed language learning much as they viewed learning to walk, and, since they could not imagine how children learned to walk other than by developing normally, they also could not imagine how they would be able to assist their children in language learning. Thus, dissonance in views of language learning can serve as a barrier to a speech-language pathologist’s attempts to have family members participate in the therapy program.

**Family Therapy Planning**

Finally, at the very heart of the federal legislation that mandates services to the youngest children with special needs or at risk for developmental problems is the requirement that families participate fully in the decision making involved in designing the therapy plan. Families are viewed as equal partners in determining priorities for treatment, with periodic reviews of the service plans drawn up in partnerships with appropriate professionals. The intent of this legislation is to acknowledge the crucial role played by families in their children’s growth and change, to promote self-esteem and empowerment.

In some cultures, however, the intent of the family’s participation is viewed with some skepticism. Family members may express that they came to a professional for guidance and that if they had been able to make their own decisions about their child’s service needs, they would have done so without seeking assistance. These families wonder how the team can have the expertise and ability to make correct decisions if the team asks for the family’s advice. This miscommunication of the purpose of the family’s participation in the decision-making process can become another barrier to gaining a family’s trust and can have a negative impact on the ability to provide family-centered therapy as intended by law.

**INDIVIDUAL DIFFERENCES IN LANGUAGE LEARNING**

Perhaps the most important facet of language learning to remember when dealing with families from multiple cultural backgrounds is that researchers are still unable to agree on a unified theory of language acquisition. There is some-
what more consensus on the position that children differ in their path toward language competencies.

A theory of language acquisition must explain the individual differences observed within cultures with regard to language-learning patterns. Just as some children appear to pay more attention or invest more in learning their motor skills at an early age, some children are more precocious language learners. Speech-language pathologists frequently hear parents say they are concerned about their child's slow language development but that same child is already climbing on and off the furniture with ease.

Within the language-learning milieu, investigators have discovered some children appear to favor learning many nouns to the exclusion of other parts of speech, while others learn some nouns but also acquire pronouns, "megawords" called formulae (eg, "gimmie-dat"), and personal-social words (eg, "uh-oh," "pattycake," "hi") that facilitate social interactions. In the earliest stages of learning vocabularies, these two different styles have been identified by Nelson and other researchers. Of most interest is that although these styles are descriptive of the young child's early word-learning preferences, within a year or so it is generally impossible to see these differences in their vocabularies or use of early sentence constructions.

Thus, styles are not indicative of disorder but of different approaches to solving the language-learning puzzle. No one appears to understand why children select a particular vocabulary-learning style; it may be based on environmental stimulation, temperament, genetic predisposition, or other factors yet to be determined.

The information about style is relevant in terms of the concerns that caregivers or professionals may express about a child's language-learning patterns. There is no overall, one-size-fits-all language-learning path. The danger in not recognizing these natural differences is incorrect diagnosis of children with language disorders, which at the least wastes professional resources and at the worst may stigmatize the child.

**REMEDYING MISMATCHES**

Several avenues are available for lessening the potentially negative effects cultural and linguistic mismatches can have when speech-language pathologists and pediatricians work with families. It is important to recognize there are individual differences among persons who are members of a particular culture. This heterogeneity within cultures means professionals cannot make rigid assumptions about the belief systems of all members of a culture. Stereotypes, besides denying the integrity of an individual, do not necessarily reflect a true picture of a particular family. It is far better to use open-ended questions when interviewing a family to determine the degree to which its members are prototypes of the characteristics of their culture than it is to make assumptions.

For example, one stereotype of families who identify themselves as Hispanic is that when beginning a therapy session, it is wise first to greet the family members and make small talk before launching into questions about the patient's progress with therapy goals since the last visit. To skip this informal and friendly prelude to therapy is viewed as rude and inappropriate. However, not all Hispanic families necessarily adhere to this belief.

In speaking with dozens of families who have identified themselves as Hispanic over the years, the responses generally fall along a continuum. Some strongly adhered to this belief, while others shared that because the speech-language pathologists were not Hispanic, their expectation that the "proper" behavior would be followed was somewhat less. Often the amount of interaction a nonmainstream family has had with persons in the mainstream culture dictates the degree to which families adhere to their cultural behaviors.

Open-ended questions include those that are assumption-free and thus judgment-free. Rather than asking a family member how often during the week a parent reads to a child at bedtime, speech-language pathologists can ask the family to describe a day in the child's life. Through this approach, which becomes more of a discussion, specific information about the opportunities for exposure to text in the home may become apparent. In contrast, asking how often a family member reads to a child before bedtime informs the respondent that reading books to children at bedtime is a good thing and probably should be done frequently. If the caregiver does not participate in this activity, how should he or she respond?

Similarly, it is important that an interviewer recognize some questions perfectly acceptable to ask of mainstream families may appear too personal to be answered by family members of non-mainstream cultures. There may be justification for asking questions involving the nature of a mother's pregnancy or the methods of discipline used in the household because they may yield important

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diagnostic or therapy planning information. However, in some cultures, these questions would be viewed as inappropriate to be asked by someone, even a professional, who had not yet established a trusting relationship with the family.

The professional usually finds, once a positive relationship has been established over time, questions of a more personal nature can be asked and will be answered. Thus, it is essential to know how to delineate which questions will yield information that is necessary immediately for diagnosis and therapy planning, and which questions can be asked at a later time. It is also critical to be able to explain to the family why a question is relevant to decision making.

As described by van Kleec,12 some speech-language pathologists are called on to be cultural guides for families who are unfamiliar with mainstream traditions. Some families are willing to make accommodations to their activities of daily living that are more in line with those of mainstream families but need assistance in doing so and understanding why these changes would be advantageous for their child.

The first step in this process is for the professional to be aware of the cultural assumptions that those in the mainstream make so freely, such as the availability of educational toys, and frequent conversation interactions between the child and caregiver. Professionals also must be ready and willing to provide explanations for any changes of the family’s activities of daily living that might be suggested, just as they must be prepared to explain why it is critical for the mother to understand why questions asked of her in an interview are relevant.

SUMMARY

The roles and responsibilities of speech-language pathologists and pediatricians have become greater with the changing population demographics in the United States. In some states, the majority of the population belongs to a national cultural minority, eg, New Mexico. Even a state such as Iowa, with only a 5% nonminority population, has a school-aged population that is almost 10% nonmajority. This growth of diversity is likely to continue.

Rather than viewing sensitivity to the influence of culture on language learning and other developmental areas as an “add-on” to a practice, it may be wiser to recognize that approaching all clients with as few assumptions about their behaviors as possible will guarantee nonbiased service delivery for all. Without nonbiased service delivery, incorrect diagnoses and provision of inappropriate therapy become more likely.

Fortunately, many resources are available to assist pediatricians and speech-language pathologists in learning about various cultures. Institutional review boards have become more vigilant about the inclusion of a cross-section of subject populations as participants in research studies in addition to protecting the rights of all participants. Funding agencies also have expressed as a priority the inclusion of research subjects from minority populations to add to the information available about the incidence and prevalence of disorders across the range of our potential patients.

In a society in which cultural differences are not just defined by race or ethnicity, but by gender, sexual orientation, age, geographic region, and religion, belief systems about disease, disability, and treatment are dynamic entities for health professionals to take into consideration. It is a challenge that speech-language pathologists and pediatricians must meet if they are to provide the best and most appropriate services for their patients.

REFERENCES