

**Mothers' beliefs about child development, parenting and
developmental delay:
A cross-cultural comparison**

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ABSTRACT

It is now widely recognised that culture plays an important role in shaping ideas about child development and parenting (e.g. Harkness, Raeff and Super, 2000). Numerous studies have shown cross-cultural differences in the types of competencies parents encourage in children, the age at which parents expect developmental skills to be acquired and the methods parents use to promote these skills. Cross-cultural differences have also emerged in relation to parents' ideas about developmental delay, their beliefs about intervention, and support seeking behaviours (e.g. Danesco, 1997). Within the UK, where referrals to child development and learning disability services are increasingly culturally diverse, it is important for professionals to develop an awareness of cultural practices and beliefs in order to provide services which are culturally sensitive. This point is soon to be echoed in the new National Service Framework for Children (Department of Health, forthcoming). Despite the recent emphasis on delivery of culturally sensitive services, previous researchers have consistently highlighted the shortcomings of health and social care services for ethnic minority groups. Inequalities faced by parents from South Asian communities who have a child with a learning difficulty, have been a particular cause for concern. This group have been shown to experience substantial discrimination and inequality in their access to health, social, education and welfare services (e.g. Mir *et al.* 2001), a factor which is often partly linked to poor professional knowledge and sensitivity to cultural and religious belief systems.

Very little is currently known about South Asian parents' beliefs about child development, parenting and developmental delay despite the relevance of these areas to clinical practice. Therefore, 10 South Asian mothers and 10 white British mothers of a child with global developmental delay were interviewed about their beliefs about typical child development, their child rearing practices and the factors influencing their ideas about child development and parenting. Beliefs about developmental delay and support seeking behaviour were also investigated. The data were analysed using thematic content analysis and quantitative methods.

In relation to typical child development, results indicated that South Asian mothers and white British mothers held similar beliefs about the age at which children achieve different developmental skills. However, differences emerged in terms of the importance attached to the development of different skills. South Asian mothers were significantly less likely to highlight the importance of self-help skills compared to white British mothers. South Asian mothers were also significantly less likely to expect gender differences in children's acquisition of skills. Factors influencing mothers' ideas about child development and parenting differed cross-culturally. Significantly more white British mothers than South Asian mothers were influenced by friends, professionals and books and media, whilst significantly more South Asian mothers were influenced by their religious beliefs. Parenting practices, such as toilet training, also differed between the two groups.

In relation to developmental delay, the groups differed in terms of their understanding and explanations of developmental delay. South Asian mothers were less likely to use medical and biological explanations of their child's difficulties than white British mothers. Help-seeking behaviours also differed cross-culturally, with South Asian mother more likely to turn to religious persons for support and less likely to turn to professionals for support than white British mothers. In relation to experiences of support services offered, mothers identified similar shortfalls in service provision. These included "being kept in the dark" about their child's difficulties, being confused about the organisation of the support system, having to "battle" to receive support, feeling that resources were either too few or inappropriate, and feeling that professionals failed to hold in mind a complete picture of their child's difficulties. These results are discussed in the context of existing literature together with suggestions for future research and the clinical implications of the study.

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CHAPTER 1 ~ INTRODUCTION

Overview

Over the past two decades, there has been growing interest in the relationship between parents' culture and their beliefs surrounding the development and rearing of children. A number of studies have documented differences in children's emotional, physical and social development across cultures (e.g. Harkness, Raeff and Super, 2000). Research studies have also described variability in parents' developmental expectations of their children (e.g. Schulze, Harwood, Schoelmerich and Leyendeker, 2002) as well as care-giving practices, such as feeding (e.g. Miller and Harwood, 2002), sleeping arrangements (e.g. Okami, Weisner and Olmstead, 2002) and toilet training (e.g. Norimatsu, 1993).

Despite the well-documented variability in child development and parenting practices cross-culturally, health care professionals in the UK typically draw upon models of child development, parenting and intervention developed in America or in Europe in their work with families of children with developmental difficulties, regardless of their cultural background. Clearly this practice is problematic since Western ideas may not always fit with the family life, expectations and belief systems of parents from non-Western cultures. In fact, research now suggests that a failure to recognise cultural variability may contribute to the low awareness, uptake and receipt of specialist services amongst ethnic minority groups (e.g. Beresford, 1995; Mir and Nocon, 2002).

Within child development and learning disability services in the UK, where caseloads are becoming increasingly culturally diverse, there is a growing need to develop practice which is appropriate for the different cultural communities. The implementation guidance for the Government White Paper 'Valuing People' (Department of Health, 2001b), for example, emphasised the need to ensure that services for persons with a learning disability are 'culturally competent' and 'able to meet the different cultural needs of all communities in the area' (p.6, para.12). The National Service Framework for Children (Department of Health, forthcoming) also points to the need to develop child services which are responsive to cultural

and religious diversity. However, whilst it is easy to endorse the principle of culturally sensitive practice, in practice, stereotypic thinking continues to cloud many efforts at providing intervention and support (Stuart, 2004). The roots of this problem have often been linked to the complexity and instability of culture and uncertainty about how to use the growing body of knowledge about culture and its influence. Unfortunately, as Stuart (2004) emphasises, cultures are not bounded and static entities, but dynamic with "fuzzy" boundaries which change with the influence of mass media, tourism, intermarriage, education and mass migrations.

The word *culture* has been referred to as being one of the two or three most complicated words in the English language (Williams, 1976). The latest thinking defines culture as the source of ties that bind members of societies through an elusive "socially constructed constellation, consisting of such things as practices, competencies, ideas, schemas, symbols, values, norms, institutions, goals, rules, artefacts and modifications of the physical environment" (Fiske, 2002, p. 85). These internalised rules create traditions that go deeper than reason. For example, Kroeber (1963) observed that as a sign of respect when entering a holy place, Muslims take off their shoes and Jews, their hats, but neither group can explain the observance, beyond saying that this is the way things have always been done. In Kelly's (1955) terms, cultural orientation might be construed as the master plan behind superordinating constructs that covertly influence manifest cognitive content. Because much of the strength of cultural influences stems from the fact that they operate in the background of behaviour at the value, linguistic and construct levels, people often have difficulty defining and measuring their cultural influences.

Equally difficult to define and measure, is the concept of 'ethnicity' or 'ethnic identity'. These terms are frequently used interchangeably with 'culture' or 'cultural identity', which further confuses picture. The concept of ethnicity is related to the Greek word *ethos*, which refers to the people of a nation or a tribe. Hence, the term refers to the affiliation of a group, which is normally characterised in terms of culture. As with culture, ethnicity is not a stable and independent entity. Immigration, for example, influences cultural outlooks by challenging the

ethnic identities with which newcomers arrive (Stuart, 2004). Immigrants may assimilate by moving away from their ethnic heritage and immersing themselves in the mainstream; they may integrate the two sets of view; withdraw altogether from the mainstream and only accept their heritage beliefs, or marginalize by failing to accept or integrate either sets of beliefs (Berry and Sam, 1997). Multiple factors affect these processes, such as the receptivity of the host culture to immigrants, the extent to which immigrants' characteristics are distinctive, and the extent to which members of the native culture are able to accept those who assimilate.

In addition to difficulties defining, describing and measuring culture and ethnicity, the effect of variables such as socio-economic status can also be confounded with the influence of culture and ethnicity. Socio-economic status (SES) is a classification aimed to bring together persons of similar economic and social situations. Factors such as income, education level and employment status tend to make up this index. (See appendix 7 for a break down of the current classification system used in the UK). Some cross-cultural studies have not taken into account SES, resulting in researchers drawing false conclusions about cultural differences. For example, Frerichs, Aneshensel and Clark (1981) found the prevalence of depressive symptomatology significantly different for Latinos, Anglos and African American community residents, with elevated levels in the Latino group compared to the others. However, when SES related variables were controlled for, cultural background was of little or no significance. Conversely, studies linking SES to outcome variables have sometimes failed to take into account cultural variables, such that false inferences about SES have been made. For example, Clarke-Sterwart (1983) criticises this research which links low social status to poor parenting skills, high punitiveness, inconsistency and unresponsiveness. Often, when ethnicity and religion are taken into account, socio-economic status is not a good predictor of parent behaviour.

Taken together, difficulties in defining culture and ethnicity, the complexities of cultural processes and the tendency of SES to covary with ethnicity, render both research into different cultural groups and the achievement of multicultural competence highly problematic. In the past, culture has often been treated as a 'nuisance' variable or else ignored by

psychological research (Sue, Bingham, Porche-Burke and Vasquez, 1999). Traditional psychological concepts and theories derived from research have been developed in a predominately European or American context (Kim and Berry, 1993) and thus may be limited in their applicability to the increasingly racially and culturally diverse population of the United Kingdom. Hall (1997) has warned that European and American psychology may become "culturally obsolete" unless revised to reflect a multicultural perspective. With this in mind, the current research sought to gain insight into the cultural belief systems of parents who come into contact with child development and learning disability services in the UK. In particular, the research gained perspectives on ideas about child development, parenting and developmental disability – areas, which, until recently, have been studied from a predominately Western view-point.

Setting the scene: Cultural diversity within the UK and barriers to service utilisation and delivery

In recent years, the UK has become increasingly diverse in terms of ethnicity, culture, language and religion (Hatton *et al.* 2003). This diversity is also apparent amongst people who have disabilities. Emerson and Hatton (1999), for example, suggest a projected 70% increase in the number of non-white people with learning disabilities from 1991 to 2021. By 2021, Hatton *et al.* (2003) estimate that 7% of all people with learning disabilities in Great Britain will be of South Asian origin*. South Asian families of a person with a learning disability frequently experience discrimination and disadvantage in terms of housing, employment and transport, income and benefits (Beresford, 1995; Shah, 1995; Hatton *et al.* 2002; Chamba *et al.* 1999; Mir *et al.* 2001). They may also experience poor access to social, education and health care services (Mir *et al.* 2001) and uptake of such services may be low (Baxter *et al.* 1990). Research into the type and quality of both informal and formal support services for South Asians with a family member with a learning disability has found that this group receive less support from family networks than White families (Hatton *et al.* 1998) and receive little support from community and faith agencies (Chamba *et al.* 1999). Despite reporting a high need for formal support services (e.g. Baxter *et al.* 1990; Hatton *et al.* 2002),

* i.e. people from India, Pakistan and Bangladesh and Indian families who have lived in Africa for a substantial period of time (see Modood *et al.* 1997).

South Asian parents are often not aware of the specialist support services on offer, a factor which has been linked to the low uptake of support services among south Asian parents (e.g. Hatton *et al.* 2002; Mir *et al.* 2001; Chamba *et al.* 1999).

South Asian parents of a child with a learning disability also have substantial need for appropriate information about their child's disability (Mir *et al.* 2001). Studies have shown that Asian parents are far less likely to know the name and the cause of the disability than their white British counterparts (Fatimilehin and Nadirshaw, 1994). Many Asian families report greater religiosity in relation to understanding and coping with their child's disability (Fatimilehin and Nadirshaw, 1994; O'Hara, 2003); these beliefs are seldom acknowledged by professionals (Mir *et al.* 2001). In addition, South Asian parents' experience of being told about their son or daughter's learning disability is often unsatisfactory (Sloper and Turner, 1993a). Language used for the disclosure is most frequently English, despite this not being the parents' preferred language, and very few parents receive written information about the disability (Hatton *et al.* 2003).

In view of the substantial inequalities faced by these groups, there has been an increase in research focusing on persons of South Asian origin who have a family member with a learning disability (e.g. Hatton *et al.* 2002; Hatton *et al.* 2003), alongside a call for achieving greater cultural competence in service provision (e.g. Mir *et al.* 2001). Additional research is needed across the full range of contexts in which these parents have contact in order to ensure their needs are appropriately identified, understood and met. With this in mind, the current research focused upon the cultural belief systems and experiences of South Asian and white British parents who have a developmentally delayed child and who have been in contact with child development services. Child development services in the UK are specialised out-patient community or hospital based centres, which provide an array of services for children with developmental disabilities.

The research sought to address the following questions:

1. Are there differences between white British and South Asian mothers' beliefs about typical child development?
2. Are there differences between white British and South Asian mothers' beliefs about parenting practices and their role in supporting a child's development?
3. Are there differences between white British and South Asian mothers in terms of the factors which influence ideas about child development and parenting?
4. Are there differences between white British and South Asian mothers' beliefs and experiences of having a child with developmental delay and support offered?

To the best of the author's knowledge, these areas have not been addressed in previous research. Unless questions such as these are raised, an over-reliance by child development professionals on Western constructions of child development, parenting and intervention, may render services inaccessible and insensitive to the needs of families from South Asian backgrounds, and likely others from non-Western cultures.

The following chapter has been arranged into three main sections. In section 1, literature on beliefs and approaches to child development and parenting is summarised. In section 2, what is known about the factors which influence parents' beliefs about child development and child care practices is discussed. In section 3, an overview of families' beliefs about developmental disability and support services is presented. Where possible, research involving South Asian families has been selected. However, where this is not available, research involving families from different cultures is discussed in order to orient the reader to the diversity of belief systems and practices that exist.

SECTION ONE ~**APPROACHES TO CHILD DEVELOPMENT AND PARENTING****Age as a marker for child development**

Child development within the western world is predominately studied according to the age at which children acquire different skills or milestones. Historically, the use of 'time since birth' or 'average age' as a marker for human development has been a customary practice since the industrialisation of European and American society:

"Awareness of age and age-grading of activities and instructions were part of a larger process of segmentation within American society during the late nineteenth and early twentieth century...New emphasis on efficiency and productivity stressed numerical measurement as a means of imposing order and predictability on human life and the environment. Age became a prominent criterion in this process of classification."
(Chudacoff, 1989, p. 5)

Today, questions relating to age of acquisition of skills form the focus of many clinical and developmental interviews used by child development professionals. Development is usually divided into 4 domains (physical, social, cognitive and language development) and numerous tables and guidelines now exist which delineate the acceptable age parameters at which a normally developing child should acquire the various skills within these domains (see, for example, 'Birth to Five', 1998, published by the Health Education Authority).

Within the domain of motor development, a typical development chart might appear as set out in Table 1, below:

Table 1: Average ages for acquisition of motor skills

Motor Skill	Average age achieved
Holds head steady when held upright	3 weeks
Lying on tummy, lifts self by arms	2 months
Rolls from side to back	2 months
Rolls from back to side	4.5 months
Sits alone with coordination	7 months
Crawls	7 months
Pulls to standing position	8 months
Uses a pincer grasp	9 months
Stands independently	11 months
Walks alone	13 months

Source: Herbert, 2003

Similar tables have been set out for competencies such as language skills (see Table 2) and play skills (see Table 3, p.20).

Table 2: Average ages for acquisition of language skills

Language Skill	Average age achieved
Startled by sudden, loud noises	From Birth
Makes 'cooing' noises	4 months
Makes repetitive noises (e.g. 'gagaga....')	6 months
Turns to mother's voice across room	7 months
Responds to own name; uses 'mama' or 'dada' to parents	12 months
Can say between 6 and 20 recognisable words and understand many more	18 months
Can put at least 2 words together in a sentence; points to parts of the body	2 years
Can talk in sentences, chant rhymes and songs	3-3½ years

Source: Health Education Authority, 1998

This method of measuring the rate of developmental skills according to age has proved useful and popular within Europe and the US. Within some communities, however, age is not tracked or is meaningless (Harkness and Super, 1987). Rogoff (2003) for example, noted how some cultures use physical changes, such as losing baby teeth or commencing menstruation as significant markers of development as opposed to age. Furthermore, in some cultures, developmental milestones are not based upon chronological age, but socially recognisable events. In Cameroon, West Africa, for example, it is the naming of the child, rather than the child's birth date and age which is important. A child is not believed to be living as part of the human community until it has been named. Other socially marked transitions include the onset of smiling, beginning to talk and social maturity in being trusted to run errands and conduct oneself well. It is these social conquests, rather than age, which are considered important (Rogoff, 2003).

Such findings from cross-cultural research have clear implications for child-care professionals who encounter parents and children from diverse ethnic communities. Parents from certain cultural communities, for example, may experience difficulties when asked to describe the age at which their child mastered different developmental tasks. Despite this, age as a

marker for child development continues to be one of the most widely used methods for describing developmental progress and identifying developmental difficulties.

Expectations about rates of development

Child development is also measured according to the rate at which children reach developmental milestones and whether or not children are behind their expected level. Concern with developing at the right pace (or a child being 'behind' or 'ahead for their age') appeared in the US and in the UK during the early 1900's when standardised measurement came to the fore (Chudacoff, 1989; Rogoff, 2003). Child-care professionals and parents became accustomed to characterising individuals in terms of their degree of 'delay' versus 'normal development'. In parallel, developmental psychologists within the US and France began to develop tests of intellectual ability (e.g. Stanford-Binet, 1916 and Wechsler, 1955, 1981). Stanford-Binet (1916), for example, developed a number of puzzles and tasks for children and determined the age at which 50% of children could complete these tasks. This normative data was used to develop the concept of 'mental age' (i.e. a measure of a child's ability expressed as the average age at which the average child performs at the same level). This concept was then replaced by the Intelligent Quotient, which measures 'mental age' as a proportion of chronological age. The Intelligence Quotient (or IQ) has now become one of the most widely used methods for measuring intellectual/cognitive ability in Western society. Chudacoff (1989), for example, noted:

"Americans particularly became obsessed with defining and measuring mental age, and their efforts to do so riveted age norms and developmental schedules in the public consciousness more tightly than ever before".
(Chudacoff, 1989; p. 7)

Today, many parents, teachers and developmental psychologists in countries such as the US, UK and France typically refer to children's development in what Rogoff (2003) describes as a uni-dimensional way which imposes a single straight path onto the dimensions and directions of human development. Among some middle class European and American families, hopes for precocity and fears of delay encourage parents to have high expectations for their children and place an emphasis on early teaching of skills (Rogoff, 2003).

Whilst these beliefs and practices might fit with some cultural communities, within others, concern with timing and comparisons may not exist or may exist to a much lesser degree. Several studies have now been conducted using a developmental timetable measure to examine mothers' ideas about the development of preschoolers in different cultures. Goodnow, Cashmore, Cotton, and Knight (1984), for example, studied both Australian born mothers and Lebanese born mothers of children living in Australia. They found that Australian mothers supported the "earlier is better" assumption and frequently reported teaching their preschoolers the alphabet and tended to be anxious that teaching might be left until it was "too late". The Lebanese born mothers on the other hand, indicated that many developmental skills could be learned when needed, provided a general willingness to learn had been maintained.

A number of other studies have shown cross-cultural variability in the types of competencies encouraged in children and the age at which parents expect a given developmental task or skill to be mastered. Hess, Kashiwagi, Azuma, Price, and Dickson (1980), for example, compared mothers in Japan with mothers in the USA. Mothers in Japan expected earlier control of emotions, whilst mothers in the USA expected earlier social skills with peers and earlier verbal assertiveness. Goldbart and Mukherjee (1999) compared the developmental expectations of Bengali mothers with 'Western norms' (the developmental milestones given in popular child-care manuals (e.g. Stoppard, 1991), the Stycar assessment (Sheridan, 1975) and a developmental psychology textbook (Bee, 1992)). Parents' expectations of "sit unsupported", "walk unaided" and "feed self unaided" were in line with Western expectations. However, toilet training was expected later and talking was expected earlier than the Western norms. Joshi and MacLean (1997) compared maternal expectations of child development in India, Japan and England. Expectations for competencies such as education/self care, compliance, peer interaction, communication, emotional control and environmental independence were compared across the groups. Results indicated that Indian expectations were significantly later than Japanese and English expectations in all domains except environmental independence (which included competency in playing in the street, going to

school without an adult present and staying at home alone for 1-2 hours). They suggested that the differences might relate to differences between the cultures in terms of living arrangements and broader cultural themes, goals and values. In Japanese and English urban society, for example, it is usually the mother who has prime responsibility for child-care and household tasks (Central Statistics Office, 1995). Thus, if the mother encourages a child's independence at an early age, these tasks become less onerous. In contrast, Indian mothers may not be under such pressure to encourage early independence, because responsibilities are often shared with other female members of the extended family and domestic employees (Standing, 1991) and joint family-life rather than autonomy is valued (Roland, 1988). Certainly within South Asian communities, children are more likely to grow up in joint or extended families (Goldbart and Mukherjee, 1999).

Approaches to supporting child development

Just as there is considerable cross-cultural variability in measurement of child development and expectations about the rate of typical development, researchers have also found differences in approaches to supporting developmental milestones and skills.

Motor development

Within the UK, standard paediatric literature surrounding children's motor development describes how the brain and nervous system control movement and co-ordination such that a child can only reach sitting, crawling and walking milestones when 'the brain is ready' (e.g. Stoppard, 1998). To a certain extent, parents might be encouraged to support a child's development of motor skills. Crawling, for example, might be encouraged by sitting a few feet away from the baby and enticing him or her forward with a favourite toy. Standing and walking might be encouraged by holding a baby so that his feet have contact with the carer's lap. However, direct teaching and 'hurrying' a child to sit, crawl or walk is discouraged and the literature tends to emphasise that children will learn in their own time (e.g. Stoppard, 1998, p.211).

In contrast, within other cultural communities, such as Africa, parents provide experiences for their children designed to directly teach these skills and as a consequence they routinely surpass British infants in their rate of learning to support their heads, sit and walk (Herbert, 2003). Among the Kipsigis of Kenya, sitting skills are encouraged by propping very young children in a sitting position, supported by rolled blankets in a hole in the ground. Walking skills are encouraged by frequently exercising the newborn's walking reflex and by bouncing babies on an adult's feet (see Kilbride, 1980; 1988; Super, 1981). In a similar way, West Indian parents encourage earlier acquisition of motor milestones through the introduction of specific exercises such as: suspending a baby by each arm; holding the infant upside down by the ankles; grasping the infant's head on both sides and propping the baby with cushions which are removed as the infant begins to sit independently (Hopkins and Westra, 1988). Hopkins (1991) compared the motor development of white English babies with that of babies of immigrant Jamaican parents. The findings showed that the Jamaican babies sat, crawled and walked earlier than their white counterparts. This acceleration only occurred if the mothers had followed the traditional routines similar to those described previously.

Further cross-cultural research has revealed that some cultural communities do not think that active encouragement or teaching of motor milestones is at all necessary. In Wogeo, New Guinea, for example, infants are not allowed to crawl or walk until approximately 2 years of age. This is because parents want to make sure that the child is able to take care of him or herself and avoid dangers before moving about freely. Hogbin (1943), for example, reported:

"No one seems to think that active encouragement of any kind is necessary. When I told natives how we coax our babies to stand, they admitted that such methods might be suitable where there was no fireplace or veranda from which to tumble, but openly laughed at me for speaking of 'teaching' children to walk. A child walks of its own accord, they said, once it has reached the appropriate stage of growth..."
(Hogbin, 1943, p.302).

Likewise, in Caudill's (1972) study of Japanese mothers' beliefs and practices in relation to motor development, the mothers felt that deliberate encouragement and training of sitting, crawling and walking was unnecessary and unimportant.

Cross-cultural research clearly points to the need for child development professionals to understand the range of cultural beliefs and parenting practices surrounding the encouragement of motor milestones. Beliefs about whether or not motor skills can be directly taught or encouraged, for example, will be an important determinant of parental compliance with intervention packages for children identified as showing delayed motor development.

Toilet training

The range of beliefs and practices surrounding toilet training also have important implications for child development professionals, and yet have been neglected as a focus for research (Schulze *et al.* 2002). The theme of "not rushing" to train a child to use the toilet and "waiting until the child is ready" is prevalent in most of the popular American and British parenting advice of the latter part of the 20th century (e.g. Stoppard, 1995; Leach, 1976). This trend has also been observed more recently in a study comparing Anglo* and Puerto Rican mothers' beliefs about toilet training and other parenting practices (Schulze *et al.* 2002). The Anglo mothers studied were clearly concerned about 'pushing' an infant to achieve this skill for fear of causing feelings of inferiority or frustration in the child. One Anglo mother, for example, commented:

"...probably psychologically if you are pushing the child too much...[then] I think you are just gonna have a negative effect on their self-confidence if anything."
(Schulze *et al.* 2002, p.172)

Schulze *et al.* (2002) concluded that Puerto Rican mothers in their study used predominately parent-guided approaches to toilet training (i.e. a more directive form of teaching), whereas Anglo mothers were more likely to use child-centred approaches (i.e. allowing the infant to learn and practice a skill unfettered by adult interference or structuring). Puerto Rican and Anglo mothers also had different ideas about why it is important for a child to learn to use the toilet independently. For Puerto Rican mothers, the emphasis was on the need to perform this skill so that a child is accepted and not judged negatively:

* The term Anglo is used by the researchers of this study to refer to white American women of non-Hispanic European ancestry.

"...If he is delayed in potty training, obviously it's going to affect him in school. Because a child that doesn't go to the bathroom – no school will enrol him".
(Schulze *et al.* 2002, p.173)

In contrast, Anglo mothers emphasised the need for a child to use the toilet independently in order to feel an emotional sense of pride and autonomy:

"I think that [children] benefit from the autonomy of having a task to do, and I think that it improves their confidence, their self-confidence, when they can do it by themselves. I think they get a great kick out of anything they can do by themselves".
(Schulze *et al.* 2002, p. 173)

As well as variability in beliefs and practices relating to toilet training across cultures, studies have also shown variability in mothers' ideas about when to commence toilet training. Joshi and MacLean (1997), for example, found that competency in using the toilet independently was expected at a later age by Indian parents compared to Japanese and English parents. Interestingly, these findings appear to conflict with advice which appears in the Indian Journal of Behaviour, which suggests that toilet training can be started when a baby starts to sit without support or when a child is 4 months old (see Pathania and Chaudhary, 1993). Given the inconsistencies in the literature and the paucity of recent research into parental beliefs about toilet training, there is a clear need to further address this topic so that professionals can provide toileting advice which is sensitive to cultural variability.

Sleep Practices

The organization of sleep, including the determination of places and possible partners for sleeping and the scheduling of sleep has been found to be highly variable cross-culturally. Within the US and UK, standard paediatric advice recommends that infants are encouraged to fall asleep alone at bedtime and stay asleep during the night (e.g. Herbert, 2003). Morelli, Rogoff, Oppenheim and Goldsmith (1992) suggest that separation at night makes day-time separations easier and helps reduce the baby's dependence on parents. In line with these recommendations, studies have shown that most European and North American parents encourage their child to sleep separately from them by a few weeks of age, usually in another room (Rogoff *et al.* 1993). Some parents who occasionally had their infant in bed with them commented that they knew it was counter to the way things are supposed to be done and that

they were violating cultural norms (Hanks and Rebelsky, 1977; Morelli *et al.* 1992). On this note, one may wish to view the research findings with some caution; parents may tend to over-report practices which adhere to cultural norms out of a wish not to be perceived as 'failing' or 'being bad parents'.

Folk wisdom in many communities in the UK and in the US has portrayed night-time separation of infants as essential for healthy psychological development (Trevathan and McKenna, 1994). This is reflected in the advice parents have received since the early 1900s from child development experts. For example, Spock and Rothenberg (1992) recommend that children should sleep in a room by themselves from the time they are born. They suggest that the child should not be taken into the parents' bed for any reason. From their perspective, co-sleeping interferes with a child's independence, exposes the child to sexual intercourse and over-stimulates the child through intimate body contact. Giving a child too much physical comfort at night is also discouraged (Morelli *et al.* 1992). Children in North America and the UK are often expected to depend upon objects for comfort (e.g. dummies, mobiles, blankets and soft toys) as opposed to people. Typical bedtime routines involve practices such as having a warm bottle or cup of milk and a story. Once in bed, the child is expected to fall asleep by themselves (Stoppard, 1998; Herbert, 2003). Professionals advising parents about night-time routines and sleep practices often advocate the need to let children fall asleep alone and encourage the mother to teach the child to self-soothe.

Whilst this advice might be consistent with mainstream white British or US cultural practices, from a world-wide perspective, putting babies to sleep apart from the mother and expecting them to fall asleep alone is an unusual practice (Trevathan and McKenna, 1994). In a study of 136 societies, for example, Whiting (1964) found that infants slept in the same bed as their mother in two thirds of the communities, and in the other communities the babies were usually in the same bedroom as the mother. More recently, in a study of Japanese, Italian, African American and European American families' sleep arrangements, Wolf, Lozoff, Latz and Paludetto (1996) found that European American children were the only group who were more likely to sleep in their own bedroom than with their parents. Japanese, African American and

Italian children were much more likely to have co-sleeping arrangements. Each cultural group had different beliefs about their choice of sleeping arrangement. For example, Japanese mothers emphasized the importance of the mother-child-relationship and interdependence. In contrast, European American families related their practice to the emphasis on independence and autonomy. Adherents of the parent-child bedsharing practice also emphasise a number of long-term long-range benefits to the child, stressing psychological variables, such as attachment security and the development of the capacity for trust and intimacy (Thevenin, 1987). Co-sleeping has also been promoted in some of the biomedical literature for its potential health benefits, for example, increased likelihood and duration of breast-feeding and protection from sudden infant death syndrome (SIDS) (McKenna and Mosko, 1990; Trevathan and McKenna, 1994; Mosko, Richard and McKenna, 1997; Cooper, Potter, Watson and Yellend, 1995).

In a comparison of bedtime routines of mothers living in North America with those living in Mexico, Morelli *et al.* (1992) noted how Mexican mothers expressed strong disapproval of the custom of putting infants to sleep alone. They regarded this routine as 'tantamount to child neglect'. Mayan mothers did not have a particular bedtime routine, such as stories or lullabies, to coax babies to sleep. Mayan toddlers slept in the same room as their parents (often with other siblings also) and usually in their mother's bed. In the Mayan sample, it was rare to find a toddler who used security objects to fall asleep and babies did not rely on thumb sucking or dummies.

The considerable variability in sleep practices and beliefs supporting these different practices, and the conviction with which different cultural groups tend to justify their practices, have clear implications for child development professionals in the UK, who may refer only to Western models of sleep arrangement and routines in their advice to parents. In fact, recent data suggests that the fears emphasised by professionals in the UK and North America, are unfounded. Okami, Wesiner and Olmstead (2002) in their longitudinal study of outcome correlates of co-sleeping, found that co-sleeping in infancy was not associated with sleep problems, sexual pathology or any other problematic pathology and suggest that

professionals should be cautious in issuing warnings to parents regarding co-sleeping. Instead, they emphasise the need to explore with parents the meanings and contexts of different night-time practices.

Children's Play

In the last fifty or sixty years, children's play has been recognised as a major agent in development and learning (Hyun, 1998). Parten (1933) recorded the changing nature of children's play and found qualitatively different stages as the child became older. Table 3 describes the different stages, which are still viewed as a useful framework with which to examine the social maturity of a child:

Table 3: Average ages for acquisition of play skills

Stage of play	Description	Age
Solitary	Child plays alone and independently even if surrounded by other children.	2 years
Parallel	Child plays independently at the same activity at the same time and in the same place. The child is aware of the presence of peers, but each child plays separately.	2-3 years
Associate	Child focused on a separate activity but there is sharing, talking, lending, taking turns and attending to the activity of one's peers.	3-4 years
Cooperate play	High level of play, which represents social and cognitive maturity. Child can organise his/her play cooperatively with a common goal and is able to differentiate and assign roles.	4+ years

Source: Parten (1933)

When child development professionals attempt to observe, describe and assess children's play, they may well follow the framework offered by Parten (1933). This influential approach, however, presupposes that the child is reared in a family emphasising individualism, self-reliance, individual problem-solving, self-help and autonomy, where interaction tends to be more object-orientated than multi-generational people-orientated (Hyun, 1998). Within this context, the child has access to toys and learns to manipulate and explore objects. A child therefore realises his or her own autonomy (solitary play) before interacting with peers and adults (co-operative play). The influence of this approach can be seen in the numerous child-

care manuals describing examples of toys promoting individual cognitive development and autonomy (e.g. Stoppard, 1998).

The difficulty with over-reliance on this approach is that it has been reported that children as young as eighteen months can sometimes co-operate in play with peers (e.g. Howes and Matheson, 1992), putting into question Parten's theory. Within extended or multi-generational family systems, there are frequent multi-age interactions and in this kind of family environment, the young child may first explore more about others than about self, leading to much earlier co-operative play (Hyun, 1998). Within Asian family contexts, for example, Hyun (1998) has described how children receive more frequent child/parent, child/adult, multi-age, child/child play opportunities compared to European and American children. From very early on, there is much eye-contact, offering and receiving of toys, sharing, lending, turn-taking and even organised co-operative play. This represents a contrast from European or American perspectives, where the emphasis is on early development of autonomy through the manipulation of objects and hence the later development of co-operative play. Despite these findings, the Western approach continues to be the conventional framework for the observation and assessment of children's play. This poses difficulties for professionals in the UK working with non-Western families and raises the need for further research in this area.

Summary and areas for further research

Section 1 clearly demonstrates how cultures differ from one another in their approaches to child development and the age at which parents from different cultures expect developmental skills to be acquired. The evidence also suggests that parents differ cross-culturally in terms of child-care practices such as supporting a child's motor development, toilet training, sleeping and play skills. These differences have been explained in terms of the broader cultural goals, values and traditions. The theoretical constructs of "individualism" and "collectivism" have proved useful in this regard, although the concepts may be more problematic than previously assumed.

Approaches to child development and parenting practices have rarely been addressed within South Asian cultures. The few articles that exist are contradictory. Joshi and MacLean (1997), for example, suggest that Indian mothers' developmental expectations may be later than those of mothers in the UK. Goldbart and Muherjee (1999) on the other hand, suggest that Bengali mothers' expectations are generally comparable to Western norms, with the exception of talking, which is expected earlier, and becoming toilet trained, which is expected later in Bengal. Given the projected rise in the number of South Asian families of a person with a learning disability living the UK (Hatton *et al.* 2003), research addressing the beliefs and child-rearing practices of this group will be important for child development and learning disability professionals. Empirical findings may lead us to question the appropriateness of applying western models of child development and intervention to South Asian families who may hold a very different repertoire of practices, beliefs and values.

**Theoretical Approaches to Cross Cultural Variability in Child Development
and Parenting Practices**

In recent years a number of theories have been proposed to describe the influence of culture (amongst other factors) on child development. One of the most important contributions is the ecological systems approach proposed by Bronfenbrenner (1975, 1977). He defined human development as involving:

"The progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between those settings, and by the larger contexts in which the settings are embedded. (1979, p.21)

Thus, the individual is viewed not as a passive entity on which the environment exerts an influence, but as a dynamic and evolving being that interacts with, and thereby restructures, the many environments with which it comes into contact. The environment is divided into four levels, which are represented diagrammatically as concentric circles.

In the first level, the microsystem represents the interactions between the child and his or her immediate environment (e.g. family) and resulting behaviours, such as independence or dependence. This level is the most basic level in which individuals engage in face-to-face interactions. Bronfenbrenner's (1993) description defines the microsystem as a "pattern of activities, roles and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social and symbolic features, which invite, permit, or inhibit engagement in sustained, progressively more complex interaction with, and activity in the immediate environment" (p.15). Examples include home, school, hospital and other factors such as background noise and the number and types of toys available to the child (Wachs, 1987). The second level, the mesosystem, refers to the "linkages and processes taking place between two or more settings containing the developing person" (1993, p.22). It is the mesosystem, which ties together information, knowledge and attitudes from one setting that help shape behaviour and development in another. For example, parents emphasising the importance of learning at home and teachers providing motivating activities at school to encourage a child to learn. The exosystem refers to the settings beyond the child's immediate environment, but which, nevertheless, influence his or her development in significant ways. As Bronfenbrenner (1993) states, the exosystem "comprises the linkages and processes taking place between two or more settings, at least one of which does not contain the developing person, but in which events occur that indirectly influence processes within the immediate setting in which the developing person lives" (1993, p.22). Such settings might include the parents' place of work or community services. Finally, the macrosystem is thought to be the most complex system and consists of the customs, belief systems, lifestyles, values and laws considered important in the child's culture. Bronfenbrenner (1993) states "the macrosystem consists of the overarching pattern of micro-, meso-, and exo-systems characteristic of a given culture, subculture, or other extended social structure, with particular reference to the belief systems, resources, hazards, opportunities...and patterns of social interchange that are embedded in such overarching systems" (p.25).

One criticism of Bronfenbrenner's model is that it is not clear how the different systems relate to one another or exactly *how* culture shapes development (Ritts, 1999). Super and Harkness

(1994) proposed a framework called 'the developmental niche' to understand how different aspects of culture guide the developmental process by focusing on the child as the unit of analysis within his or her sociocultural setting or context. The developmental niche is conceptualised as being composed of three subsystems: the physical and social settings, culturally regulated practices of childcare and childrearing and the psychology of the caregivers. The first subsystem, the setting in which the child is reared, is thought to play a role in shaping the child's development. Physical aspects of the child's setting may include the size and shape of the child's living space, the climate and visual ecology, nutrition and the availability of resources and education. The social aspects may include the company the child keeps, the family structure (e.g. nuclear or extended), eating and sleeping schedules (such as those described previously), languages spoken and caretaker arrangements (e.g. single or multiple). The second component of the developmental niche thought to shape a child's development relates to the culturally regulated customs and childrearing practices. This includes practices such as the carrying and handling practices, sleeping and eating routines, play/work practices, informal vs. formal education practices. The third component of the developmental niche is the caregiver psychology or psychological characteristics of the child's parents. This includes factors such as parental mood, psychological characteristics, physical health, values, cultural beliefs, skills and religious beliefs. Parents' cultural belief systems and cultural models underlie the customs of child-rearing and validate the organization of physical and social settings of life for children.

Cross-cultural researchers have confirmed the existence of two broad and contrasting cultural models (Triandis, 1995), namely, individualism and collectivism. The core element of individualism is the assumption that individuals are independent of one another. Hofstede (1980) defined individualism as a focus on rights above duties, a concern for oneself and immediate family, an emphasis on personal autonomy and self-fulfilment, and the basing of one's identity on one's personal accomplishments. Waterman (1984) defined normative individualism as a focus on personal responsibility and freedom of choice, living up to one's potential, and respecting the integrity of others. These definitions all conceptualise individualism as a worldview that centralizes the personal (personal goals, personal

uniqueness, and personal control) and peripheralises the social (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Hsu, 1983; Kagitcibasi, 1994; Kim, 1994; Markus & Kitayama, 1991; Sampson, 1977; Triandis, 1995). Parents in individualistic cultures prefer strategies associated with the goal of independence. They are less likely to value physical closeness with their children, expressing concern that their children become overly dependent and unable to do things for themselves (Harkness *et al.*, 1992; Richman, Miller and Solomon, 1988).

In contrast, the core element of collectivism is the assumption that groups bind and mutually obligate individuals. Although sometimes seen as simple opposites, it is probably more accurate to conceptualise individualism and collectivism as worldviews that differ in the issues they make salient (Kagitcibasi, 1987, 1997; Kwan & Singelis, 1998). According to Schwartz (1990), collectivist societies are communal societies characterised by diffuse and mutual obligations and expectations based on ascribed statuses. In these societies, social units with common fate, common goals, and common values are centralised; the personal is simply a component of the social, making the in-group the key unit of analysis (e.g. Triandis, 1995). This description focuses on collectivism as a social way of being, oriented toward in-groups and away from out-groups (Oyserman, 1993). In relation to parenting, parents in collectivist societies where interdependence is emphasised, tend to have more physical, proximal interactions with their children and have goals associated with conformity to the norms regulating social interactions (LeVine *et al.*, 1994).

Many authors have characterized European and American cultural practices as emphasising individualism and African, Asian and Latin American practices as emphasising collectivism (Harwood *et al.* 1995; Kagitcibasi, 1996; Strauss, 2000). Individualistic cultures emphasise early acquisition of skills that display individual action, standing up for one's rights and other forms of verbal assertion. On the other hand, collectivist cultures desire early mastery of skills that show self-control, compliance with adult authority and courtesy in social interaction with adults (Hess *et al.* 1980). Milestones which are related to individual autonomy, such as

self-feeding, for example, tend to be encouraged and expected later in collectivist than individualistic cultures (Pomerleau *et al.* 1991; Schulze *et al.* 2002).

Despite the popularity of the individualism/collectivism framework as cultural models influencing child development and parenting, some researchers (e.g. Kagitcibasi, 1997) have argued that the approach is too simplistic and denies the presence of individualism within collectivist cultures and collectivism within individualistic cultures. The case of France is a particularly apt example of this. As a highly industrialised, Western society, France theoretically falls on the more individualist end of the continuum. French parents might therefore be expected to prefer the goal of independence, which is associated with less physical proximity. However, studies of French parents' values and goals suggest that interdependence and independence goal orientations co-exist. Hofstede (1991), for example, found that whereas the French share the goal of developing one's individuality and independence from the group, they also recognise the power exerted by the group on the individual, as do members of collectivist cultures. The practice of teaching children to conform to group norms so that they will be "bien élevés" (properly reared), has been reported in several studies of French families (e.g. Curtis, Grab and Johnston, 1996); Le Wita, 1994; Suizzo, 2002). This may suggest that the French may fall somewhere in the middle on the continuum of individualist to collectivist cultures.

In fact, Killen and Wainryb (2002) suggest that the cultural models of independence and interdependence may not be opposed but may co-exist within all individuals, varying according to the particular situation or domain. For example, as previously discussed, most European American parents tend to regulate their children's sleep and prefer infants to sleep on their own, believing such practice promotes independence (Morelli *et al.* 1992). Yet, when it comes to eating, parents withdraw the element of control and believe that children should not be forced to eat against their will (Richman *et al.* 1988). Thus, parental control appears to be appropriate in one situation (sleeping) but not in another (eating). Measuring parental beliefs in only one domain may yield incomplete conclusions. Therefore, the present study sought to explore beliefs about a variety of childrearing practices in a variety of specific

situations (e.g. beliefs about the child's development of language skills, toileting skills and play skills).

Summary

There have been a number of recent explanatory models to understand cross-cultural differences in child development and parenting practices. Bronfenbrenner's ecological systems framework considers the influence of the attitudes and ideologies of the culture on development. The developmental niche paradigm is a useful framework for studying how adult beliefs about the nature of children and about the world in general result in cross-cultural differences in parenting beliefs and behaviours. Furthermore, cultural values and practices – for example, the extent to which individualism and collectivism are emphasised, also have a substantial impact on the context for development, although more recent research suggests that these dimensions may be more complex than originally thought. Whilst all these theories assert that culture plays a role in development and parenting, it should also be noted, however, that cross-cultural differences are multi-determined. Many variables contribute to variability across cultures, including, education level, socio-economic status, family structure, place of residence and religious beliefs.

SECTION 2~**FACTORS INFLUENCING PARENTS' BELIEFS ABOUT CHILD DEVELOPMENT
AND CHILD REARING**

Parenting is one of the most important, challenging and rewarding roles undertaken during an individual's lifetime (Ateah, 2003). Despite this, what is known about where parents receive their ideas about child development and child-rearing, and whether or not the source is different for parents in different cultures is minimal. Holden (1997) found more than 30 variables influencing parenting behaviours, which are most easily organised into 3 areas. Firstly, parents' beliefs about child development and child rearing practices are influenced by individual parent characteristics, such as parents' experiences of their family of origin, personality, education, social support, occupation and mood. Secondly, the characteristics of the child are important, including the child's sex, age, attractiveness, temperament, behaviour birth order and whether or not the child is developmentally delayed. Finally, the social context affects parents' ideas about child development and parenting; this might include factors such as the parents' culture, socio economic status and religious beliefs. The first two factors are beyond the scope of the current research and will not be described here (for further details see Holden and Miller's (1999) meta-analytic review of factors contributing to parenting behaviours). The remainder of the section describes the influences of the third main factor - the social context - in influencing and determining parents' ideas about child development and child rearing, since this is the focus of the present study.

The Impact of culture

At the broadest level, culture plays an important part in influencing parents' ideas about child rearing and child development (Bornstein, 1991, 1995). As discussed in Section One, culture shapes parents' beliefs about issues such as how to care for infants (e.g. Schuize *et al.* 2002) and when particular competencies are expected (e.g. Joshi and Maclean, 1997). Beliefs and expectations about whether or not children should sleep separately from parents (Morelli *et al.* 1992; Rogoff *et al.* 1993), when to start toilet training or whether to promote or suppress early motor development (Valsiner, 1989) are similarly influenced by parents' culture. Hewlett and

Cavalli Sforza, (1988) investigated the mode through which some of these care-giving practices are learned and transmitted in different cultures. They interviewed Aka and Ngandu parents (foragers and farmers who are neighbours in the rural southern region of the Central African Republic) about a variety of parenting behaviours, such as how to soothe a fussy infant and how to hold and carry the infant. Most parents interviewed indicated that the skills were learned from their own mothers and fathers. The parents indicated that they had learnt the skills from as early as ten years old. Behavioural observations confirmed these reports; when young children cared for infants, their parents usually supervised them and showed them how to hold and care for the infants. Hewlett and Lamb (2003) describe the care-giving practices amongst this group as being acquired through "vertical transmission" i.e. the child adopts and learns the practices of his or her own parents.

In contrast, researchers have noted how many parents from Europe or America rely on the advice of paediatricians or family doctors, 'how to' books, handouts, magazines, videotapes, websites, television and radio shows and close friends who have children (Hewlett and Lamb, 2003; Angeli, Christy, Howe and Wolff, 1994; Klar and Coleman, 1995; Glascoe, Oberklaid, Dworkin and Trimm, 1998). Ateah (2003), for example, collected information from 170 Canadian parents of children attending day care settings. Results indicated that for this group of parents, the most frequently identified source of parent knowledge was from parenting books (71%) and discussions with other parents (69% of respondents). Even children's magazines have incorporated messages to parents about supporting a child's development (Buckingham and Scanlon, 2001). In *Playdays* (2000, No.331, p.2), for example, parents are urged to "encourage [children] to be inquisitive, noticing things and asking questions" and to use "mathematical vocabulary in everyday situations" in order that children can hear and understand it. Such modes of communication of parenting information might be referred to as "horizontal" and "one to many" transmission (Hewlett and Lamb, 2003). According to this view, parenting ideas are passed on via a range of unrelated individuals (such as teachers, doctors and friends) and influences such as the mass media. It is quite likely that linked to cultural preferences, social and historical changes also contribute to the way in which parenting ideas are transmitted. Certainly, in the UK, the mass media has become more

important and there has been a recent boom in the production of 'educative' materials for parents and children, such as CD-ROMs, illustrated information books and educative television programmes (Buckingham and Scanlon, 2001). In addition, increased mobility and a tendency to live apart from extended family members, may have reduced the significance of parental advice and ideas.

Although a little is now known about British and North American mothers' sources of parenting information, very little is known about the sources of information for other cultural groups, and in particular, South Asian groups. This is surprising given the significant clinical implications of this line of enquiry. Many studies have highlighted the considerable information needs of South Asian parents of children with learning disabilities (e.g. Azmi *et al.* 1997; Butt and Mirza, 1996; Hatton *et al.* 1998). By finding out about mothers' actual and preferred sources of information, child development professionals can gain some understanding of the different practices and preferences which exist and plan parent education programmes which are sensitive to cultural differences. It might be, for example, that South Asian families turn to extended family members for parenting information as opposed to books or media. If this were the case, attempts to promote parenting information might be more appropriately targeted at the whole family, and perhaps communicated via community groups as opposed to individual professionals. Certainly, in Bhopal's (1998) study of motherhood amongst South Asian mothers living in East London, many of the mothers highlighted the importance of immediate and extended family members in offering support and advice in relation to child rearing.

The Impact of Social Class and Religious Beliefs

In a similar fashion to culture, membership in a social class and religious group can also influence parents' ideas and parenting behaviours (Holden and Miller, 1999). Many researchers, for example have emphasised how poverty contributes to poor parenting skills (Goodson, Layzer, St. Pierre, Bernstein and Lopez, 2000). Low income parents have been found to be more punitive and less nurturing towards their children, more likely to use power-assertive techniques in disciplinary encounters, less supportive of their children; value

obedience more, less likely to use reasoning and more likely to use physical punishment, more likely to issue commands without explanation, less likely to consult with a child over his or her wishes, less likely to reward the child verbally for behaving in desirable ways and are less likely to show affection (Conger, McCarthy, Yang and Kropp, 1984; Gecas, 1979; Hess, 1970; Kriesberg, 1970; Langer, Herson, Greene, Jameson and Goff, 1970; Peterson and Peters, 1985; Portes, Dunham and Williams, 1986; Wilson, 1974). Fergusson, Swain-Campbell and Horwood (2004), in their 21-year longitudinal study, also found that socio-economic disadvantage was associated with high rates of self-reported crime in children and officially recorded convictions. Young people born into low socio-economic status families had rates of later crime that were over three times that of those born into high socio-economic status families. Parenting practices and behaviours (amongst other factors), such as higher rates of physical punishment, were found to mediate this association.

A number of studies have attempted to explain the link between low socio-economic status and poor parenting skills. McLoyd (1990), for example, pointed out that high parental punitiveness, inconsistency and unresponsiveness is linked to the acute and chronic stressors that characterise the lives of low-income families. Indeed, poor parents have been shown to have elevated rates of mental health problems (Elder, Nguyen and Caposi, 1985; Liem and Liem, 1978; McAdoo, 1986; McLoyd, Jayaratne, Ceballo and Borquez, 1994; McLoyd and Wilson, 1990), marital problems (Furstenberg, Brooks-Gunn and Morgan, 1990) and increased vulnerability to the effects of negative life events (Liem and Liem, 1978). Clarke-Sterwart (1983), however, criticises this research, pointing out that, when ethnicity and religion are taken into account, socio-economic status is not a good predictor of parent behaviour.

Despite the argument that religion may account for variability in parenting behaviours, very few studies have addressed this issue. Mahoney *et al.* (2001) conducted a meta-analytic review of literature since 1980. They noted that most studies in this area have focussed on the influence of religion on parents' disciplinary practices. A consistent finding was that Christian conservatism promoted stronger valuation of child obedience and physical discipline

relative to other religious orientations. Several studies reviewed concluded that greater Christian conservatism was associated with greater use of corporal punishment by parents. This association was maintained even after taking into account demographic variables, denomination affiliation, the degree of child misbehaviour and general authoritarian attitudes about childrearing (Ellison *et al.* 1996a). A number of studies have also tied religiosity to greater warmth in family relationships (e.g. Alwin, 1986; Brody *et al.* 1994; Gunoe, Hetherington and Reiss, 1999; Pearce and Axinn, 1998). However, a major limitation of research investigating the impact of religion on parenting idea is that the only empirical research that appears to exist involves English-speaking populations in Western societies (e.g. United States, Canada, New Zealand) and is implicitly rooted in Judeo-Christian institutions. Research about the impact of other religions, such as Buddhism, Confucianism, Hinduism and Islam, is distinctly lacking.

Summary

Very few studies have investigated the modes through which parents acquire their parenting ideas and practices. Broadly speaking, factors such as culture, religious beliefs and socio-economic status appear to be important determinants of parenting behaviours. Culture, in particular, may influence the way in which beliefs and practices are transmitted. Thus, parents from some cultures might turn predominately to other family members for parenting ideas, whilst parents from other cultures might turn to friends, professionals or child care books. To the best of the author's knowledge, these issues have not been addressed in relation to South Asian parents and compared to white British parents. In addition, little is known about the role of religion as an influence on parents' beliefs and practices outside the Judeo-Christian context. Therefore, the impact of religion was investigated alongside culture in the current study. Information about the sources of parental information for parents from non-Western cultures will have important implications for child development professionals in the development and provision of culturally sensitive forms of intervention and parenting education.

SECTION 3~

BELIEFS ABOUT DEVELOPMENTAL DELAY AND SUPPORT SERVICES

Approaches to Developmental Delay and Disability

Developmental delay refers to a slower rate of development whereby a child exhibits a functional level below the norm for his or her age. A child may show global developmental delay, or delay in a particular area. Professionals often use the term 'global developmental delay' when a clear lag in development has been identified and yet a diagnosis of a specific disability cannot be made, often because the symptoms of a specific disability may be unclear in young children. In the process of diagnosis, professionals routinely use standardized tools and assessments to classify children's skills as "within the normal range", "advanced/superior" or "delayed". However, when working with culturally and linguistically diverse families in the UK, there are obvious difficulties with this practice.

Firstly, the populations on which the assessment norms are based may not represent the norms found within the local community. In the UK validation project for the Wechsler Intelligence Scale for Children III (WISC-III), 3.1% of the validation sample were described as being Indian, Pakistani or Bangladeshi (McKeown, 2003), closely approximating the UK 1989 national census data. Within the UK, however, there is huge variability in terms of local population norms. In the London borough of Newham, for example, current census data indicates that 29.4% of the local population describe themselves as being Indian, Pakistani and Bangladeshi (Office for National Statistics, 2001). This implies that the sample on which the WISC-III norms were based does not represent the cultural diversity found within certain local communities.

Secondly, due to the need for standardisation, it is frequently not possible to conduct assessments in the child's dominant language. When a test instrument is translated, the question arises as to whether the translations are conceptually equivalent and measure the same underlying construct. Hambleton (1994), for example, provided an example of how direct translation of a test item can produce an invalid result. The test item "Where is a bird

with webbed feet most likely to live?" was included as part of a large international study of educational achievement. Compared to the overall pattern of results, this item appeared to be exceptionally easy for the Swedish sample. An inspection of the translation indicated that the Swedish translation of the English was: "Where is a bird with swimming feet most likely to live?" which gave respondents a strong clue about the solution, which was not present in the English original. This example clearly demonstrates the difficulties with straight translation of assessment tools for use with different cultural and linguistic groups. Although some of the most popular developmental assessment scales such as the WPPSI-III and WISC-III have been translated and adapted into a number of different language (the WISC-III, for example, has now been successfully translated and adapted for 16 different countries (see van de Vijver, Mylonas, Pavlopoulos and Georgas, 2003)), the tools have not been translated for use with South Asian populations.

Finally, cultural value systems are built in to the development, administration and interpretation of tests. A compelling demonstration of the impact of these value systems has been provided by Kingsolver (1995), who describes the testing of immigrants to the United States during the early 1900s at a time of growing racism towards immigrant populations. There was concern in the United States at this time that immigrant populations would 'contaminate the American gene pool'. The United States Public Health Service employed a psychologist (H.H. Goddard) who developed the term 'moron' and created his own test for screening out the 'morons' amongst the immigrant populations. Goddard administered his test as soon as immigrants arrived in the United States, despite the fact that many had never held a pencil before and had no frame of reference for understanding what was being asked of them. Following testing, Goddard diagnosed 83% of Jews, 87% of Russians, 80% of Hungarians and 70% of Italians as 'morons' (Kingsolver, 1995). Clearly, political value systems played a significant role in determining what was considered 'moronic' and how this should be measured.

There are clear differences between cultures in terms of the value placed upon different skills and even conceptual differences in the understanding of intelligence. Popular conceptions of

intelligence in Europe and North America, emphasise the value of technical intelligence as distinct from social and emotional skills (Rogoff, 2003). This is reflected in current tests of intellectual functioning in the West (e.g. WISC-III), which do not incorporate emotional and social skills into measures of overall intellectual ability. This approach may not fit with some cultural communities where notions of intelligence may be more socially based. The Ifaluk of the western Pacific, for example, regard intelligence as including knowledge and practice of good social behaviour (Lutz and Levine, 1982). Kenyan parents interpret intelligence as including trustworthy, responsible participation in family and social life (Super and Harkness, 1983; Ogunnaike and Houser, 2002).

These factors point to the importance of viewing intelligence, human development and disability not as universal constructs, but as socially and culturally situated constructs (Danesco, 1997; McDermott and Varenne, 1996). Whilst a family or professional from one particular cultural group may identify a certain series of behaviours or symptoms as suggestive of delay or disability, a family or professional from an entirely different cultural group may not. As the following section summarises, culture is a major factor in shaping ideas about developmental delay and disability. Without acknowledgement of these different belief systems and conceptualisations, services may be insensitive to the needs of families from different cultural communities.

Understanding of Developmental Disability

It is now well-documented that parents from different cultures hold a diverse repertoire of ideas about the nature and cause of childhood disability. Religious, spiritual and magical beliefs in relation to parents' understanding of disability are often cited in the literature. Edgerton (1981), for example, reviewed attitudes towards a child's disability in some parts of India and Nepal. Parents saw their disabled child as 'possessing divine qualities' or as being mediums through which divine intentions could be expressed. Ryan and Smith (1989) for example, interviewed Chinese-American parents and found that over a fifth regarded having a child with a disability as due to fate or as punishment for a violation of a religious, ethical or cultural code. Disability was also believed to have been caused by colds or high fevers,

symbolising a disharmony between the yin and yang forces. In a similar study, Stahl (1991) found that traditional Jewish-Oriental mothers in Israel also ascribed religious or magical causes to their child's disability. These included fate, punishment for sin, the "evil eye", and prenatal events such as meeting a person with a disability. Fatimilehin and Nadirshaw (1994) also found that some South Asian families in the UK believed their son or daughter's learning disability had a spiritual or religious causation, such as a bad spell or an evil spirit.

Many cultural groups studied have been reported to believe their child's condition to be temporary, with hopes that their child would grow out of the problem. Reiter *et al.* (1986), for example, found that Druse parents in Arab communities in Israel had positive attitudes towards persons with disabilities because they regarded the disability as a 'temporary or passing condition' with possibilities of change in life after death. Similarly, Fatimilehin and Nadirshaw (1994) found that over half of Asian families in their sample thought their son or daughter with a learning disability would be 'cured' or 'become normal' over time. Amongst groups believing in reincarnation, Leonard (1985) noted that disability was seen as a temporary condition.

DanESCO (1997) also notes how parents may hold onto supernatural, magical, metaphysical or religious beliefs about disability alongside biomedically-orientated beliefs. Among Mexican American parents for example, Mardiros (1989) found that parents cited biomedical causes for disability, which included chronic health problems during pregnancy, negative health habits, insufficient rest and exercise, environmental factors (e.g. toxic waste and pollutants), accidents and medical interventions (e.g. anaesthesia and medications). At the same time, parents ascribed to socio-cultural views, which included marital difficulties, divine punishment for former transgressions, wife abuse and fate or predestination.

A number of researchers have found that parents' from non-Western cultures living in the US or in the UK frequently report that they do not understand their child's disability. Fatimilehin and Nadirshaw (1994), for example found that South Asian parents living in the UK were much less likely to know the name or diagnosis of their child's problem and were more likely

to be unaware of the cause. Wong *et al.* (2004) found that many parents of children with developmental disabilities in China lacked information about their child's difficulties and were unable to account for causative factors. Likewise, Ryan and Smith (1989) found that Chinese parents in the US lacked awareness and understanding about their child's disability, a factor which was attributed to parents' difficulties in understanding the English language. For example, one parent stated that he found conversations with child health care professionals:

"...Very difficult because we don't understand English and the doctors don't understand Mandarin. We do not know how to ask questions. The only thing we could do was think about it on our own all the time...."
(Ryan and Smith, 1989, p.290)

Not having the child's diagnosis disclosed in the appropriate language is a frequently cited reason for parents' not understanding their child's learning disability (e.g. Mir *et al.* 2001). Hatton *et al.* (2003), found that most disclosures to South Asian parents of a child with a learning disability were conducted in English, despite this being the preferred language of a minority of their sample. 20% of parents in their study indicated that the language used was difficult to understand and 26% indicated that it had been quite technical. In addition, O'Hara (2003) and Mir *et al.* (2001) highlight the lack of culturally appropriate leaflets or audio-visual material for the carers of a person with a learning disability. These findings are surprising given the government's commitment to providing better information for carers (see 'Valuing People', DOH, 2001b).

Summary and areas for further research

A number of key issues emerge when viewing disability or delay from a cultural context. Firstly, the factors which constitute a delay or disability in one culture, may not be viewed as such in another culture. This may be linked to differing parental expectations, beliefs and values about promoting and achieving different skills at different stages of a child's development (see Section 1). Secondly, there are wide-ranging beliefs about the meaning of disability amongst parents from different cultures. Religious, mythical, magical beliefs and beliefs about disability as a punishment are common amongst traditional non-Western societies (Danesco, 1997). Southern and Eastern Asian parents report that developing a biomedical understanding of disability is hindered by language differences and not having the

meaning of disability communicated to them in their preferred language (Hatton, 2003; Ryan and Smith, 1989).

Further research in this area is clearly needed in order to highlight and understand the range of beliefs about developmental delay and disability amongst South Asian parents in the UK. Such findings will have important clinical implications for the way in which professionals assess and identify developmental delay and the types of interventions offered.

Approaches to intervention

Studies have shown that beliefs about the causes of disability influence the types of interventions preferred by parents. Parents from cultures who believe that disability is caused by evil spirits, might seek ways to drive the demons away or seek the help of faith healers. Stahl (1991), for example, interviewed Jewish Oriental parents of children with disabilities. They found that many parents reported "putting an iron object under the child's mattress" or burning the child with a hot iron. This practice was based upon the belief that evil spirits are afraid of iron. Other practices included seeking folk healers to perform rituals, changing the name of their child (because names are thought to allude to certain desired states), performing religious rituals and going on pilgrimages. Parents who regard their child's disability as stemming from supernatural causes might be more inclined to seek interventions from members of their own culture who share their belief system and less inclined to seek professional advice and help. Ryan and Smith (1989) for example, reported how the Chinese parents of a child with epilepsy sought medical help for their child but also the help of a medium to drive evil spirits away. Acupuncture and wearing of silver bangles were other practices used by some Chinese parents. Further research has shown how Asian parents who believe in fatalism and a search for a 'cure' are also less likely to seek advice and help offered by statutory services (Ryan and Smith, 1989).

Despite the evidence to suggest that religious and socio-cultural beliefs are important in determining families' willingness to accept professional services (Azmi *et al.* 1997; Baxter, 1998; Bignall and Butt, 2000), professionals seldom acknowledge these beliefs (Mir *et al.*

2001). Evidence has shown that professionals working with South Asian families may lack respect for or dismiss views which are not based upon a Western medical model (Baxter, 1998). As a consequence, many South Asian families users perceive services as inappropriate or insensitive to their needs (Butt and Mirza, 1996; Hatton *et al.* 1998; Nothard, 1993; Pasha, 1996). These factors have been thought to contribute to poor uptake of services amongst families from South Asian communities (Baxter *et al.* 1990; Mir *et al.* 2001) and a lack of interest in educational and rehabilitative programmes (Srinivasan and Karlan, 1997), despite the fact that these are often routinely offered by child development services in the UK.

Most forms of intervention for children with developmental delays follow logically on from Western models of child development, which emphasise developmental sequences, stages and milestones (see Section 1). There is a high emphasis on intervention programmes which aim to maximise skill development. The mother, either implicitly or explicitly is viewed as the key agent of change. The Portage Guide to Early Intervention (Shearer and Shearer, 1972) is one such form of early intervention, which is used widely in the UK. This is a home-based, educational approach to supporting children with developmental delays. A home-visitor makes weekly visits to see the child and parents (usually the mother), who carries out an assessment on a criterion related developmental checklist (Bluma *et al.* 1976). Each week, teaching goals are identified and the home visitor shows the mother how to teach the child the skills required to meet the goals. The Treatment and Education for Autistic and Communication Handicapped Children (TEACCH) (Schopler, 1994), is another popular treatment programme, which aims to promote children's skills and level of independence. The programme involves several components. Firstly an individual education programme is developed. Verbal and visual prompts and tangible and social reward systems are developed to teach and encourage the development of specific skills. Secondly, the environment is adapted to promote learning. This might include the use of visually clear areas and boundaries for specific activities and providing visual timetables to facilitate organisational skills and compensate for problems with receptive language. Finally, alternative

communication is encouraged. This might involve the use of objects, pictures, drawings and written words according to the child's developmental level alongside verbal communication.

Whilst these approaches fit with white British families, who are familiar with the idea of child development as being broken down into a series of steps and skills within various domains, the extent to which it can be applied to mothers from different cultures has been questioned (Sturmey *et al.* 1992). The literature reviewed so far indicates that mothers from different cultures may hold very different conceptions and expectations about child development. As noted earlier, Lebanese mothers, for example, were found to adopt a laid back approach to their child's acquisition of milestones; they felt that children achieve skills when they are ready and did not see the use in teaching these skills (Goodnow *et al.* 1984). Srinivasan and Karlan (1997) also describe how Indian mothers tend to anticipate the needs of their infants so that they will become and remain contented. However, if all needs are thus anticipated, the infant may not have the opportunity to learn how to communicate in increasingly complex ways. In addition, the infant may lose opportunities to practice newly acquired skills. By Western standards and models of intervention, the authors indicate that this approach may hinder development.

Finally, in cultures where extended families are common and where family members have different roles, the Western approach to identifying the mother as the primary agent of change may simply not fit. In Goldbart and Mukherjee (1998) and Peshwaria *et al.* (1995) study of mothers of a child with a disability in India, the researchers both found that close relatives play a significant supporting role in raising children. Should this be the case for South Asian families living in the UK, the families' commitment to a developmentally based, taught intervention programmes carried out mainly by the child's mother may be in doubt. A more appropriate form of intervention might therefore incorporate the extended family. As O'Hara (2003) recommends, understanding and respect for the different family organisations are vital to service delivery for ethnic minority populations.

Summary

The literature reviewed in this section clearly indicates that parents' beliefs about disability influence the type of intervention preferred. Where parents attribute their child's disability to supernatural, magical or religious cause, parents may turn to healers, folk rituals and mediums in preference to professional advice (Danesco, 1997). A failure by professionals to acknowledge such diversity in belief systems may link to dissatisfaction amongst South Asian groups (e.g. Butt and Mirza, 1996) and result in a low uptake of services (Baxter *et al.* 1990; Mir *et al.* 2001).

Early intervention programmes, such as the Portage programme or TEACCH, which are based upon Western models of child development may not fit with the belief systems of family members from non-Western cultures. These intervention programmes, which rely exclusively on the mother as the primary agent of change do not take into account the involvement of the extended family and thus may not fit with the practices and organisation of some cultural groups.

RATIONALE AND DESCRIPTION OF CURRENT STUDY

The literature reviewed thus far highlights the following key points, which provided the rationale for the current study:

- Cultures differ in their approaches to child development, the types of competencies that parents encourage and the age at which they expect children to acquire competency in a particular skill.
- Cultures also differ from one another in terms of parents' approaches to supporting their child's development. Toilet training, the development of motor skills, sleep routines and children's play all differ cross-culturally in terms of the level and type of parental support and involvement.
- Very few studies have addressed these issues in relation to South Asian families. The few studies that exist suggest that South Asian parents may have expectations for their

children's development which could be viewed as 'delayed' from a Western perspective. However, further research is needed in order to fully understand the cultural context for this finding and its clinical implications.

- Different cultures hold different beliefs about developmental delay and disability. Whether or not a set of behaviours constitutes a delay in one cultural group compared to another is linked to beliefs that parents and professionals hold about child development and the extent to which different skills are valued and encouraged. Different cultures also hold different views about the appropriateness of the various types of intervention on offer. Such views are often tied to parents' understanding and concepts of delay and disability.
- These findings pose difficulties for child development professionals in the UK who commonly assess and intervene according to Western conceptualisations of child development and developmental delay.
- Given that South Asian carers of a family member with a learning disability frequently face discrimination, poor access to and low uptake of specialist services (Rudat, 1994; Ahmed and Atkin, 1996; Baxter *et al.* 1990; Mir *et al.* 2001), further research is clearly needed to identify the cultural beliefs and practices held by this group. This will help to ensure that services are responsive to the needs of parents and children from different cultural communities as outlined in the implementation guidance for the Government White Paper 'Valuing People' (Department of Health, 2001b) and The National Service Framework for Children (Department of Health, forthcoming).

In view of these points, the current research investigated the differences between South Asian and white British mothers' beliefs about child development and parenting practices. Differences between the two cultural groups in terms of beliefs about developmental delay and support services were also investigated. Recent practice guidance for professionals working with disabled children ('Together From The Start', DOH/DfES 2003) has emphasised the need to develop an integrated response to children and families, which is sensitive to differing family cultures and religions. Therefore, mothers with a developmentally delayed child were selected for inclusion in the study. For these mothers, there is a high likelihood that they will engage in discourse with professionals about developmental milestones and

parenting practices. They may also turn to different sources of formal and informal support. Developing an understanding of these mothers' beliefs about child development, parenting and developmental delay will be an important step in developing culturally sensitive services. Mothers were selected for two reasons: Firstly, it was felt that mothers were most likely to provide the primary care-giving role for the child (and thus be in a good position to talk about child development and care-giving practices). Although the extended family play an important part in South Asian care-giving practices, mothers still tend to hold the greatest participation in day and night care of the child as well as dressing, feeding and bathing (Goldbart and Mukherjee, 1999). Secondly, previous studies investigating developmental expectations across cultures have involved mothers (e.g. Joshi and MacLean, 1997), which allows for comparisons to be made with the existing research.

Research Questions

The following research questions summarise the four key areas investigated in the current study:

1. Are there differences between white British and South Asian mothers' beliefs about typical child development?
2. Are there differences between white British and South Asian mothers' beliefs about parenting practices and their role in supporting a child's development?
3. Are there differences between white British and South Asian mothers in terms of the factors which influence ideas about child development and parenting?
4. Are there differences between white British and South Asian mothers' beliefs and experiences of having a child with developmental delay and support offered?

CHAPTER 2 ~ METHOD

Overview

Twenty semi-structured interviews were conducted with mothers of a child with global developmental delay. Half the mothers were of white British origin and half were of South Asian origin. Quantitative and qualitative approaches were used to analyse the data.

This chapter is divided into five main sections. The first section describes the participants, the recruitment process and the procedure. The second section outlines the process of ethical approval. The third section describes the researcher's perspective and the fourth section describes the semi-structured interview used. Finally the methods of qualitative and quantitative data analysis are described.

Participants

A total of 10 South Asian mothers and 10 white British mothers living in Greater London took part in the study. All mothers had a young child aged 5 years or under with global developmental delay and were known to local child development services.

Selection Criteria

The following criteria were used in selecting the samples.

The South Asian Group

In line with previous research involving south Asian families caring for a family member with a learning disability (e.g. Fatimilehin and Nadirshar, 1994), the South Asian group included mothers who were born in India, Pakistan or Bangladesh and who were Muslim or Hindu. South Asian participants were given the option of being interviewed with an interpreter from an interpreting service used by local health and social services. None of the participants, however, chose to take up this option; all agreed to be interviewed in English.

The white British Group

The white British group included mothers who were born in England, Scotland and Wales.

Both groups included mothers who had a child aged 5 years or under, and who was diagnosed with global developmental delay by a professional or agency at least 6-months prior to the research interview. Global developmental delay was defined as being an across the board lag in the areas of motor, language, social and cognitive development. In some cases, children had additional diagnoses, such as cerebral palsy or autistic spectrum disorder. Mothers who had recently received a diagnosis for their child were excluded from the sample. This was to avoid burdening mothers who may have been recently distressed by receiving a diagnosis and may already be in contact with a large number of professionals.

The age-span of children used in the study (i.e. 1 year to 5 years) was set in order to reflect the typical age-span at which children come into contact with child development services. In addition, the first five years of a child's life are likely to be a time in which mothers' beliefs about child development, parenting practices and concerns about developmental delay are paramount, before wider influences such as schooling acquire a greater influence.

Recruitment Process

Participants were recruited from two healthcare trusts in London. There were two phases of recruitment.

Phase 1

During the first phase of recruitment, information about the study and the inclusion criteria was circulated to the child development teams, the local nurseries and schools for children with special needs, voluntary sector carers associations and local support groups within a large healthcare trust in inner London. Professionals from within these organisations identified mothers who met the inclusion criteria. Meetings with these professionals were arranged in order to collect details about the potential participants and to verify whether the suggested participants met the inclusion criteria.

Information passed on to the researcher about potential participants was limited to include only the name of the mother, the date of birth and first name of the child, the child's diagnosis, date of diagnosis, the ethnicity, postal address and telephone contact details. Additional information about the child or family situation was not shared with the researcher to protect confidentiality and prevent the researcher from forming any preconceptions, which might have biased the interview content.

Once potential participants had been identified, invitational letters and information sheets describing the aims and methods of the study were sent out (see appendix 2). Mothers were asked to use a detachable reply slip to indicate whether or not they were willing to take part in the study. A stamped addressed envelope was provided for participants to return their reply slip. Those mothers who indicated on their reply slip a willingness to participate were contacted by telephone to discuss the research in more detail, ascertain whether or not an interpreter was required and to make arrangements for setting up an interview. Issues of confidentiality, voluntary participation and consent were explained and mothers were also given a chance to ask questions. Following this telephone contact, a letter confirming the interview date and time was sent out. Those mothers who did not return their reply slip, or indicated on their reply slip that they did not wish to participate, were not contacted by telephone and no further follow-up was attempted in accordance with requirements set by the local research ethics committee.

In total, 80 letters of invitation to participate in the study were sent out during this initial recruitment stage (40 to South Asian mothers and 40 to white British mothers). Thirteen of the 80 mothers contacted (15%) completed the reply slip to indicate they would like to take part. These thirteen were made up of 7 South Asian mothers and 6 white British mothers. 1 White British mother returned the reply slip to indicate she did not want to take part. The remaining 66 mothers contacted did not return the reply slip. These were made up of 33 South Asian mothers and 33 white British mothers.

Phase 2

During this phase of recruitment, a poster about the research and an information sheet was circulated to 250 mothers of children with disabilities, who were on a disability register held by an outer London healthcare trust (see appendix 2). The poster asked mothers matching the inclusion criteria to contact the researcher by telephone if they were interested in taking part in the study or wanted to find out more about it. Due to the low response rate during the first phase of recruitment, participants were offered a small sum of money for taking part in the research. Participants who contacted the researcher in response to the poster were asked a number of screening questions to ensure they met the inclusion criteria and understood the nature of the research. Again, issues of confidentiality, voluntary participation and consent were explained. Mothers were given the chance to ask questions and asked whether an interpreter would be required. If participants met the criteria and consented to taking part, an interview date was arranged and a letter confirming the interview details was sent out.

In total, 9 out of the 250 mothers (3.6%) contacted the researcher by telephone to express an interest in participating in the study. Two of the 9 mothers (1 white British and 1 South Asian) did not meet the inclusion criteria and had to be excluded. This left a total of 7 mothers (2.8%) (4 white British and 3 South Asian) who met the criteria and were thus included in the study.

Ethical Considerations

Ethical approval for the study was obtained from two NHS Local Research Ethics Committees (see Appendix 1).

All the participants received a full information sheet (see Appendix 2), which gave an outline of what the study entailed, the possible costs and benefits of taking part. Care was taken to emphasise that the information would be kept entirely confidential and any identifiable material would be substituted for secure research codes. Participants were also made aware that their participation in the study was entirely voluntary, independent from any services they were currently receiving or might receive in the future and that they had the right to withdraw

from participation at any time. Prior to each interview, the participant was asked to complete and sign a participant consent form (see appendix 2).

Procedure

In-depth individual interviews were conducted with each mother in her own home. Interviews lasted between 1 and 3 hours, and were tape-recorded for later transcription. Mothers were mostly interviewed individually. However, in three cases, South Asian mothers asked for their husbands to be present during the interview and this request was respected.

At the start of each interview, a brief description of the purpose of the interview was given and the interviewer ensured that participants fully understood the nature of the research project. Consent for the interview and tape recording was also sought and recorded on the consent form. Participants were made aware that participation was entirely voluntary and that they had the right to withdraw from the study at any stage. Participants were informed that a summary of the results of the study would be sent to them, should they wish, at the end of the study. In addition, following the interview, if the participant expressed an interest, the researcher left a sheet of information and contact details for local resources, such as carers groups and organisations.

Basic Demographic Information

Before the interview commenced, participants were asked to provide background information about the family. This served to elicit basic demographic information and provided the researcher with an opportunity to begin to build a rapport with the mother being interviewed.

Information in relation to the following areas was elicited:

- Age, sex and number of persons in the immediate family
- Composition of the household
- Birthplace of parents
- Length of time parents had lived in Britain
- Occupation of main earner (if employed)
- Religion

Semi-Structured Interview

A semi-structured interview schedule was developed for use in the study (see appendix 3). In designing the interview, the researcher was guided by the previous literature about maternal expectations for children's development of different milestones (e.g. Joshi and MacLean, 1997) as well as the research into parenting practices and beliefs about childhood disability. The interview also sought information about those areas where previous research is limited, such as the origins of mothers' beliefs about child development. An excerpt from an interview with a South Asian participant can be found in appendix 4.

The semi-structured interview was made up of 4 sections:

Section 1 ~ Developmental Expectations

Participants were asked to examine photographs of children of different ages (6 months, 12 months and 3 years), ethnicity and sex. They were asked an open-ended question about what they expected a child at each of these ages to be able to do. It was thought that this open-ended question would allow mothers to describe aspects of child development in their own way without imposing suggestions based upon Western beliefs about skills and competencies.

Next, participants were presented with a number of different developmental skills and asked to indicate whether or not they expected the child to have acquired these skills. The skills selected reflected those covered by developmental assessments commonly used by professionals in the West (e.g. the Vineland Adaptive Behaviour Scales). This forced-choice component was developed and included to reflect the methodology used previously by researchers to uncover differences in mother's developmental expectations (see Hess *et al.* 1980 and Joshi and MacLean, 1997).

Finally, participants were asked to discuss the developmental milestones they considered to be the most important for a child at 6-months, 1 year and 3 years. Again, this gave

participants the opportunity to describe skills, competencies or other entities considered important at these different stages of development in their own way, without imposing suggestions based upon Western ideas. They were also asked to comment on whether or not they would expect to see sex differences in terms of children's competencies.

Section 2 ~ Factors influencing beliefs about child development and parenting

In this section of the interview, mothers were asked to describe the factors which influence their ideas about child development and child rearing. Again, this section of the interview started with a broad, open-ended question designed to tap into participants' own ideas and beliefs. Follow-up questions were then added, which were based upon previous research concerning the types of factors shown to influence parents' ideas about child development. These included questions about the role of family, friends, books, professionals etc. (see Ateah, 2003, for example). They were also asked to comment on the role of culture and religion in shaping their ideas about child development and child rearing. These questions were based upon previous studies suggesting that these factors play a role in influencing parents' beliefs about child development and parenting practices (see, for example, Bornstein, 1995 and Mahoney *et al.* 2001).

Section 3 ~ Beliefs about supporting a child's development

In this section, participants were shown photographs of children of different ages, ethnicity and sex. The photographs portrayed children who had reached particular developmental milestones (e.g. picture of child using the toilet, picture of a child learning language skills and picture of a child demonstrating co-operative play skills). They were asked to discuss their beliefs about how a child acquires these skills and the role of other persons (parents, professionals, family, friends etc) and factors (e.g. religion and culture) in helping a child to develop these skills. It was thought that by focusing on three rather distinct areas of a child's development, differences in mothers' beliefs, if existent, would be uncovered. In addition, the areas selected reflected areas in which cross-cultural differences have emerged in terms of parents' beliefs and practices (see Schulze *et al.* 2002, for example).

Section 4 ~ Beliefs about developmental delay and beliefs about support services

In the final section of the interview, participants were asked to think about their child with developmental delay, and to describe how they first noticed the delay and what they did in response to noticing. They were also asked how they understand developmental delay; what informs their ideas about developmental delay and to comment on the advice and support offered by statutory and voluntary services. This section of the interview was informed by previous research concerning parents' beliefs about childhood disability and experiences of support services (e.g. Fatimilehin and Nadirshaw, 1994).

At the end of the interview, the interviewer asked for feedback about the interview process and whether the interview had aroused strong emotions or distress. The intention was to offer participants a chance to talk about this further or for the interviewer to feed back to an appropriate member of the child development team (with the participant's consent) in cases of extreme distress. In practice, all mothers indicated that they felt happy with the questions asked. One mother became tearful during the interview and was given the opportunity to discuss this at the end of the interview. She was also asked whether she would like this feedback to a member of the child development team or whether she needed any follow-up support, but declined this offer.

In developing the interview, as well as being guided by previous literature concerning cross-cultural variability in beliefs about child development, parenting and developmental delay, the researcher was also guided by feedback from piloting. Sections 1 to 3 of the interview were piloted with four mothers (2 white British and 2 South Asian) of normally developing children. (The original aim was to pilot all sections of the interview with mothers of developmentally delayed children. However, time constraints and a low response rate from participants matching the inclusion criteria, precluded this from occurring). In addition, the interview schedule was discussed with two South Asian bilingual co-workers from a Child and Adolescent Mental Health Service. Feedback from the mothers and bilingual co-workers was

used to refine interview questions and ensure questions were understandable and culturally sensitive.

Researcher's Perspective

In conducting qualitative research, a researcher's own assumptions and values are likely to play a role in understanding and communicating the data. In view of this, Elliot, Fischer and Rennie (1999) note that it is good practice for the researcher to describe their theoretical, methodological or personal orientations relevant to the research. This helps the reader interpret the data and to consider possible alternatives.

The impetus for conducting this research came from my experiences as a white British woman conducting clinical work within a child development team serving a culturally diverse population. I often reflected on how assessments typically covered a range of questions about a child's development, which I felt were very much based upon Western ideas about developmental milestones and sequence. For some parents, particularly those from different cultures, I observed how these questions were often not understood or misinterpreted. For example, I can recall a mother's puzzled expression when asked to describe her child's eye contact and looking skills; her response was to assure me that her child could see perfectly well. I considered a number of reasons as to why the misunderstanding might have arisen, for example, had I asked the question in a confusing manner? Did the parent have difficulties understanding and speaking English? But most, importantly, I began to wonder how parents from different cultures view child development – are parents' ideas similar or different from my ideas based upon Western models of developmental psychology? Do parents observe, value and encourage the same competencies in their children? How do parents from different cultures describe child development and what role do they view themselves as having in supporting their child's development? I felt that answers to such questions would be helpful in helping me to work with families from different cultural backgrounds, both in terms of the types of questions I might ask during assessment and in terms of being able to offer (or at least, understand) support and interventions which fit more closely with the families' cultural belief systems. Previous research addressed some of these questions, but there were large

gaps, particularly for certain cultural groups, such as South Asian families. Seeking answers to these types of questions, therefore, formed the driving force for my research.

Analysis

All the interviews were audio-taped and transcribed verbatim. Details which might identify the participants, the family or professionals involved, were omitted to protect anonymity.

Qualitative methods

Responses to the open-ended questions were assigned to coding categories using the process of thematic content analysis methodology. This is a process for encoding qualitative information, which has been used by scholars and researchers in psychology (Crabtree and Miller, 1992; Denzin and Lincoln, 1994; Silverman, 1993). It is a way of seeing and making sense out of seemingly unrelated material, analysing qualitative information and converting this information into quantitative data (Boyatzis, 1998). By means of thematic content analysis, a large body of information can be reduced to a more manageable form of representation. With a complete view of information available, the researcher can appreciate both the easily evident and difficult to discern aspects of the information. Previously silenced aspects of the information can be brought forward and recognised. Thematic content analysis uses either theory-driven or inductive approaches. Since the current research was exploratory, an inductive approach was applied. An advantage of this approach is that it uses, as much as possible, the way in which the themes appear in the raw material as the starting point in code development (Boyatzis, 1998).

There are several stages involved in the process of thematic content analysis. The following section describes the various steps followed in the study, based upon guidelines described by Boyatzis (1998):

Selecting a sub-sample

The first step involved selecting a sub-sample of 4 transcripts from the white British group and 4 transcripts from the South Asian group. The raw material from these sub-groups formed the

basis for developing the coding system, which was then applied to the 12 remaining transcripts (i.e. 6 white British interview transcripts and 6 South Asian interview transcripts).

Developing themes and a code

The next step comprised of four main stages. Firstly, the raw information was reduced into more manageable summaries. This was achieved by reading each transcript from the South Asian sub-group and the white British sub-group to become familiar with the raw information. Next, a synopsis/summary of key items of the data was produced for each transcript. For example:

Quote	Summary
<i>"Wearing nappies makes it harder for a child to learn toilet training. In India we let the child run around in knickers so they have to use the toilet much quicker." (SA)</i>	Wearing nappies makes it harder Quicker without nappies Toilet training in India
<i>"The child is taken to the toilet every few hours by the parent and shown what to do." (SA)</i>	Parents take child to toilet Demonstration
<i>"Parents need to show a child how to use the potty." (WB)</i>	Parents Demonstration
<i>"It's important not to start toilet training too early – you need to wait until the child is ready". (WB)</i>	Don't start too early Wait until child ready

Following this, themes within the South Asian and white British samples were determined. This was achieved by comparing the summaries of the data in order to determine similarities among pieces of information within each sub-group (e.g. looking for patterns within the Asian sub group and patterns within the white British sub group). A list of similar themes was produced for each sub-group. For example:

South Asian Preliminary Themes	White British Preliminary Themes
Wearing a nappy delays toilet training Quicker in India Demonstration important Parents involved	Wait until child is ready Demonstration important Parents involved

* SA denotes South Asian participant; WB denotes white British participant.

Next, the themes were compared across the samples. Similarities seen within the white British sub-sample were compared to the similarities seen within the South Asian sub-sample. On the basis of this comparison, a list of emergent coding categories was produced. For example, on the basis of the above quotes, the following coding categories were created:

- Child's readiness
- Parental involvement
- Demonstration

During the process of creating categories, the researcher returned to the raw information and reread the transcripts to determine the presence or absence of the themes. Where necessary, coding categories were edited or re-written to capture the data appropriately, until a final list of categories was produced. The remaining 6 South Asian and 6 white British interview transcripts were then coded using these categories. In some cases, the original coding category needed to be refined in order to capture the data of the remaining transcripts. A final list of coding categories and descriptions can be found in appendix 5.

Reliability and Consistency

In order to verify whether or not the data under investigation had been adequately and reliably captured, a second researcher experienced in coding, independently applied the coding categories to the same material. Inter-rater reliability was calculated using the percentage agreement index developed by McClelland (1985) (see also Smith, 1992). Details of inter-rater reliability for each category are shown in appendix 6. The mean percentage agreement score was 94.1% (range = 75%-100%), indicating good reliability.

Quantitative Analysis

Differences between the number of South Asian mothers and the number of white British mothers indicating the presence of each category were analysed using Fisher's Exact Test. Bonferroni corrections were used to safeguard against chance findings due to multiple tests.

CHAPTER 3 ~ RESULTS

Overview

This chapter commences with a description of socio-demographic characteristics of the sample. The remainder of the chapter is organised into four sections, which correspond to the four research questions. The first section presents information about differences in mothers' developmental expectations. The second section describes differences in mothers' sources of information and factors influencing ideas about child development and child-rearing. The third section presents the analysis of differences in mothers' beliefs about their role in supporting a child's development. The final section presents differences in mothers' beliefs about global developmental delay and associated support services.

Characteristics of the Sample

White British Sample

The white British sample comprised of 10 mothers aged between 25 and 44 years old (mean = 34.9 years). All the mothers were born in the UK and had lived in the UK for all their lives. 9 of the mothers were married and 1 mother was divorced. The average number of persons living in the household was 4 (range = 3-6). On average, mothers had 2.1 children (range = 1 to 4) including one child with a diagnosis of global developmental delay. 7 of the children with global developmental delay were male and 3 were female. Their ages ranged from 2 to 5 years (mean = 3.9). In all but one case, at least one person in the household was employed. Social Class was measured according to the indices used by the National Statistics Office (i.e. from Social class I to Social class VIII; see appendix 5 for a description of this system). 5 mothers were classified as belonging to social classes I or II, 3 were classified as belonging to social classes III or IV and 2 belonged to social class VII or VIII. 8 of the mothers described themselves as being practising Christians and 2 mothers stated that they did not hold any particular religious beliefs.

South Asian Sample

The South Asian sample comprised of 10 mothers aged between 21 and 42 years old (mean = 31.3 years). 5 of the mothers were born in India, 3 of the mothers were born in Bangladesh and 2 were born in Pakistan. On average, the mothers had lived in the UK for 10.1 years (range = 3 years to 20 years). All mothers in this group were married with an average of 4.6 persons in the household (range = 3-8). Mothers had between 1 and 3 children, with the average being 2.1. In all cases the mothers had a child with a diagnosis of global developmental delay; half of these children were male and half were female. Their ages ranged from 2 to 5 years (mean = 3.6). In every case, at least one person in the household was employed. 2 mothers were classified as belonging to social class I or II, 2 mothers were classified as belonging to social class III or IV and 6 mothers were classified as belonging to social class VII. All mothers indicated they were Muslim.

To ensure the appropriateness of group comparisons and to establish the extent to which the two samples were well-matched, the samples were tested for differences in a number of socio-demographic variables (other than culture and religion), using t-tests for interval data and Fisher's Exact Test for categorical variables. No significant differences were found for mothers' age, total number of children, age and sex of child with developmental delay, number of persons in the household, social class and marital status (see Table 4 and Table 5).

Table 4: Mean age of mother, number of children, age of child with developmental delay and number of persons in the household

Characteristic	Mean & (Standard deviation)		t	P Value
	South Asian	White British		
Mothers' age	31.3 (56.7)	34.9 (8.1)	-1.072	0.298
Total number of children	2.1 (0.5)	2.1 (0.9)	0.000	1.000
Age of child with developmental delay	3.6 (1.0)	3.9 (1.1)	-0.590	0.563
Number of persons in household	4.6 (1.3)	4.0 (0.9)	1.152	0.264

Table 5: Sex of child with developmental delay, marital status of mother and social class

Characteristic	Frequency		P Value
	South Asian (n=10)	White British (n=10)	
Males with developmental delay	5	7	0.325
Females with developmental delay	5	3	0.325
Married	10	9	0.500
Divorced	0	1	0.500
Social class I or II	2	5	0.175
Social class III or IV	2	3	0.500
Social class V or VI	0	0	n/a
Social class VII or VIII	6	2	0.085

SECTION 1 ~ MOTHERS' DEVELOPMENTAL EXPECTATIONS

The results presented in this section relate to mothers' responses to the following interview questions:

- a) Forced-choice questions asking mothers to indicate whether or not they would expect a child of a specified age to have achieved a given skill.
- b) Open-ended questions asking mothers to indicate which skills they considered to be most important at a given age.
- c) Questions about whether or not mothers have different developmental expectations for girls compared to boys.

a) Forced-Choice Questions

Mothers were asked to indicate whether or not they expected a normally developing child of a specified age to have achieved a given skill. Fisher's Exact Test was used to statistically analyse the differences between South Asian mothers and white British mothers in relation to their developmental expectations. This test was selected as opposed to Chi-squared because the expected frequencies in each cell (category) were less than required for Chi-squared analysis. Bonferroni corrections were applied to avoid the risk of type I errors arising from multiple tests.

Skills expected in 6-month old children

As can be seen in Table 6, after adjusting for multiple tests using Bonferroni correction, there were no significant differences between the two groups in terms of mother's developmental expectations for a 6-month old child.

Table 6: Mothers' expectations about skill development in a normally developing**6-month old**

Skill/competency	Number expecting acquisition of this skill		P value
	South Asian (n=10)	White British (n=10)	
Support head when lifted up	9	10	0.500
Grasp objects	10	10	n/a
Make sounds	10	10	n/a
Smile	10	10	n/a
Let someone know if he/she is hungry	10	10	n/a
Breast fed	10	10	n/a
Started on solids	10	10	n/a
Sit independently	9	10	0.500
Show an interest in toys	10	10	n/a
Play with family	10	10	n/a
Play with peers	7	2	0.03*

* n.s. after Bonferroni correction

Skills expected in 1-year old children

Table 7 shows mothers' expectations regarding the development of skills in a normally developing 1-year old child. Again, there were no significant differences between the South Asian and white British mothers' developmental expectations for a 1-year old child.

Table 7: Mothers' expectations about skill development in a 1-year old child

Skill/competency	Number expecting acquisition of this skill		P value
	South Asian (n=10)	White British (n=10)	
Sit independently	10	10	n/a
Crawl	10	10	n/a
Start to walk	10	9	0.500
Wave good-bye	10	10	n/a
Say first word	10	10	n/a
Understand simple instructions	10	9	0.500
Feed self	7	9	0.291
Start toilet training	10	5	0.01*
Show an interest in toys	10	10	n/a
Play with family	10	10	n/a
Play with peers	10	8	0.237

* n.s. after Bonferroni correction

Skills expected in 3-year old children

Table 8 shows mothers' developmental expectations of a normally developing 3-year old. Both South Asian mothers and white British mothers shared the same expectations for children's development at this age.

Table 8: Mothers' expectations about skill development in a 3-year old child

Skill/competency	Number expecting acquisition of this skill		P value
	South Asian (n=10)	White British (n=10)	
Talk (use phrases and sentences)	10	10	n/a
Understand instructions	10	10	n/a
Name parts of the body	10	10	n/a
Name colours	10	10	n/a
Count to 5	10	10	n/a
Count to 10	10	10	n/a
Toilet trained	10	10	n/a
Feed self	10	10	n/a
Get dressed	10	10	n/a
Show an interest in toys	10	10	n/a
Play with family	10	10	n/a
Play with peers	10	10	n/a

b) Open Ended Questions

Mothers were asked which skills they considered to be the most important for a child of a specified age. They were able to name as many as were considered of high importance. Mothers' statements were assigned to coding categories using procedures of thematic content analyses described earlier. (See appendix 4 for details and examples of the different categories identified for each age group). Fisher's Exact Test was used to examine statistically significant differences between the two groups, followed by Bonferroni corrections for multiple tests.

Most important skills for a 6 -month old

Table 9 shows the number of South Asian and white British mothers endorsing each category of developmental skill as being of high importance for a 6-month old:

Table 9: Number of mothers highlighting this skill as important for a 6-month old

Category	Number of mothers indicating this is an important skill for a 6-month old		P value
	South Asian (n=10)	White British (n=10)	
Motor skills	10	10	n/a
Eating Solids	5	4	0.500
Social Skills	5	1	0.070
Making Sounds	3	8	0.03*
Awareness & Understanding	2	1	0.500
Exploratory Behaviour	5	4	0.500

*n.s. after Bonferroni correction

After adjusting for multiple tests, there were no significant differences between the number of mothers indicating each skill as being important.

Most important skills for a 1-year old

Table 10 shows the number of South Asian and white British mothers endorsing each category of developmental skill as of high importance for a 1-year old:

Table 10: Number of mothers highlighting this skill as important for a 1-year old

Category	Number of mothers indicating this is an important skill for a 1-year old		P value
	South Asian (n=10)	White British (n=10)	
Motor skills	8	6	0.31
Play skills	3	1	0.29
Social skills	0	4	0.04*
Eating Solids	5	0	0.01*
Self-help skills	0	4	0.04*
Talking	4	8	0.08
Toilet training	4	0	0.04*

*n.s. after Bonferroni correction

Again, there were no significant differences between the South Asian mothers and white British mothers in terms of the numbers indicating each of the skills as being important for a 1-year old.

Most important skills for a 3-year old

Table 11 shows the number of South Asian and white British mothers identifying each category of developmental skill as of high importance for a 3-year old:

Table 11: Number of mothers highlighting this skill as important for a 3-year old

Category	Number of mothers indicating this is an important skill for a 3-year old		P value
	South Asian (n=10)	White British (n=10)	
Motor skills	3	6	0.185
Social skills	4	5	0.500
Talking skills	7	6	0.500
Self-help skills	2	10	0.001**
Started nursery	2	2	n/a
Toilet trained	2	7	0.03*

*n.s. after Bonferroni correction

**significant after Bonferroni correction

Significantly more white British mothers than South Asian mothers indicated that self-help skills are important for a 3-year old ($p < 0.001$).

c) Differences In Competencies According to Child's Sex

Mothers were asked whether they would expect a girl to be more advanced in certain skills compared to a same aged boy and vice versa. For a 6-month old child and a 1-year old child, there were no significant differences between the number of South Asian mothers and white British mothers expecting a gender difference. However, significantly more white British mothers expected to see a gender difference in 3-year old children compared to South Asian mothers ($p < 0.01$).

Table 12: Mothers' beliefs about gender differences in skill development at 6 months, 1 year and 3 years

Age of Child	Number indicating 'yes' there would be a gender difference in terms of skill development		P value
	South Asian (n=10)	White British (n=10)	
6-month old	3	5	0.325
1-year old	2	7	0.03*
3-year old	2	8	0.01**

*n.s. after Bonferroni correction

**significant after Bonferroni correction

When describing the sex differences in skills for a 3-year old child, white British mothers indicated that girls would have advanced language skills compared to boys and that boys would have advanced motor skills compared to girls:

"I think girls are more ahead than boys, certainly by about 18 months or 2 years, you notice a huge difference, especially with language skills." (WB 1)*

"I think a girl would show more interest in another person – better social skills. A girl might be making more sounds as well. Everyone just says it – that girls are talking quicker than boys." (WB 6)

"Probably a girl of 3 would be talking more, or speech would be more advanced." (WB 2)

* Throughout, "WB" denotes a white British participant and "SA" denotes a South Asian participant.

"I think a 3-year old boy would be better at climbing, hopping and running than a girl of the same age. You know, the rough and tumble stuff." (WB 10)

Summary

The samples selected were well-matched demographically on all variables (except country of origin and religious beliefs). On the whole, South Asian mothers and white British mothers were similar in relation to their expectations about children's skill development. South Asian mothers and white British mothers were also similar in the skills they highlighted as being important for a 6-month old, a 1-year old and a 3 year old child. There was however, one exception. Specifically, significantly more white British mothers indicated self-help skills as being important for a 3-year old compared to South Asian mothers. Mothers also differed in their beliefs about differences in children's competencies according to the child's sex. Significantly more white British mothers expected a gender difference in children's skills at 3-years old compared to south Asian mothers.

**SECTION 2 ~ FACTORS INFLUENCING PARENTS' BELIEFS ABOUT
CHILD DEVELOPMENT AND CHILD REARING**

The results presented in this section relate to interview questions about factors influencing mothers' ideas about child development and parenting. An initial analysis of transcripts yielded 7 major categories (or sources of influence): family, friends, culture and changing ideas over time, professional advice, books and media and religious beliefs. See appendix 5 for descriptions of these coding categories. Table 13 shows the number of mothers indicating each category as being an important source of their knowledge and ideas about parenting.

Table 13: Factors influencing parents' beliefs about child development

Category	Number of mothers indicating this as important		P value
	South Asian (n=10)	White British (n=10)	
Family	10	10	n.a
Friends	0	8	0.001**
Culture & changing ideas over time	8	6	0.314
Professional Advice	4	10	p<0.005**
Books and Media	1	8	p<0.003**
Religious beliefs	10	2	p<0.001**

**significant after Bonferroni correction

Fisher's Exact Test was used to analyse differences between the number of mothers from each cultural group indicating each category as being important. Bonferroni corrections for multiple tests were also used.

Results indicated that significantly more white British mothers than South Asian mothers indicated that friends, professionals and books and media are important factors in shaping beliefs about child development ($p<0.001$; $p<0.005$ and $p<0.003$, respectively). In contrast, more South Asian mothers indicated that religious beliefs are important factors in shaping ideas about child development compared to white British mothers ($p<0.001$). These results all reached statistical significance after Bonferroni corrections.

Each of the factors identified are described below, together with illustrative examples.

The Influence of Family

All South Asian mothers and white British mothers indicated that family were important in influencing their ideas about child development and parenting. Within this category, two important sub-themes emerged: 'learning from family members' and 'doing things differently'. In the first sub-theme, parents acknowledged the importance of learning ideas (e.g. bathing or holding the baby) directly from the family. In the second sub-theme, whilst parents were aware of family influences on their ideas about parenting, they had also opted to do things in their own way, at times going against family advice or traditions. The two sub-themes are described below.

Learning from family members

All the parents described their family as being an important context for learning about children and child-care practices. Within the South Asian mothers' responses, there was an emphasis on how living within an extended family system afforded many opportunities to observe child-care activities:

"In our culture, we have a joint family system...We have more opportunity to learn from elders, so we learn most things from the family....A mother will always know how to handle a baby because she has watched her family or her husband's family." (SA 9)

"I have seen my own sisters and how they do things with their children. My mother always gave me advice about what to do and what not to do – so I have just followed these ideas." (SA 5)

"In my culture, you get most of your ideas from your elders. I know there are Health Visitors here and mums learn from books and baby groups. But in my culture, you never ever go to any doctors or groups unless the babies have a serious medical problem. The other problems, you discuss with your mother or mother-in-law. So, if mine had a tummy ache, for example, I would ask my mother. She might suggest I use a type of gripe water with hot water." (SA 9)

Mothers described a period during the first 6 weeks of a babies' life in which the mother-in-law or mother stays with the new mother (if she is not already living in the same house) and provides care for the baby as well as care and specific instruction for the new mother:

"When you have a baby, your mother or mother-in-law looks after you for the first 6 weeks. You are not allowed to go outside the house. They bring you special food...soups and healthy foods...and they pamper you". (SA 2)

"When my child was very young, my ideas came from my parents. My mother told me what I was supposed to do...She told me that after a child is born, we have to hold the baby carefully – support the head and the bottom. She told me how to bathe the baby too. I remember her telling me to make sure the water is not too cold or too hot and to test the water first. She told me how to wash the baby as well...She started by washing the baby herself until I knew how to do it." (SA 6)

All white British mothers also indicated that ideas from their families provided an important source of information:

"I think with me, my ideas come largely from my mother and my husband's mother. She [my mother-in-law] was looking after my son in the early stages. She was so experienced with babies and had lots of ideas". (WB 2)

However, almost half of this group of mothers also mentioned factors which appeared to reduce the amount of family influence. These factors included the feeling that parents were too old to offer meaningful advice, feeling that parents lived too far away to make any significant contribution, having a small family and an absence of close family relationships. None of these themes arose for South Asian mothers.

"I don't get so much help from my parents now because they are a lot older – they are in their 80s. My mum always says that she can't remember or that her ideas won't count nowadays – you know – it was such a long time ago that she had young children". (WB 9)

"I think for my mother's generation, family were much more important. If you think back to then, you know, years ago, they used to live next door to each other. My mother would have popped round to her sister's house for help. Everyone used to be closer in those days. Now, families are spread all over the country and you are not seeing each other regularly, so it's a bit harder to get help and ideas". (WB 10)

"I have just one sibling, so does my husband. We come from a small family, really, so there is not a lot of input from the family. To be honest, I would still turn to my sister-in-law if there was ever an issue, but I think it's harder to get ideas about parenting when your family is small". (WB 5)

"We are not really close to any of our family, so when I had kids, it was me on my own. There was a bit of help from my mother-in-law, but we are really not close and I did things a bit differently to her". (WB 3)

Doing things differently

Whilst all of the white British mothers acknowledged the importance of family in influencing their ideas about parenting, 60% indicated that they had also done things differently from their parents:

"I've tended to do things my own way. For example, my mother-in-law used to say to me 'dress your children in a certain way!' She would put them in romper suits...I mean, they went out in the sixties! It's things like that I have had to be flexible about." (WB 5)

"My mother-in-law was around for a bit when I had my first one. She tried to give me advice about weaning babies onto food. I can tell you, I did things completely differently! I mean, she was trying to give my 6-month old sausages. I really couldn't agree with that." (WB 3)

"When I come to think of it, I have noticed all the things my mother wouldn't let me do and has since advised me against, I have allowed my children to do." (WB 6)

On one occasion, not following parents' advice and choosing to follow the advice of others was the cause of conflict:

"Both my children suffered once or twice with colic. My mother-in-law had all these lotions and potions she suggested I gave them. She told me it had worked for her children so it would work for mine. So I gave my children whatever it was and they were violently sick! So I asked my health visitor. She suggested something to give them, which I did....and it worked.....It caused a big hoocha at the time...she (mother-in-law) really didn't seem to like it". (WB 5)

None of the South Asian mothers indicated that they had chosen to do things differently from their own families.

The Influence of Friends and Other Mothers

White British mothers were significantly more likely than South Asian mothers to indicate that their ideas about child development and parenting were influenced by friends and other non-family members with children.

"I'd ask my friends if I had a question about child development....For example, if X wasn't well and it wasn't serious enough to go down to casualty, I might just ring up a friend and ask what to do". (WB 9)

"Mainly I'm influenced by people who have been there and done that...parents who have children with special needs. I normally take their advice – whatever they have tried and has worked for them, I tend to try it too". (WB 4)

This category also included parents at toddler groups and parents in the school playground:

"I think a lot of ideas of mine have come from asking people from the various mums and toddler groups". (WB 5)

"You get your ideas from parents around the schools. You see how they are bringing up their children and you think to yourself 'I might try and do that'. When there's a group of you together and you talk about what to do if your child has a tantrum, for example, it's a really good way to share ideas". (WB 3)

In contrast, none of the South Asian mothers identified friends as important sources of ideas or information about parenting.

Culture and Changing Ideas over Time

8 South Asian and 6 white British mothers reflected on how culture might contribute to different ideas about child development and different approaches to parenting. There was a sense, for example that white British culture and access to education might encourage parents to be concerned about the rate of a child's development, getting things wrong or psychologically damaging a child:

"When I think about how I was brought up in India, my mother was never too worried about us because I think she thought when the time comes, we would learn everything. But here, mothers have to be thinking of their children and concentrate on what they are doing all the time. Otherwise the children might be developing in the wrong way. Our parents were never so concerned about how we were developing. Look at us now though, we are worried about all kinds of things to do with our children...We are so concerned about whether our children are doing things at the right age, what their needs are and what their environment is like". (SA 7)

"Back home (in India) many women are not educated and do not bother about it. Now, with all this education, we are comparing children and are concerned they are developing at the right time". (SA 7)

"British mothers are anxious...they worry about what is going on in their child's mind...psychological ideas. British women worry they may affect children negatively. I think this is a kind of...I wouldn't say preoccupation, but I think it is in the psyche of white women in a way that isn't in other cultures". (WB 2)

On the other hand, there was also the idea that Asian culture promotes earlier skills development in children. Reasons for this included the fact that Asian children are

surrounded by elders in the household and are left to 'get on with it'. Children are not provided with specific instruction or training from other adults, they are simply given the freedom to learn at their own pace and develop quickly by observing the adults around them:

"I think children are more clever back home (India). I think they develop at a quicker age. Whereas children in this country (UK) are pampered and fussed over, children in India are left to it so they can discover the world for themselves....Kids grow up with a lot of people in the house...family, workers...people that do the cleaning. That way they develop quicker because they have so many people around them and are just left to get on with it." (SA 3)

Mothers also talked about approaches to parenting in the past and how ideas have changed over time:

"When I think back to my childhood – the way that children were viewed at this time. There was a married couple and children just happened to be there – in the background. Nowadays, children are so much more part of the family. When we were younger, we never used to do things with the family – our parents would do things and we would tag along. Whereas now, we take the children out to where they want to go. It is that kind of outlook that has changed now." (WB 4)

Mothers expressed also how changing ideas had sometimes left them confused about the best parenting approach:

"I think there is a conflict for mothers at the moment. No, not a conflict, a dilemma. In the 60s and 70s people said 'a child must express themselves' and 'you should reason with your children'. But I think what actually works is to give a child firm parameters and boundaries. I think some of the 'woolly' advice from the 60s hasn't been that helpful...and parents are left in a dilemma. Treating children as 'their own beings' can go a bit too far". (WB 2)

Books and Media Influences

Significantly more white British than South Asian mothers indicated that books, television, magazines and other media had been important sources of information about child development and parenting. One of the two South Asian mothers who had consulted child-care books even noted that this practice might be atypical compared to other Asian women:

"When I was pregnant with my first child, I read so many books about children's behaviour. Reading books is a hobby of mine. I think it varies how much other Asian women read books about children. I think they are far less likely to look in books....they are more likely to get advice from family". (SA 8)

Amongst the white British women consulting books, there was a general acknowledgement that these were useful sources of information:

"I suppose books have been important too. I was reading a lot of books especially when I had my first child. There is one about how to be a good mum and it told me all sorts of things that I could do with my children." (WB 4)

"I do take notice of things I read. Childcare books...like the one given to us by the health authority were really good. Also, Dr Spock...That phrase he uses - 'you should trust yourself' – that was really helpful to me." (WB 2)

However, there was also the sense that childcare books created a sense of anxiety or distress for mothers because of the precise nature of the guidance:

"I've read a dreaded book about child rearing...I can't remember the name exactly. It was enough to reduce me to tears. It tells you exactly when and what your child should have for breakfast and when your baby must be asleep by. It is very, very precise...an old fashioned English take on child rearing." (WB 9)

Likewise, one mother commented on how constant media coverage of the dangers of childhood or the dangers of certain child-care practices evoked a sense of anxiety:

"I know I'm over-cautious. I think that we have so much stuff in the media – things like worries about paedophilia and things telling you what to do. Like today, for example...there was a thing telling you about cot death and that you shouldn't have children in bed with you under 8 weeks. There's always things like that in a news report or whatever...I think it makes mums really worried." (WB 2)

Professional Advice

White British mothers were significantly more likely than South Asian mothers to indicate professional advice as being an important source of parenting advice compared to South Asian mothers. All white British mothers compared to only 4 south Asian mothers identified professional advice as being important. "Professional advice" included any mentions of a health-care professional as being important in shaping parenting ideas. Professionals mentioned by the participants included the GP, paediatrician, Child Development Centre (CDC), speech and language therapist, health visitor, psychologist and psychiatrist:

"Actually midwives were very important. Also CDC experts...you know, people like psychologists and speech and language therapists. They give you ideas about the

key milestones you would normally expect an average child to achieve. Although these things were in books too, it was helpful to have the ideas repeated consistently". (WB 3)

"I had a very good portage teacher. She was very good. She used to give us lots of ideas and she was excellent. Anything I needed to know, she pointed me in the right direction. She gave me ideas about feeding, drinking and the different services we could go to." (WB 9)

"I got a few of my ideas from the health visitor – she has been a great help to me. Also the CDC doctor – we see him every 6 months. He compares my child's development with what a normal child should be doing and this has helped me get ideas about how children develop." (SA 3)

Religious Beliefs

Significantly more South Asian than white British mothers indicated that religious beliefs had been an important influence in relation to their parenting ideas and beliefs. In general, South Asian mothers emphasised the importance of devoting time to children:

"Within our (Muslim) religion, you have to give a lot of time for your baby. If you are a serious mother, you have to put back your career and your study. Mothers should spend all their time with the children and the baby – at least until the child is about one or two." (SA 7).

In addition, all South Asian mothers indicated that an important aspect of child rearing involves teaching the child about religion. This starts when the child is a baby, when the mother might calm the baby with the words "Allah":

"There is lots of advice from religion. You have to teach children religion from a young age. When a child is a baby, we say to him 'Allah' when he cries to calm the child down. It is important the child learns to say 'Allah' first." (SA 4)

Learning to say 'Allah' is an important part of the initial teaching, not only in terms of religious education, but also in the development of language skills:

"They say you need to teach the child first to say 'Allah'. When they do this, they believe it opens the child's tongue for language. So you need to teach this word first". (SA 8)

Several mothers described how Asian parents think that early baby sounds are the baby trying to form the word 'Allah':

When the baby makes 'aaa-aaa' noises, we believe this is opening their mouth so they can say 'Allah' (SA 2)

Once a child has learned to speak, the child is taught the Koran, which is taught in stages:

"When they have learned to speak, we teach them the Koran. When they eat, we teach them to pray before the food. When they are 4 or 5, they start something like nursery at the mosque. You learn the Koran in stages." (SA 6)

"In the Muslim religion, as soon as the child is 5 we need to start religion training. It's like nursery to start with – it starts simple. When the child is 6 they are taken to the Mosque." (SA 7)

Children are also taught about the status of males versus females:

"If you have a baby girl, you need to teach them that they are different from boys in terms of status. The baby girl cannot do everything she wants independently. It's the same when you are older. For example, if I want to get my hair cut, I have to ask my parents or my husband. If they say no – I would have to obey and keep my long hair. You need to teach children the same things." (SA 9)

Although most of the white British groups identified themselves as having religious beliefs, only two suggested that these beliefs influenced parenting activities. There was no mention of direct teaching of religion, but an emphasis on setting an example to children so that they follow parents' lead:

"I believe my children should be brought up in a good Christian way and I think if parents lead their life in this way, the children will follow your lead. They used to come to church with me, but I found they were too noisy. I like to think though, that they are aware of Christian beliefs." (WB 5)

In addition, there was an emphasis on how activities which go hand in hand with going to church, are positive influences for children:

"I know when I was young, my parents sent us to Sunday School when we went to church, and things like cubs and brownies. I think that idea is lovely. I mean, if X wanted to go to scouts, I would like it and would encourage him to go. It teaches you all sorts of things about growing up. At least it gets them away from being stuck in front of a computer." (WB 19)

Summary

The results in this section indicate that there are differences between the two cultural groups in terms of the factors which influence ideas about child development and parenting. Significantly more white British mothers than Asian mothers are influenced by friends, professionals, books and media. Significantly more South Asian compared to white British mothers are influenced by religious beliefs. Equal numbers of white British and South Asian mothers are influenced by family members, with South Asian mothers in particular finding that the extended family system is a conducive environment for acquiring parenting skills.

SECTION 3 ~ BELIEFS ABOUT SUPPORTING A CHILD'S DEVELOPMENT

The results presented in this section relate to questions about beliefs about supporting children's development in 3 specific key areas, namely language development, potty training and co-operative play skills. Specifically, parents were asked what strategies might be important in developing these skills and who might be involved in supporting the development of these skills. It was thought that by focusing on three rather distinct areas of a child's development, differences in mothers' beliefs, if existent, would be uncovered.

Strategies to support a Child's Language Skills

In relation to language development, mothers indicated the following strategies as being important aspects of supporting a child's language development: talking to the child, simplifying language when speaking to the child, allowing the child to pick up language naturally, making eye contact with the child, using gestures to support spoken words, playing with the child and directly teaching the child to say words. These categories are described in more detail in the appendix.

Table 14 shows the number of mothers indicating each strategy as being an important aspect of language development. Differences between the two cultural groups were analysed using Fisher's Exact Test followed by Bonferroni corrections.

Table 14: Important aspects of a child's language development

Category	Number of mothers indicating this is an important aspect of supporting a child's language development		P value
	South Asian (n=10)	White British (n=10)	
Talking to the child	6	7	0.500
Simplify language	2	4	0.314
Child acquires language naturally	3	2	0.500
Eye Contact	3	4	0.500
Gestures	1	2	0.500
Teaching	3	5	0.325

Results indicated that there were no statistical differences between the two groups in terms of the numbers of mothers indicating each category as being important.

Talking to the child

Most of the mothers indicated that children needed to *hear language being spoken* in order to develop language skills. Many suggested that the more one talks to children, the more they are likely to pick up language skills:

"Children learn by seeing adults talking to one another...A child who sees a lot of language going on will have a better chance of picking it up." (WB 2)

"Children learn language by hearing adults talk to them...you tell them about what you are eating...what you are doing and so on. The more you talk, the more you learn." (SA 8)

"I remember my grandmother asking why I was talking to my baby. That was something that always stuck in my mind. I remember thinking – surely you need to talk to a baby because that's how you are going to get them to talk? I always talked and talked to mine to help him pick it up." (WB 5)

Simplifying language

Slightly more (although not significantly more) white British mothers compared to South Asian mothers noted that *simplifying language* was an important aspect of supporting children's language development:

"You have to lessen your words slightly. Instead of saying full sentences to them, you have to cut it down into one or two words and that way, they understand you better. I

know it sounds silly, but me and my husband help X by going through a load of sounds. Like "dinosaur"... we break it down into "di" "no" "saur". (WB 4)

"Parents would also simplify their language...break things down. We would start simple...things like Allah to start with and then mama or dada." (SA 1)

Children acquire language naturally

A few of the mothers indicated that *children acquire language naturally* without specific adult structuring or instruction:

"I think language comes naturally to children...Children are very careful to look at the actions of their mother and father or people around them. A lot of the time you don't realise that your child is looking at you. You might think he is playing, but actually he's learning from you. Sometimes a child will hear what you have said to your husband and the child will suddenly repeat it. And you think to yourself 'I didn't realise he could say that!' (SA 7)

"I think children pick up language just by watching what goes on around them. I didn't really do anything to get X to talk. I think that even when she was a baby she was looking at me...looking at my lips and listening to my words and it sort of came naturally. I think that's how children learn." (WB 3)

Making eye contact and using gestures

Making eye contact with the child and gestures were additional strategies identified by parents:

"If the child and parents make eye contact with the mother and father, the child learns to speak and use words." (SA 9)

"I think eye contact from the parent is important for a child to learn how to talk." (WB 1)

Direct teaching

A final strategy identified by parents involved teaching the child directly:

"You have got to teach the child certain sounds and words. You say a word and get the child to say it back to you. So you do a lot of repeating again and again." (SA 3)

"My husband suggested we use flash cards to help X learn words. We test him on different words as often as we can and his language has really picked up. So I think it's important to teach children to speak." (WB 4)

Strategies to Support Toilet Training

The following categories were identified by mothers as being important aspects of toilet training: parent-guided strategies, offering praise and rewards, child's feeling of dirtiness prompts learning, nappies delay learning, child's readiness and biological determination. These categories are described in more detail in appendix 5.

Table 15 shows the numbers of South Asian compared to white British mothers indicating each category as being an important aspect of toilet training.

Table 15: Important aspects of toilet training

Category	Number of mothers indicating this is an important aspect of toilet training		P value
	South Asian	White British	
Parent-guided strategies	7	8	0.500
Offering praise & rewards	0	8	0.001**
Child's feeling of dirtiness prompts learning	8	0	0.001**
Nappies delay learning	5	1	0.070
Child's readiness	0	7	0.002**
Biological determination	0	3	0.105

**significant after Bonferroni correction

Differences between the two cultural groups were analysed using Fisher's Exact test followed by Bonferroni corrections. Significantly more white British mothers than South Asian mothers indicated that praise and rewards are important aspects of toilet training ($p < 0.001$). Significantly more White British mothers also indicated that toilet training should only commence when a child is ready ($p < 0.002$). Significantly more South Asian mothers than white British mothers indicated that toilet training should commence when a child feels and recognises that they feel dirty in a nappy ($p < 0.001$).

Parent-guided strategies

Almost equal numbers of South Asian compared to white British mothers mentioned parent-guided approaches to toilet training. These approaches included: parents taking the child to use the potty regularly, parents demonstrating how to use a potty or a toilet, showing the child pictures of someone using the toilet and introducing this in gradual stages (i.e. child given

pull-ups, child given pants, child taken to potty, child given special seat over the toilet, child uses the toilet):

"You need to take the child to the toilet twice a day and make the potty part of the room. You might show a child by putting a teddy on the potty and show the child a picture of someone using the potty." (SA 8)

"First I would give the child pull ups, then I would take the child to the toilet every hour. And then the mother would show the child how to use the toilet." (SA 1)

"I would start potty training by popping him on the toilet after every nappy change or after a drink. In our family, what I've seen a lot of people do is let them run around in the summer with no nappy on and keep a potty around so that they always see it." (WB 9)

"I kept X in for a week without nappies. I gave her knickers and even went for a wee in the potty to show her what to do. She did have a few accidents, but within a week she was out of nappies forever." (WB 14)

Offering praise and rewards

Significantly more white British mothers than south Asian mothers indicated that reward systems and praise were a necessary part of toilet training:

"If children manage to do a wee in the potty, it is really important to offer them praise and give them a treat, like a banana or chocolate. That way they will want to do it again." (WB 10)

"She did get a lot of praise the first times she did it. I think they need praise and rewards to help them to go again." (WB 4)

"You might encourage a child by using star charts and giving them a star or a sticker when they have managed to use the potty. You can exchange the stars for a present or a treat if they manage to use the potty every day." (WB 7)

Child's feeling of dirtiness prompts learning

Significantly more South Asian compared to white British mothers indicated that toilet training is prompted by a child feeling or realising they are dirty and uncomfortable in a nappy:

"Children feel the wetness and the dirtiness and this distresses them. So they become toilet trained quickly." (SA 8).

"In Indian culture, we make them understand from an early age that your bottom should be clean. They learn quickly that it isn't comfortable or clean and so they start to use the toilet quickly." (SA 7)

"Children know when to go to the toilet because they realise they feel dirty and they can't live with this." (SA 2)

"As soon as the child understands that they are dirty, parents encourage the child to use the toilet". (SA 1)

One mother indicated that within Islamic religion, children cannot offer prayers if they are dirty, so it is important a child learns to become toilet trained:

"...In Islam, when the baby is 7 years old, you have to force the baby to offer his or her prayers. If the child is still in nappies, it means the baby is not clean and they cannot offer prayers." (SA 9)

Several South Asian mothers mentioned that they could not take their developmentally delayed child to the Mosque because they had not achieved complete bowel or bladder control.

Nappies delay learning

5 South Asian mothers compared to 1 white British mother indicated that wearing nappies means that a child does not need (or is not ready) to be toilet trained until a later age. Many of the South Asian mothers indicated that in Asia, where children wear pants instead of disposable nappies and parents do not have carpets to protect, children become toilet trained at a much earlier age because they can see and sense what is happening to them when they go to the toilet:

"In Pakistan, the situation is different because children don't wear nappies...But when they have a nappy on, they don't feel the wetness so it takes much longer to learn." (SA 8)

"Here [UK], children are so used to being in nappies which makes understanding the feeling of going to the toilet difficult for them. It takes a long time to explain to them that they stop wearing nappies. They are so used to wearing nappies, they don't want to leave their wee or pooh." (SA 7)

"Back home [India] we don't put the children in nappies. We can leave the child with knickers on out in the open. The atmosphere is different so they can be outside instead of wrapped up inside. So if a child has an accident we are not worried about the mess. Also we do not have a carpet system in India so it doesn't matter if a child has an accident. I think this means the child learns a lot quicker." (SA 7)

"Of course, we have disposable nappies now so children don't have to be potty trained until later because it's easier when you have disposable nappies – you don't have to wash them." (WB 10)

Child's readiness

Significantly more white British compared to South Asian mothers emphasised the importance of a child showing they are ready before toilet training can be started. Coupled with this idea, was the notion that children could not be rushed into toilet training and if they were, it would cause problems for the child later on:

"You can't push a child into toilet training. The child has to take the lead. I think you can see some kind of sign from the child that the child is ready. They seem to get to a stage when they've had enough of nappies...but you can't push this. A child has to be really ready. If you push a child who is not ready, you are going to cause other problems." (WB 8)

"I think you should leave the child until they start to show signs. I think if a child is not ready, it can be cruel in a way. A child must show that they are ready otherwise your child could come to fear that kind of thing. I've seen a niece of mine. They were trying to potty train her really early and she developed a fear of toilets. It's like I said, it has got to be when the child is ready and when they are accepting of doing it". (WB 14)

"I think children have so much to do in their first couple of years – you know, talking and that kind of thing, that potty training should be left until they are ready." (WB 5)

When asked to comment on the idea of waiting until a child is ready and the possibility of causing the child later problems if toilet training commenced too early, a South Asian mother indicated:

I think starting at an early age is not at all harmful for the baby. It just makes sense! I think if you leave it for longer and start it later, you are going to cause problems, because the child will find it much more difficult to learn. (SA 9)

Biological determination

3 of the white British mothers but none of the South Asian mothers indicated that there is an aspect of becoming toilet trained that is biologically determined. Whilst parents acknowledged their role in teaching and showing a child how to use the potty or toilet, they also mentioned an aspect which is governed by a biological mechanism which dictates when toilet training can commence:

"I think there is something physical which dictates when a child can start to learn to use the potty. Something physical which helps them hold it in or go when they want." (WB 4)

"I read somewhere in a book...I don't know how true it is, that there is a part of the brain that doesn't hook up to another part of the brain they need for toilet training until they are at least 18 months, so there is no point in trying to potty train your child until then." (WB 5)

"I think a child has to be ready in a biological sense before you start toilet training. They have to be ready mentally and physically." (WB, 20)

Strategies to Support Co-operative Play

Thematic content analysis was used to derive a set of categories relevant to parents' ideas about supporting co-operative play. White British mothers and South Asian mothers expressed the following themes in relation to supporting co-operative play: co-operative play occurs naturally and parental involvement is needed. These themes are described in more detail in appendix 5. Table 16 shows the numbers of South Asian compared to white British mothers' indicating each category as being an important aspect of developing co-operative play skills.

Table 16: Important aspects of co-operative play skills

Category	Number of mothers indicating this is an important aspect of co-operative play		P value
	South Asian	White British	
Co-operative play occurs naturally	5	3	0.325
Parental involvement needed	5	7	0.325

There were no significant differences between the cultural groups in terms of number of mothers indicating each category as being an important aspect of developing co-operative play skills.

Co-operative play occurs naturally

5 South Asian and 3 white British parents indicated that co-operative play skills come naturally to children. These parents indicated that children observe what is going on around

them and gradually pick the skills up. Parents in this category did not indicate that adult involvement is required:

"I think children acquire this skill fairly naturally. They just see other children and adults interacting and they want to imitate it." (WB 2)

"I think play skills are a natural thing. Children are left to play with other children. If they are surrounded by other children they get used to this and they learn to play with each other." (SA 1)

Parental involvement needed

5 South Asian and 7 white British mothers indicated that parents' or other adults need to demonstrate co-operative play skills to their children in order for them to learn these skills.

"I think it's down to the parents. Because when they are young – if they have a toy and the other one wants it, the parents have to teach the child about sharing. Parents have to sit with a child and play turn-taking games." (SA 3)

"You have to teach the child to play with others - take turns and share things." (SA 2)

"You need to teach children things like sharing. If you play with them yourself from an early age, you might teach them by saying 'one for mummy.....one for you'. You share things with the child so they understand it as they get older." (WB 4)

One South Asian mother noted how mothers in the UK might be more involved in children's play than mothers in India. She suggested that Indian children are allowed to run free in the countryside. On the other hand, children in the UK are restricted to being in the house; as a consequence children in the UK become bored easily and parents have to get involved:

"In the UK you cannot go out most of the time. But in the countryside in India, there is more freedom. There are people around who can see how the children are getting on, but generally children are left to get on with it. In the UK parents have to be more involved in play. The child is cooped up in the house and gets bored easily so the mother has to get involved and play with them". (SA 7)

Persons involved in supporting a child's language, toileting and co-operative play skills

Participants were asked to identify the main persons involved in supporting a child's development. Using thematic content analysis, 5 categories emerged from the transcripts:

parents, friends, extended family, school/nursery and other professionals. Table 17 shows the number of mothers indicating each category as being important in supporting a child's development.

Table 17: Persons involved in supporting a child's development

Category	Number of mothers indicating this is an important person in supporting a child's development		P value
	South Asian (n=10)	White British (n=10)	
Child's Parents	10	10	n/a
Friends	0	4	0.043*
Extended family	8	0	0.001**
School/nursery	4	4	n/a
Other Professionals	2	1	0.500

*n.s. after Bonferroni correction

**significant after Bonferroni correction

Differences between the two cultural groups were analysed using Fisher's Exact test followed by adjustment for multiple tests. As the above table indicates, after adjustment for multiple tests, significantly more South Asian mothers than white British indicated that extended family are important in supporting a child's development ($p < 0.001$).

Summary

The results in this section show that the South Asian mothers and white British mothers differ from one another in *some* aspects of their beliefs about supporting a child's development. Specifically, South Asian and white British mothers have similar beliefs about strategies involved in supporting the development of a child's language and co-operative play skills. In relation to toilet training, significantly more South Asian mothers compared to white British mothers indicated that toilet training commences when a child has a sense of being dirty. Significantly more White British mothers emphasised the use of praise and reward systems in a child's toilet training and the need to wait until a child is ready before toilet training can commence. Significantly more South Asian mothers indicated that extended family members are important persons involved in supporting a child's development.

SECTION 4 ~
BELIEFS ABOUT DEVELOPMENTAL DELAY
AND BELIEFS ABOUT SUPPORT SERVICES

The results presented in this section relate to section 4 of the semi-structured interview schedule in which mothers were asked to describe their beliefs about developmental delay and experiences of the support services offered and received.

Mothers' understanding of global developmental delay

Mothers were asked to describe the nature of their child's difficulties. Two different categories of responses were identified using thematic content analysis: medical and skills-based descriptions. Mothers' responses containing a medical or diagnostic label (such as Global Developmental Delay, Cerebral Palsy or Learning Disability) were coded as medical. Mothers' responses containing a reference to loss or lack of global or individual skills (e.g. 'he can't walk or speak'; 'his development is behind') were coded as skills-based. Table 18 shows the number of South Asian compared to white British mothers using each category of description.

Table 18: South Asian and white British mothers' descriptions of their child's difficulty

Category	Number of mothers describing their child's difficulties in these terms		P value
	South Asian (n=10)	White British (n=10)	
Medical	4	9	0.029**
Skills-based	10	9	0.500

**significant after Bonferroni correction

Quantitative analysis using Fisher's Exact Test indicated that significantly more white British mothers than South Asian mothers described their child's difficulties using a medical label ($p < 0.029$):

"He has got global developmental delay. This means that everything you can imagine is about 2 or 3 years behind. So it's things like feeding, dressing himself, washing, toileting, talking, understanding...everything." (WB 9)

"She has cerebral palsy and developmental delay. She is globally delayed in all areas: speaking, understanding, motor skills and mental skills." (WB 1)

In contrast, medical labels were absent from the South Asian mothers' descriptions, who did not use medical labels or diagnoses:

"As she got older, we realised she wasn't doing the things she was supposed to be doing, like smiling. She didn't do this until she was 6 months, whereas this should be done at one or two months. So gradually, as she got older, she wasn't doing the things she was supposed to be doing." (SA 2)

"He doesn't speak. When he can't express what he wants – everything is bad. He still uses nappies and has a walking problem. He gets very angry and disturbed and grinds his teeth and scratches himself". (SA 9)

Mothers were also asked about their understanding of what had caused their child's difficulties. Their statements were categorised using thematic content analysis. Four themes of explanation emerged from the data: biological, psychological, religious, retribution ideas and no explanation. Many mothers' responses contained more than one theme. The number of mothers highlighting each category of explanation is given in table 19.

Table 19: Mothers' beliefs about the cause of their child's difficulty

Category	Number of mothers describing their understanding of their child's difficulties in these terms		P Value
	South Asian (n=10)	White British (n=10)	
Biological	4	10	0.005**
Psychological	1	0	0.500
Spiritual and retribution ideas	4	3	0.500
No explanation	3	1	0.291

**significant after Bonferroni correction

Significantly more white British mothers compared to South Asian mothers had a biological explanation for their child's difficulties ($p < 0.005$). Explanations highlighted the role of genetics, birth complications, pre-maturity and illnesses during pregnancy:

"Well, the doctor's told me what may have caused it. I mean he was pre-mature and I had an infection. So that predisposes the child to bleeding in the brain and he had a

bad bleed. So the bleeding in the brain has obviously affected his brain, which has affected his development.” (WB 1)

“I think having chicken pox when I was pregnant was partly linked to the problem...at least, that’s what the doctors have suggested”. (WB 6)

“One of my doctors said it might have been between me and my husband making the child together – you know something to do with genetics”. (WB 10)

“I think there is a genetic link. It’s something biological. It makes sense, there are not any other possibilities.” (WB 3)

Almost equal numbers of south Asian compared to white British mothers cited spiritual and retribution ideas in talking about their understanding of the cause of their child’s difficulties. Interestingly, white British mothers describing spiritual or retribution ideas indicated that these beliefs existed alongside a more ‘rational’ or ‘scientific’ reason explanation.

“We’re not too sure why she has these problems. Part of me wonders whether it is because of unseen things. What do you call it here? The spirit or ghost or something.” (SA 1)

“Muslims believe that these things happen because it is god’s will because god knows what is best for you. You have to accept what happens from god.” (SA 7)

“Occasionally I have bad thoughts like ‘I must have been a bad person in a former life’. But then I go back to my rational medical explanation. It’s just when you are having those bad days and you know at a rational level it isn’t true but it doesn’t stop you feeling this way.” (WB 1)

“Of course there are times when I have thoughts like ‘what have I done...am I being punished for something?’ But the logical side of me knows that there isn’t anything other than a scientific reason.” (WB 7)

3 South Asian and 1 white British mother indicated that they had not received any kind of explanation about their child’s difficulties. In all these cases, mothers indicated that their child had undergone numerous tests and that they felt the need to draw the line even if this meant not knowing the cause:

“They keep saying they will get another doctor to look at him. But I’ve gone beyond the stage of wanting to know. I think at the end of the day, they don’t know themselves and they are just going to use him as a guinea pig. I’d rather just leave it and get on with life...I’ve had enough of the in and out of hospital”. (SA 3)

“They think in a few years time they may develop a test which will tell us what caused it. But there is a limit to how many tests I want him to go through. You know, the amount of times these junior doctors come and give him a test and can’t find a vein. He used to come out like a little pin-cushion. It’s awful...there comes a time where you don’t want to put him through that again”. (WB 9)

Identification of the child's difficulties: when, who and how

Mothers were asked to indicate the age at which the child's difficulties were first noticed. The mean age of identification is given in table 20.

Table 20: Mean age of child when the difficulties were first noticed

Child's mean age in months		P Value
South Asian	White British	
8.2	8.3	Non significant

An independent samples t-test indicated that there was not a significant difference between the different groups in terms of mean age of first noticing a child's difficulties.

Mothers were also asked who first noticed that the child's difficulties. The results are shown in Table 21:

Table 21: Person first noticing the child's difficulties

Category	Number of mothers ascribing to each category		P value
	South Asian (n=10)	White British (n=10)	
Family member	8	5	0.175
Medical profession	2	5	0.175

Slightly more South Asian compared to white British mothers indicated that the child's difficulties were first noticed by a family member, although this difference did not reach statistical significance. Likewise, slightly more white British mothers than south Asian indicated that a member of the medical profession had picked up the difficulties; again this did not reach statistical significance.

Mothers were also asked to indicate how the child's difficulties had been identified. 9 South Asian mothers and 8 white British mothers indicated that difficulties or delay with one or more

aspects of the child's development (e.g. motor skills, language skills, feeding difficulties) had alerted them or a medical professional to the problem:

"I had concerns that he wasn't developing as quickly as other children. Mainly that he wasn't walking at 18 months old. He wasn't really responding to me or understanding me in the same way as other children. From this I knew there was definitely a problem." (SA 8)

"When he was about 1½, there was no walking and there was no 'dada dada'. I remember thinking to myself 'my other child was walking by this time'. I thought that something was definitely not right and so I mentioned it to my health visitor." (WB 4)

For the remaining south Asian mother, her child's epileptic fit and subsequent investigations by the hospital revealed the difficulties. For the remaining two white British mothers, birth complications and subsequent scans highlighted that developmental difficulties would be likely.

Following identification of the problem, half of the white British mothers, yet none of the South Asian mothers described how the process of acknowledgement and acceptance came much later on:

"When we left the hospital, we knew that there was something wrong with him logically. But it just didn't sink in until much later. The actual extent of his difficulties didn't really drop until last summer. You go on believing he will get better...it will just need a bit of intensive work and it will sort itself out. But you finally come to a stage where you think – no, it isn't going to get better." (WB 1)

"I noticed a lot of things were wrong with him at the back of my mind, but I kept telling myself that things would be OK. I don't think it was until much later on that it sank in...that he really had a problem". (WB 6)

"Although the doctor had told us there was a problem, I don't think we really faced up to it at that time. I mean...he looked fine. I used to think kids with a disability looked different and that you could pick up that there was a problem straight away. But to look at ours, we thought he was too good looking to have anything wrong with him. It took us a long time to realise". (WB 9)

Mothers' Sources of Initial Support

Mothers were asked to whom they first turned for support once they were aware of their child's difficulties. Responses were coded using thematic content analysis, which yielded two categories: family support and professional support. The frequency with which mothers' responses fell into the two categories are presented in table 22 below:

Table 22: Mothers' sources of initial support

Category	Number of mothers ascribing to each category		P Value
	South Asian (n=10)	White British (n=10)	
Family support	10	5	P<0.016**
Professional support	1	8	P<0.003**

**significant after Bonferroni correction

Quantitative analysis using Fisher's Exact Test indicated that significantly more South Asian mothers than white British mothers indicated the use of family support ($p<0.01$) in their responses. Family support included the assistance of partners, parents, in laws, siblings and extended family members:

"I turned to my husband and mother in law. She looked after my child...my mother-in-law was living with us at this time so she was able to look after him. We would always go to family first – you know, elders in the family." (SA 1)

In some cases, family members offered advice and suggested trying out an assortment of remedies to help with the child's difficulties:

"I turned to my sister-in-law and my mum. They came to the house regularly to give me help. So many people from the family have offered me support and advice. My mum told me to get a kind of oil to put on my baby to help him walk and she suggested I try giving him a special kind of grain for his wetting problem. I think these things really helped." (SA 6)

"My family were my main source of support. My sister-in-law told me that if I gave X some holy sugar, he will start to talk again." (SA 7)

Despite turning to family as initial sources of support, one South Asian mother and one white British mother described how their families' responses precluded any future requests for support:

"I turned mostly to my family for support. But I've come to realise I cannot ask them any more. My mum has high blood pressure and whenever she sees my child or asks about her, it stresses her out so much she needs to take another tablet. I just can't ask her for support any more." (SA 2)

"Initially I tuned to my husband and parents. My parents were rather...they just became very, very upset and stressed about it. It wasn't a great source of back up and I don't really like to burden them no because they get so upset about it". (WB 7)

In contrast, significantly more white British mothers than South Asian mothers indicated that they had turned to professionals for initial sources of support ($p < 0.003$). Professional support included the assistance of health visitors, CDC professionals and in one case, a dietician:

"It's difficult to remember now. It feels like such a blur in my life. My health visitor was actually really supportive. The hospital was too. It was definitely the professionals as opposed to family...Because of your child's difficulties you need support from people who will understand....Anyway, by the time you have spent most of your day talking to professionals, there isn't much time even to turn to anyone else because you have the other children to look after. Also, I didn't want to bother my friends because most people don't want to hear the same things over and over." (WB 1)

"I really turned to professionals for support, particularly as this was something I didn't really know too much about and neither did friends or family. I think most people who are British would turn to professionals first with this kind of problem." (WB 2)

Additional Sources of Support and Advice

Mothers were also asked to discuss all other aspects of support and advice offered. Table 23 shows different persons involved in offering support for each cultural group.

Table 23: Additional sources of support

Category	Number of mothers indicating each category of support		P Value
	South Asian (n=10)	White British (n=10)	
CDC involvement	10	10	n/a
Speech & language therapy	7	10	0.105
Occupational therapist	6	5	0.500
Physiotherapist	3	4	0.500
Paediatrician	8	10	0.237
Educational or clinical psychologist	2	2	n/a
Child psychiatrist	1	1	n/a
Social services	3	2	0.500
Portage	4	6	0.328
Voluntary & community support groups	2	3	0.500
Religious person	8	1	0.003**

**significant after Bonferroni correction

Fisher's Exact Test indicated that significantly more South Asian than white British mothers received and sought religious sources of support than white British mothers ($p < 0.003$). This difference remained significant after Bonferroni corrections.

Other mothers indicated that they had consulted religious leaders in order to receive chosen verses from the Koran for their child:

"Once we had found out what was wrong, we prayed and prayed. We took her to a religious elder. He gave us something from the Koran in a box and told us to put it next to her. I think my husband would have tried to get more help from a religious person if he could, but it is much more difficult here because not so many people share our religion." (SA 9)

"We've taken her to a religious person who gave her a little thing to wear around her neck. It contains something from the Koran. We sometimes take her to a religious person when she is going through a bad phase ...usually in the winter because it's darker and colder and she can't go out...and I pray and pray that she will get better. I go through phases of asking god 'why have you done this to us?' but then I know that it is god's wish and we must accept it". (SA 2)

Beliefs about the formal support offered

Mothers were asked to comment on unhelpful aspects of coming into contact with formal services for their child. The following themes emerged from the data: being kept in the dark, confusion and fear of the system, resource problems, battling for support and lack of an overview. The number of mothers indicating these themes is shown in table 24.

Table 24: Beliefs about formal support offered

Category	Number of mothers mentioning this theme		P Value
	South Asian (n=10)	White British (n=10)	
Being kept in the dark	5	6	0.500
Confusion and fear of the system	2	5	0.175
Battling for support	4	4	n/a
Resource problems	5	4	0.500
Lack of an overview	1	4	0.152

There were no significant differences between the two groups in relation to the number of mothers mentioning each theme.

Being kept in the Dark

This category included responses containing references to professionals not sharing or withholding information about the child or relevant resources. The responses of 5 South Asian and 6 white British mothers fell within this category.

The following quotes are illustrative of this category:

"Two months ago, I was really unhappy and angry because my child had this problem for nearly two years and I just wasn't ever really told what was wrong with him. Even if they had said to me at that time 'we are sorry, but we don't know', it would have been OK. But they kept calling me to this and that appointment, never explaining why or what they had found." (SA 9)

"Nobody told me what was going on at the beginning. We took X to an appointment and someone wrote down global developmental delay in his red book. No one bothered to explain to me what it meant. But I think mums need someone to sit down with them so that we can get an understanding too. It would be nice to know what they are saying about X because in these appointments, they will start saying something and then turn to their colleague and it's all in these long words. It all goes right over my head." (WB 4)

"Obviously they knew something was wrong with our child and that he was entitled to DLA, but we weren't told about it. It wasn't until my dad told me about it that I found out about it. He had all those hospital appointments and no-one ever mentioned it to me. Doctors...nurses...they didn't tell us anything. Even my health visitor – she didn't tell me anything, but then I hardly saw her anyway. (SA 3)

"Social services were useless. They never told me about any of the groups for children or anything. I wasn't told about benefits I could get or extra support I could get – nothing. It's always been up to me to find these things out for myself." (WB 1)

Confusion and fear of the system

This category contained statements about the support system around the child being difficult to understand and scary for mothers. Half of the white British mothers' statements compared to 2 of the South Asian mothers' statements fell within this category:

"I was so confused about the statementing process. They made it sound so serious and formal. It was actually quite scary. I mean, I am English, but for women who can't speak English I can imagine it must be quite frightening. It's so scary and horrible." (WB 9)

"The thing that surprised me was how complicated the system around the child is. The first few times you have contact with services is enough to put a person off because it can be so confusing. You need some information about the organisation

and the process you go through – things like what the different appointments are for and why you need them". (WB 2)

"I find the whole system really confusing. Why do you get a different service depending on where you live? In one area you might get an OT and in another area you don't. There should be a standard service for everyone...Also, I'm still not really sure what all the different professionals do." (WB 7)

Battling for support

This category contained references to the struggles faced by parents in accessing and receiving services. Having to constantly ask for resources and making endless telephone calls to no effect were among statements in this category. In some cases, mothers commented on how the only way to access support would be by creating a crisis (e.g. by handing over a child to social services). 4 South Asian and 4 white British mothers' responses fell within this category:

"Even now, there are things I want and you have to keep asking. Nothing is ever given to you – it's up to you to fight for it. It feels like a constant battle". (WB 10)

"We have asked for respite so many times now, but we keep getting told that our case is still being considered. I sometimes think the only way to get help is to give up completely and leave the kids on social services' doorstep". (WB 3)

"Getting into contact with people has been really difficult. You have to keep ringing and ringing and leaving messages. Half the time they don't ring you back. Or they leave. Why can't anything be straightforward? Everything is a struggle." (SA 5)

"I need a lift to take her up the stairs and a car parking space. I've been phoning now for 3 years. Every time they say it's under review. How can it take 3 years to review something! Why can't they just give you something? Why can't they make it easier for us? I'm starting to think the only way to get any help here is by going to social services and saying 'I can't cope...here, you take her'. Of course I would never do that but it's almost as if they are driving you to that point." (SA 2)

Resource Problems

This category contained statements about resource problems in relation to the following areas:

- Complete absence of support in a particular area;
- Not enough support in a particular area;
- Support offered was inappropriate (in that it didn't quite match the mothers' needs or was provided by an inappropriately qualified person).

5 South Asian mothers compared to 4 white British mothers' responses contained references to this category, as illustrated in the quotes below:

"We didn't get any kind of help at the beginning at all. The worst time is when your child has to go into hospital for all these tests. You are in a cubicle on your own. You have a chair and a cot and that is it. You're lucky if you get a TV. You are there on your own all day and it's rare that you get any kind of help. The doctor comes in for a few minutes, looks at your child and says 'see you tomorrow' and that's it." (SA 3)

"They have offered her a 6-week block of speech therapy. Once a week it is. How is this going to make any difference? They need something intensively – every day." (WB 7)

"They have offered me respite, but it isn't the type I need. They don't have that kind of support. I just need an hours support at short notice – someone to come here so that I can get on with my things. But the only type of support they offer is to take your children away for 2 or 3 days. I don't need this...I just want someone you can ring up and have them come over for a little while now and again". (SA 7)

"The people they have sent me from social services are definitely not able to look after your children because they haven't had the training. They once sent out this old lady and poor thing, I used to feel sorry for her. She told me she had a heart problem and diabetes and that she is living alone. I felt so sorry for her - how was I supposed to then ask her to clean my kitchen cupboards? And how on earth can an old lady with heart problems lift my daughter into a wheelchair? They need specially trained people to help you." (SA 2)

Lack of an overview

4 of the white British compared to 1 of the South Asian parents indicated that they felt that nobody held an overview of their child's case. Responses in this category contained references to mothers having to repeat information to professionals, being asked the same questions by professionals, professionals not reading all the reports or amalgamating all the information about the child:

"With the GP appointments or the hospital and CDC appointments, sometimes you think it's a waste of time. Like, every time we see the neurologist, they ask the same questions: Is she getting physio? Is she getting OT? How old is she now? And they look through the file and even read it while you are sitting there. They say the same things over and over and you start repeating the same things too. Surely they need to prepare themselves and read the reports rather than going through the same questions again and again. They need to bring together all the information and read it before they see you so that they know what is going on. That way you would feel that someone really knows your child and wants to support you." (SA 2)

"You need someone in charge of your case who tried to keep an overview of what is going on. It gets so frustrating when you have to repeat the same things over and over. You know, the junior doctor will tell you your child's got a urine infection, but

you have to tell him to look at the notes because they have told you that before and it's turned out to be something completely different.” (WB 6)

“Someone needs to hold an overview of the child. Even if the information is pulled together on a database would be better than nothing. Otherwise you end up having to tell all the different professionals the same things all the time. I remember one parent telling me that she thought the medics kept asking the same questions all the time because they were trying to catch her out”. (WB 2)

Summary

This section described the results relating to mothers' beliefs about developmental delay and their experiences of the associated support services. The age at which the child's difficulties were initially picked up was roughly comparable between the two cultural groups. There were no differences between the cultural groups in terms of who first noticed the difficulties (member of the medical profession versus family member). In describing the child's difficulties, significantly more white British compared to South Asian mothers used medical terminology and labels. White British mothers were also more likely to give a biological explanation of their child's difficulties. Psychological and spiritual explanations were also given by parents, although the cultural groups did not differ in the number of mothers in each category. Several parents indicated that they had not received any clear explanation for their child's difficulties. South Asian mothers were significantly more likely to turn to family as a source of initial support, whereas white British mothers were significantly more likely to turn to professionals. South Asian mothers and white British mothers were comparable in their receipt of the standard statutory and voluntary services (e.g. CDC involvement, paediatrician involvement). However, South Asian mothers were significantly more likely to consult a religious person in relation to their child's difficulties. Both South Asian and White British mothers identified several aspects of formal support services which were unhelpful. These aspects included 'being kept in the dark' (i.e. not being told enough about a child's difficulty or the resources available), 'confusion about and fear of the system' (i.e. not understanding the process or the role of the professionals), 'battling for support' (i.e. having to constantly push for assistance in the face of set-backs and disappointments), 'resource problems' (i.e. inadequate or inappropriate resources) and a lack of an overview' (i.e. an absence of

someone responsible for pulling together information to avoid duplication and repetition for mothers).

CHAPTER 4 ~ DISCUSSION

Overview

This study aimed to explore differences between white British and South Asian mothers' beliefs about child development and parenting practices. Differences between the two cultural groups in terms of beliefs about developmental delay and support services were also investigated. There were four main research questions:

1. Are there differences between white British and South Asian mothers' beliefs about typical child development?
2. Are there differences between white British and South Asian mothers' beliefs about parenting practices and their role in supporting a child's development?
3. Are there differences between white British and South Asian mothers in terms of the factors which influence ideas about child development and parenting?
4. Are there differences between white British and South Asian mothers' beliefs and experiences of having a child with developmental delay and support offered?

Interviews with 10 South Asian mothers and 10 white British mothers of a child with global developmental delay yielded rich qualitative and quantitative data which addressed the research questions. The results of this study pose clear practice implications for child development and learning disability services in the UK, which serve increasingly culturally diverse communities. This chapter is divided into 4 parts. Firstly, the results of the study will be discussed in relation to the 4 main research questions and the existing literature. Secondly, methodological issues relating to strengths and weaknesses of the study will be explored, together with ideas for future research. Finally, the clinical implications of the study will be addressed alongside suggestions for improving practice.

Are there differences between white British and South Asian mothers' beliefs about typical child development?

Mothers' Developmental Expectations

Mothers were asked whether or not they expected a child of 6-months, 1 year and 3 years to have acquired a set of pre-determined developmental skills. Results indicated that South Asian and white British mothers' developmental expectations were very similar in most domains. As indicated in Chapter 1, there has been only one previous study comparing the developmental expectations of South Asian and white British mothers. In this study, South Asian mothers were found to have significantly later expectations for the development of a whole range of developmental skills compared to Japanese and English mothers (Joshi and MacLean, 1997). Psychoanalytic writers have similarly commented on South Asian mothers' later developmental expectations (Roland, 1988). Kakar (1978), for example, observed that:

"An Indian mother is inclined towards a total indulgence of her infants' wishes and demands, whether these be related to feeding, sleeping, cleaning or being kept company. Moreover, she tends to extend this kind of mothering well beyond the time when the "infant" is ready for independent functioning in many areas...The Indian toddler takes his own time learning to control his bowels, and proceeds at his own pace to master other skills such as walking, talking and dressing himself" (p. 81)

There are a number of explanations as to why the results of the present study appear to differ from those reported by Joshi and McLean (1997) in a previous study. Firstly, it was some time since Joshi and MacLean (1997) conducted their study. It is possible that the current situation is different and few differences between white British and South Asian mothers' developmental expectations may now exist. Certainly, since the 1990s some South Asian societies, such as India, have undergone tremendous economic change (Srinivasan and Karlan, 1997). Economic change often results in social change, especially as reflected by how society views children (Alwin, 1989). Secondly, Joshi and MacLean (1997) compared mothers living in India with mothers living in the UK. South Asian mothers in the present study, however, had been living in the UK for an average of 10.1 years. It is likely that the process of moving to the UK and coming into contact with British ideas about child development, child development services and professionals (amongst other factors) modifies

mothers' developmental expectations. The fact that all the mothers in this study had a developmentally delayed child and are therefore likely to have been exposed to discussions about child development from a Western viewpoint, lends weight to this hypothesis.

The extent to which South Asian families, like any other members of an immigrant population, acculturate and adapt beliefs and attitudes to the majority culture, whilst at the same time retaining their own cultural identity has been a topic of interest in recent years (e.g. Cote and Bornstein, 2003; Farver and Yoolim Lee-Shin, 2000). Researchers have identified four ways ethnic group members can associate with their host culture. Individuals can assimilate (identify solely with the dominant culture and sever ties with their own), marginalize (reject both their own and the host culture), separate (identify solely with their own group and reject the host's culture) and integrate (become 'bicultural' by maintaining characteristics of their own ethnic groups whilst selectively acquiring those of the host culture) (Berry, 1980; Berry *et al.* 1989). The fact that parents in the present study had very similar developmental expectations regardless of cultural background may suggest that South Asian mothers might be described as having assimilated, or at least integrated into white British culture.

In relation to South Asian families, there has been one study which investigates whether Indian mothers living in the United States exclusively retain traditional Asian parenting expectations and attitudes (separation) or whether they adopt a belief system which is more reflective of European American parenting attitudes as a result of living in a predominately European American society (assimilation). In this study, Jambunathan and Counselman (2002) found that the Indian mothers, who had lived in the United States from between four and five years, were less likely to have 'unrealistic expectations' for their child's development than mothers still living in India. Parents' expectations were measured via the 'developmental expectations' subscale of the Adolescent-Adult Parenting Inventory (AAPI, Bavolek, 1984). This measures whether or not parents are realistic in their developmental expectations of their children (e.g. "Children should be able to express themselves verbally before the age of one"), as defined by the cultural norms of the scale. The results suggested that for the Indian mothers who had moved to the United States, there was a shift in their developmental

expectations towards those of the dominant culture. The same may be true for the current study: South Asian mothers in the UK may similarly adapt their beliefs and expectations about child development as they are exposed to the beliefs held by the majority culture. This may be the case even more so for mothers with developmentally delayed children, since they come into contact with a range of child development professionals who are likely to discuss developmental issues from a Western viewpoint. Such high frequency discussion and consideration of Western approaches to child development may play a role in shifting the belief systems of South Asian mothers.

However, not all the South Asian mothers' developmental beliefs in this study were reflective of white British mothers' beliefs. Although these results did not reach statistical significance after controlling for multiple tests, there were slight differences between the mothers in terms of beliefs about the age at which children begin to play with peers and start toilet training. The fact that some of the South Asian mothers' beliefs resembled those of white British parents, whilst some resembled those of their culture of origin suggests that the process of acculturation is not a uniform, 'all or nothing' process whereby immigrant groups are either fully assimilated, separated, marginalized or integrated. Instead, the process may be much more complex, evolving and dynamic, with different beliefs retained, modified or rejected at different points and under different circumstances. In a recent study comparing parenting cognitions (self-attributions and self-perceptions) of Japanese and South American immigrant mothers with those of Japanese, South American and European American mothers, Bornstein and Cote (2004) found that the extent to which different parenting cognitions acculturated varied. Some cognitions closely resembled those of the culture of origin, whilst some resembled those of the culture of destination and some were intermediate. In a similar fashion, in the present study, some South Asian mothers' beliefs about child development were remarkably similar to those of white British mothers, whilst others appeared to differ, and perhaps reflect the beliefs of their country of origin.

More South Asian mothers than white British mothers, for example, indicated that they expected a 6-month old to start to play with peers. This differs considerably from Western

stage-models of play. Within Parten's (1933) framework, becoming aware of, and joining in with peers is assumed to be a much later stage of play, which is generally not achieved until 2 to 3 years of age. However, this model does not accommodate contextual and cultural differences (Roopnarine and Johnson, 1994). It has been reported, for example, that children from non-Western cultures demonstrate an interest in peers from a much younger age (Howes and Matheson, 1992) and this has been linked to differences in family organisation. The fact that 70% of South Asian mothers in this study expected at least some evidence of this skill at 6-months may relate to Hyun's (1998) suggestion that children from Asian backgrounds typically receive more and earlier child/child play opportunities than European and American children. Children within Asian families are more likely to be raised within an extended family environment (Ranganath and Ranganath, 2001). In these environments, people are constantly present and infants seldom sit alone and play with objects (Rogoff, 2003). Bardsley and Perkins (1985), for example, found that Asian families using Portage were less likely than white families to have manufactured toys in the home. Rather, children spend more time oriented to the group (Paradise, 1994). Within this socio-cultural context, where social exchanges are frequent, developing knowledge of others before knowledge of the self may be an inevitable developmental phenomenon (Hyun, 1998).

The results of this study also indicate that 50% of the South Asian mothers compared to none of the white British mothers expected toilet training to commence at 1 year. This finding is consistent with figures reported by Pathania and Chaudhary (1993) who found that over half of the Indian mothers in their study indicated that the ideal time to commence toilet training was between 6 months and 1 year. Rogoff *et al.* (1993) similarly observed that the majority of children aged between 12 and 24 months in a tribal village in India were fully toilet trained by day, a factor which has been linked to non-availability of nappies. These figures contrast with the mainstream advice appearing in popular child-care manuals and texts in the United States and the UK. Stoppard (1998) and Herbert (2003), for example, suggest that bladder and bowel control rarely begins before the age of 18 months, and in many cases, is much later than this. In a study of 706 3-year olds living in an outer London borough, Weir (1982) found that 55% of boys and 40% of girls did not have complete bladder control at night. The fact

that in this study, South Asian mothers and white British mothers had different beliefs about the age at which toilet training should typically commence may suggest that South Asian parents retained some of the ideas and traditions from their culture of origin. In part, these ideas may have been linked to the need for a child to become toilet trained as early as possible in order to fulfil religious duties (cleansing oneself before offering prayers). These findings have important clinical implications in that South Asian and white British parents may attach different levels of significance to the development of early toileting skills. Parents may also differ cross-culturally in relation to ideas about what constitutes 'delayed' toileting skills. Professionals need to be cautious in applying Western normative beliefs to families from non-Western cultures.

Importance of different developmental skills

Mothers in this study were also asked to indicate which skills they considered to be most important for a child of 6-months, 1 year and 3 years. Researchers have consistently found that mothers attach different values to different skills and vary in their efforts and timing in relation to promotion of these skills (e.g. Edwards, 1994; Super and Harkness, 1997). In the present study, significantly more white British mothers compared to South Asian mothers emphasised the importance of self-help skills (feeding self, dressing and undressing) for 3-year old children. The value placed upon self-help by white British mothers is consistent with the characterization of European and American values as emphasising individualism and independence (Harwood *et al.* 1990, 1995; Kagitcibasi, 1996; Strauss, 2000). Amongst middle class European American parents, independence has been identified as being one of the most important long-term goals for children (Richman, Miller and Solomon, 1988). In contrast, families from Asian cultural backgrounds emphasise and encourage interdependence (Hyun, 1998) and therefore may not place the same importance on early development of self-help skills. Sharma (1984) and Standing (1991) even go so far as to suggest that South Asian mothers are not under such pressure to foster early independence because the responsibility for child-care is shared with other female members of the extended family.

However, the fact that the present study also showed that there was a high level of concordance between the two groups both in terms of developmental expectations for children and in terms of the types of competencies valued, suggest that the individualism and collectivism dichotomy is not as straightforward as originally thought. Rather than dichotomising the South Asian group as sharing collectivist cultural belief systems and the white British group as sharing individualist belief systems, the study suggests that both types of belief systems may co-exist to some degree within both groups, depending on the skills, goals or competencies being investigated. Indeed, emerging evidence from cross-cultural research seems to support this assertion. Suizzo (2004), for example, found that French mothers and American mothers valued both individualistic goals for their children (such as autonomy and self-confidence), and collectivist goals (such as group conformity). Influences from the mass media, education and migration may further complicate the picture such that groups can no longer be differentiated according to these dimensions.

Differences in competencies according to a child's sex

The current study also investigated whether or not parents expect differences in children's developmental competencies according to their sex. The results suggest that significantly more white British mothers than South Asian mothers expected to see gender differences. Specifically, white British mothers expected girls to show advanced social and communication skills in comparison to same age boys. In contrast, they expected boys to have greater agility, motor and co-ordination skills. These expectations are consistent with studies which show that pre-school girls are slightly ahead of boys in terms of early vocabulary growth (Fenson *et al.* 1994; Jacklin and Maccoby, 1983) and that pre-school boys are slightly ahead of girls in motor skills that emphasise force and power (Berk, 1998). Researchers have also often found that parents differentiate between males and females in terms of the types of skills they encourage or even hinder (Lindsey, 1990). Nasser (2002), for example, found that European mothers rated the following skills as being more important for girls than boys: compliance, politeness, independence, school skills and cultural skills (knowing one's own history and cultural traditions). Keats (1997) also noted that despite the recently emerging strength of the feminist movement in Western societies, the traditional forms of separate

gender roles remain dominant. Some parents, for example, feel that appropriate gender roles should be developed as early as pre-school. They may express concern if they think that correct behaviour is not being encouraged (i.e. if boys are permitted to play "house" and girls are permitted to play with cars or take part in boisterous outside games) (Keats, 1997).

The fact that few South Asian mothers indicated that they would expect to see a gender difference is perhaps a little surprising. Although to the best of the author's knowledge, there have been no previous studies addressing whether or not South Asian parents living in the UK have different developmental expectations for males compared to females, members of South Asian families have been shown to assign clear gender roles. Male children, for example, are socialized to be decisive whilst girls are socialised to become more passive (Ranganath and Ranganath, 2001). In the present study, this was illustrated by a mother who described how women and girls have to seek permission from males as to whether they are allowed to have their hair cut. Traditionally, within Asian culture, males tend to be valued more than females because they carry the family name. In an early study of infant behaviour in Western Bengal, Graves (1978) noted that mothers interacted more with their sons than their daughters. Verma (1995) explained that less interaction with a female child occurs because they are viewed as temporary members of the household who will move away:

"An unmarried girl is a guest in her parents' home and an unmarried girl is like a bird sitting in the branches of the tree in her father's courtyard, ready to fly to her husband's home". (Verma, 1995, p.138)

The extent to which this is true for South Asian families living in the UK is not known. The results of the present study, at any rate, showed that South Asian parents only mentioned differences in relation to the status of males versus females but did not mention any differences with respect to skills and competencies.

Are there differences between white British and South Asian mothers in terms of the factors which influence ideas about child development and parenting?

Mothers were asked to identify the factors which had been important in contributing to their ideas about child development and parenting. Mothers viewed the following sources as important: family, friends, culture, professional advice, books and media and religious beliefs. There were marked differences between the two cultural groups in terms of the numbers of mothers identifying each category as important. Significantly more white British mothers than South Asian mothers indicated that friends, professionals and books and media were important factors in shaping their beliefs and practices. Although there have been few studies in this area, those that exist have also highlighted the importance of these factors for European or American parents. Ateah (2003), for example, found that Canadian parents turned mainly to other parents, their own parents, parenting books and television for parenting advice. A few studies have reported how American mothers also turn to professionals for advice (e.g. Angeli, Christy, Howe and Wolff, 1994; Hickson, Altemeier and O'Conner, 1983; Klar and Coleman, 1995; Scultz and Vaughn, 1999). Parents from Western backgrounds have also been found to rely on parent training books, magazines, websites, videotapes, television and radio shows designed to address general and specific aspects of parenting (Young, Davis, Schoen and Parker, 1998; Glascoe, Oberklaid, Dworkin and Trimm, 1998).

Very few South Asian mothers in this study indicated professional advice as being an important source of parenting and child-care information, despite the fact that all mothers were connected to child development and other health services. A possible explanation for this is that South Asian mothers were perhaps unaware of the type of advice and services that might be available. Hatton *et al.* (1998), for example, found that few South Asian carers of children with learning disabilities knew what services were available. In addition, South Asian mothers may have had negative experiences of accessing advice. Baxter *et al.* (1990), for example, reported that South Asian women tend not to use maternal health care services because they perceive these as culturally inappropriate and unwelcoming. The quality of care offered by midwives and GPs to South Asian women has also been shown to be affected by

negative stereotypes (Ahmad and Jones, 1998). Mir *et al.* (2001) suggest that parents' concerns are sometimes dismissed by practitioners and this situation is exacerbated by poor standards of communication and the use of non-professional interpreters (Azmi *et al.* 1996a; Baxter, 1998; Butt and Mirza, 1996). Such explanations may account for the low reliance on professional advice amongst South Asian mothers in relation to child development and parenting. However, another possible explanation relates to the fact that for South Asian mothers, other influences may be much more important or that South Asian mothers may have more ready access to other sources of advice and support than their white British counterparts. For example, significantly more South Asian women in the present study indicated that family provided a more important source of parenting information compared to professionals, books and media. Qualitative data indicated that South Asian mothers emphasised the role of their own mothers, mothers-in-law and the extended family in providing such information. In a study of motherhood and social support involving South Asian mothers living in East London, Bhopal (1998) also highlighted the importance of immediate and extended family in offering support in relation to child rearing. The tendency for South Asian mothers to identify family as being an important influence in providing information about child development and parenting may therefore represent a cultural tradition and possible preference. (Although this does not mean that identified short-comings of services should be underestimated). Hewlett and Lamb (2003) describe this practice as representing the 'vertical transmission' tradition in which ideas about child development and parenting are passed on via parents. The approach contrasts with the 'horizontal transmission' tradition which is perhaps more reflective of white British and North American culture and involves passing on ideas via unrelated individuals and mass media.

Another interesting finding in the present study was the fact that significantly more South Asian mothers than white British mothers indicated religion as being an important factor in shaping parenting beliefs and behaviours. As Nydell (1987) writes, the Koran contains doctrines which guide Muslims to 'correct' behaviours and guides an entire way of life and thinking. In the present study, religious beliefs contributed to the way in which women saw their role as a mother. Giving up or putting back a career and offering complete devotion to

the child were viewed as essential ingredients of motherhood. Ranganath and Ranganath's (2001) description of Muslim and Hindu South Asian women similarly emphasises how the primary role of the mother is to care for her children often at the cost of giving up her own needs and ambitions. Another aspect of Muslim religion mentioned by South Asian mothers in the study related to incorporating religious education into the child's routine. Religious education was viewed as being of similar importance to academic education. Even language development appeared to be connected to religious ideas with mothers indicating that the first sounds made by an infant are attempts to say "Allah". Once an infant is able to make this sound, this is believed to 'open up the baby's tongue for language'. Although, to the best of the author's knowledge, previous research has not described these beliefs amongst South Asian women living in the UK, it is clearly an interesting area for further follow-up, since attention to religious beliefs and practices is an important aspect of ensuring quality and sensitivity in service delivery by child development professionals.

Are there differences between white British and South Asian mothers' beliefs about parenting practices and their role in supporting a child's development?

Mothers were asked to discuss the various strategies and beliefs surrounding a child's development of language, toileting and co-operative play skills. They were also asked to discuss the persons that might be involved in supporting these skills.

Development of language skills

Mothers mentioned a range of strategies involved in supporting a child's language development, including: talking to the child, simplifying language, allowing the child to acquire language naturally, making eye contact, using gestures, playing with the child and directly teaching the child to pronounce words. There were no differences between South Asian mothers and white British mothers in terms of the numbers identifying each strategy. This implies that South Asian and white British mothers have similar beliefs about how to support a child's language development. Interestingly, the strategies identified closely parallel the social interactionist perspective of language development (Bohannon and Bonvillian 1997) used by

speech and language therapists and other health professionals. The social interactionist perspective purports that language development is facilitated by: (1) contingent language input that is semantically related to the child's previous attempts to communicate, and (2) simplified language input that models comprehensible, short and less complex language structures. A number of studies have shown how these strategies promote the development of linguistic competence, particularly in children with language delays (e. g. Nelson *et al.* 1996). The social interactionist perspective of language acquisition has given rise to numerous intervention programmes that instruct parents how to facilitate language development during naturalistic, daily activities. Examples of these programmes include the Transactional Intervention Program (Mahoney and Powell 1986) and The Hanen Program for Parents (Manolson, 1992). It is possible that the fact that the majority (85%) of mothers in this sample had received speech and language therapy input for their child may account for the striking similarity between mothers' responses and the type of advice offered by professionals. Furthermore, the results may also imply that through contact with professionals, South Asian mothers incorporate ideas about child development which are reflective of Western models and traditions.

Toilet training

There were a number of significant differences between South Asian mothers and white British mothers in terms of their beliefs about toilet training. Although both South Asian and white British mothers indicated that parents' need to put into place a number of strategies to encourage toileting skills (e.g. taking the child to the toilet regularly, demonstrating using a potty), mothers differed in terms of when toilet training is expected to start and the types of factors which might encourage a parent to start toilet training. For example, 80% of the South Asian mothers compared to none of the white British mothers emphasised that training should commence when a child has recognised that they feel dirty. The fact that so many mothers in the study made reference to a child's sense of dirtiness may be connected to the importance placed upon cleanliness within Islam. Within the religion the prophet Mohammed is said to have stated, "being clean is half of religion". Muslims regularly perform 'Wudu' (an Arabic term referring to ritualistic washing) before they pray in order to ensure they are pure (see

Wolfe, 1998). As one mother in the present study indicated, it is important that children are toilet trained so that they can be in a pure and clean state when they offer their prayers.

In contrast, significantly more white British mothers (70%) compared to South Asian mothers (0%) indicated that toilet training should commence 'when a child is ready'. This theme is consistent with the advice prevalent in many of the popular American and British parenting manuals (e.g. Spock, 1995; Stoppard, 1998; Herbert, 2003). Some of the parents in the present study indicated that they felt that pushing a child into potty training before it is ready causes psychological harm. These beliefs parallel those of those white American mothers interviewed by Schulze *et al.* (2002). American mothers in this study also spoke of the harmful consequences to the child of premature toilet training. However, despite the overwhelming preponderance of the belief that toilet training too early leads to subsequent psychological problems, there is very little evidence to substantiate this belief. In a recent study conducted in the United States researchers found no benefits for starting toilet training before 27 months of age, but also found no association between earlier initiation of intensive toilet training and later problems (Blum, Taubman and Nemeth, 2003).

Another finding in the present study was that mothers differed cross-culturally in their use of reward strategies in order to encourage a child to use the potty or toilet appropriately. None of the South Asian mothers identified behavioural reward systems as being an important aspect of toilet training, compared to 80% of the white British mothers. Offering rewards and developing reward systems for supporting the development of children's skills is an idea drawn from western behaviourist approaches. The concept of using reward systems may be consistent with a worldview which emphasises personal goals and individual achievement. These attributes are valued within individualistic societies, such as Europe and the United States (e.g. Bellah, Madsen, Sullivan, Swindler and Tipton, 1985; Hsu, 1983; Kagitcibasi, 1994; Triandis, 1995). Within collectivist societies (such as Asia), there is less emphasis on the individual, which may suggest that there is little use for reward systems to promote individual achievement. Although (to the best of the author's knowledge) these ideas have

not been systematically studied, they highlight important areas of further research and have important clinical implications (see below in the section entitled 'Clinical Implications').

Persons involved in supporting a child's development

Parents, friends, extended family, school/nursery and professionals were all cited as being important persons involved in supporting a child's development. Significantly more South Asian mothers indicated that extended family were important in supporting a child's development compared to white British mothers. This is consistent with Ranganath and Ranganath's (2001) description of Indian parents living in the United States and Bhopal's (1998) study of South Asian mothers living in the UK. In Bhopal's (1998) study, involvement from the extended family was hierarchical. South Asian mothers indicated that the mother-in-law (who either lived with the mother or close by) exerted the most powerful influence, followed by the mother of the child. Sister(s)-in-law, followed last in the hierarchy. The finding that child care and support is shared with a number of adults in the extended family suggests the need for professionals to carefully consider the extended family in designing and implementing intervention programs (Goldbart and Mukherjee, 1999; O'Hara, 2003). However, professionals should not assume that South Asian parents can draw on support from the extended family. Faust (2003) found that South Asian parents of a child with learning disabilities respond with anger to the common assumption that they are in receipt of such support:

" I was so angry with the GP because he used to say Oh you have this extended family, this wonderful family who are there for us beck and call. But the reality is that they are not. They are more of hindrance." (Faust, 2003; p.80)

It is thus important for professionals to respectfully enquire about the availability and role of extended family members, rather than perpetuating common misunderstandings and stereotypes.

Are there differences between white British and South Asian mothers' beliefs and experiences of having a child with developmental delay and support offered?

Research has demonstrated that families vary cross-culturally in terms of their understanding of and the meaning attached to a family member's learning disability (e.g. McGrother *et al.* 2002; Fatimilehin and Nadirshaw, 1994; Reading, 1999). Families also differ in terms of their experiences of support services (e.g. Hatton *et al.* 2002) and their support-seeking behaviour (e.g. Fatimilehin and Nadirshaw, 1994). Following on from these studies, the current research investigated differences between mothers' understanding and explanations of their child's global developmental delay. Differences between the two cultural groups in relation to the process of identifying the difficulties were also investigated, as were mothers' sources of support and beliefs about formal support services offered.

Mothers' Understanding of Global Developmental Delay

Differences between the two cultural groups emerged in terms of *how* mothers described their child's difficulties. White British mothers were much more likely to include medical or diagnostic labels in their descriptions than South Asian mothers (i.e. use the term 'global developmental delay' or mention an actual diagnosis such as cerebral palsy). On the other hand, South Asian mothers tended to describe their child's difficulties in terms of the functional loss of skills without using medical or diagnostic terms. A number of possible explanations for these differences exist. Firstly, South Asian mothers may not understand the medical and diagnostic terms used by professionals and may therefore be less likely to describe their child's difficulties in these terms. Although not investigated in the current study, this may be related to the language used and information given during the disclosure process. Hatton *et al.* (2003), for example, found that most disclosures to South Asian parents of a child with a learning disability were conducted in English, despite this being the preferred language of only a minority of their sample. 20% of parents in their study indicated that the language used was difficult to understand and 26% indicated that it had been quite technical. The South Asian mothers in this study may also have experienced the disclosure process as being difficult to understand and may not have taken on board the actual medical or

diagnostic terminology. Another explanation may relate to the fact that parents are not fully informed about their child's difficulties (perhaps because of false assumptions or stereotypes held by the medical profession). Some studies suggest, for example, that prenatal diagnosis is sometimes withheld from Muslim families on the assumption that they will not consider termination of pregnancy (O'Hara, 2003). Furthermore, even when parents are given an explanation of their son or daughter's difficulty, South Asian parents are less likely than white British families to receive an explanation in medical terms (Fatimilehin and Nadirshaw, 1994). Finally, medical terms may be absent from South Asian mothers' descriptions because the use of diagnostic labels and medical terms is a predominately Western concept and practice. Many non-Western medical systems incorporate spiritual and supernatural elements and problems are not viewed simply in physical or bio-medical terms (O'Hara, 2003). For example, the Hindu concept of Karma is often interwoven into explanations of learning disability (or any other disability) (e.g. O'Hara, 2003; Fatimilehin and Nadirshaw, 1994). Middle Eastern cultures may regard disability as a punishment from heaven, emanating from the spirits or caused by the 'evil eye' (Danesco, 1997) and hence may be more likely to describe their son or daughter's difficulties in these terms.

Mothers' Understanding of the Cause of Global Developmental Delay

The results of this study showed that mothers gave a variety of explanations for the cause of their child's disability, including biological causes, psychological causes and spiritual causes. In some cases, mothers could not give a causal explanation for their child's difficulties. This finding is consistent with research conducted by Wong *et al.* (2004) who found that many parents of children with developmental disabilities in China lacked information about their child's difficulties and were unable to account for causative factors. Additionally, in the present study, significantly more white British mothers gave a biological reason for their son or daughter's difficulty compared to South Asian mothers. These differences are consistent with those reported by Fatimilehin and Nadirshaw (1994) and, as previously discussed, may relate to the quality of the disclosure process (Hatton *et al.* 2003). Good practice in disclosure includes prompt disclosure, disclosure occurring in the appropriate language, clear information about a child's disability and information about the practical implications of this for

the family. Disclosure should also be conveyed in an emotionally supportive way and with both parents present (if possible). The process should result in the appropriate provision of support services (Hatton *et al.* 2003). These practice guidelines are similar to those for white British families (Sloper and Turner, 1993a), with one exception. For South Asian parents, there is the need for disclosure to occur in the appropriate language (Hatton *et al.* 2003; Shah, 1998). In relation to the current study, it is possible that parents did not receive a biological causative explanation in the appropriate language (reflecting the often described lack of professional interpreters (e.g. Mir *et al.* 2001)) and therefore were much less likely to be able to describe their son or daughter's difficulties in these terms.

In addition, as previously discussed, differences in approaches to medicine may account for some of the differences between groups in the current study. Whilst American or European conceptualisations are often based upon biological explanations, Asian approaches are often related to religious or spiritual explanations (O'Hara, 2003). Several South Asian mothers in the present study did, indeed, offer spiritual explanations for their child's difficulties. However, so too did the white British mothers, who tended to emphasise a duality of beliefs. On the one hand (and often during periods of distress), they believed their child's difficulty had been caused by spiritual factors (e.g. they viewed their child's difficulty as representing a punishment from god for something they had done in a former life). On the other hand (often during more 'rational' or 'logical' moments), they believed their child's difficulty had a biological cause. This is consistent with Danesco (1997) who found that parents hold onto both biomedical/physical causes for their child's disability alongside socio-cultural beliefs, which are related to supernatural, magical, spiritual and religious factors.

Identification of the child's difficulties: when, who and how

In the present study, there was no significant difference between cultural groups in terms of the mean age of identification of the child's difficulties. This is perhaps surprising given that findings suggest South Asian parents receive a diagnosis later than white parents (Mir *et al.* 2001). A later diagnosis could be taken to imply that there is a delay in recognition of the child's difficulties. Previous researchers have pointed out that differences between cultural

groups in terms of parents' normative expectations for a child and parents' beliefs about which behaviours constitute a delay or difficulty, may affect recognition and diagnosis of developmental delay (Valdivia, 1999), as well as uptake of services. However, the fact that this study demonstrated that South Asian parents hold very similar normative expectations for child development compared to white British counterparts, suggests that the age at which parents of both cultural groups identify a difficulty will be comparable.

Similar numbers of South Asian mothers compared to white British mothers indicated that a family member had identified the difficulties (usually the mother). Similar numbers of South Asian mothers compared to white British mothers indicated that a member of the medical profession had first identified the difficulties. Although there were no differences between the groups in terms of the persons first noticing the child's difficulties, differences existed within the groups. More South Asian mothers indicated that the problem was first noticed by a family member rather than a member of the medical profession. This is consistent with the view that Asian families tend to solve and discuss family problems in privacy and may not turn to the assistance of outside professionals until the problem can no longer be contained within the confines of the family (Ranganath and Ranganath, 2001). Concerns by South Asian parents' that they will not be taken seriously by professionals (Mir *et al.* 2001) may also contribute to the tendency to keep problems within the family.

Finally, in relation to *how* the difficulties were first identified, most South Asian mothers and most white British mothers indicated that difficulties or delay in one or more aspects of the child's development had alerted them or a medical professional to the problem. Again, this links to findings from the first section, which indicate that parents from both cultural groups hold similar ideas about normative child development and are thus likely to have similar ideas about what constitutes a delay or difficulty (perhaps with the exception of a few skills, which *do* appear to be different for the cultural groups, such as becoming toilet trained and the development of self-help skills).

Interestingly, in describing the identification and recognition of the problem, half the white British mothers, yet none of the South Asian mothers described how the process of acknowledgement and acceptance of their child's difficulties (if at all) came much later on. Certainly, the diagnosis of developmental delay or learning disability brings with it a series of complex reactions. Within the learning disability literature, there is now a widely recognised series of psychological stages through which parents pass, reflecting their grief at the loss of the anticipated idealised child (Bicknell, 1983). Denial of reality is common, ranging from short-term inability to understand the news (shock) to long-term denial of the child's needs and abilities. Indeed, in the present study, some mothers indicated that despite "knowing" on a logical level that their child had a difficulty, this knowledge was pushed to the back of their minds as if it wasn't really true. The fact that none of the South Asian mothers described this process may reflect the findings that some cultural groups may not feel comfortable being overly expressive or talkative about difficulties outside the family unit (Chae, 2002). Families from collectivist cultures, for example, may not admit to problems or struggles they are faced with because they do not want to bring shame on the family (Chae, 2002). Literature regarding beliefs about mental illness, for example, has found that community stigma in Pakistani Muslim and Indian Hindu groups, results in a preference for private coping strategies (Cinnirella and Loewenthal, 1999). Thus, in the present study, the fact that none of the South Asian parents made reference to struggling to come to terms with the diagnosis may be linked to fear of stigma or shame in front of the interviewer. In Faust's (2003) study of parents of adolescents with a learning disability and a mental health problem, shame was a significant factor in deterring families from seeking outside professional help. Amongst ethnic minority families of a person with a mental illness, fear of stigma has also been linked to their tendency to keep problems private (Cinnirella and Loewenthal, 1999). Therefore it is possible that in this study, shame and stigma prevented South Asian families from being able to talk comfortably about the full extent of the difficulties, which accompany acknowledgement and coping with a child's developmental disability.

Mothers' Sources of Initial Support

Mothers were asked to indicate to whom they first turned for support. Significantly more white British mothers than South Asian mothers indicated that they had turned to professionals for support. Again, the low tendency for South Asian mothers to seek professional support is consistent with previous research (e.g. Faust, 2003) and may indicate a preference for trying to solve problems in private (Ranganath and Ranganath, 2001) and perhaps an avoidance of shame associated with learning disability (Chae, 2002). However, the findings may also indicate a failure by professionals to make services available and appropriate for ethnic minority groups. Firstly, parental awareness of specialist services has been found to be low (e.g. Mir *et al.* 2001) and therefore, South Asian parents may be much less likely to turn to professionals as an initial source of support. Secondly, language barriers may prevent ethnic minority parents from doing so. The majority of South Asian parents of a person with a learning disability are not able to speak, read or write English (Baxter *et al.* 1990; Hatton *et al.* 2002, Chamba *et al.* 1999; Mir *et al.* 2001). Many of the mothers in the study would have received their child's diagnosis very shortly after moving to the UK. At this time, their proficiency and confidence in their English language abilities may not have been as great. This may have prevented them from turning to English-speaking professionals as their first source of support. At any rate, Bhugra (2002) noted that using a second language can block thoughts and emotions. Thus, talking to professionals who do not share one's first language may not be as helpful as talking to a family member who shares the same language and meanings.

Additional Sources of Support

Mothers were also asked to discuss the other persons involved in offering support. Results indicated that in most areas, there were no differences between the cultural groups in terms of the types of support sought and accessed. Most mothers had received input from the typical range of health professionals, including the Child Development Centre, speech and language therapy, psychology, psychiatry, physiotherapy, occupational therapy, paediatrics, social services, portage and voluntary/community support groups. There was, however, one area in which South Asian mothers differed from white British mothers and this was in their

significantly increased tendency to consult a religious person in relation to their child's difficulties. Again, this finding is consistent with Fatimilehin and Nadirshaw's (1994) findings that half of their Asian sample had taken their son or daughter to a religious person to be healed. The finding that South Asian mothers in this study eventually sought help from healthcare professionals *and* religious persons is similar to Ryan and Smith's (1989) observations amongst Chinese parents of a child with a disability. In their study, parents had links with formal support networks (in accordance with biological ideas about their child's difficulties) and links with religious persons (in accordance with religious explanations of the difficulty). As well as reflecting different parental beliefs and expectations about childhood disability, the two paths of support-seeking may also reflect mothers' move towards biculturalism. Mothers may both maintain the beliefs and practices of their own cultural group, whilst selectively acquiring those of the host culture. This has already been discussed in relation to the developmental expectations of South Asian mothers in the current study (i.e. South Asian mothers appeared to have integrated beliefs about child development reflective of Western or white British norms and yet retained some beliefs reflective of their culture of origin). The same may be true for South Asian parents' approaches to help-seeking and intervention. Thus, the South Asian mothers in this study may have incorporate both Western approaches to intervention (i.e. seeking support from the formal/professional support network) at the same time as retaining approaches which may be reflective of their own cultural traditions (i.e. seeking support from a religious leader or healer).

Beliefs about formal support offered

Mothers were asked to comment on unhelpful aspects of coming into contact with formal support services for their child. Areas identified were very similar for South Asian mothers and white British mothers. Based upon previous studies highlighting the inequalities faced by ethnic minority groups in relation to access to and receipt of health, social and welfare service (e.g. Mir et al. 2001; Hatton et al. 2002; Beresford, 1995), one might have expected South Asian mothers to report more dissatisfaction with services than the white British group. However, this was not the case, and may again link to the fact that South Asian groups may prefer to keep discussion of difficulties within the family (Ranganath and Ranganath, 2001).

Being kept in the Dark

Many parents described a sense of not being given information relevant to their child or services on offer. In some cases, mothers were not told anything about their child's diagnosis. For most families, a clear diagnosis of their child's condition is an important starting point for being able to move forwards. A diagnosis can help families to readjust to their situation, to understand the nature of the condition and its likely impact and to plan for the future (Department of Education and Skills/Department of Health, 2003). The practice guidance for professionals working with disabled children and their families (DfES/DOH, 2003) recommends that professionals unable to provide a child and family with an appropriate diagnosis should take the appropriate steps in response to parental anxiety. The fact that mothers in this study described how they were 'kept in the dark' about their child's difficulties suggests that there is some way to go before guidance is put into practice. Mothers also indicated that they had not been appropriately informed of the range of services and resources on offer. This is consistent with numerous studies showing that parents (particularly those from ethnic minorities) of children with learning disabilities have a low awareness of support services (Mir *et al.* 2001; Northard, 1993; Butt and Mirza, 1996; Chamba *et al.* 1999; Tait *et al.* 1998; Hatton *et al.* 1998). Studies have frequently shown how an absence of translated or accessible materials and a lack information about the nature of impairment and its implications, contributes to the low awareness and uptake of services for families from South Asian communities (Azmi *et al.* 1997; Butt and Mirza, 1996; Hatton *et al.* 2000; Mir *et al.* 2001). Despite these findings, several key governmental publications and policies repeatedly emphasise the need to provide information for parents and carers. Under the Children's Act (1989), for example, local authorities have a duty to publish information about the services they provide to families. The DfES/DOH (2003) practice guidance for professionals working with families of children with a disability recommends that parents receive a directory of services, at an appropriate time, outlining the standard range of services available locally, with up to date contact details, early in the process of responding to the news of disability in their child. The Government White Paper 'Valuing People' (DOH, 2001a) similarly emphasises the need for carers to have more and better information. However, the

results of this study (and, indeed, the results of previous studies) suggest that these recommendations are not put into practice and parents still consistently report a lack of appropriate information.

Confusion and fear of the system

Mothers in this study emphasised that they did not understand the organisation, function and role of the professional network involved in offering services to their child. Issues such as not knowing who the professionals were or what they did, not knowing the purpose of appointments and not understanding the process of educational statementing, were all raised by participants. The parents studied by Faust (2003) also identified the service network as being problematic. There was agreement that there were too many points of contact and that a single point of contact might ease the burden experienced by parents. This is in line with current service policy which aims to achieve closer integration between social and health services and better 'work in partnership' over the next few years (DOH, 2001a). Closer integration, information sharing and work in partnership would improve coherence not only for parents but also for service providers (Scior and Grierson, in press).

Battling for support

Mothers in the present study emphasised how every step of the way they had to 'battle' in order to get the support they needed. Under the Carers and Disabled Children's Act (HMSO, 2000) all carers have the right to a full assessment of their needs and ongoing support from services in their own right. This entitlement indicates that parents and carers should by no means need to "battle" or "fight" for the assessment and care they require. Nevertheless, the view expressed by some of the mothers in the present study was that the only way to obtain the help they needed was to create a crisis (e.g. by "giving up" and handing their child over to the social services). Faust (2003) also found that parents needed to reach a crisis point and have some kind of breakdown before services paid attention to them. This is also consistent with research investigating the experiences of parents of adolescents with learning disabilities (Turner, 2002), yet in clear contradiction with the apparent ethos and policies of services. Under current legislation, young people with significant learning disabilities have the right to a

full assessment of needs and regular reviews, with greater support provided at times of increased need (Department for Education and Skills, 2001). The experiences of the mothers in the present study suggest there is some way to go to ensure that services are needs led and preventative rather than reactive to a crisis.

Resource Problems

Mothers in this study also identified a number of problems in relation to the resources available, namely that support was lacking, that there was not enough and that it was often inappropriate to needs. The Government White Paper 'Valuing People' (DOH, 2001a) emphasises the immense support needs of disabled children and their families, and the problems faced by many in terms of too little family support, little help in the home and too few short breaks especially for more severely disabled children. These findings have been consistently reported in the literature. Ellahi and Hatfield (1992), for example, indicated that over a third of Asian families received no help or support when they first discovered their child's disability. Hatton *et al.* (1998) indicated that South Asian families tend to find services inadequate and inappropriate to their needs. Many families, for example, require respite for the occasional night and yet respite is only available in blocks of one or two weeks (Hatton *et al.* 1997). Cocking and Athwal (1990) note that many families may end up rejecting services because they are not adequate or flexible enough. Once again, these reports appear to conflict with government guidelines and initiatives previously described.

Lack of an overview

Mothers also reported feeling that there was nobody holding an 'overview' of the child's difficulties. This resulted in parents being asked the same questions again and again at assessment and a sense of having to start at the beginning with each professional contact. Again, these experiences appear at odds with guidance set out by the DfES and DOH (2003), which highlights the importance of flexible and efficient arrangements to share information about the child and the family between all the professionals and agencies involved. The guidance warns professionals that without this overview, the opportunity to build a cumulative picture of the child's abilities and needs over time is lost and parents are left with the

responsibility of bringing every new professional they meet up to date. However, as the present study shows, these guidelines are not always operationalised.

Summary of Main Findings

Interviews with 10 white British and 10 South Asian participants yielded rich qualitative data relating to the 4 main research questions. The data was coded using the process of thematic content analysis and quantified using Fisher's Exact Test. Table 25, below summarises the results from quantitative analysis. Tables 26-30 summarise the key themes arising from qualitative analysis. The extent to which these results converge with or expand previous research has been discussed throughout the chapter thus far and is further summarised below.

Table 25: Summary of Results from the Quantitative Analysis

Research Question	Quantitative Findings
Are there differences between white British and south Asian mothers' beliefs about typical child development?	<ul style="list-style-type: none"> • There were no significant differences between South Asian and white British mothers' developmental expectations. • Significantly more White British mothers than South Asian mothers highlighted self-help skills as being important at 3-year. • Significantly more white British mothers than South Asian mothers expected a gender difference in terms of skill development at 3-years.
Are there differences between white British and South Asian mothers' beliefs about parenting practices and their role in supporting a child's development?	<ul style="list-style-type: none"> • There were no significant differences between South Asian and white British mothers' beliefs about supporting a child's language development or co-operative play skills. • There were differences between South Asian and white British mothers' beliefs about toilet training. Specifically, significantly more white British mothers than South Asian mothers emphasised the importance of praise and reward systems. Significantly more South Asian mothers than white British mothers indicated that toilet training commences when the child senses that they are 'dirty'. Significantly more White British than South Asian mothers emphasised the need to wait until the child is ready before commencing toilet training. • Significantly more South Asian mothers than white British mothers indicated that extended family members are important in supporting a child's development.
Are there differences between white British and South Asian mothers in terms of the factors which influence ideas about child development and	<ul style="list-style-type: none"> • Significantly more white British mothers than South Asian mothers indicated that friends are important in influencing ideas about child development. • Significantly more white British mothers than South Asian mothers indicated that professional advice is important in influencing ideas about child development. • Significantly more white British mothers than South Asian mothers

parenting?	<p>indicated that books and media are important in influencing ideas about child development.</p> <ul style="list-style-type: none"> • Significantly more South Asian than white British mothers indicated that their religious beliefs are important in influencing ideas about child development.
Are there differences between white British and South Asian mothers' beliefs and experiences of having a child with developmental delay and support offered?	<ul style="list-style-type: none"> • Significantly more white British mothers than South Asian mothers described their child's difficulty in medical terms. • Significantly more white British mothers than South Asian mothers described a biological cause for their child's difficulty. • There were no differences between the South Asian and white British mothers in terms of when the child's difficulties were first noticed. • There were no differences between the South Asian and white British mothers in terms of who identified the difficulties. • Significantly more White British mothers than South Asian mothers turned to professionals as an initial source of support. • Significantly more South Asian mothers than white British mothers turned to a religious person as an additional source of support. • There were no differences between the South Asian and white British mothers in terms of their beliefs about the support services offered.

Tables 26-30: Summary of Results from the Qualitative Analysis

Table 26: Factors influencing child development and parenting

Theme	Description
The influence of family	<ul style="list-style-type: none"> • Both South Asian and white British mothers described how family had been important in influencing ideas about child development and parenting.
Learning from family members	<ul style="list-style-type: none"> • South Asian mothers emphasised how living within the joint family system afforded many opportunities to observe child-care activities and learn from and receive direct instruction from family members. This type of learning was deemed to be more important and more frequently practiced than consulting child care books or seeking professional advice. • For the white British group, mothers described how factors such as parents living too far away, having a small family and having an absence of close family relationships, reduced the amount of family influence in reality.
Doing things differently	<ul style="list-style-type: none"> • White British mothers described how their child-care practices and customs differed from that of their own parents. They acknowledged the importance of parents but also mentioned how they had actively chosen to take matters into their own hands and 'do things differently' from the suggestions of practices of their family. None of the South Asian group alluded to this theme.
The influence of friends and other mothers	<ul style="list-style-type: none"> • White British mothers described how friends, parents at toddler groups and parents in the school playground also contributed to their ideas about child development and parenting. None of the South Asian group alluded to this theme.

Culture and changing ideas over time	<ul style="list-style-type: none"> Both white British and South Asian mothers reflected on the impact of culture in terms of shaping ideas about child development. White British culture was seen as encouraging parents to become overly concerned about their children. Worries about whether children are developing at the correct pace or whether parents are 'psychologically damaging' the child were seen as being a preoccupation of white British culture. Many mothers, particularly the White British, reflected on how ideas about child development and parenting change over time, as family composition changes and ideas about childhood change. Some parents described experiencing confusion about whether or not to hold onto traditional values and apply them in the present.
Books and Media Influences	<ul style="list-style-type: none"> Books, television, magazines were seen as being important sources of information for the white British mothers. At times, childcare books cause mothers to feel anxious that they are not 'parenting to the book'. South Asian mothers saw consulting childcare books as being an unusual practice.
Professional advice	<ul style="list-style-type: none"> White British mothers described how important professionals, such as the GP, paediatrician and CDC experts had influenced ideas about child development.
Religious beliefs	<ul style="list-style-type: none"> South Asian mothers described how ideas from religion influenced their approach to parenting. The babies' first sounds are important because they signal that the child is learning to say 'Allah'. Teaching from the Koran comes at an early age, as does teaching about status.

Table 27: Strategies to Support Toilet Training

Theme	Description
Parent-guided strategies	<ul style="list-style-type: none"> South Asian and white British mothers mostly believed that parents were involved in promoting a child's toileting skills. This included parents showing a child how to use a potty and introducing using the toilet in gradual stages.
Offering praise and rewards	<ul style="list-style-type: none"> This theme arose for the white British mothers, who described how they used reward systems to promote toileting skills. None of the South Asian mothers described this practice.
Child's feeling of dirtiness prompts learning	<ul style="list-style-type: none"> South Asian mothers described how toilet training commences when the child feels that he or she is dirty. This was connected to the need for children to learn the difference between cleanliness and dirtiness in order that they are clean prior to offering prayers.
Nappies delay learning	<ul style="list-style-type: none"> South Asian mothers described how children learn to use the toilet much quicker without the use of nappies.
Child's readiness	<ul style="list-style-type: none"> White British mothers described how children should be ready before commencing toilet training. Rushing into toilet training was viewed a potential source of psychological damage to a child.
Biological Determination	<ul style="list-style-type: none"> Some white British women described how a biological mechanism dictates when toilet training can commence.

Table 28: Understanding of Developmental Delay

Theme	Description
Medical	<ul style="list-style-type: none"> White British mothers, in particular described their child's difficulty by using medical or diagnostic labels.
Skills based	<ul style="list-style-type: none"> South Asian mothers tended to describe skills deficits or delays when describing their child's difficulties.

Table 29: Cause of Developmental Delay

Theme	Description
Biological	<ul style="list-style-type: none"> White British mothers described the cause of their son or daughter's difficulties in biological terms. Examples included birth complications, pre-maturity and genetics.
Psychological	<ul style="list-style-type: none"> One mother offered a psychological cause for her child's difficulties (e.g. mother states that the child is psychologically damaged).
Spiritual and retribution ideas	<ul style="list-style-type: none"> Mothers described how their child's difficulty was a punishment from god, or that having a child with global developmental delay was part of god's plan or will.
No explanation	<ul style="list-style-type: none"> Some mothers indicated that they could not give an explanation because a cause had not been identified by the medical profession.

Table 30: Beliefs about Formal Support

Theme	Description
Being kept in the dark	<ul style="list-style-type: none"> Mothers described how professionals had not shared or withheld information about the child or relevant resources.
Confusion and fear of the system	<ul style="list-style-type: none"> Mothers described how confusing the support system is. Not knowing about the different roles of the professionals, not knowing how to access services and not knowing the purposes of assessment were among the examples given.
Battling for support	<ul style="list-style-type: none"> Mothers described the struggles in relation to accessing and receiving services. Having to constantly ask for resources and making endless telephone calls to no effect were examples. In some cases, mothers commented on how the only way to access support would be by creating a crisis (e.g. by handing over a child to social services).
Resource problems	<ul style="list-style-type: none"> Mothers described how the resources available were either inappropriate, too few or non-existent.
Lack of overview	<ul style="list-style-type: none"> Mothers described how they frequently had to repeat information to professionals and how they had a sense that they were asked the same questions endlessly. They felt that nobody took responsibility for holding in mind all the information relevant to their child.

The fact that there were no differences between the two groups in terms of developmental expectations is discordant with previous studies showing that South Asian parents' have developmental expectations for their children which are later than those of American and European parents (e.g. Joshi and MacLean, 1997; Roland, 1988). The process of acculturation may explain this disparity. The South Asian group in this study have assimilated into White British culture, as reflected by the concordance between the South Asian mothers' beliefs about child development and those held by the white British mothers. Only one previous study has addressed this process and has confirmed that parenting beliefs change and adapt following migration to reflect those held by the majority culture (Jamunathan and Counselman, 2002). Another possible explanation for the few differences uncovered, however may relate to the statistical power of the study, which may not have been great enough to detect differences which exist. Having a greater number of participants in the present study would have overcome this difficulty.

The finding that significantly more white British mothers than South Asian mothers highlighted the importance of self-help skills when the child is 3-years old is consistent with the characterisation of European values as emphasising individualism (e.g. Harwood *et al.* 1990, 1995). However, the fact that South Asian and white British mothers highlighted similar skills as being important in a child's development in all other domains suggests that South Asian mothers' cultural models may not be completely characterised as reflecting collectivism, as previously thought (e.g. Harwood *et al.* 1995). Indeed, recent studies have emerged showing that parents' cultural models of parenting may contain element of both individualist and collectivist values, which are expressed according to the particular situation or domain (Suizzo, 2004).

The finding that white British mothers were significantly more likely to expect sex differences in children's skills is consistent with previous studies which show that pre-school girls are slightly ahead of boys in terms of early vocabulary growth (e.g. Fenson *et al.* 1994) and pre-school boys are slightly ahead of girls in terms of motor skills (Berk, 1998). The fact that South Asian mothers did not expect to see a gender difference is perhaps surprising given

that South Asian parents have been shown to assign clear social roles (Ranganath and Ranganath, 2001) for their children based upon gender. However, social role differences do not necessarily imply that there will be differences between males and females in terms of developmental skills. Further research in this area is needed in order to fully understand whether a child's sex has a bearing on South Asian parents' developmental expectations.

The finding that white British mothers were more likely to identify friends, professionals, books and media as being important for shaping their beliefs about child development and parenting is consistent with previous research, which shows these factors to be important for Western parents (e.g. Ateah, 2003). Theoretically, this finding is consistent with the idea that white British and North American parenting ideas are passed on via horizontal means (i.e. ideas are passed on via unrelated individuals and the mass media) (Hewlett and Lamb, 2003). In contrast, parents from Asian culture are thought to pass on parenting ideas via vertical means (i.e. ideas are handed down from grandparents to parents to children). According to Hewlett and Lamb (2003), horizontal transmission results in faster exchange of ideas and evolution of parenting ideas. Indeed, in their qualitative accounts, the white British mothers discussed how they chose to 'do things differently' from their own parents and emphasised the importance of consulting professionals and child-care books. None of the South Asian mothers, in contrast, talked about choosing to 'do things differently' and emphasised the importance of learning parenting skills from their family.

In relation to beliefs about specific parenting practices such as supporting co-operative play skills, language development and toileting, there were again few differences between the two cultural groups. As previously discussed, this might reflect the process of assimilation into white British culture. There was, however, one aspect of supporting a child's development, where the cultural groups differed. South Asian mothers emphasised that toilet training should commence when a child has a sense that he or she is dirty. Qualitative information elaborated that 'being clean' is an important requirement for offering prayers. Indeed, throughout the Muslim religion, there is a high emphasis placed upon cleanliness and Muslims regularly perform ritualistic washing before praying (Wolfe, 1998). This suggests that

becoming toilet trained is important for a young Muslim to participate in his or her religious duties.

White British mothers were significantly more likely to indicate the use of behavioural reward systems in promoting toileting skills. The use of reward systems may be consistent with a worldview which emphasises personal goals and individual achievement. Such attributes are reflective of values which fall along the more individualistic end of the continuum (e.g. Triandis, 1995). Since professionals in the West routinely suggest the use of such systems in facilitating children's learning, further research in the area is needed to investigate the extent to which these methods fit with cultural models which fall at the more collectivist end of the continuum.

In relation to mothers' understanding of developmental delay, the finding that South Asian mothers were significantly less likely to use a diagnostic or medical term for their child's difficulty or to identify a biological cause, is consistent with findings reported by Fatimilehin and Nadirshaw (1994). The finding may also add weight to previous studies which show that information given during the disclosure process is unsatisfactory and that parents do not adequately understand the terminology used by professionals (Fatimilehin and Nadirshaw, 1994; Hatton *et al.* 2003).

The finding that South Asian mothers were less likely to seek professional help as an initial source of support and more likely to consult with a religious person for additional support, also converges with previous findings (e.g. Fatimilehin and Nadirshaw, 1994; Faust, 2003). The findings may also indicate a failure on the part of professionals to make services available and accessible to ethnic minority groups. Several studies have documented the shortfalls of service provision, including the scant attention paid to religious beliefs (e.g. Mir *et al.* 2001).

The fact that the white British group and South Asian group shared similar beliefs about the formal support services offered is perhaps surprising. Mothers felt that they 'kept in the dark' about their child's difficulties, that the healthcare system was confusing, that they had to

'battle' in order to receive support, that resources were either too few, inappropriate or non-existent and that professionals failed to hold in mind a complete overview of the child's difficulties. One might have expected the South Asian group to report higher levels of dissatisfaction than the white British group on the basis of previous studies highlighting the inequalities faced by ethnic minority groups in relation to access and receipt of health care services (Mir *et al.* 2001). Socially desirable modes of responding may have biased the responses of the South Asian group. Further research is needed to uncover the extent to which this may indeed be the case.

Methodological Issues

This section discusses the strengths and weaknesses of the present study in terms of sampling, design issues, procedures and data analysis.

Sampling and recruitment

The white British and South Asian sample were well-matched on socio-demographic variables with the exception of religious beliefs and cultural background. The benefit of homogeneity is that extraneous variability is reduced and thus differences between the two groups are more likely to be owing to differences in religious beliefs and cultural background than other factors. As previously discussed, many previous studies in cross-cultural research have neglected to take into account the socio-economic status of participants as an explanatory variable contributing to group differences (e.g. Frerichs, Aneshensel and Clark, 1981). The strength of the current research, however, is that the two groups studied were well-matched in terms of socio-economic status, and hence the differences between the two groups are more likely to be owing to differences in cultural background than to differences in other social variables.

Mothers of a child aged 5 years and under were specifically selected in order to enhance ecological validity and clinical relevance of the study, since children in this age-range reflect the majority of referrals to child development services. In addition, given that previous studies have tended to focus on mothers' developmental expectations for preschool aged children, it was felt that retaining this age-bracket for the current study would be important for making

comparisons. Mothers from South Asian backgrounds were specifically selected for two reasons. Firstly, there are growing numbers of South Asian persons with a learning disability in the UK (e.g. Hatton *et al.* 2003). In line with this trend, it is likely that there will be a rise in the number of South Asian families who come into contact with child development services. Secondly, studies have consistently highlighted the failure of services to appropriately meet the needs of families from South Asian communities (e.g. Mir *et al.* 2001). Therefore, it was felt that research into the beliefs and practices of this group in relation to child development, parenting and developmental delay (previously uncharted areas) would be important for developing knowledge which can be incorporated into clinical practice. On the other hand, selecting such stringent inclusion/exclusion criteria had the disadvantage of rendering the results less generalisable. For example, the findings may not apply to mothers of older children with developmental delay, or fathers of a learning disabled child.

The final South Asian sample comprised only of mothers who described themselves as Muslim, (despite the fact that Hindus were also included within the inclusion criteria, in line with previous research conducted by Fatimilehin and Nadirshaw (1994)). Unfortunately, this meant that other religious groups were not represented in the study. This is a limitation, given the fact that there are considerable numbers of Hindus amongst the South Asian community in the UK. Among the Indian population, for example, 45% are Hindu (Office for National Statistics, 2001). Thus, the results cannot be generalised to South Asian groups holding other religious beliefs. In addition, all the South Asian mothers interviewed had (subjectively) sufficient levels of English language ability. Previous reports have suggested that the majority of South Asian parents of a person with a learning disability do not speak, read or write English (Baxter *et al.* 1990; Hatton *et al.* 1998, 2002; Chamba *et al.* 1999). It is possible that having proficiency in English affects mothers' experiences, knowledge and access to services. Hatton *et al.* (1998), for example, found that if carers of a person with a learning disability were able to speak and write English, they were much more likely to be aware of services available. Thus, it may be that the mothers in this sample are not wholly representative of the larger South Asian community and different results might have been obtained from a South Asian sample without English language proficiency.

Only mothers were recruited for participation in the current study given the fact that it is *usually* the mother who has most involvement in early child care and has most contact with child development services. However, it may have been useful to also include the views of other family members, particularly given the results of the present study (and previous studies e.g. Ranganath and Ranganath, 2001), which suggest that, for South Asian families, extended family members play a large part in supporting a child's development. In addition, the mothers recruited were self-selected and there may have been differences between responders and non-responders (perhaps in terms of factors such as education level, interest, experiences of having a developmentally delayed child etc.). Thus, the sample may not have been truly representative of the wider population of white British mothers and South Asian mothers of a child with a developmental disability.

The low response rate and resultant small sample require further consideration. During phase 1 of recruitment, in which potential participants were identified by professionals and then contacted by letter, there was a response rate of 15%. During phase 2 of recruitment, in which a poster about the research was sent out to mothers of children with a disability, there was a response rate of 3.6%. There are a number of potential reasons for this low response rate. Firstly, the letters were written in English. When participants were invited to take part in the study, the researcher did not have access to information relating to the language(s) spoken at home and hence it was not possible to translate invitation letters into appropriate languages. Low response rates may thus have reflected the fact that some of the participants contacted did not sufficiently understand the invitation letter in order to volunteer themselves. However, the low response rate was not specific to the South Asian group. A number of factors may have reduced the response rate. Firstly, the group selected represent a group for whom there are many demands of their time. Usually this group are in contact with a wide range of health and other professionals and are required to attend numerous appointments. Additional demands, in the form of research may simply be too much for many mothers with developmentally delayed children. Secondly, the researcher invited participants via letters, thereby relying on factors such as having the correct address, postal services, potential

participants having adequate literacy skills, participants understanding the nature and requirements of the research. Face-to-face contact with the researcher and subsequent invitation via community groups, out-patient appointments and informal support services may have increased the response rate.

The low sample size limited the amount of statistical power of the analysis. This reduced the chances of detecting meaningful differences between the two groups, which may actually have existed (i.e. the probability of making Type II errors is increased). When considering the concordance between the two groups in relation to their developmental expectations, it is possible that, given a larger sample size, the power would be increased sufficiently to detect meaningful differences. Thus, the issue of low power needs to be borne in mind when interpreting the results.

The semi-structured interview

Sections 1 to 3 of the interview were piloted with four mothers (2 white British and 2 South Asian) of normally developing children in order to gather feedback about the interview questions. The questions were refined on the basis of this feedback. In addition, the researcher consulted two south Asian bilingual co-workers from an outer-London Child and Adolescent Mental Health Service. Both workers were mothers of children under 5 and one of the mothers had a child with learning and physical disabilities. Again, feedback from these mothers was used to refine interview questions. These steps helped to ensure that the questions asked were both understandable and culturally sensitive. The process of checking the appropriateness of interview questions and openness to refinement was maintained throughout the research process, with each participant being asked for feedback at the end of each interview conducted.

Despite these steps taken to ensure participants understood questions asked, the fact that the interview was designed by a white British researcher and contained references to a set of pre-determined developmental skills (drawn from Western-based scales of child development) means that Western construct bias is unavoidable. Previous cross-cultural

studies have encountered similar problems when measuring the construct of intelligence. Many studies in non-Western cultures have shown that conceptions of intelligence are often broader than those covered in most IQ tests (e.g. Sternberg, 1985; Serpell, 1993). In relation to the current study, the Western conception that child development is divided into a number of separate "skills", introduces an element of Western bias – South Asian participants may not conceptualise child development in such terms. Furthermore, it is possible that the developmental skills included in the interview may have different meanings or definitions for mothers from South Asian backgrounds. For example, in a study conducted by Goldbart and Mukherjee (1999), parents living in Western Bengal were asked to indicate the age at which children say their first words. 'Saying words' has different meanings according to culture. Traditionally, Indian parents view the intonated babble strings that children produce before they use single words, as having the same status as the use of single words in the West (Goldbart and Mukherjee, 1999). This presents problems when asking parents about different developmental skills because these skills may have different definitions, values and meanings to parents from different cultural backgrounds. Throughout the interview, differences in conceptual understanding of developmental skills may have affected participants' responses and therefore should be borne in mind when interpreting the results.

In order to reduce the chances of misunderstanding arising from differences in conceptual understanding and to facilitate discussion, participants were asked open-ended questions about the types of competencies a child may have accomplished at different ages (as well as the forced-choice questions). The aim of these open-ended questions was to allow participants to describe aspects of child development in their own way. Participants were also shown photographs of children (from different cultural backgrounds) at different ages and demonstrating different skills (e.g. using the toilet; playing co-operatively with peers). It was hoped that these pictures would also help mothers think more clearly about children of different ages. The photographs were also used to provide mothers with a reminder cue of what a typical 6-month old, 1-year old or 3-year old looks like and thus may be capable of. Without a visual prompt, parents may find it difficult to imagine a child of a particular age and thus think about the developmental skills a child that age may have mastered. None of the

previous studies relating to mothers' developmental expectations appear to have used pictures to help mothers think about developmental 'norms' and may therefore have been confounded by the abstractness of the task.

The interview process

Throughout the interview process, I was mindful of the difference between my own ethnic background (white British) and that of the South Asian participants. I wondered whether mothers felt comfortable talking with a person from a different cultural background about issues of child development and disability. I also wondered why none of the mothers had taken up the offer of being interviewed through a bilingual co-worker. But, as Bhugra (2002) notes, ethnic matching is not always necessary or desirable. One reason for this is that interviewees may feel ashamed to talk in front of an interpreter, who may well be from the same cultural community (Granger and Baker, 2003). Certainly talking about disability can be stigmatising within many cultural contexts and therefore sharing experiences with an interpreter can appear even more daunting (Tribe and Morrissey, 2003). In relation to the present study, it is difficult to draw any firm conclusions about whether or not the South Asian participants felt comfortable talking to a white British researcher, or whether the data was affected by culturally appropriate forms of responding. Subjectively, the rapport with participants appeared positive and the interviews yielded rich qualitative data. However, some of the results were perhaps unexpected (when compared to previous findings) which may lend support to the idea that participants did not feel comfortable about revealing some of their true feelings in front of the researcher. Bias in response styles, such as the tendency to acquiesce and the tendency to give socially desirable responses may have affected the data and should thus be born in mind when interpreting the results. For example, when asked to discuss the unhelpful aspects of formal services South Asian mothers' responses were very similar to those of white British mothers. Given the previous findings that South Asian carers of a family member with a learning disability are more likely to be disadvantaged when it comes to access and receipt of services (e.g. Hatton *et al.* 2002), one might have expected the South Asian mothers in the present study to identify significantly more problems than the white British mothers. Certainly, some cross-cultural researchers have found that different

cultural groups have differential response styles. Ross and Mirowsky (1984), for example, found that in a mental health survey, Mexicans were more likely to give socially desirable responses than Anglo Americans.

Data analysis

The data was analysed using a mixture of quantitative and qualitative methods.

Qualitative Methods

The researcher used thematic content analysis to group the data into meaningful themes. In relation to evaluation of qualitative methodology, a number of guidelines have been published (Elliot, Fischer and Rennie, 1999). Firstly, Elliot *et al.* (1999) recommend that researchers recognise their own 'values, interest and assumptions and the role these play in understanding' (p.221). The researcher's perspective is clearly stated in the method section (page 45). Particularly relevant is the ethnicity of the researcher. As a white British female, I recognise that my beliefs and conceptualisations of child development, parenting and developmental disability are very much drawn from Western models and perspectives. Without doubt, this influenced the questions asked at interview, the responses given (in particular, by South Asian participants) and the interpretation of the data. Where possible, the researcher gained feedback from participants and bilingual co-workers about the interview process and questions asked in order to avoid cultural bias. However, as with any research, it is impossible to set aside all biases and assumptions and it is therefore acknowledged that these will have influenced my interpretation of the data and the conclusions drawn. Elliot *et al.* (1999) also emphasise the need to "situate the sample" i.e. provide enough demographic data to help contextualise participants' accounts. Details of socio-demographic data are presented in the results section and a consideration of the generalisability has been previously covered in this chapter. "Grounding in examples" (i.e. supporting ideas with quotations) is another important aspect of qualitative research. Throughout the results section, examples and direct quotes from participants were used to illustrate the categories identified. A detailed explanation of the coding categories is also provided in the appendix (see appendix 5) and where possible participants' own language has been used in the

development of themes. Elliot *et al.* (1999) suggest that the qualitative researcher provide credibility checks on the themes derived from the data. A second researcher skilled in coding methods reviewed all the categories identified and gave feedback to the first researcher. The second researcher also applied the coding system to the data and good inter-rater reliability was obtained (mean inter-rater reliability of 94.1%). The fact that coding categories had high face validity and were based upon participants' own words enhanced reliability. Ideally, the study would have benefited from further credibility checks from the participants themselves. Unfortunately, time constraints precluded this form of validation. Elliot *et al.* (1999) also emphasise the need to present the phenomena under investigation in a coherent and integrated way, whilst "preserving nuances in the data" (p.222). The amalgamation of data into clear categories and themes, which closely related to the four research questions went some way towards achieving this aim. Finally, good qualitative research should 'resonate with readers'. It is my hope that the research contributes to our understanding of the differences and similarities in parents' ideas about child development and developmental delay as well as parents' experiences of formal support services. The clinical implications of the study are many and are likely to resonate with health care professionals who come into contact with families from different ethnic backgrounds.

Quantitative methods

Fisher's exact test was used to analyse statistical differences between the two groups in terms of the number of participants indicating each theme. Because participants varied in their fluency, the researcher conducted counts for whether or not a theme was present for each participant, rather than conducting counts for the frequency with which the theme appeared for each participant (i.e. each theme was only counted once for each participant). The data were subjected to Bonferroni Tests in order to apply a more stringent alpha level and therefore reduce the likelihood of type 1 errors. As previously mentioned, the small sample size limited the amount of statistical power of the analysis and thus some important differences may have been overlooked.

Combining qualitative and quantitative approaches

Until recently there has been an apparent paradigm schism between qualitative and quantitative methodologies. This has been based upon deep-seated epistemological and ontological concerns and the divide between positivism and interpretivism (Dixon-Woods, Agarwal, Young, Jones and Sutton, 2004). However, researchers have also asserted that the methods complement each other and that there is "a strong essential common ground between the two approaches" (Yin, 1994). The use of both qualitative and quantitative methods in the current study has several advantages. Firstly, cross-cultural researchers (e.g. Crano, 1981; Gardener, 2001) recommend the use of triangulation designs, in which quantitative and qualitative methods are combined to increase the validity of the findings. Secondly, mixed method approaches not only expand the research toolbox, but they also provide the researcher with insights that are beyond the scope of any single technique. They have the advantage of gaining entry into participants' lived realities explored by open-ended qualitative methods, but they also have the potential to create generalisability and statistical reliability that is the strength of quantitative research (Cresswell, Fettes and Ivankova, 2004). Combining both methods in the present study allowed the quantitative findings to be elaborated and given meaning, whilst the qualitative findings could also be quantified to address specific research questions and allow generalisability.

However, the mixed method approach in the current study was not without limitations. First, as previously discussed, the low sample size reduced the power of the study meaning that statistical differences may have been overlooked. Second, the process of coding imposed an artificial structure on the data and thus may have introduced distortions or bias. Although the researcher attempted to keep coding categories as close to the text as possible and discussed the categories with a second researcher, it is impossible to remove all aspects of bias from the methodology. As previously discussed, Elliot *et al.* (1999) recommend that the researcher values and perspectives are made available to the reader so that these are considered when interpreting the data. A section discussing the researcher's perspective is set out in the method section of the research.

Areas for Further Research

The current findings point to a need for further research in a number of areas. Firstly, the present study showed few differences in relation to South Asian and white British mothers' developmental expectations. These results were perhaps surprising in view of previous research highlighting cultural differences. The few differences between cultural groups may have been related to the fact that parents in this study had lived in the UK for some time and had come into contact with many child development professionals. These parents may thus have been socialised into western beliefs about normative expectations. Therefore, it would be interesting to investigate whether the results of the present study still hold for parents who are not in contact with child development services, or for parents who have recently moved to the UK. Certainly, there are now emerging studies in the United States showing how acculturation style affects parenting cognitions (e.g. Cote and Bornstein, 2003).

The results of the study showed that South Asian mothers acquired ideas about child-rearing from different sources than white British mothers. It would be interesting to gain further clarification in relation to the reasons for these differences. For example, do South Asian mothers traditionally turn to mothers-in-law for parenting information (i.e. a difference in cultural practices), or do South Asian mothers simply not have access to appropriately translated books and parenting information or have lower literacy rates? Further studies into mothers' actual and preferred sources of parenting information would be helpful in helping services to plan appropriate forms of parent education.

The current study also highlighted differences in mothers' ideas about developing a child's toileting skills. Since studies conducted in the United States have revealed cultural differences in relation to beliefs about a range of developmental skills (such as self-feeding, developing motor skills and sleeping independently) (e.g. Schulze *et al.* 2002), further research might look at a range of other developmental skills. Again, such findings may have important implications for child development and even CAMHS services since professionals increasingly encounter a diversity of cultural belief systems and practices and will need to have knowledge of these in order to deliver culturally sensitive services. Similarly, further

research might address South Asian and white British mothers' beliefs about the interventions offered by child development and other health professionals, particularly those for which the ultimate goal is to promote independence (a concept which, as highlighted, may not be of equal value for families from non-western cultures). Since the results of the current study also highlighted how South Asian mothers were less likely to use reward systems in relation to promoting a child's toileting skills, additional research could address the views of South Asian and other ethnic minority families in relation to the appropriateness and usefulness of behavioural models, which so often form part of western intervention packages.

Given the significance of religious beliefs in relation to bringing up children, understanding children's developmental difficulties and seeking support, further research should investigate how professionals can most appropriately acknowledge these factors in service provision. (This might be done via focus groups with South Asian families to investigate ways in which practitioners can best incorporate socio-cultural and religious ideas into clinical practice). As well as indicating religious beliefs as being important, the current study also showed how South Asian mothers were more likely than white British mothers to indicate extended family members as being significant in supporting a child's development. Research looking at the impact of wider family involvement on service user satisfaction and outcome may be an important aspect of evaluating the clinical application of this finding.

The study showed that South Asian mothers and white British mothers had very similar ideas about aspects of service delivery. Based upon previous findings, one might have expected that South Asian mothers would have reported higher dissatisfaction with services than white British mothers. The results may relate to the cultural (or religious) appropriateness for South Asian mothers of disclosing dissatisfaction with services. Certainly, previous studies have found that there may be a tendency to keep problems private (perhaps to avoid shame) amongst South Asian communities (e.g. Cinnirella and Loewenthal, 1999). In view of this, further research might explore these belief systems further and consider the impact of these beliefs on the research process.

Finally, the mothers in the current study had all received a diagnosis at least 6 months prior to the research interview. Additional studies might address parents' beliefs and experiences at different stages in the 'family life cycle' (Carter and McGoldrick, 1989), and at differences stages of the acculturation process since these factors are likely to impact upon parents' beliefs, practices and service needs.

Clinical Implications of the Study

Clinical implications of the study have been raised throughout the chapter. However, this final section outlines the key areas for further consideration by child development and learning disability services.

South Asian mothers and white British mothers may share similar expectations in relation to typical child development.

The results of this study suggest that professionals need not necessarily assume that South Asian mothers have later (or markedly different) developmental expectations than white British mothers, as reported in previous studies. Although differences may exist for some mothers, beliefs about child development are not a static entity and may become modified through migration. When professionals encounter clients from culturally diverse communities, there is perhaps a danger of assuming the presence of cultural differences, in areas where these do not exist. There is also the danger of adopting a 'colour blind' approach whereby cultural differences are not appropriately considered and acknowledged. Thus, professionals need to adopt a stance which gives credence to both possibilities and allows for exploration of convergent and divergent beliefs and expectations.

South Asian mothers and white British mothers may differ in relation to the skills they view as important.

The fact that white British mothers were significantly more likely to indicate self-help skills as being important at 3-years compared to South Asian mothers has clear clinical implications. Intervention programmes typically emphasise the importance of developing children's self-help skills, reflecting the value placed upon the promotion of independence in Western

society. Bignall and Butt (2000), however, note that the Western approach to independence may not be shared by persons from all ethnic and faith groups. South Asian families, for example, may place a higher emphasis on collectivism and interdependence. Interventions aimed at promoting independent self-help skills at an early age, may therefore not fit with the cultural belief system of the family and may lead to a poor outcome. Professionals therefore need to acknowledge the possibility that parents may have different goals for their children and value the promotion of different skills from those valued in the West. Higher consideration needs to be given to the role of more collectivist philosophies in shaping parents' short and long-term socialisation goals and value-systems.

South Asian mothers and white British mothers acquire their knowledge about parenting from different sources.

The study also highlighted that South Asian mothers were less likely to obtain ideas and advice about child-rearing from friends, professionals and books/media than white British mothers. This has important implications for the development of parent-education programmes and consideration of the modes used to disseminate parenting information for South Asian families. Many studies have highlighted the information needs of South Asian parents of a child with a learning disability (e.g. Azmi *et al.* 1997; Butt and Mirza, 1996; Hatton *et al.* 2000). However, in the light of the present study, simply passing on an information leaflet, recommending a book (even if it is appropriately translated), or advising parents that they speak to a suitably qualified professional may not be the most effective modes of parent education. Whilst these modes may be appropriate for white British mothers, as the present study showed, South Asian mothers are significantly more likely to turn to their own families (particularly higher status family members, such as the mother-in-law) for advice about child development and child rearing. The strong influence of family members needs to be acknowledged and respected by professionals. Parent education programmes for South Asian parents might be more appropriately targeted at the family systems level and through mothers' own cultural communities as opposed to the individual. Furthermore, professionals need to be aware that 'vertical' forms of transmission of parenting advice may be more

important and culturally appropriate than Western 'horizontal' forms of transmission of parenting ideas and practices.

South Asian mothers in the current study were also significantly more likely to emphasise the importance of religious beliefs in shaping ideas about child development and parenting. The importance of religious beliefs is seldom acknowledged by services (Mir *et al.* 20001), despite the evidence that religion plays an important part in shaping beliefs about parenting (see present study), developmental disability, and approaches to intervention (e.g. Danesco, 1997). Professionals clearly need to pay close attention to clients' religious beliefs if they are to provide a service in a culturally sensitive and respectful manner.

South Asian mothers may differ from white British mothers in relation to supporting aspects of a child's development.

Although South Asian mothers and white British mothers had similar ideas about supporting a child's language and co-operative play skills, differences emerged in relation to the beliefs and practices surrounding toilet training. These differences have important clinical implications. Mothers differed in relation to the factors identified as being indicators for starting toilet training. South Asian mothers believed that training should commence when a child recognises that they are dirty and unclean in a nappy. White British mothers, on the other hand emphasised the need to wait until the child is ready before commencing toilet training. South Asian mothers' ideas about the child "feeling dirty" may link to the importance of cleanliness and purity within the Muslim religion. Prayers can only be offered if a person is clean (or has performed 'Wasu'). As many South Asian mothers noted during the interviews, children who had not been toilet trained or who were incontinent were disallowed from the Mosque. Therefore, teaching and recognition of cleanliness versus dirtiness appear to be important aspect of toilet training among Muslim mothers and professionals need to be aware of the wider implications if a child does not develop toileting skills. Professionals also need to be aware that the Western concept of 'waiting until a child is ready' which appears in many of the popular child care and child development texts (e.g. Stoppard, 1998; Herbert, 2003) does not appear to feature in South Asian mothers' beliefs about starting toilet training.

South Asian mothers may differ from white British mothers in their use of behavioural reward systems.

South Asian mothers in the present study were much less likely than white British mothers to indicate praise and reward systems as being an important aspect of supporting a child's development of toileting skills. This may suggest that there may be a poor fit between behavioural models relying on reward systems and the beliefs of South Asian mothers, which in turn could lead to poor treatment outcome. Although the results of the present study apply specifically to the use of reward systems in toilet training, should these ideas also apply more broadly to other aspects of parenting, the implications are considerable. At any rate, professionals introducing behavioural methods may need to consider carefully whether this approach fits with the beliefs and practices of South Asian families.

South Asian mothers may be more likely to involve extended family members in supporting a child's development than white British mothers.

Significantly more South Asian mothers compared to white British mothers indicated that extended family members were important in supporting a child's development. Just as extended family members provide important guidance for South Asian mothers in relation to child-rearing, so too are they involved in aspects of child-care. These findings point to the need for professionals to acknowledge the importance of and offer involvement to extended family members. This might include involving extended family members at initial assessment, during disclosure of a child's difficulties and throughout intervention and follow-up. Similar conclusions were reached by Peshawaria *et al.* (1995), where by virtue of their influence in decision-making and child-care, the involvement of grandparents and other family members was seen as being an important aspect of service delivery. However, given the fact that a large proportion of South Asian families have few relatives in the UK (Ahmad and Atkin, 1996), professionals also need to be aware of the potential implications of bringing up a child without extended family support when this has been the usual custom. Evidence suggests that carers can sometimes feel overwhelmed by their situation. Amongst mothers of a child with physical impairments, researchers have found elevated instances of long-term

depression, health problems and even attempted suicides as a result of worrying about their child (Mir *et al.* 2001).

South Asian mothers and white British mothers may have different beliefs about the nature and cause of developmental delay.

Results of this study indicated that white British mothers were more likely than South Asian mothers to offer medical and biological explanations of global developmental delay. There may be a number of reasons for this, all of which have corresponding clinical implications. Firstly, this may be related to the fact that professionals do not communicate information about diagnosis or causation in an understandable way. Previous findings, for example, indicate that disclosure (about a child's difficulty) to South Asian families does not often occur via the use of a professional interpreter (Hatton *et al.* 1998) and may not occur in front of other family members (including extended family) (Hatton *et al.* 2003). Therefore, professionals need to arrange for disclosure to be relayed in an appropriate language, although this needs to be negotiated with parents first, given that shame relating to the disclosure may present difficulties when using interpreters (Granger and Baker, 2003). Likewise, information needs to be presented clearly, in an understandable way and in the presence of both parents (and other family members if desired and possible). In the light of the current findings that South Asian mothers tend not to turn to books or other such sources of information in relation to child development and parenting, consideration needs to be given as to whether or not supplementary written information will be an effective additional mode of parent education. Discussion with the family about the most appropriate means of promoting understanding about the nature and cause of the child's difficulty may be a helpful strategy to ensure the modes employed are culturally sensitive.

Secondly, different beliefs about the nature and cause of developmental delay may be owing to differences in conceptualisations of disability which exist in different cultural communities. Professionals should be aware of these different meaning systems and should not dismiss accounts which are not bio-medically orientated. As Serpell (1994) argues, there should be a process of negotiation between parents and professionals, whereby differences in

perspectives are identified so that they can work towards a "fusion of horizons". Simply aiming to 'correct' parents' beliefs to a medical perspective is not appropriate. Instead, professionals should encourage articulation and exploration of the range of views that exist.

South Asian mothers may be less likely to turn to formal support networks (as an initial source of support) and more likely to turn to religious persons for support compared to white British mothers.

The study highlighted how South Asian mothers are less likely to seek the support of professional services than white British mothers. There may be several reasons for this. First, services may be culturally insensitive, inappropriate and unwelcoming in their nature (e.g. Baxter *et al.* 1990). Second, South Asian parents may simply be unaware of the services on offer (e.g. Hatton *et al.* 1998). In addition, South Asian families may face discrimination, negative stereotypes and have their concerns dismissed (e.g. Mir *et al.* 2001). This may be exacerbated by poor standards of communication and a lack of professional interpreters (e.g. Baxter, 1998). The implications of these findings are clear; professionals need to ensure that increased attention is paid to cultural issues in relation to assessment, communication and service delivery. Stereotypes must be avoided and assumptions suspended; instead practitioners should adopt a 'respectful curiosity' in relation to the experiences, beliefs and values of families from South Asian communities. By involving persons from South Asian communities in service planning and encouraging greater user-involvement in the co-ordination of services, steps can be made to improve the cultural sensitivity of services. In addition, parents need information about the range of services on offer. As previously discussed, local authorities have a duty under the Children Act (1989) to publish information about the services they provide to families. In addition, the provision of better information for carers is a priority addressed in the Government White Paper 'Valuing People' (DOH, 2001). However, simply providing information is not enough. Services need to consider the most effective and appropriate modes of communicating information. In view of the current findings, for example, information may need to be targeted at a family level as opposed to the individual level. Communication of information about services should be seen as an ongoing process as the needs of the family and child change over time. Finally,

professionals need to be aware that seeking professional support in the first instance may not be the cultural norm for some South Asian families. Seeking the advice of family or religious persons may be a more widely accepted practice than seeking the immediate support of professionals.

The finding that South Asian mothers are more likely to seek the support of religious persons in relation to their child's disability also fits with the idea that these mothers place a high value on religion as providing guidance with respect to child rearing. Services therefore need to be aware of and acknowledge the role of religious belief systems in parents' every-day care of children as well as the impact of religious beliefs on parents' ideas about developmental delay and intervention. Parents who ascribe to strong religious explanations may be much less likely to embrace Western intervention models, which are based upon biomedical or behavioural principles. To some families, taking a child to a religious leader or offering prayers for the child may be a far more effective means of providing help for their child.

South Asian mothers and white British mothers share similar beliefs about the nature of formal support offered.

Both South Asian mothers and white British mothers highlighted similar themes in relation to the unhelpful aspects of current service provision. Many of the ideas raised are not new and in fact, are in line with current health services policies. Clearly there is some way to go before policy is translated into appropriate practice. The key recommendations arising from the current study can be summarised as follows:

- Professionals need to provide more information about the range of services on offer, including information about community groups and non-statutory services, advice about benefits, housing, schooling and respite care.
- Parents need to be told about the purpose and nature of assessments, the role of professionals involved and the meaning of medical labels and diagnoses. The term 'assessment' is used amongst professionals and parents in slightly different contexts, which may result in some confusion (DOH/DfES, 2003). Thus, it is important for

professionals to be very clear about why a child is invited for an assessment and what the likely outcome may be.

- Parents are 'experts' on their child and have the right to be respected by professionals. This includes not being 'kept in the dark' about what is happening for the child, even if this means professionals having to communicate potentially distressing information about the child.
- Parents' 'confusion and fear of the system' could be greatly lessened through creating more robust links between health, social services and education and the voluntary sector services. This is in line with current Department of Health policy (2001a) and will be set out as a priority in the new Children's National Service Framework, which will be published later this year. The plan is to develop new national standards for children across the health services, social services and the interface with education in order to provide a much more co-ordinated and integrated approach to services for disabled children.
- Carers should not feel that they have to 'battle' or create a crisis in order to access the support they need. Carers may need support in being able to access the help they require. Advocacy may be one means of facilitating this. As Atkinson (1999, p.16) explains, advocacy is 'a way to defend the interest of a person, and to make sure their needs are met'. Advocates, including those for persons from ethnic minority communities, need to work alongside the family to ensure that the needs, wishes and values of clients are listened to, respected and met.
- Finally, it is essential to ensure that professionals have an information and communication system, which allows them to build up a cumulative picture of the child over time without requiring the parents to have to repeat the same information at each and every professional contact. There is currently a Department of Health priority to develop an Integrated Children's System (Department of Health, forthcoming), which ensures that information about children's developmental progress and interventions are retained in a common format, so that professionals are quickly brought up to speed in relation to an individual child's care and progress. Hopefully, this will help parents to feel

that professionals have an overview of their child's case and do not feel that valuable appointment time is wasted through having to repeat previously covered information.

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APPENDIX 1 ~

Participant invitation letter (phase 1 of recruitment)
Poster about the research (phase 2 of recruitment)
Participant information sheet
Participant consent form

Invitation to take part in a research study!!!



Dear (Name)

My name is Rebecca Rowley and I am a Trainee Clinical Psychologist based at University College, London.

I am writing to invite you to take part in a research study, which aims to investigate how culture influences mothers' beliefs about child development.

I have enclosed an information sheet about the study, which hopefully provides you with an idea about what it will involve.

My hope is that information gathered from the research study will help to contribute to the planning and provision of child services which are culturally sensitive.

I would be delighted if you could take part in the research, but also emphasise that your participation is entirely voluntary and independent from your involvement at the Child Development Centre.

Please fill in the reply slip below and return in the stamped addressed envelope, to indicate whether or not you would be willing to take part in the study. I would be really grateful if you could respond by **date**.

In the meantime, if you have any questions about this study, please do not hesitate to contact me on: number.

I look forward to hearing from you soon,

Yours sincerely

Rebecca Rowley
Trainee Clinical Psychologist

REPLY SLIP

Name (in block capitals): _____

Telephone number: _____

Please tick the box that applies:

- I am willing to take part in the research study. I am happy for Rebecca to contact me by telephone to arrange an interview.
- I would like to discuss the research in more detail on the telephone before I decide whether or not I want to take part.
- I will need an interpreter for the telephone contact.
- I will need an interpreter if I decide to take part in the research interview.
- I do not want to take part in the study.

Signed: _____

Date: _____

Please return in the stamped addressed envelope by (date).



Dear mother/carer,

Re: Invitation to take part in a research study

My name is Rebecca Rowley and I am a trainee Clinical Psychologist based at University College, London. I am currently conducting a research project involving parents of children who are known to the Child Development Service at XXXXXXXXXXXXXXXX.

I am writing to ask whether you would be interested in taking part in the research study, which aims to investigate how culture influences mothers' beliefs about child development. The research involves being interviewed in your own home for about 1.5 hours. A payment of £15 will be made for your time. Further information about the research is enclosed.

I am specifically looking for the following volunteers to take part:

White British mothers (born in England, Scotland and Wales) of a child with global developmental delay.

Asian mothers (born in India, Pakistan or Bangladesh) or a child with global developmental delay.

If you meet the above criteria and would like to take part or find out more about the study, please contact me on (telephone number supplied) or via e-mail (r.rowley@ucl.ac.uk) by **DATE**.

I look forward to hearing from you soon,

Yours sincerely

Rebecca Rowley
Trainee Clinical Psychologist

INFORMATION SHEET
**A cross-cultural investigation of mother's beliefs about
child development**

I would like to invite you to take part in a research study investigating how culture influences mothers' beliefs about child development.

Full details of the study are given below:

Who is conducting the study?

The study is being conducted by a Trainee Clinical Psychologist (Rebecca Rowley) based at University College London. The study forms part of her doctoral research project.

What is the reason for the study?

Psychologists are becoming increasingly aware that people from different cultures have different beliefs about:

- When children develop (e.g. when a child should walk or talk)
- How children develop
- How to support a child's development

This means that it is really important for people working in Child Development Services to have a broad understanding of the range of different ideas and beliefs that parents hold about child development. This will enable them to incorporate some of these ideas into services that are offered to parents in the future.

For this reason, Rebecca is looking for volunteers to take part in her study, which aims to explore ideas about child development from different cultural perspectives.

Details of the study are given below:

Who can take part in the study?

Asian mothers and white British mothers who have contact with child development services can take part. Entry to the study is entirely voluntary and mothers have the right to withdraw from the study at any time.

What will the study involve?

Rebecca will come to visit you in your home (at an agreed time) to talk about the following 3 areas:

1. Your beliefs and expectations about the way in which children develop.
2. Your beliefs about how children achieve particular milestones, and what may have led you to hold these beliefs.
3. Your experiences of having a child with developmental difficulties and the support offered.

The interview will probably last about 1½ hours and will be audio-taped (provided you consent to this).

There are no right or wrong answers to the questions you will be asked. Rebecca is just interested to hear about your views and ideas.

What happens if I don't want to take part?

You do not have to take part in the research. Participation is entirely voluntary. You may also withdraw from the study at any stage.

The research is entirely independent of doctors or other therapists at the Child Development Service. This means that whether you decide to participate in the research or not, or you decide to withdraw from the study, your current or future support from the Child Development Team will not be affected in any way.

What are the benefits of taking part?

The research provides an opportunity to reflect upon and gain insights into your own beliefs about the development of your child.

In addition, the research provides an opportunity for you to have a voice and contribute to information which may be incorporated into future health-care service provision.

Will the research be confidential?

The research will remain anonymous. This means that your name and personal details will be separated from the information you provide at the interview. You will be identifiable only to the researcher who will hold protected research codes.

If the research is published, your name will be altered to protect confidentiality.

Recordings of the interviews will be held securely by the researcher and will be destroyed when the research has been completed.

Your GP will not have access to the recordings or research notes.

Who can I contact for more information about the research?

You can contact the researcher who will be interviewing you:

Rebecca Rowley
Trainee Clinical Psychologist, Sub Department of Clinical Health Psychology
University College London, Email r.rowley@ucl.ac.uk
Telephone number supplied.

CONSENT FORM

AGREEMENT TO PARTICIPATE IN RESEARCH PROJECT

I, (name of participant)

Of (address)

Agree to take part in the research project:

Mothers beliefs, expectations and practices in relation to child development and developmental delay: A cross-cultural comparison

I confirm that the nature and demands of the research have been explained to me and I understand and accept them.

I give my consent for the interview to be audio-taped.

I understand that my consent is entirely voluntary and that I may withdraw from the research project if I find that I am unable to continue for any reason and this will not affect my medical care.

Signed:

Print Name:

Date:

Investigator's Statement:

I have explained the nature, demands and foreseeable risks of the above research to the subject:

Signature:

Date:

APPENDIX 2 ~

Semi-structured interview schedule

Interview Cover Sheet

Identification and Consent

Participant Code	
Date	
Consent for interview? Consent for audio taping?	

Background Information

Household Composition (ages):	Parental Birthplace:
	Length of time in UK:
Occupation of main earner:	Religion: (practising or non)

Interview Schedule

Preamble

As you know, different people and different cultures have different ideas about the way in which children develop and the way children should be brought up. I am really interested to find out what these different ideas are. We will be discussing these ideas in the next hour or so. There are no right or wrong answers to my questions. I'm just interested in finding out your views....

Section 1 ~ Developmental expectations

I would like to begin by thinking about the ages at which children achieve different milestones (for example – what age can a child talk? What age can a child walk?). To help us discuss this, I have some photographs of children for us to look at.

This is a picture of a 6-month old boy.

- What do you think a child can do at this age?

Follow-up questions: Do you think he can:

Skill/milestone	Yes	No
Support his head when lifted up?		
Grasp objects?		
Make sounds?		
Give example.....		
Smile at someone?		
Let someone know if he is hungry?		
Is he breast fed at this age?		
What age would this stop?		
Would he have been started on solids at this age?		
Would he be able to sit independently?		
Would he show an interest in toys?		
Would members of the family be playing with him?		
Would he be playing with other children of his age?		

- Which skills do you think are the most important skills for a 6-month old to have achieved?
- Supposing I had shown you a picture of a 6 month old girl. Would you have given me the same answers as you've given me for a 6-month old boy?
- Would a 6-month old girl be able to do more or less? Where do these ideas come from?

Here is a picture of a 1-year old girl.

- What do you think a child can do at this age?

Skill/milestone	Yes	No
Sit independently?		
Crawl?		
Start to walk?		
Wave good-bye?		
Say her first word?		
Understand simple instructions?		
Feed herself?		
Start toilet training?		

Show an interest in toys? Would members of the family be playing with her? Would she show an interest in playing with other children her age?		
---	--	--

- Which skills do you think are the most important skills?
- Supposing I had shown you a picture of a 1-year old boy. Would you have given me the same answers as you've given me for a 1-year old girl?
- Would a 1-year old boy be able to do more or less? Where do your ideas come from?

Here is a picture of an even older child. He is 3 years old.

- What do you think a child can do at this age?

Skill/milestone	Yes	No
Talk in sentences?		
Understand instructions?		
Name parts of the body?		
Name colours?		
Count to 5?		
Count to 10?		
Would he be fully toilet trained?		
Would he be able to feed himself?		
Would he be able to dress himself?		
Would he show an interest in toys?		
Would he show an interest in playing with family members?		
Would he show an interest in playing with other children his age?		

- Which skills do you think are the most important for a 3-year old to have achieved?
- Supposing I had shown you a picture of a 3-year old girl. Would you have given me the same answers as you've given me for a boy?
- Would a 3-year old girl be able to do more or less? Where do your ideas come from?

Section 2 ~ Factors influencing beliefs about child development and child rearing

We've just thought about when you would expect children to achieve different skills. People's ideas about when and how and when children develop come from a variety of places, like family and friends, the TV, magazines, newspapers and books.

- When you think about when and how children achieve different skills – Where do your ideas come from?
- Follow up prompts: Are you influenced by:
 - family traditions, sayings or stories you've heard
 - books
 - TV and/or media
 - parents, grandparents?
 - own experiences of growing up
 - instinct?
 - expert advice/professionals
 - other ideas?

Please give details.

- What about other members of your culture – would other Asian/white British women have been influenced by the same things or would they have drawn upon different things?
- What about other people who share the same religious beliefs as you do – would they have been influenced by the same things or would they have drawn upon different things?

Section 3 ~ Beliefs about supporting a child's development

I'd like to turn to thinking about the role of parents and others in helping children to develop. Again, to help us think about this, I have some photos to show you...

This is a picture of a child who is learning to talk and understand language.

- What are your ideas about how this child managed to talk and understand language?
- Is it something which is inbuilt or is it influenced by something else?
- Who would encourage these skills? (e.g. family/school/social network etc)
- How might they encourage the achievement of these skills? What would they do?
- Where do your ideas come from?
- Follow up prompts: Do they come from:
 - family traditions, sayings or stories you've heard
 - books
 - TV and/or media
 - parents, grandparents?
 - own experiences of growing up
 - instinct
 - expert advice/professionals
 - other ideas?

Please give details.

This is a picture of a child who is toilet trained.

- What are your ideas about how this child managed to become toilet trained?
- Is it something which is inbuilt or influenced by something else?
- Who would encourage these skills? (e.g. family/school/social network etc)
- How might they encourage the achievement of these skills? What would they do?
- Where do your ideas come from?
- Follow up prompts: Do they come from:
 - family traditions, sayings or stories you've heard
 - books
 - TV and/or media
 - parents, grandparents?
 - own experiences of growing up
 - instinct
 - expert advice/professionals
 - other ideas?

Please give details.

This is a picture of a child who is able to play co-operatively with friends of the same age.

- What are your ideas about how this child managed to achieve these skills?
- Is it something which is inbuilt or is it influenced by something else?

- Who would encourage these skills? (e.g. family/school/social network etc)
- How might they encourage the achievement of these skills? What would they do?
- Where do your ideas come from?
- Follow up prompts: Do they come from:
 - family traditions, sayings or stories you've heard
 - books
 - TV and/or media
 - parents, grandparents?
 - own experiences of growing up
 - instinct
 - expert advice/professionals
 - other ideas?

Please give details.

Section 4 ~ Beliefs about developmental delay and beliefs about support services

Finally in this last section of the interview, I'd like to turn to thinking about your child (name), who I understand has brought you in contact with the Child Development Service.

Nature of difficulties

- Can you describe your son/daughter's difficulties?
- When did you first notice that your child had difficulties?
- Who was it that noticed and how?
- Once noticed, what happened next?

Understanding the cause of disability

- What ideas did you have about how X came to have these difficulties?
- Where did these ideas come from?

Seeking advice and help

- Who did you first turn to for help or advice about your child?
- What kind of help and advice did they offer?
- How did you find this? Was it helpful?
- Were there any aspects that were unhelpful?
- Is there anyone else who has been involved in offering support?
- What kind of help and advice have they offered?
- How have you found this? Helpful? Unhelpful?
- If you think back to your overall experience of the help and advice you have received in relation to you and your child, is there anything that you would have liked done differently?

Closing the interview

- Thank you very much for participating in the study. It has been really interesting to hear your ideas today.
- Do you have any questions about what we have talked about, or about the study in general?

Feedback/reflection on the interview process

- How do you feel about the areas we have talked about today? Do you have any questions or concerns about any of the things we have spoken about?
- Did you find the questions were worded in a way you understood?
- Are there any changes you think should be made to questions to make them more understandable?
- Are there any other areas or questions you think would be important to ask?

APPENDIX 3~

Excerpt from an interview transcript

Interview 2 (South Asian participant)

I denotes "interviewer"

P denotes "participant"

- I We've reached the last part of the interview now, where I'd like to ask you a few questions about your daughter who I understand has brought you in contact with the Child Development Service. Can you describe X's difficulties?
- P My daughter has had lots of difficulties from when she was very young. As she got older, we realised she wasn't doing the things she was supposed to be doing, like smiling. She didn't do this until she was about 6 months, whereas this should be done at one or two months. So gradually as she got older, she wasn't doing what she was supposed to be doing. This made me think there must be a problem.
- I So it sounds like you knew from early on there was a problem because your daughter was not doing the things you expected. Can you remember how old she was when you noticed?
- P I think it was at about 6-months because we expected her to be responding more at this age, and she just wasn't doing anything.
- I Who noticed this?
- P It was me mainly. I think my husband realised as well, but he was not so worried about it. There are a lot of young children in the family and I remember thinking there was something different about X and that's when I started to be concerned.
- I And then what happened?
- P We talked about it and I asked my sister what to do. She was concerned too. She thought we should ask the health visitor and that's what I did. That's how we were referred to the CDC for an assessment. They said that there was definitely a problem but they said it was still quite early so they couldn't tell us too much information, just wait and see.
- I Do you have an idea of what caused the problems?
- P Well, I don't think anyone really knows what caused it. X has had lots of tests and the doctor at the CDC hasn't given us any answers really. I think they think there is something wrong with the brain but I don't know what it is. We just have to accept this and wait and see.
- I So you've mentioned the health visitor and the doctor at the CDC being involved...Can you remember who it was you first turned to for support?
- P I turned mostly to family for support. But I've come to realise I cannot ask them any more. My mum has high blood pressure and whenever she sees my child or asks about her, it stresses her out so much she needs to take another tablet. I just can't ask her for support any more. But I guess my sister has been helpful. You know, she can come round and look after the children when I need a break.
- I So your sister has been helpful...has there been any other kinds of support?
- P We've taken her to a religious person who gave her a thing to wear around her neck. It contains something from the Koran. We sometimes take her to a religious person when she is going through a bad phase ...usually in the winter because it's darker and colder and she can't get out. And I pray and pray that she will get better. I go through phases of asking god 'why have you done this to us?' but then I know it is god's wish and we must accept it.

- I Is this something other Muslim women might do in a similar situation?
- P Yes, think lots of parents do this. My friend has a child with special needs and she has done the same as well. It is part of our religion and we pray that she will get better. If she does not we must accept that it is god's will.
- I So it sounds like support from religion is important to you and maybe even other parents in your situation?
- P Yes
- I I was wondering too if there have been any other people or places you have turned to for support?
- P Well, the GP has been no help. He has not referred her to one person. Even to this day. I think GP's are useless anyway. Everyone is complaining about them. CDC got involved and that was OK. But what I found difficult was putting things into practice like physio and OT and things like that. It's difficult. You have to put it into practice every day...but we, as parents are just so tired. Just doing the usual caring is had enough, let alone doing the physio and things like that. It's really hard. Doing that and the you've got the house to run and your husband is working too. [pause] We have had some help from social services I suppose. But the people they've sent from social services are definitely not able to look after your children because they haven't had the training. They once sent out this old lady, and poor thing, I felt sorry for her. She told me she had a heart problem and diabetes and that she is living alone. I felt so sorry for her – how was I supposed to then ask her to clean my kitchen cupboards? And how on earth can an old lady with heart problems lift my daughter into a wheelchair? They need specially trained people to help you....
- I So it sounds like this hasn't been very helpful for you. Is there anything else you have found unhelpful?
- P I need a lift to take her up the stairs and a car parking space. I've been phoning now for 3 years. Every time they say it's under review. How can it take 3 years to review something?! Why can't they just give you something? Why can't they make it easier for us? I'm starting to think the only way to get any help here is by going to social services and saying "I can't cope...Here, you take her". Of course I would never do that, but it's almost as if they are driving you to that point. Actually, I heard that someone actually did that – they took their child to social services and then they were forced to give them some support. A few years ago I did a course and we learnt about people with special needs. They said that if you gave help early and teach people to do things - like if you have intensive teaching on walking up the stairs, you will teach a child how to do this. When they are older they will not need a stair lift. So if you give the child support when they are younger it is cheaper when they are older. It makes sense.
- I So are you saying that if help is offered early, it will be cheaper in the long run because you will not need to get equipment for the child because they will have been taught how to do things without equipment?
- P Yes. But this does not happen here. You have to keep asking and asking for things and you still don't get the help you need. Then it becomes too late.
- I Is there anything else that has been unhelpful for you?
- Mmmm...lots of things have been difficult [pause]. With the GP appointments or the hospital or the appointments, sometimes you think it's a waste of time. Like, every time we see the neurologist, they ask the same questions: Is she getting physio? Is she getting OT? How old is she now? And they look through the file and even read it

while you are sitting there. They say the same things over and over and you start repeating the same things too. Surely they need to prepare themselves and read the reports rather than going through the same questions again and again. They need to bring together all the information and read it before they see you so that they know what is going on. That way you would feel that someone really knows your child and wants to support you.

APPENDIX 4 ~

Description of coding categories

Description of Coding categories**Section 1: Most important skills for a 6-month old, 1-year old and 3-year old child.**

Category	Description
Motor skills	<p>In coding for this category, the mother must mention references to any of the following gross and/or fine motor milestones: sitting up, rolling over, grasping objects, crawling, standing, pulling to stand, walking, climbing, jumping, hopping, lying on stomach and propping arms up and bottom shuffling.</p> <p>It does not include references to motor skills, which might have been part of a self-help skill (e.g. getting dressed, feeding self) or an exploratory behaviour (e.g. putting things in mouth, reaching for objects).</p>
Awareness & understanding	In coding for this category, the mother must make reference to the child showing an awareness of surroundings and people in child's surroundings
Started nursery	This category includes any reference to starting nursery, playgroup or school
Toilet training	This category includes reference to any stage of potty or toilet training
Talking skills	In coding for this category, the mother must mention speech using actual words, putting words together, using phrases and sentences, having conversations
Play skills	This includes any reference to actual play involving toys and or peers. Does not include general exploratory behaviour
Solids	This category implies the child is either moving or has moved onto solids.
Social skills	This category includes references to smiling, being sociable, responding to others, interaction with others (i.e. communication with social intent), showing an interest in others.
Self-help skills	This category includes holding spoon, finger feeding, eating with a spoon and fork, or dressing and/or undressing some or all items of clothing with and without help. It does not include toilet training which is coded separately.
Exploratory behaviour	To score this category, the mother must indicate the child is exploring things, reaching for things, putting things in mouth.
Making sounds	This category includes reference to making sounds, such as babble and the beginnings of words, coos and laughter. Does not include actual words or phrases, which are coded under 'language skills'

Section 2: Factors Influencing Mothers' Beliefs about Child Development

Category	Description
Family	As the label suggests, in coding for this category, the mother must indicate that a family member has influenced ideas about child development and parenting. This can include husband or partner, parents, grandparents, siblings, in-laws and extended family members.
Friends	This category is coded when the mother indicates that friends have influenced their ideas about child development.
Cultural and historical influences	Cultural influences – this is coded when a mother reflects on her own culture or other cultures and recognises that there may be different cultural parenting practices, or that a particular belief or practice is specific to a particular culture. Historical influences include references to particular parenting practices or traditions from the past (e.g. previous generations), which are either carried forward or rejected.
Professional advice	This includes mothers who acknowledge that some of their parenting ideas come from health professionals, including health visitors, speech and language therapists, psychologists, psychiatrists, CDC and paediatrician.
Books and media	This category refers to any books, magazines, newspaper articles, films or television programmes which may have influenced a mothers' ideas about child development or parenting.
Religious beliefs	Any reference to religious beliefs and the way these might influence or guide parenting. Examples might include teaching children the difference between male and female status within Muslim belief systems; teaching children to pray; teaching children about religious beliefs.

Section 3: Important aspects of a child's language development

Category	Description
Talk to the child	This category is coded when mothers indicate that it is necessary to talk to the child for language to develop. There is also the suggestion that the more you talk to a child the more likely they are to acquire language skills. This category is different from the 'child acquires language naturally' category in that it implies an adult or other person has to talk to the child (i.e. do something to the child) in order for them to learn language. In the 'child acquires language naturally' category, the child absorbs language naturally.
Simplify language	This refers to breaking down sounds, words, or sentences to make them simpler for a child to understand. It also refers to shortening sentences and using simple words to facilitate understanding.
Child acquires language naturally	This category is scored when a mother indicates that children observe what is going on around them (words, language, actions) and acquire language naturally. In this category, there is no suggestion that parents or others have to do anything to the child to facilitate learning; simply that it is developed through the process of hearing language.
Eye contact	This category is coded when the mother emphasises using eye contact as a means of facilitating language development.
Gestures	This category is scored when a mother indicates that using gesture, facial expression or non-verbal signals are helpful strategies to support language development.
Teaching	This category is coded when the mother indicates that language skills have to be taught through directly encouraging the child to imitate sounds, using flashcards, constant repetition of words, and other educational methods (e.g. word-naming books) methods.

Important aspects of toilet training

Category	Description
Parent-guided strategies	To code this category, a mother must mention one or more of the following strategies: taking the child to the toilet at regular intervals, demonstrating and teaching a child how to use a potty or toilet, taking training in stages from wearing training pants, to knickers and moving from potty to toilet etc.
Offering praise and rewards	This category included reference to the use of verbal and tangible rewards and praise.
Child's feeling of dirtiness prompts learning	This category is scored when a mother indicates that a child feel dirty and it is at this point that potty training should commence.
Child's readiness	This category is coded when a mother indicates that a child has to be ready for toilet training; a child must not be pushed into toilet training. This category also includes responses which imply that a child can be damaged psychologically or adversely affected by introducing toilet training too young.
Biological determination	This category is coded when mothers indicate that there is a biological mechanism dictating when children are physically ready to be toilet trained.

Important aspects of co-operative play skills

Category	Description
Co-operative play comes naturally	This category is coded when mothers suggest that some or all of the child's co-operative play skills are learnt naturally without adult instruction. There is the suggestion that children will 'just pick it up' if they are left in the company of other children.
Parental involvement is needed	To score this category, mothers must indicate that parents' need to assist the development of co-operative play skills through guidance and instruction in turn-taking and sharing.

Section 4: Mothers' understanding of global developmental delay

Category	Description
Medical	To code this category, mothers' responses must contain a medical or diagnostic label (such as Global Developmental Delay, Cerebral Palsy or Learning Disability).
Skills-based	To code this category, mothers' responses must contain a reference to loss or lack of global or individual skills (e.g. 'he can't walk or speak'; 'his development is behind').

Beliefs about the cause of global developmental delay

Category	Description
Biological	To code this category, mothers need to indicate any of the following explanations for their child's difficulties: Genetic problems, family history of disability, pre-natal and peri-natal difficulties, pre-natal and pot-natal infections.
Psychological	The mother must offer a psychological cause for the child's difficulties (e.g. mother states that the child is psychologically damaged).
Spiritual	The mother views global developmental delay as being a punishment from god, or that having a child with global developmental delay was part of god's plan or will. The mother might indicate that she has done something wrong in a former life. The mother might also indicate that global developmental delay was caused by a spirit or a ghost.
No Explanation	To code this category, the mother must indicate that she cannot give an explanation because no cause has been identified by the medical profession.

Beliefs about the formal support offered

Category	Description
Being kept in the dark	This category included responses containing references to professionals not sharing or withholding information about the child or relevant resources.
Confusion and fear of the system	This category contained statements about the support system around the child being difficult to understand and scary for mothers.
Battling for support	This category contained references to the struggles faced by parents in accessing and receiving services. Having to constantly ask for resources and making endless telephone calls to no effect were among statements in this category. In some cases, mothers commented on how the only way to access support would be by creating a crisis (e.g. by handing over a child to social services).
Resource problems	This category contained statements which highlighted resource problems in relation to the following areas: <ul style="list-style-type: none"> - Complete absence of support in a particular area - Not enough support in a particular area - Support offered was inappropriate (in that it didn't quite match the mothers' needs or was provided by an inappropriately qualified person).
Lack of overview	Responses in this category contained references to mothers having to repeat information to professionals, being asked the same questions by professionals, professionals not reading all the reports or amalgamating all the information about the child:

APPENDIX 5 ~

Inter-rater reliability analyses

Inter-rater reliability Analyses

Reliabilities were calculated for all the sample between the author and an independent judge (a research psychologist trained in using coding systems). The independent rater was blind to each mothers' group membership.

The independent rater was asked to indicate whether the category was present within each transcript (i.e. scoring for presence as opposed to frequency of occurrence). The percentage agreement was calculated using the index developed by McClelland et al. (1985) (see also Smith, 1992):

$$\frac{2(\# \text{ of agreements between scores on presence of a category})}{(\# \text{ scored present by scorer 1}) + (\# \text{ scored present by scorer 2})}$$

Section 1

Most important skills for a 6-month old

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Motor skills	20	20	100%
Solids	9	7	87.5%
Social skills	6	8	85.7%
Making sounds	11	9	90%
Awareness & understanding	3	4	85.7%
Exploratory behaviour	9	6	80%

Most important skills for a 1 year old

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Motor skills	14	13	96.2%
Play skills	4	6	80%
Social skills	4	5	88.8%
Solids	5	5	100%
Self-help skills	4	4	100%
Talking	12	11	95.6%
Toilet training	4	4	100%

Most important skills for a 3-year old

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Motor skills	9	9	100%
Social skills	9	8	94.1%
Talking skills	13	13	100%
Self-help skills	20	18	94.7%
Started nursery	4	4	100%
Toilet trained	9	9	100%

Section 2:**Factors Influencing Mothers' Beliefs about Child Development**

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Family	20	20	100%
Friends	8	8	100%
Culture & changing ideas over time	14	11	88%
Professional advice	14	14	100%
Books & Media	9	10	94.7%
Religious beliefs	12	11	95.6%

Important aspects of a child's language development

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Talk to the child	13	11	95.6%
Simplify language	6	7	92.3%
Child acquires language naturally	5	3	75%
Eye contact	7	7	100%
Gestures	3	3	100%
Teaching	8	6	85.7%

Important aspects of toilet training

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Parent-guided strategies	15	11	84.6%
Offering praise and rewards	8	10	88.8%
Child feeling dirty prompts learning	8	9	94.1%
Nappies delay learning	6	7	92.3%
Child's readiness	7	7	100%
Biological determination	3	3	100%

Important aspects of co-operative play skills

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Co-operative play occurs naturally	8	11	84.2%
Parental involvement needed	12	13	96%

Mothers' understanding of global developmental delay

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Medical	13	13	100%
Skills-based	19	19	100%

Beliefs about the cause of global developmental delay

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Biological	15	16	97.7%
Psychological	1	1	100%
Spiritual and retribution ideas	7	8	93.3%
No explanation	4	4	100%

Beliefs about the formal support offered

Category	Number of times the theme is present		Percentage agreement
	Author	Independent judge	
Being kept in the dark	11	15	84.6%
Confusion and fear of the system	7	7	100%
Battling for support	8	7	93.3%
Resource problems	9	11	90%
Lack of an overview	5	5	100%

Mean inter-rater reliability = 94.1% (range = 75%-100%)

APPENDIX 6 ~

Description of social class classification system

Social Class Classification System

Social Class		Typical employment
Higher managerial & professional occupations	1.1	Company directors, Police Inspectors, Bank Managers, Senior Civil Servants, Military Officers.
	1.2	Doctor, Barrister, Solicitor, Clergy, Librarian, Teacher.
Lower managerial & professional occupations	2	Nurses and midwives, Journalists, Actors, Prison Officers, Police and Soldiers (below NCO).
Intermediate	3	Clerks, Secretaries, Driving Instructors, Computer Operator.
Small employers	4	Publicans, Farmers, Play group leader, Window cleaner, Painter and Decorator.
Low Supervisory and craft	5	Printers, Plumbers, Butchers, Bus Inspectors, TV engineers, Train drivers.
Semi-routine occupations	6	Shop assistant, Traffic Warden, Cook, Bus drivers, Hairdressers, Postal workers.
Routine occupations	7	Waiters, road sweepers, Cleaners, Couriers, Building labourers, Refuse collectors.
Never worked and long-term unemployment	8	Long term unemployed and non-workers.

Source: Rose, D., & O'Reilly, K. (2001). *The ESRC Review of Government Social Classifications*. London: Office for National Statistics.