HOME MOTIVATION PROGRAM EFFECT ON DEVELOPMENTALLY DELAYED MEXICAN-AMERICAN CHILDREN

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NUTRITION, TEXTILES AND HUMAN DEVELOPMENT

BY

MARY HELEN SOSA, B.A.

DENTON, TEXAS

AUGUST, 1981

The Graduate School

Texas Woman's University

Denton, Texas

July 17, 1981

We hereby recommend that the Thesis prepared under our supervision by Mary Helen Sosa

entitled Home Motivation Program Effect on Developmentally Delayed Mexican American Children

be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

Committee:

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

ABSTRACT

Mary Helen Sosa

A Home Motivation Program Effect on Developmentally Delayed Mexican-American Children.

August, 1981

This study was designed to test a Home Motivation Program curriculum and its effect on developmentally delayed Mexican-American children. The program attempted to provide the parents of the children with the competence needed to teach their children basic self help skills. Ten developmentally delayed Mexican-American children were chosen from the Texas Research Institute of Mental Sciences Child Development Clinic in Houston, Texas to participate in the study. The children were between the ages of three and six, (4 girls and 6 boys). For eight weeks (twice a week), the researcher went into the homes of the children with an individualized home program based on an assessment of the child's developmental needs and parent's concerns. The Vineland Social Maturity Scale was utilized as a pre-post test measure of the children's self help skills. A case study of each child was done and descriptively analyzed. The study found that parents and children benefited from the home approach. The children's Vineland scores showed an increase of two to six months in social age. The parents became more effective in working with their children as shown by follow up interviews with them and with their child's school teacher. It was concluded that a Parent Counseling Program would increase its effectiveness. Further research in the use of the play technique approach and studies allowing for statistical analysis of the program's effectiveness is suggested.

ACKNOWLEDGEMENTS

The author wishes to express her gratitude to the TRIMS Child Development Clinic Chief, Dr. Kay R. Lewis and to her colleagues on the Staff for their guidance, suggestions and support throughout this project, especially Myriam, David and Amy.

A vote of thanks to my Committee, Toby Myers, Bill Duer and Irene Robertson.

A special thanks to my husband, Sabino Garcia de Acilu for his patience and understanding.

y....sobre todo mi agradecimiento a los diez niños/niñas, sus padres y todos los familiares. Si no fuera por su gentileza en permitirme entrar en sus casas y sus vidas, éste proyecto no hubiera sido posible.

GRACIAS!

He/She grows in the same patterns and
has the same basic needs as all children.
His/Her growth may be slower in some areas,
but the goals are the same:

-to help them attain as much independence
as possible

-to give them a sense of worth

-to help them achieve their full potential...

THANKS...to my nieces and nephews who helped me see what that potential could be and more...Thanks: Leo, Dora, Angie, Sara, Frankie, Susie, Tony, Elizabeth and Melissa too.

Table of Contents

HOME MOTIVATION PROGRAM EFFECT ON DEVELOPMENTALLY DELAYED MEXICAN-AMERICAN CHILDREN

Introduction

Child rearing in poor families operates under a number of difficulties. Parents are hard pressed by the problems of daily living and are often lonely and discouraged. They feel helpless to affect the course of their children's development, and they prefer the passive, even apathetic child because he/she is easier to live with. In Texas, 31.4% of all Mexican-American families were classified as below the poverty level (1970, Census Data). Padilla (1976) argues that if mental health care is to be adequate for the Mexican-American, it must be preventive. In particular, it must focus on the mental well being of the Mexican-American child. If children live in an environment in which they are not forced to attempt tasks for which they are not ready, their sense of competence need not suffer during early childhood (White, 1958). Developmentally delayed children typically encounter tasks which are so difficult for them that there can be little pleasure in accomplishment. This study is presented as an evaluation of one program which attempted to reach developmentally delayed Mexican American children in one aspect of their lives - self help skills. The children were chosen from the Texas Research Institute of Mental Sciences (TRIMS) Child Development Clinic where they were outpatients. The TRIMS clinic provides a comprehensive evaluation (physical, psychological, social and educational), and offers treatment, (therapy, counseling and/or medication). The Child Development Clinic helps

parents to coordinate medical, educational, and other services their child may need. The researcher worked in the TRIMS Child Development Clinic program for four years prior to the study. Isolated home visits made especially to the Mexican-American, Spanish-speaking families made her aware of the need for a Home Motivation Program (HMP). The home visits made an improvement in the relationship with the family and their effectiveness in working with their child. The research brought a clinic program to the homes for the purpose of enhancing effectiveness.

Within the child development literature, specifically that literature which addresses developmental delay, problems stem from inadequacies in the social-cognitive environment (Meier, 1976). Furthermore, even when problems do originate from such factors as poor prenatal care, obstetric complications, sub-standard nutrition, inadequate medical care, and/or biological abnormalities, the quality of a child's environment may determine in large measure the degree of actual risk for that child. A study was done by Werner, Bierman, and French (1971) presenting data pertaining to the relation of perinatal stress, environmental factors, and intelligence among Hawaiian children. They concluded that "environmental factors tend to interact with various risk conditions to determine the likely course of development" (p. 73). Based on these findings, that environmental factors and organic factors tend to interact in their effect on development, this study is presented as an assessment of environment and actual work in the homes of developmentally delayed children as an effective measure for stimulating the child's development.

Understanding about families of children with developmental disorders has progressed considerably over the past decade. Previous thought was that a developmentally delayed child learned more effectively in a "special setting, however, recent research has confirmed that new methods of involving parents in the treatment process is more effective" (Lovaas, Schopler and Reichler, 1970, p. 216). Moore & Bailey in 1973 developed an individualized home program based on an assessment of the child's learning and developmental needs and parental concerns. Parents observe therapists work with their child and thus learn to work with their own child. This parent-child interaction increases their skill competence and helps them to recognize the child's potential and his/her limitations. These home programs are tailored to the resources and capacities of the family. Marcus and Lansing, in their 1978 study cite the purpose of parents as co-therapist

> is to build a lasting support system for families faced with a chronic disorder of learning and adaptation in their child. With an improved understanding of their child's functioning, parents are better able to deal with educators, physicians and other service providers (p. 638).

If parents are involved in all aspects of an integrated approach to service delivery, they are in a better position to make rational decisions about their child's welfare.

The many complex problems faced by the parent of a developmentally delayed child are exacerbated for the Mexican-American parent who is Spanish-speaking only and is living in the United States.

Dr. Alberto Serrano in 1973 did a study in San Antonio, Texas, which concluded that "the best role for the mental health professional

is that of a consultant, facilitator, go-between coach, decreasing our role as direct 'therapists' as time goes on" (p. 1057).

Statement of Problem

Can a home motivation program for Mexican-American parents of a developmentally delayed child encourage acceptance, involvement and the competence needed to enhance their child's self help skills and social adjustment?

Since developmental delay poses stress and special learning situations, parents needing some outside help in coping is expected. At present, no formal program in the Houston community designed specifically for the Spanish-speaking parents of developmentally delayed children is available.

A pilot program to test a TRIMS Child Development curriculum, developed by the researcher, was implemented in the Home Motivation Program and was tested in the homes of ten developmentally delayed Mexican American children. The HMP was sensitive to the culture and traditions of the Mexican American. The Vineland Social Maturity Scale was administered before and after the program (Appendix A) to assist in determining each child's acquisition of self help skills.

Statement of Hypothesis

Although the learning of self help skills for a developmentally delayed child is an on-going project, the hypothesis is that a structured Home Motivation Program that works with the parent and the child in his/her own home, through observation, demonstration, and coaching enables the parent to become a co-therapist in

behavior management and enables the child's self help skills to increase.

Definition of Terms

Developmentally delayed child for the purposes of this study refers to those children who through psychological testing are shown to be functioning in the IQ ranges of between 50 and 70 and are between the ages of three and six.

Mexican-American child is defined as one who is born in the United States, whose parents are from Mexico, and who is for the most part either monolingual in Spanish or bilingual in Spanish and English.

Barrio is that area or neighborhood which is predominantly Mexican American and is identified as such by its residents.

Self help skills as defined in the Vineland Social Maturity Scale is "maturation in social independence and encompasses self help, self direction, locomotion, occupation, communication, and social relations" (Doll, 1965, p. 23).

Limitations

This study has been carefully and thoroughly planned to obtain the best data possible. Even with the most careful planning, however, problems do arise for which there is no control. These are the limitations of the study. The present study has limitations which must be noted. The subject pool is only ten. Bias is expected in this study because the researcher and the data collector were the same person. The implementation of the program depended on the effectiveness of one person - therapist, data collector, researcher, who took the program to the children's homes. Learning atmosphere was not always

at an optimum because health problems of the children interfered. Adequate space for carrying out the HMP was difficult as some children lived in small crowded homes. The researcher was able to compensate constructively for the deficiency by incorporating other significant persons present in the home as trainers in the HMP.

Review of Literature

Child development, developmental delay, the effect of parents as co-therapists, parent-child interaction, Mexican-Americans in Texas, various modes of therapy, environmental deprivation and the social service delivery system are included in the literature review.

Over the years much research has been done (and the results have shown consistently) that the young disabled child develops much better and more fully when cared for at home. Today, professionals consistently recommend that parents keep their disabled child at home within the family if this is at all possible (Klebanoff, 1973). The most important factors in a child's development are parents, caretakers, and environment. The developmental environment of a child consists of space, toys and stimulation. The child needs to grow at his/her own rate and play is the child's way of learning (Klebanoff, 1973).

Kagan (1969) emphasized that early intervention is needed to change the behavior of those mothers who have a negative attitude toward their children, "to alleviate the stress and increase the support of mothers at the time of the initial mother-child relationship" (p. 261). The mother is the source of stimulation and the mediator of environmental stimuli. Farber, Jenne and Toigo, (1960) stated that "the parents of

developmentally delayed children experience enormous changes, including serious symptoms of psychological stress, a terrible sense of loss, a prolonged crisis, a lowering in self esteem" (p. 345). In 1980, Waisbren noted that "the parents of a developmentally delayed child tended to see themselves negatively and express more negative feelings about the child" (p. 216).

The parent contributes to the continuity of the child's individuality by providing a relatively constant interpersonal environment during important formative years. This constancy is a function of the longitudinal consistency of the parent's personality and child rearing attitudes (Murphy, 1964). In general, by virtue of prior conditioning, a child tends to be selectively influenced by value judgments emanating from the parental social class and other institutional affiliations. Hood, (1971) stated that:

> the poor home harbors many hazards for the developing child. A variety of substandard living conditions have been shown to contribute to physical effects on health and the living conditions of the poor have a number of other consequences for childrearing, nearly all of them detrimental to what we know as optimal child development: 1) the passive and conforming child is valued, 2) home becomes a place from which to escape, 3) poor children have little exposure to the kinds of materials they will use in school and 4) home is likely to be disorganized and chaotic (p. 174).

Cognitive development according to Hebb (1949) occurs in response to a variable range of stimulation, the more variable the environment to which individuals are exposed, the higher is the resulting level of effective stimulation. Hebb further stressed the importance of early sensory and perceptual experience for later problem solving, while

Piaget (1952) emphasized the importance of such experience for the early stages of development. Uzgiris (1968) maintained: "it is not the mere absence of stimulation per se that is important, but rather the absence of variety and possibly certain types of redundancy in stimulation" (p.404). The disadvantaged home is characterized by a conflicting array of stimulation resulting in the child's inability to attend to the most relevant stimuli for increasing intellectual development.

The developmentally delayed child is in need of a special approach to help him/her. Therapy is based upon the principle of effectiveness. Whatever proves to be for the betterment of the individual, to his/her visible, measurable betterment, is sound therapy. Axline (1947), and Moustakas (1953) provided the opinion that group therapy procedures were appropriate for the disturbed retarded child, especially regarding activity play. Ginott (1960) discussed the effective selection of toys and concluded that appropriate choices be derived from the basis upon which the therapy is being directed. Skinner's type operant method "establishes the importance of modifying the environment to provide learning experiences, using the reinforcement variables to induce changes in adaptive behavior" (p. 107).

Robert W. White (1970) a psychologist, focused attention on the development of competence, an aspect of motivation which had until then received little attention. He defined "competence in its broad biological sense as 'fitness or ability'". (p.100). His theory implied that if children lived in an accepting environment and were not forced

to take on more than they were ready for, their sense of competence need not suffer during early childhood. White went on to say that when young retarded children develop strong feelings of inferiority, the environment may not be suitably simplified or there may be difficulties in the childrer relationships with family members. White argued for training delayed children in self help and in useful tasks. If they can gain these skills, they may gain a measure of worth which can become the focus of there sense of competence. Like everyone else, they seek to be master of their environment.

Most of the recent empirical work in social learning was propounded by Albert Bandura (1962, 1969). He pointed out "that human subjects in social settings can acquire new behaviors simply by seeing them made by a model" (p. 312). In Skinner's model, learning cannot be assumed to take place until after the response has been performed and reinforced. Bandura maintained that if the observer does not make the response himself/herself, and if at the time neither he/she nor the model is reinforced for the behavior, he/she may nevertheless learn the response so that he/she can perform it later as it is called for. Imitation, according to Bandura, is an active, not a passive process and imitative responses are much more likely to be translated into behavior when thre is motivation or incentive (reinforcement). Lovaas (1967) described imitative learning as:

> a pervasive part of learning throughout life, whatever the individual's mental maturity. In treatment programs for retarded subjects, a combination of modeling and reinforcement has been used in teaching new motor and verbal skills (p. 314).

Imitative learning is a process which the mentally retarded employ as readily as do nonretarded persons, provided that the situation is designed to fit within the limits of their capabilities. Imitation provides a simple and natural teaching technique.

Padilla, Ruiz and Alvarez (1975) discussed the "Family Adaptation Model as a therapeutic model in which family centered therapy would be offered, perhaps in a home like setting, and in which the traditional roles of the Latino family might be acknowledged in the therapeutic process or actually reenacted by the therapist" (p. 70). The President's Commission on Mental Health (1978) stated that:

> there is considerable clinical evidence that many of the treatment techniques commonly used in hospital settings and community mental health centers are not effective with Hispanic clients (p. 66).

The Committee cited the great need for research on the appropriateness and efficacy of different treatment modalities developed for Hispanics in general as well as specific sub populations such as Hispanic women, children and, the elderly.

Serrano (1973) concluded in his study that mental health professionals who work with the Mexican-American must work toward helping parents and children to identify and actualize developmental goals and expand their awareness of the environmental realities. "An understanding of the impact of the 'barrio' on the growth and development of the Mexican American children is necessary to understand their life styles and cultural perceptions of family roles" (p. 1056).

Waisbren in 1980 noted that:

the system of services for the developmentally delayed

> and their families in the United States is disjointed and incomplete. Parents must hunt out the program for their child since central referral agencies are inadequate, slow and overly specialized (p. 346).

If this is true for the English-speaking person, it must be more of a problem for the non English-speaking person.

In 1979, Young proposed:

> that the Mexican-American mother and her child often have cultural and language barriers that also interfere with their use of health services. They must of necessity rely on others to translate for them and this is never an efficient way to deal with such problems (p. 310).

The Mexican-American people as a whole continue to maintain close ties (socially, linguistically, economically and culturally) to their country of origin, Mexico. Briggs, (1973) stated that "a very strong indicator of the current strength of this linkage is the fact that Spanish continues to be the preferred language spoken in the home; one estimate suggests that 47.3% of families of Mexican origin in Texas prefer Spanish to be spoken at home" (p. 62). The incidence of this practice is probably much higher along the border, in the Rio Grande Valley and in the traditional barrio sections of such cities as San Antonio, Dallas and Houston.

In relation to Mexican-American mental health, the review of the literature by Padilla and Ruiz (1973) documented conclusively that Mexican-Americans are underrepresented in terms of their utilization of mental health service delivery systems. Padilla in 1975 emphasized "that in particular, language barriers, cultural bound values and class-bound values of the service providers are what block effective utiliza-

tion of the system by the Spanish speaking" (p. 70). The Community Mental Health Center Amendments of 1975 (P.L. 94-63) provided a federal mandate for culturally and linguistically appropriate services in communities where community mental health centers were established. It stated:

> The center's services. .shall be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services. .(Sec. 101 (b)-2).

Since Mexican-Americans constitute such a sizeable minority population within Texas, 19% of the state's population (1970, U. S. Bureau of Census), one would expect them to utilize proportionately mental health/mental retardation health services. They should in fact overutilize mental health services due to the fact that Hispanics generally have been only marginally integrated socially and economically and therefore experience higher levels of social, psychological and economic stress. (Report of the Special Population Panel on Mental Health of Hispanic Americans, 1978, p. 30). One of the explanations in mental health literature for the underutilization of services by Mexican Americans according to Ramirez (1980) is the inaccessibility of MH/MR service centers to the Mexican-American barrios. Valdez (1980) conducted an archival research, which relied upon census data, maps and mass transit service systems. He concluded that "within the state, Mexican-Americans have limited accessibility to these services, since Mexican-Americans are primarily in the southwest section of the state while the Mental Health Centers are primarily in the northeastern

portion of the state" (p. 16).

Conclusions from the Literature

The literature reviewed addressed issues of developmental delay, parent interaction with developmentally delayed children, an overview of Mexican-Americans in Texas, and learning theory. The literature described different approaches for working with the developmentally delayed Mexican-American child, and acknowledged the underutilization of mental health/mental retardation services by the Mexican-American population in Texas.

Methodology

Subjects

Ten children between the ages of three and six who were outpatient clients of the Texas Research Institute of Mental Sciences Child Development Clinic were the subjects of this research project. The intelligence quotients (IQ's) of the children ranged between 50 and 70 and were determined through psychological testing done in the Child Development Clinic by a licensed psychologist. All ten (4 girls and 6 boys) displayed an array of language delay, hyperactive behavior, and limited self help skills.

In order to obtain the subjects for this study the researcher went to the homes and explained the study to both parents in Spanish/English. Parents were permitted to ask questions; if they agreed to participate, they signed the consent form and a time and day were confirmed for the program. The parents of the children who participated in the study were all born in Mexico and were either monolingual in

Spanish or bilingual in Spanish and English. All of the participants of the study lived in the barrio, except for one child who lived in an ethnically mixed neighborhood.

Parents were free to allow their child to be in the study and special emphasis was placed on explaining that participation or non-participation would not in any way hinder or diminish the services they normally received in the TRIMS Child Development Clinic. Confidentiality of data collected was assured. Human Subject's Review Committee approval form is found in Appendix B, and the Agency Approval form is to be found in Appendix C. Informed consent agreement is found in Appendix D.

Apparatus

The materials used in the program by the children were familiar toys, homemade toys and some toys provided by the TRIMS Child Development Clinic. Materials of the program are found in the appendices. Appendix E is the curriculum, Appendix F is parents assignments, and Appendix G is other program materials.

Procedure

The study was conducted in the homes of ten Mexican American developmentally delayed children, over a span of eight weeks with the researcher going into the home twice a week for one hour sessions. The first session consisted of explaining the program to the parents and interviewing them about their child. The child was measured by the Vineland Social Maturity Scale in order to obtain his actual performance level in self help skills. The parents agreed to a day and time for the following sessions, which consisted of implementing the set curric-

ulum according to the needs of the child. The researcher obtained the name of each child's teacher and spent some time interviewing them. The last session of the program on the eighth week repeated the Vineland in order to obtain a measure of the child's self help skills. An informal interview with parents and child assessed other aspects of the results. School progress and carry-over of program goals were discussed with the teacher.

Results

The Vineland Social Maturity Scale scores were combined with other data (interviews, history, observation of child and parent, plus the researcher's clinical impressions) to predict the clinical utility of the program and curriculum. Case Histories (Appendix H) were designed to illustrate the emotional, social and economic implications of the presence of a developmentally disabled child in the homes of Mexican American Families. Demographic data on parents (Appendix I) is included.

The changes in self help skills through the HMP were measured by the Vineland Social Maturity Scale, as shown in Tables 1 and 2.

Table 1

Increase in Adaptive Behavior for Program Subjects N=10

Increase	Frequency
1 mo.	0
2 mo.	1
3 mo.	0
4 mo.	4
5 mo.	3
6 mo.	1
7 mo.	1
	10

Table 2

Vineland Social Maturity Scale N =10

Subject	CA[a]	Before HMP SA[b]
Ester	5.10	2.2
Ricky	5.2	2.0
Leo	4.9	4.0
Andres	6.8	2.1
Sara	5.9	4.0
Tony	3.0	2.5
Benito	2.6	.94
Alberto	6.4	3.4
Maria	3.8	.94
Ruth	6.2	4.2
		After HMP
Ester	6.1	2.4
Ricky	5.4	2.4
Leo	4.11	4.6
Andres	6.10	2.6
Sara	5.11	4.7
Tony	3.2	2.10
Benito	2.8	1.35
Alberto	6.6	3.8
Maria	3.10	1.3
Ruth	6.4	4.6

[a] Chronological Age

[b] Social Age

Conclusions

A Home Motivation Program was implemented for ten developmentally delayed Mexican-American children. The hypothesis appears to be supported since an improvement was found in the children's self help skills and the parent's ability to work with their children. Individually and as a group, parents exhibited improvement in their home teaching effectiveness. Parents began use of behavior management principles, and they realized that they could teach their child in a consistent, structured manner. Parents learned special training was not necessary to teach a delayed child. The researcher found it exciting to see mother, dad, brothers and sisters down on the floor with the delayed child, all participating in the joy of the child's accomplishments.

In the ten families, behavior management was a common problem and attention had to be paid to behavior problems of the children and or siblings in the study. Play therapy techniques for the HMP were based on observational and imitative learning. Family members became part of the project by helping to make the necessary play materials. Through puppets, family members were models for desired behavior. Subjects imitated their "teachers" and patterned after them. The playing was encouraged to continue at times when the researcher-therapist was not present.

Since much maladaptive behavior originates and is maintained in the home, working in the home and with the school was advantageous. Through school visits, mothers observed teachers working with children. They were made aware of their own reinforcement of undesirable behavior. Though the program was begun in Spanish, some children responded more

favorably to English even though their parents were primarily Spanish-speaking. This was attributed to the fact that their teacher, for whom they had positive regard, spoke English. The children who had negative experiences with English speaking teachers preferred Spanish. The researcher maintained flexibility and coordination with the school throughout the HMP. School and home were mutually reinforcing. Encouraging mothers to interact with the school further potentiated positive results. Parents learned to negotiate the complicated service delivery system more effectively by their interaction with the researcher-therapist. From "front porch" meetings with the parents, the need for a parent counseling program emerged, and is suggested for further study.

Impressionistic data convinced researcher of the merits of the HMP. However, statistical analysis might yield more objective evidence of program merit. A question of concern is raised concerning cost effectiveness and long term effects of such a program. The intensive nature of the program indicates that eight weeks is not enough time and, in relation to this study, the researcher believes more experimental work needs to be done in the area of combining a Home Motivation Program with a Parent Counseling Program.

For the researcher, the implementation of such a project invigorated an otherwise routine assignment and encouraged her belief in the merits of a Home Motivation Program.

AGS Vineland Social Maturity Scale

BY EDGAR A. DOLL, Ph.D.

ME..... Sex..... Grade..... Date.....
Last First Year Month Day

idence..... School..... Born.....
Year Month Day

A..... I.Q..... Test Used..... When..... Age.....
Years Months Days

upation..... Class..... Years Exp..... Schooling.....

her's Occupation..... Class..... Years Exp..... Schooling.....

ther's Occupation..... Class..... Years Exp..... Schooling.....

ormant..... Relationship..... Recorder.....

ormant's est..... Basal Score*.....

ndicaps..... Additional pts.....

EMARKS: Total score.....

Age equivalent.....

Social quotient.....

Age Periods

O - I

*egory†	*Score**	*Items*	*LA Mean*
C		1. "Crows"; laughs	.25
HG		2. Balances head	.25
HG		3. Grasps objects within reach	.30
S		4. Reaches for familiar persons	.30
HG		5. Rolls over	.30
HG		6. Reaches for nearby objects	.35
O		7. Occupies self unattended	.43
HG		8. Sits unsupported	.45
HG		9. Pulls self upright	.55
C		10. "Talks"; imitates sounds	.55
HE		11. Drinks from cup or glass assisted	.55
L		12. Moves about on floor	.63
HG		13. Grasps with thumb and finger	.65
S		14. Demands personal attention	.70
HG		15. Stands alone	.85
HE		16. Does not drool	.90
C		17. Follows simple instructions	.93

ey to categorical arrangement of items:
G — Self-help general
D — Self-help dressing
E — Self-help eating
C — Communication
S D — Self-direction
S — Socialization
L — Locomotion
O — Occupation

or method of scoring see "The Measurement of Social Competence."

AMERICAN GUIDANCE SERVICE, INC.
PUBLISHERS' BUILDING, CIRCLE PINES, MINNESOTA 55014

I - II

L ..... 18. Walks about room unattended .....
O ..... 19. Marks with pencil or crayon .....
SHE ..... 20. Masticates food .....
SHD ..... 21. Pulls off socks .....
O ..... 22. Transfers objects .....
SHG ..... 23. Overcomes simple obstacles .....
O ..... 24. Fetches or carries familiar objects .....
SHE ..... 25. Drinks from cup or glass unassisted .....
SHG ..... 26. Gives up baby carriage .....
S ..... 27. Plays with other children .....
SHE ..... 28. Eats with spoon .....
L ..... 29. Goes about house or yard .....
SHE ..... 30. Discriminates edible substances .....
C ..... 31. Uses names of familiar objects .....
L ..... 32. Walks upstairs unassisted .....
SHE ..... 33. Unwraps candy .....
C ..... 34. Talks in short sentences .....

II - III

SHG ..... 35. Asks to go to toilet .....
O ..... 36. Initiates own play activities .....
SHD ..... 37. Removes coat or dress .....
SHE ..... 38. Eats with fork .....
SHE ..... 39. Gets drink unassisted .....
SHD ..... 40. Dries own hands .....
SHG ..... 41. Avoids simple hazards .....
SHD ..... 42. Puts on coat or dress unassisted .....
O ..... 43. Cuts with scissors .....
C ..... 44. Relates experiences .....

III - IV

L ..... 45. Walks downstairs one step per tread .....
S ..... 46. Plays cooperatively at kindergarten level .....
SHD ..... 47. Buttons coat or dress .....
O ..... 48. Helps at little household tasks .....
S ..... 49. "Performs" for others .....
SHD ..... 50. Washes hands unaided .....

IV - V

SHG ..... 51. Cares for self at toilet .....
SHD ..... 52. Washes face unassisted .....
L ..... 53. Goes about neighborhood unattended .....
SHD ..... 54. Dresses self except tying .....
O ..... 55. Uses pencil or crayon for drawing .....
S ..... 56. Plays competitive exercise games .....

V - VI

O	57. Uses skates, sled, wagon	5.13
C	58. Prints simple words	5.23
S	59. Plays simple table games	5.63
SD	60. Is trusted with money	5.83
L	61. Goes to school unattended	5.83

VI - VII

SHE	62. Uses table knife for spreading	6.03
C	63. Uses pencil for writing	6.15
SHD	64. Bathes self assisted	6.23
SHD	65. Goes to bed unassisted	6.75

VII - VIII

SHG	66. Tells time to quarter hour	7.28
SHE	67. Uses table knife for cutting	8.05
S	68. Disavows literal Santa Claus	8.28
S	69. Participates in pre-adolescent play	8.28
SHD	70. Combs or brushes hair	8.45

VIII - IX

O	71. Uses tools or utensils	8.50
O	72. Does routine household tasks	8.53
C	73. Reads on own initiative	8.55
SHD	74. Bathes self unaided	8.85

IX - X

SHE	75. Cares for self at table	9.03
SD	76. Makes minor purchases	9.38
L	77. Goes about home town freely	9.43

X - XI

C	78. Writes occasional short letters	9.63
C	79. Makes telephone calls	10.30
O	80. Does small remunerative work	10.90
C	81. Answers ads; purchases by mail	11.20

XI - XII

O	82. Does simple creative work	11.25
SD	83. Is left to care for self or others	11.45
C	84. Enjoys books, newspapers, magazines	11.58

XII - XV

S	85. Plays difficult games	12.30
SHD	86. Exercises complete care of dress	12.38
SD	87. Buys own clothing accessories	13.00
S	88. Engages in adolescent group activities	14.10
O	89. Performs responsible routine chores	14.65

XV - XVIII

C	90. Communicates by letter	14.95
C	91. Follows current events	15.35
L	92. Goes to nearby places alone	15.85
SD	93. Goes out unsupervised daytime	16.13
SD	94. Has own spending money	16.53
SD	95. Buys all own clothing	17.37

XVIII - XX

L	96. Goes to distant points alone	18.05
SD	97. Looks after own health	18.48
O	98. Has a job or continues schooling	18.53
SD	99. Goes out nights unrestricted	18.70
SD	100. Controls own major expenditures	19.68
SD	101. Assumes personal responsibility	20.53

XX - XXV

SD	102. Uses money providently	21.5+
S	103. Assumes responsibility beyond own needs	21.5+
S	104. Contributes to social welfare	25+
SD	105. Provides for future	25+

XXV+

O	106. Performs skilled work	25+
O	107. Engages in beneficial recreation	25+
O	108. Systematizes own work	25+
S	109. Inspires confidence	25+
S	110. Promotes civic progress	25+
O	111. Supervises occupational pursuits	25+
SD	112. Purchases for others	25+
O	113. Directs or manages affairs of others	25+
O	114. Performs expert or professional work	25+
S	115. Shares community responsibility	25+
O	116. Creates own opportunities	25+
S	117. Advances general welfare	25+

AGS AMERICAN GUIDANCE SERVICE, INC. Publishers' Building, Circle Pines, Minnesota 55014

TEXAS WOMAN'S UNIVERSITY
HOUSTON CAMPUS
HUMAN RESEARCH REVIEW COMMITTEE
REPORT

STUDENT'S NAME Mary Helen Loca

PROPOSAL TITLE Home Motivation Program Effect On Developmentally Delayed Mexican American Children

COMMENTS: _____

DATE: April 6, 1981

Donna J. Robertson
~~Disapprove~~ Approve

Vera M Harman
~~Disapprove~~ Approve

Susan K. Gardner
Disapprove Approve

~~Disapprove~~ Approve

Appendix C

Consent Form
TEXAS WOMAN'S UNIVERSITY
HUMAN SUBJECTS REVIEW COMMITTEE

(Form B)

Title of Project: _____

_____

Consent to Act as A Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time. I further understand that no medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

_____
Signature Date

_____
Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____
Signature Date

_____
Position

_____
Witness Date

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

TEXAS RESEARCH INSTITUTE OF MENTAL SCIENCES
1300 Moursund, Texas Medical Center, Houston, Texas 77030 713 797-1976

John J. Kavanagh, M.D.
Commissioner

Appendix D

February 18, 1981

Mary Helen Sosa
5206 A Arboles #3
Houston, Texas 77035

Dear Mary Helen:

Your request to use ten of our active patients from the Child Development Clinic in a pilot project, Home Motivation Program as a part of your graduate study at Texas Woman's University is granted.

I understand that a copy of this study will be submitted to our staff. I look forward to seeing the results of your study.

Respectfully,

Kay R. Lewis, M.D.

Kay R. Lewis, M.D.
Chief, Child Development

Appendix E

LESSON PLANS

A

I. Review (10 minutes)

II. Area: Toilet Training

III. Objective
The child will let parent, teacher know when they need to go to the bathroom.
If developmentally cannot communicate this, will be able to have a schedule for using bathroom.

IV. Materials
M&M's - Potty or commode

V. Lesson Plan
1) Show child bathroom area and use.
2) Teach child times to use bathroom.
3) Encourage mother to follow schedule.
4) Reinforce when child uses toilet.

B

I. Review

II. Area: Toilet Training

III. Objective
Child will care for self after using bathroom

IV. Materials
Toilet paper, towel, soap

V. Lesson Plan
1) Show child toilet paper, teach him how it is used.
2) When to use paper - discuss.
3) Show child handle on toilet and teach how to flush.
4) Proceed to sink and teach to wash hands.

C

I. Review

II. Area: Eating

III. Objective
Child will properly use table utensils

IV. Materials
Plate, cup, silverware, napkin

V. Lesson Plan
1) Child will be taught use of each article for table use.
2) Demonstration and practice of use of utensils.
3) Use of glass with water without spilling.

D

I. Review

II. Area: Eating

III. Objective
Child will demonstrate good manners at table and consideration of others.

IV. Materials
Dishes (serving platters)

V. Lesson Plan
1) Role playing of sitting at table and passing platters, waiting for turn.

E

I. Review

II. Area: Communication

III. Objective
According to child's speech development, motivation either in pre-verbal expression or word usage.

IV. Materials
Picture book, mirror, bell

V. Lesson Plan - (Pre-verbal Expression)
1) Introduce simple sound combinations, ba-ba, da-da, ma-ma, pa-pa, ... etc.
2) Describe objects and events as they occur, practice sounds made by pets ...

F

V. Lesson Plan (Word Usage)
1) Read simple picture book made by parent.

2) Make sounds and show picture.
3) Name body parts with mirror
4) Use short commands:
sit down - stand up - shut the door - come here.

G

I. Review

II. Area: Socialization

III. Objective
The child will be aware of others will share and cooperate according to his own developmental level.

IV. Materials
Dolls, puppets, ball, plastic soldiers, animals or cars.

V. Lesson Plan
1) Hold child close to you - try to obtain some eye contact.
2) Play game with ball where parent or teacher or sibling holds ball with child and both throw together.

H

V. Lesson Plan
1) To learn consideration for others - role play with puppets - dolls.
2) Cooperation to be learned by playing with plastic toys (animal farm, soldiers or car races).

I

I. Review

II. Area: Groom and dressing

III. Objective
The child will learn importance of personal hygiene and will learn the basics.

IV. Materials
Toothbrush - soap and towel - comb - brush.

V. Lesson Plan
1) Role play washing hands and face.
2) Role play bathing.
3) Role play brushing teeth and grooming hair.

J

I. Review

II. Area: Dressing - Self care

III. Objective
Child will learn to dress and undress self - if developmentally not able, will at least dress with assistance.

IV. Materials
Articles of clothing

V. Lesson Plan
1) Role play dressing with various articles of clothing.
2) Buttoning, zipping, lacing.

K

I. Review

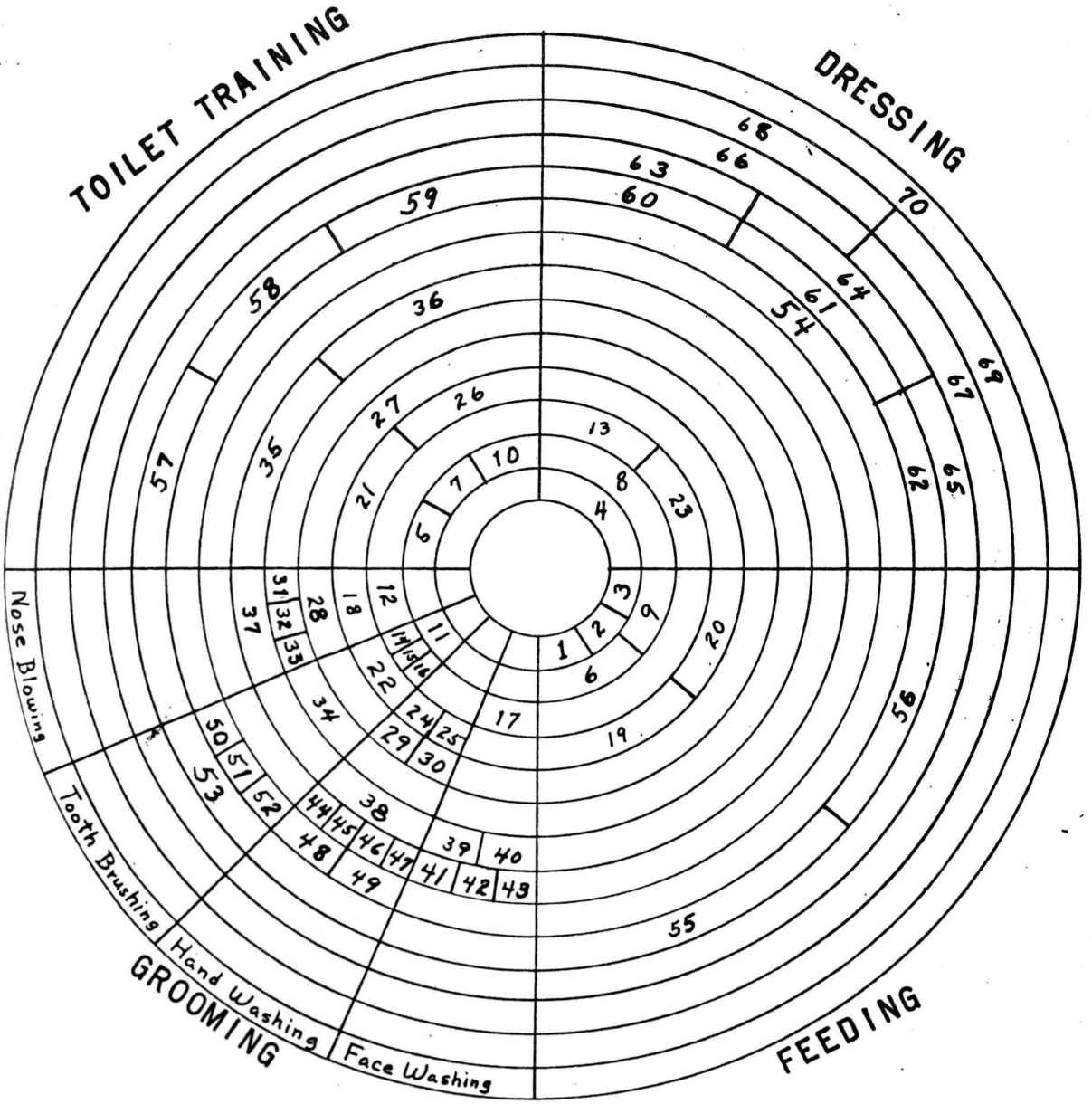
II. Area: Ambulation

III. Objective
Child will exercise body according to physical and developmentally capacities.

IV. Materials
Jump Rope

V. Lesson Plan
1) Body balance - lifting head - lifting body.
2) Jumping, skipping, running.
3) Review limb functions.

SELF HELP ASSESSMENT CHART



NAME_____

DATE_____

SELF HELP ASSESSMENT CHART

FEEDING

1 Sucks food well.

2 Recognizes food.

3 Opens mouth for food.

6 Uses fingers for feeding self.

9 Chews soft foods.

19 Uses spoon. (some spilling)

20 Drinks from cup with help.

55 Drinks from cup unaided. (some spilling)

74 Knows when to use spoon/fork.

75 Uses spoon/fork/glass unaided without spilling.

76 Uses napkin

77 Spreads (butter, peanut butter, etc.) with knife.

100 Uses knife for cutting soft foods.

101 Uses knife with fork well.

102 Serves self without spilling.

110 Uses salt, pepper, sugar appropriately.

111 Uses acceptable table manners.

112 Provides for self in self-service restaurant.

113 Eats balanced meals.

SELF HELP ASSESSMENT CHART

TOILET TRAINING

5 Maintains dry diapers/pants for at least two hours.

7 Bowel movements are generally regular.

10 Has established some regularity of bladder during day time.

21 Indicates when wet and/or dirty.

26 Sits on toilet when placed and supervised.

27 When taken to toilet responds within reasonable time.

35 Indicates need to go to the toilet.

36 Bladder control during the day but has to go quite often.

57 Males urinate in toilet standing up.

58 Undresses as far as necessary when using the toilet.

59 Adjusts clothes after having used the toilet before leaving bathroom.

71 Uses toilet paper adequately.

72 Flushes the toilet and leaves it in good order.

73 Uses the toilet by self.

93 Closes bathroom door when using toilet.

99 Washes hands automatically after using toilet.

103 Males use urinals.

109 Finds correct bathroom in public place.

SELF HELP ASSESSMENT CHART

HAND WASHING

24 Rolls up sleeves, takes off jewelry.

25 Holds hands under adjusted water.

29 Rubs hands with soap.

30 Rinses soap off hands.

38 Rinses sink.

44 Turns water off.

45 Takes one paper towel or cloth towel.

46 Dries hands.

47 Dries sink counter.

48 Hangs up (disposes of) towel properly.

49 Turns on water.

84 Adjust water temperature.

85 Cleans fingernails.

105 Washes hands completely and is self critical.

SELF HELP ASSESSMENT CHART

NOSE BLOWING

12 Pulls tissue from box.

18 Puts tissue over nose.

28 Blows air through nose.

31 Pinches both nostrils closed.

32 Wipes area around nose.

33 Makes a final check.

37 Throws the tissue away.

82 Knows when to use kleenex.

SELF HELP ASSESSMENT CHART

TOOTH BRUSHING

11 Holds tooth brush.

14 Brushes outside surfaces of teeth with help.

15 Brushes biting surfaces of teeth with help.

16 Brushes inside surfaces of teeth with help.

22 Rinses mouth.

34 Wipes mouth clean.

50 Brushes outside surfaces of teeth independently.

51 Brushes biting surfaces of teeth independently.

52 Brushes inside surfaces of teeth independently.

53 Identifies own tooth brush.

78 Prepares tooth brush independently -

- wets brush
- applies tooth paste
- puts cap back on tooth paste

79 Brushes teeth when reminded.

80 Rinses sink.

81 Puts all equipment away.

104 Brushes teeth after each meal independently.

108 Understands importance of brushing teeth.

SELF HELP ASSESSMENT CHART

DRESSING

4 Allows others to dress/undress him/her.

8 Cooperates in dressing/undressing.

13 Pulls off own socks, pants.

23 Pulls off sweater, jacket.

54 Removes tee-shirt, pullover shirt, dress.

60 Removes shoes.

61 Pulls up pants.

62 Puts on pants, underpants, pajamas.

63 Unsnaps

64 Unzips

65 Unbuttons

66 Puts on socks.

67 Puts on sweater, coat.

68 Puts on tee-shirt, pullover shirt, dress.

69 Unties shoes.

70 Puts on shoes.

88 Snaps

89 Zips

90 Buttons

91 Hooks

92 Laces shoes.

94 Knots shoe laces.

95 Ties shoe laces.

96 Unbuckles belt.

97 Treads belt through loops.

98 Buckles belt.

Appendix G

PARENTAL STRATEGIES

Toilet Training:

1. If not toilet trained, continue strategy discussed in lesson.

2. If toilet trained - stress self care at toilet (cleanliness).

Eating:

1. Using table utensils (play game of pretend - if siblings in house, have them do this).

2. Drinking - same as above praise when does not spill - ignore if spill occurs.

3. Table manners - game of pretend, teach to use napkins, to ask for food.

Communication:

1. Pre-verbal expression.

   a. Introduce simple sound combinations ba-ba, da-da, bu-bu, be-be.
   b. Describe objects and events as obey occur, practice sounds made by pets, cars, bells, ... telephone...

2. Word Usage

   a. Read simple picture book.
   b. Make sounds and show picture.
   c. Name body parts with mirror.
   d. Use short commands:
      "sit down"
      "stand up"
      "shut the door"
      " come here"

Socialization:

1. Cooperation, play game with child (ball, have child hold ball with you and throw together).

2. Consideration and awareness of others (puppet game - if no puppets use dolls or plastic toys).

3. Variety of games possible - according to child's developmentally stage.

Grooming and Dressing:

1. Personal Hygiene

    a. Washing hands and face.
    b. Bathing
    c. Tooth Brushing

2. Dressing and undressing

Ambulation:

1. Body balance - exercises according to child's capability.

    a. lifting head
    b. lifting self
    c. jumping - skipping - running
    d. limb functions

TOOLS NEEDED:

Toilet Training:

Candy, toilet paper, towel and soap.

Eating:

Dishes (plate, cup, utensils)
Napkin
Serving dishes

Communication:

Picture book (can be made by parent),
Mirror

Socialization:

Dolls, puppets, ball, plastic soldiers or animals or cars.

Grooming and Dressing:

Toothbrush, soap and towel, shoe with laces, shirt with buttons.

Ambulation:

Jump rope.

TAREA PARA LA SEMANA

ENTRENAMIENTO PARA EL BAÑO

1) Si su hijo no esta entrenado para ir al baño, continue los ejercicios discutidos en la primera leccion.

2) Si ya esta entrenado para ir al baño, se pondra enfasis en el aseo personal del nino:

   a. como limpiarse despues de usar el baño.
   b. se lavara las manos siempre que use el baño.
   c. se le insistira que tiene que tirar de la cadena siempre que use el baño.

EL ALIMENTO

1) El uso d'elos cubiertos en la mesa (hacer un juego de imaginacion con el plato. el vaso y otros utensilios de la mesa).

2) La bebida: hacer otro juego con el vaso lleno de agua y darle animo al nino si no tira el agua.

3) Comportamiento en la mesa: ensenar al niño el uso de la servilleta y como pedir la comida.

LA COMUNICACION

1) Expresion pre-verbal:

   a. introducir combinaciones de sonidos sencillos, ba-ba; da-da; be-be....
   b. describir objetos y acontecimientos cuando ocurren, practicar y repetir sonidos de los animales, carros, campanas, telefono....

2) Uso de las palabras

   a. leer palabras en un librito sencillo
   b. hacer sonidos con los dibujos.
   c. nombrar partes del cuerpo con un espejo.
   d. darle breves mandatos al niño: por ejemplo:

      1. sientate
      2. parate
      3. cierra la puerta
      4. ven aqui.....

LA SOCIALIZACION

1). Cooperacion, jugar con el niño (los dos cojen la pelota y la tiran a la vez)

2) Consideracion y conocimiento de quienes le rodean (juego con munecas u otros juguetes).
(existen una variedad de juegos posibles segun la etapa del desarrollo en que se encuentre el nino)

HIGIENE PERSONAL Y VESTUARIO

1) Higiene Personal

a. lavarse las manos y la cara
b. el baño
c. lavarse los dientes

2) Practicar el vestirse y desvestirse.

AMBULACION - MOVIMIENTO FISICO

1) Equilibrio del cuerpo: ejercicios segun la capacidad del nino.

a. alzar la cabeza
b. alzar el cuerpo
c. brincar, correr....
d. ejercitar la funcion de las piernas, brazos, manos

Appendix H

Case History - 1

Leo is the four year old son of young parents who came to the United States at an early age. These parents attended high school but dropped out at age sixteen to get married. The marriage has been chaotic since the father keeps himself totally isolated from his wife and children, preferring to spend all of his time and money with his friends. The family lives in a very small frame house that is in great need of repair. Their is no yard space, no running water and no heat in the winter. The mother's family lives near by and it is there that they spend most of their time. The father rarely keeps a job and mother has to depend on her parents for money to buy groceries, clothing and medications for her children. The youngest child is epileptic and takes phenobarbital regularly.

Leo was the product of a normal pregnancy with premature birth (31 weeks gestation). Labor lasted one hour and Leo weighed 2 pounds and 10 ounces. At birth he was found to have Hirchprung's disease necessitating an ileostomy. Leo spent the first five months of his life in the hospital. Mother visited her son every day and was physically and verbally abused by her husband for doing so. Leo's developmental milestones were all delayed. At two years of age he contracted spinal meningitis for which he was again hospitalized. Hermann Hospital's High Risk Clinic had followed this child's development and at age three referred the family to the TRIMS Child Development Clinic for an intense diagnostic work-up and comprehensive casemanagement. At TRIMS Leo was evaluated and the Stanford Binet Intelligence Test was administered. A mental age of two years, 5 months which showed him to have significant language delay, articulation and oral motor problems were the results. On the Bayley Scale of Infant Development he had a

developmental index of 66 on the mental scale.

This researcher attempted to interview both parents for the Vineland Social Maturity Scale at the onset of the program but the subject's father refused to cooperate and was never home throughout the eight weeks. Mother asked the researcher to come to the grandmother's home for the program. Leo's siblings (3 year old girl and 2 year old boy) were found to be a liability to the therapy and it was difficult to do anything with Leo since they would interfere and wanted attention for themselves. This researcher was aware that these children were all so deprived that they could not tolerate one getting more attention than them. Special efforts were made to have them in another room with some of the program materials while the mother and researcher worked with Leo. Mother was encouraged to give Leo a special time every day since he was showing signs of withdrawal and depression. Leo's self help skills were good except for toilet training. Mother had been afraid to work on this because of the ileostomy and other intestinal complications the child had. With some modeling and encouragement Leo was successfully toilet trained by the end of the program. His language delay was of great concern and Leo was enrolled in the Early Childhood program of the Houston Independent School District. The mother was taught some speech therapy techniques to use at home. Good communication was established between Leo's mom and teacher. With school and the home program Leo began to initiate his own play activities and little by little was more assertive with the brother and sister. He started to express much more emotion; feelings of anger, sadness, happiness and fatigue. Leo's passiveness was diminished.

On going intervention with this family is needed because this young mother is alone in coping with two sick children and she needs encouragement to become independent and make it on her own.

Case History - 2 -

Sara is the six year old daughter of a father who is twenty years older than his wife. He is in his late forties and she in her mid twenties. This father was born in Mexico and came to the United States in his teens to work and be on his own. Eight years ago he went back to Mexico hoping to find a younger woman who would marry him and give him a family. The couple initally lived in a Mexican border town while the father worked on the american side. Once they were all legally admitted to the United States they came to Houston. The father has always worked as a bartender in exclusive clubs but is not paid very well. The family is not doing well financially but mother keeps a neat clean home and the children are always clean and well dressed. After renting a small duplex in the north side barrio of Houston for seven years they have now moved to a larger home in Southeast Houston which they are buying. This home is a neat frame house with a large yard. The children are enjoying their new play space.

These parents had very little formal education and appear to be limited in their intellectual capacity. Their is no extended family in Houston, however they do make frequent trips to the border to visit family.

Sara is reported to be the product of an uncomplicated pregnancy and delivery. Her developmental milestones were all within normal limits except for speech. At age six the parents finally decided that Sara was not "out-

growing" her speech delay. They took her to a neighborhood clinc which referred them to the TRIMS Child Development Clinic. At TRIMS several testing instruments were used to evaluate Sara: the Bayley Scale of Infant Development, the Leiter International Performance Test, and the Vineland. The Leiter revealed a mental age of two years and three months with an IQ of 52. On the Bayley she was unable to do any language items beyond 20 months, all other items ceilinged out at 30 months. The Vineland placed her at the four year level with comments by the psychologist that the parents were probably overestimating. A hearing evaluation was done to rule out hearing loss and it was found that hearing was within normal limits.

This researcher immediately assisted the family in enrolling Sara in an Early Childhood Program. This was seen to be extremely important because the parents were not able to understand the extent of developmental delay their child was exhibiting. Sara is an attractive child who, except for language delay looks like a normal child.

The Home Motivation Program found that the parents expectations of Sara were beyond her capacity, the child was continuously frustrated and depressed, she showed anger for her siblings and was beginning to exhibit spoiled and acting out behaviors. The school was reporting Sara's resistance to structure, her extreme fear, nervousness and sensitivity. This researcher worked with the mother trying to point out the child's limitations by having the mother observe how to teach Sara by concentrating on one small area, asking them to repeat and to structure her time at home. Communication with Sara's teacher was improved through the program by having the parents attend school meetings. In a follow up interview to the program, Sara's teacher said

that she is now sending mother written instructions for tasks she can do with Sara at home. The parents are learning to speak openly of their daughter's limitations and they are giving equal time to her and to the twins. The parents also followed through on community agency contacts obtaining Social Security Benefits for Sara as well as a recreation program for the summer.

Case history - 3 -

Andres is the six year old son of young parents born in Mexico but raised in Texas. Both father and mother were the only parents in the study with a United States High School Diploma. Father served in the Air Force for ten years, he met his wife in high school and married her after graduation. While in the Air Force he received specialized training which gave him the opportunity to get a good job in Houston. This family lives comfortably in a large brick home in a Southwest Houston neighborhood of mixed ethnicity. They are also in a small school district which provides adequate programs in special education. The parents, Andres, and his sister, who is three years older, live in the home. A maternal aunt lives close by and provides some extended family support. The maternal/paternal grandparents live in San Antonio, Texas and each year take turns caring for Andres and his sister while the parents take a vacation alone. This couple was the most acculturated of the study, however, this in itself posed other peculiar problems in coping with a developmentally delayed child. On an intellectual level they were accepting and planning for their child in an "anglo" way, emotionally their Mexican background got the better of them and made them feel guilty for thinking

they could institutionalize their child. These parents handled their guilt by infantilizing their son in hopes of keeping him longer.

Andres was born in an Air Force Hospital, pregnancy had been normal, except for an infection which was treated. Delivery was complicated, labor lasted too long and a caesaearan section was done apparently too late to avoid brain damage. Andres was diagnosed soon after birth as Cerebral Palsied, Spastic Quadraparesis and Microcephaly. Many attempts at intervention were made while the family was still in the Air Force, little was accomplished due to the parent's resistance. Upon leaving the Air Force they settled in Houston and procedures were begun to enroll the child in the local Cerebral Palsy Center. Several evaluations were done, however, the family moved out of the Harris County limits and were no longer eligible for these services. In their new home they decided to remain obscure and not seek services, convinced that their was nothing to be done for their son. Andres at age six was still on baby food, slept in a crib, took most of his nourishment in a baby bottle and received limited stimulation. His sister was ashamed of him and would close the door to his room when her friends came over. Mother would leave to her job in the evening as soon as the father came home, this, she said was for her own therapy. Father would feed Andres and play with him in the living room for about an hour, this was the extent of anyones emotional interaction with this child.

In 1979 Andres was taken to a private pediatrician because of loss of weight. The doctor immediately recognized the severity of the problem and referred the family to the TRIMS Child Development Clinic for evaluation and family counseling. A complete diagnostic workup was done at TRIMS using

the Vineland Social Maturity Scale. Results of the Vineland were a Social Age of 0.21 placing this child in the range of profound mental retardation. The evaluation showed the child to have no eye contact, no language skills, self stimulating behavior, finger sucking, no receptive language, no interest in toys. A multi-sensory stimulation program was reccomended and for a whole year this researcher worked with Andy's parents making frequent evening and week-end visits trying to help the parents come to the realization that their son could be helped. The mother was the first to show signs of cooperating, mostly because she wanted help with her son. The school district was notified of this child in their area and they too made several home contacts explaining to the parents what they had to offer.

In August of 1980 the father decided to try the school program for his son. Almost immediately this child started to thrive to the amazement of the parents. This researcher continued to monitor the case and on implementation of the Home Motivation Program decided that Andres had progressed to the point of benefiting from such a program. Andres had gone from soft baby food to solid finger food and was beginning to learn to self-feed. His spasticity had improved with the continuous physical therapy he was receiving both at school and at home. Eye contact had been established and he was interested in toys. He could engage in play and his sister was beginning to feel she really had a little brother. The Home Motivation Program set as it's goals to reinforce and encourage the continuous therapy this child needed at home and to begin to introduce the idea of some limited self-help skills. Both parents and the sister were enthusiastic about learning skills to teach Andy at home. At christmas time this researcher was told that Andy was to play the part of Santa Claus in the school program. He now has

a wheel chair which makes it easier to move him around. The parents are convinced that their son can learn and they know that for now they can care for him at home.

Case History - 4 -

Maria is the four year old daughter of young parents who were born and raised in Mexico. At an early age the father came to the United States to live and work. However, as many Mexican young men do, he returned to his home town to find the woman he would marry. The young couple were able to come to this country legally and because of the availability of jobs in Houston, they settled here. Maria is their first child, the second was also a girl and in June of 1981 the Mother is expecting her third child.

This family is doing well financially since Maria's father is a hard and responsible worker. He has bought them a nice brick home in South-east Houston which is well kept and has ample yard space for the children to play in. The house is small and though it would be sufficient for this family they are cramped because of a paternal uncle, aunt and their child who are also living in the home. Maria and her sister have to sleep in the parents bedroom. Mother is emotionally upset about this, she feels her space has been invaded and she does not get along with her in-law's. This compounds the stress she and her husband have to face in addition to their child's developmental delay.

Maria was born in Houston and by report Mother had a normal pregnancy and delivery. Maria's developmental milestones were within normal limits except for speech which at age two was beginning to develop but was seriously curtailed by an episode of high fever and convulsions. Parents began to

notice unusual and abnormal behaviors following the convulsions. Maria exhibited self stimulating and self abusive behaviors, lots of rocking and an unusual gait. The parents proceeded to take Maria back to Mexico for treatment, first to a renowned pediatrician who prescribed medication, then the folk doctors who also gave them more medicines, they even went on several religious pilgrimages far into Mexico hoping for a miracle. They finally returned to Houston after spending much time and money in Mexico to no avail. Father took Maria to a Spanish speaking physician in the barrio who referred them to a pediatric neurologist in the Medical Center. Maria was hospitalized, a complete workup revealed an abnormal electro-encephalogram and a possible metabolic disorder. A child psychiatrist was called in on the case and she raised the question of Autism. Maria was then referred to the TRIMS Child Development Clinic to determine the extent of developmental delay, rule out Autism and to assist the family in finding the necessary services for the child.

The diagnostic workup at TRIMS used the Bayley Scale of Infant Development and found Maria to be functioning at a mental age of 12.2 months with a mental development index of 50 which put her in the severe mental retardation range. On the motor scale Maria had a motor age of 15.9 months.

The interpretation of these results for Maria's parents was very painful, however, it appeared that Mother was more at a denial stage than her husband was, he presented himself as more in the grief stage. A need for extensive parent counseling was noted at that time, especially intervention with the mother.

Maria was enrolled in the Houston Early Childhood Special Education

Program. Her teacher reported that the child had a great resistance to structure, a high activity level, extreme changes in behavior, lots of self-stimulation such as rocking, and no speech. Work was begun immediately in the school to eliminate some of the maladaptive behaviors by employing behavior modification techniques.

The Home Motivation Program was begun soon after Maria was enrolled in school and the teachers recognized the need to decrease the severe behavior problems in order to facilitate her emotional development. Maria was not quite ready for learning self-help skills.

Working closely with the school the researcher tried to reinforce the same techniques at home and teach the parents to work on them. With the intensive effort of this therapy, some progress was made and this researcher decided to introduce some self-help goals to stimulate the parents in working with their child. The school also saw this as a good idea and introduced some self feeding skills, dressing, and toileting. The researcher found that Maria's toilet training was going to be difficult because no schedule could be established since the child had a serious constipation problem. This prompted the researcher to work on a diet plan for Maria. The same was done at school and it proved to be successful to a degree. The school cafeteria had a little difficulty in preparing a special menu for one child.

In the self feeding skills Maria's father discovered that his daughter needed her own private space to attempt her finger feeding, he proceeded to build her a chair with a large tray attached which was her private dining area, mother decorated the tray and some improvement was noted.

After several visits to Maria's home the researcher observed Maria's

increased attention to music, this was seen to be a positive factor and it was introduced into her specialized program. All musical toys she had in the home were utilized to increase her awareness of those in the room with her and to decrease the rocking and self stimulating behaviors. Maria's younger sister was at times an asset to the program in that she provided constant modeling behavior for Maria. However, she tended to "steal" the show and it was necessary to allow her only a limited time in the room, structuring her intervention.

These parents, in my clinical estimation, made great strides together in working with their child. They initiated several visits to the school and have been very cooperative with the doctors who follow their daughter's treatment. On an emotional level, they are still hurting and an intense counseling program will have to be designed for them. Mother will soon have a new baby to cope with and the added stress will have to be monitored as it will most probably affect Maria's progress. This will most certainly be a long term case in the Child Development Clinic.

Case History - 5 -

Alberto is the six year old son of a fifty six year old father and fifty two year old mother. Alberto has five older siblings, three of whom are still living in the home. These parents chose to come to the United States when they realized that their son would have no schooling in Mexico because of his developmental delay. The father immigrated first, bringing the older children with him. Alberto and his mother remained in Mexico. When he was six years old his father decided to bring him to the United States even though he had not yet been admitted legally. The parents

were concerned that their son should start school at an early age. This family is presently living in a rented home in the barrio with a nice big yard where the neighborhood children play with Alberto. The mother keeps the home very neat and clean. Alberto is cared for by his mother and two older sisters.

This mother was in her late forties when she had this child, she relates her pregnancy and delivery were normal. Soon after birth she realized her son was not developing as her other children had done and he also had an unusual facies. She traveled from her village to a larger city in Mexico to ask a Pediatrician what was wrong with her son. The Doctor explained that the boy was a Downs syndrome and attributed his condition to the mother's advanced age at the time of conception. Mother proudly described the many efforts she and her older children had made on behalf of this child. However this researcher has observed that Alberto is overprotected by his family. Some of his maladaptive behaviors and lack of self help skills are most likely attributed to the overprotection. His development in expressive language especially has been stifled by the family's anticipating his every need.

In 1980 this family received a letter from the United States Department of Immigration instructing them to find a physician or an institution that would sponsor Alberto for five years, sending biannual reports to the Center for Disease Control. This was a requisite for legal admission to the country. The school referred the mother to TRIMS Child Development where Alberto was tested using the Leiter International Performance Test and the Vineland Social Maturity Scale. The Leiter gave him

an IQ of 43 placing him in the moderate range of mental retardation, the Vineland showed a social age of 2 years, 8 months with a social quotient of 34.

The Home Motivation Program was received enthusiastically by Alberto's parents and siblings, they all realized that they needed help in working with this child. They saw the consequences of their spoiling him and his language delay seriously concerned them. The two older sisters helped their mother prepare the materials for the program. Alberto was not too happy with the program at the beginning because it imposed structure and discipline in the home which he was not used to. He tried to manipulate the researcher as he did so well with his mother and sisters. The researcher resisted Alberto's manipulation and thus served as a good model for parents and sisters. When Alberto realized he couldnt get what he wanted, he started to give some attention to the tasks being proposed. He liked the play approach and after a few sessions, he was fully invested in the program. The researcher would find him waiting on the front porch eager to share what he had learned and wanting to know what the new lesson would be. Mother was also enthused with her son's progress. For example, she went out and bought him some new jogging shoes so he could learn to tie his shoe laces.

The researcher worked with the family to encourage structure for Alberto in his home schedule. It was suggested that he not watch too much television and that he get to bed early in the evening. In language development, the researcher found a problem in that the family spoke Spanish at home and Alberto was needing to learn English for school. One sister was beginning to learn English and she proved to be helpful in this area.

Good communication was established with the teacher and the family made a point to attend school meetings and extra curricular activities. Mother applied for Social Security benefits for her son after the researcher indicated where they should go to do this. The researcher was unable to fully engage the father in working with Alberto due to his work schedule and the fact that he felt it was a woman's job and his wife and daughter's were doing a good job. The researcher did get him to take Alberto out on week-end's to the park, zoo, shopping or just to be with him in a special way. Some front porch counseling was done with these parents since they were still grieving and feeling guilty for having brought this child into the world at their age. The continued involvement with this family will be to monitor the child's school placement, his language delay and his behavior at home.

Case History - 6 -

Ruth is the six year old daughter of deaf mute parents who came to live in the United States at an early age. Father did not attend school and has learned some sign language through friends. The natural mother of this child abandoned her family when Ruthie was four years old, her sister was six and a brother was two. The father proceeded to leave the children with his mother for a time. Over the last two years these children have lived at times with their father and different surrogate mothers. Six months ago he took them to live with their present stepmother. This is the first time they have lived this long as a family. This stepmother is also deaf mute but she did finish high school, she is teaching the children sign

language and appears to be a good mother to them.

Ruth was the product of a normal pregnancy and delivery. Her developmental milestones were a little slow as reported by her grandmother. She attributes this to the lack of stimulation by the mother or father. At age six, Ruth was enrolled in school and it was at that time that her mother left the home. Grandmother and Ruth's teacher at that time both report that the child became extremely withdrawn and depressed. Ruth did not perform in school and she was eventually transferred into the Special Education Department where she tested out in the mild mental retardation range. Ruthie was tested using the Slosson Intelligence Test and results were consistent with the school's testing placing her in the mild range. Several recommendations were made to the family and the school. The school implemented these recommendations for Ruthie but received no cooperation from the home which made their efforts futile. In 1980 the school referred the family to the TRIMS Child Development Clinic for casemanagement and family counseling.

Ruth was considered an ideal subject for the Home Motivation Program, given her lack of adaptive behaviors and the need to teach her parents how to work with her. Intervention with the parents was difficult since this researcher had very limited sign language. The older sibling turned out to be a good interpreter. Also, with a tablet and pen, most of the communication was accomplished. Sibling interaction in this family was found to be very favorable for the subject of the study. Brother and sister tried very hard to help Ruth come out of hwr withdrawn state. They encouraged her to respond verbally when spoken to in an audible voice. Much of this was done through

puppets and drawings. Also, all the children took turns at telling stories. Ruth eventually started to initiate some of the play activities on her own. The parents also learned to be therapists for their daughter in spite of their handicaps. They showed more interest in Ruthie and came to realize that she did have a handicap and they could help her overcome her delay by allowing her to grow at her pace. Her self help skills improved as she became more out going. The school was helped to understand that they could communicate with Ruthies parents by sending notes. This created a good relationship between home and school and this in turn improved the subject's self image. A public health nurse was engaged to work with this family to improve their parenting since evidence of medical neglect was observed during the home program. The highlight of the program was that Ruthie participated in the special olympics. She won some First Prizes which made her eligible to attend the State Special Olympics in Austin, Texas.

Case History - 7 -

Benito is the three year old son of a young possibly mentally retarded mother and an epileptic father. Reportedly, the mother and two children left Mexico because life with the epileptic father and his family was unbearable for them. She came here illegally and has not applied for her visa. Mother joined a brother and his family here in Houston only to find that they were barely making it financially and their children had been removed from the home for abuse and neglect. Soon after coming here she met an older man and because of her family's situation she chose to go live with him. Mother has recently had a child by this man. The family

is currently living in a one room apartment which was formerly a cheap motel on the outskirts of the city. The living accomodations are very bad and this man barely provides for the family. Their is no play space for these children and the researcher suspected abuse and neglect. Abuse and neglect had been reported in the past.

Benito is the second child born to this mother who reports that during her pregnancy she was undernourished and overworked by the husband's family. She had no prenatal care and gave birth to Benito in her mother-in-law's home with minimal help from a sister-in-law who happened to be in the house at the time. Benito received no medical care until at age two the family came to live in the United States. At that time a Hispanic Counselor involved with the abuse and neglect of the nieces and nephews noticed Benito and asked if their was anything wrong with him. The counselor examined the child and was impressed by his small size, large head and over all delay. The counselor referred the family to TRIMS where he was evaluated with the Bayley Scale of Infant Development. Findings were: Mental age of 13.4 months and a motor age of 12. 6 months with few self help skills, no expressive language, limited receptive language and an extreme fear of strangers. The physical exam revealed that this child was a year behind in his bone development.

The Home Motivation Program immediately began to work with Benito attempting in the first visits to establish some degree of rapport with this child. These parents were very resistant and difficult to work with. The mother was not realistic in her assessment of Benito and the stepfather was not at all interested in doing anything for Benito. He stated that a retarded male child is useless and should not be allowed to live. At times,

this researcher felt that it would be impossible to continue the program for this child since the mother did not seem to understand what needed to be done nor could she do it. Half way through the program, however, the researcher became aware of the four year old sister's alertness and her ability to teach Benito. The program was then addressed to the sibling and she helped the researcher to teach Benito and his mother. This home offered no stimulation for any of the children, and nutrition was very poor. This researcher proceeded to work with the Houston Independent School District to enroll Benito and his sister in an Early Childhood program. The newborn baby was also showing signs of developmental deprivation, thus prompting a referral to the Public Health Department and the Department of Child Welfare. Getting the family exposed to the appropriate agencies that will provide some parenting skills to them will benefit not only the subject of this study but his siblings as well.

Case History - 8 -

Ricky is the six year old son of parents born in Mexico and who came to live in the United States shortly after being married. The father was trained as a machinist and has a good job in Houston. He provides for his family adequately in spite of a drinking problem. The mother was trained as a nurse in Mexico and worked in a hospital there before marrying. Since her marriage, her husband has not allowed her to work or even to go to school to learn english which she would need to be able to validate her degree in the United States. This family lives in a neat frame house on the fringe of the barrio. The home has a nice yard and is surrounded by a respectable

neighborhood. Ricky has two brothers, one twelve years old and one nine years old.

This child was born in Houston, the product of a normal pregnancy and birth. At five months of age he developed a very high fever and had his first convulsion. Ricky has been a very sick child, and his brain damage is reportedly extensive. He is on phenobarbital but seizures are not entirely controlled. Ricky has autistic like behaviors, self stimulation, head banging, hyperactivity and no eye contact. He treats people as objects. His parents have sought help for their son in many hospitals, clinics, and agencies. They have traveled back and forth to Mexico to a neurologist.

Two years ago this family was referred to the TRIMS Child Development Clinic in order to have a Spanish speaking person work with them. The referral was made because they were not complying with the doctors at the hospital. The parents continuously complained that no one understood them. At TRIMS an evaluation was done and on the Bayley he had a mental age of ten months and a motor age of 16.4 months. On the Slosson Intelligence Test he had a mental age of 1 year, 1 month. The Vineland placed him in the 1-2 year range, with a social quotient of 46. This researcher interpreted these findings to the parents in Spanish and became aware of the father's resistance to accept the diagnosis. His anger and grief were being handled by excessive drinking and blaming his wife. She had turned to religion and was more accepting of the situation but in a fatalistic fashion, which was felt to be unhealthy.

In the Home Motivation Program, this researcher knew that much had to be done in this home. For example, Ricky was not yet toilet trained, and

had very poor self help skills. His behavior was grossly inappropriate. Soon, the father stopped drinking and turned to religion. When the Vineland was administered their was little hope in these parents. They continued to describe Ricky as hopeless and beyond their control. In one of the visits the researcher observed Ricky's brothers at play with their friends outside. When asked if Ricky would play with them, mother explained that the boys were ashamed of their brother. They said their friends were afraid of him and called him the monster. These boys were apparently reflecting the attitude held by their parents in regard to Ricky.

The researcher initially decided to attempt the strategy in the program for which the goal was to teach the parents to be their son's therapist. On the first day, the researcher began by taking Ricky to the bathroom with toys and M & M's for reinforcers. The scene became a traumatic experience for all involved. Ricky went into a severe tantrum which had the researcher and the child sprawled on the floor, M & M's everywhere and Ricky soiling inappropriately. The researcher observed that what happened after this incident was very interesting. Ricky was picked up by his mother, taken to his bed and mother proceeded to clean and change him much like you would an infant. Ricky calmed down and mother took him in her arms. She sat on the rocker and put him to sleep. Researcher also found that food was available to Ricky at all times. He was free to roam the house in his tricycle, all furniture was set aside for him. After only two sessions it became apparent that this whole family was reinforcing Ricky's maladaptive behaviors. A talk with Ricky's teacher revealed that he was toilet trained at school and

they had no real problems with him as far as behavioral management. The researcher informed mother of this and arranged to have her observe her son through a two way mirror at the school. Mother cried when she saw her son at school and compared that behavior to what she had at home.

The school was very sensitive to this mother. In spite of language barriers, they invited her to come regularly to the school so she could observe how they worked with her son. Several more sessions were held in the home during which I talked to the parents and pointed out some of their difficulties in behavioral management. I suggested alternative measures in parenting. Some of these sessions continued to reveal that in their dissatisfaction with their son's programs they seemed to be hiding their guilt and anger by projecting the blame on schools, doctors and therapists. Ricky's seizures continued to be a problem. Several referrals were made for evaluation and treatment but the parents failed to comply. The researcher continues to view this family and their son as a high risk case.

Case History - 9 -

Ester is the six year old daughter of young parents who only recently came to live in the United States. They are here illegally and are very fearful of being deported. Father has worked at menial jobs that pay very little. Neither parent has had much formal education. In Mexico they lived in close proximity to the father's extended family. Here in Houston they have no relatives except for the father's brother who lives with them. The family has bought a house in an alley not far from the Harris County Jail, the home is surrounded by bail bond offices and a very undesirable environment. It is badly in need of repairs and has no yard space for the

children. Mother is a poor housekeeper and is overwhelmed by three little ones (ages 4 to 4 months) and Ester who is developmentally delayed and hyperactive.

Ester is the product of a full term, normal pregnancy and birth. Developmental milestones were within normal limits except for speech. Ester's father was very disappointed when his daughter was born as he had wanted his first child to be a son. Mother reports that he blatantly rejected the child. When Ester was a year and seven months, a baby sister was born whom father accepted more readily. Ester began to regress shortly after the birth of this sibling. She is described as having been very depressed and withdrawn. She would not play with anyone. She would cry incessantly, want baby food and had to be watched constantly as she tried to harm her sister every chance she got. When this sibling was about a year and a half old, the family was riding down a highway and she opened the car door, falling out and sustaining a severe skull fracture. Ester was in the car at the time and to date she continues to repeat a three word sentence in Spanish which means "she fell down".

Ester was enrolled in a community kindergarten at age four. She had limited speech, poor self help skills and she was described as very aggressive and hyperactive. The school made a referral to TRIMS Child Development where Ester was diagnosed as functioning in the developmentally delayed range. The Bayley Scale of Infant Development rendered a mental age of 21.9 months and the Leiter International Performance Test was attempted but discontinued due to lack of cooperation. The TRIMS Child Psychiatrist placed Ester on medication for hyperactivity and she was enrolled in the Houston

Independent School District's Early Childhood Program. The interpretation of the findings was discussed with the mother and she in turn conveyed the information to the father. He completely denied that anything was wrong with his daughter. He told the mother she was not to give Ester any medication. Ester's mother tried to stay away from TRIMS but her Caseworker (this researcher) and the teacher made home visits explaining to the parents how important it was for their daughter to be treated and helped. The father was reminded tactfully that in this country he could be reported to the Welfare Department for medical neglect. He finally gave in and medication compliance improved.

The Home Motivation Program was difficult to implement in Ester's case because of limited space and the three siblings who require so much time and attention from the mother. Researcher obtained the help of a caseworker who came for a few sessions and cared for the little ones while the researcher worked with the parents and Ester. This home offered very little stimulation for Ester and she was totally frustrated by her younger sister who could perform more skillfully and who had expressive language. The sibling rivalry continues and poses a real problem for this family. Ester was proud of having a "teacher" at home and seemed to prefer that the researcher speak in english. Due to the burdens of this mother, she was not totally able to concentrate on the program. The father slowly seemed to be understanding the extent of his daughters handicaps and how he could help his wife. It is this researcher's clinical impression that Ester will do better when and if her parents can consolidate their efforts and eventually provide structure and discipline in the home.

Case History - 10 -

Tony is a three year old Down's Syndrome child whose parents are a fifty year old mother and a thirty year old father. Tony's parents were both born and raised in Mexico. The mother came to live in the United States at an early age and the father came only recently. Tony's mother has had several children fathered by arious men. Of those six siblings, five are still living with their mother. Two of her sons have lived in the state penitentiary at different periods of their lives on drug charges. At the time of this study, all five children were living with their mother in a low income housing apartment in an undesirable area of the barrio. This apartment complex is on a busy street, high crime area and surrounded by bars. The children's play space is a paved court yard where children play, men drink and fight and adolescents smoke marijuana and/or sniff glue. This undesirable envirnoment and the subsequent divorce of these parents prompted Tony's mother to accept the proposal of a seventy year old widower. This man offered them a home in Pasadena with plenty of yard space and distance from the barrio where the older boys were constantly getting into trouble.

Tony was born in a border town on the american side where his mother went to a midwife. The mother had no pre natal care but reports she had an easy pregnancy and delivery was within normal limits. Tony's first medical check-up after birth was in a Houston barrio clinic where the mother was told she had a Downs Syndrome child. The physical characteristics were pointed out to the mother and she was referred to a Genetecist and to a pediatric clinic. Tony was immediately enrolled in an Infant Stimulation

Program sponsored by TRIMS. Nearing his third birthday he was referred to the Child Development Clinic for evaluation and appropriate referrals.

In 1980 Tony was tested using the Bayley Scale of Infant Development and a mental age of 13.4 months was established, his motor development was 24 months. On the Vineland he showed a social age of 1.89. Mother was assisted by the Caseworker (this researcher) to enroll Tony in Early Childhood. Tony has thrived in this program and the teacher has begun working on self help skills and speech therapy.

Downssyndrome children have a reputation for being happier, more friendly and more easily managed than other delayed children, although they can be quite stubborn. Tony is certainly a typical Down's child in spite of the very depressing circumstances he was living in during the program, he always had a ready smile. Tony is an active, exploratory child and because of the early intervention he has acquired some positive skills and appropriate behaviors. Tony is most delayed in expressive language.

The Home Motivation Program interviewed the parents and found them to be very realistic about Tony's abilities. The parents were most concerned about language development, toilet training and self dressing. These three areas were concentrated on and the researcher spoke to Tony's teacher who was also working on these skills. Tony tried to manipulate his teaching time, he was upset at being structured at home and tried to get out of the situation by crying. As rapport was established he began to enjoy the play techniques. Mother followed through on home assignments, she was very cooperative and kept close contact with Tony's teacher. The teacher

commented that she could tell the skills were being reinforced at home. Tony has a pleasant personality and is a source of joy to his family, his siblings interact in a very positive manner with him and were easily taught to be their brothers therapist. The mother was encouraged to watch cartoons with her son and repeat sounds and words, while doing so, mom reported she too was learning english. The program had a positive effect on this child and his family and because of their close involvement with the school, it is this researcher's opinion that Tony will one day be self sufficient with minor supervision.

Appendix I

BIOGRAPHICAL AND PERSONAL CHARACTERISTICS OF PARENTS IN STUDY

N = 20

CHARACTERISTIC	FREQUENCY
Age	
20-30	13
31-50	7
Education Obtained	
0-3	6
0-6	8
6-12	6
12-above	0
Year migrated to United States	
1940-1960	5
1961-1980	15
Legally in this country	14
Illegally in this country	6
Monolingual (Spanish)	13
Bilingual (Spanish/English)	7

References

Axline, V.M. Some observations on play therapy. Journal of Consulting Psychology, 1948, 12, 209-216.

Bandura, A. Principles of behavior modification. New York: Holt, Rinehart & Winston, 1969.

Bradley, R.H. and Caldwell, B.M. Home observation for measurement of the environment. American Journal of Mental Deficiency, 1979, 84, 235-244.

Briggs, V.M. Chicanos and Rural Poverty. The Johns Hopkins University Press, 1973.

Cervantes, R.A. The failure of comprehensive health services to serve the urban chicano. Health Services Reports, 1972, 87, 923-940.

Cohen, L.M. and Fernandez, C.L. Ethnic identity and psychocultural adaptation of spanish speaking families. Child Welfare, 1974, 43 413-421.

Doll, E.A. Vineland social maturity scale. Condensed Manual of Directions, Circle Pines, Minnesota: Publisher's Building, 1965.

Farber, B., Jelle, W.D., & Toigo, R. Family crisis and the decision to institutionalize the retarded child. Research Monographs of the Council for Exceptional Children, 1960, Series A (1).

Hebb, D.O. The organization of behavior. New York: Wiley, 1949.

Hood, C. Social and cultural factors in health of children of immigrants. Archives of Disease in Childhood, 1971, 46, 371-375.

Johnson, D.L. The Houston parent child development center. American Journal of Orthopsychiatry, 1974, 44, 121-128.

Kagan, J. Mother child interaction: Social class differences in the first years of life. Proceedings, 78th Annual Convention of the American Psychological Association, 1970.

Kagan, J. Impulsive and reflective children: Significance of conceptual tempo. In J.D. Krumboltz (Ed.), Learning and the educational process. Chicago: Rand & McNally, 1965. (a).

Klebanoff, L.B. Home Stimulation for the young developmentally disabled child. Massachusetts: Media Resource Center.

Landman, J.T. Alternative approaches to the measurement of adaptive behavior. American Journal of Mental Deficiency, 1979, 84, 304-309.

Lovaas, O.I. Parents as therapists. In M. Rutter & E. Schopler (Eds.), Autism, New York: Plenum, 1978, 369-378.

Marcus, L.M., Lansing, M., Andrews, C.E., & Schopler, E., Improvement of teaching effectiveness in parents of autistic children. In M. Rutter & E. Scholper (Eds.), Autism New York: Plenum, 1978, 625-638.

Meier, J. Developmental and Learning Disabilities. Baltimore: University Park Press, 1976.

Moore, B.L. & Bailey, J.S. Social punishment in the modification of a pre-school child's 'autistic like' behavior with a mother as a therapist. Journal Applied Behavioral Analysis, 1979, 6, 497-507.

Murphy, D.P. Ovarian irradiation: Its effect on the health of subsequent children. Surgery, Gynecology, and Obstetrics, 1928, 47, 201-215.

Padilla, A.M. Psychological research and the Mexican American. In C.A. Hernandez, M.J. Haug, & N.M. Wagner (Eds), Chicanos: Social and psychological perspectives. St. Louis: C.V. Mosby, 1976 (revised edition).

Padilla, A.M. & Ruiz, R.A. Latino mental health: A review of the literature. Rockville Md.: National Institute of Mental Health, 1973.

Ramirez, D.G. A review of the literature on the underutilization of mental health services by Mexican Americans: Implications for future research and service delivery. San Antonio, Ts.: Intercultural Development Research Association, 1980.

Report from the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans. Task panel reports submitted to the President's Commission on Mental Health, Vol. III. Washington, D.C.: U. S. Government Printing Office, 1978.

Serrano, A.C. & Gibson, G. Mental health services to the Mexican American community in San Antonio, Texas. American Journal of Public Health, 1973, 63, 1055-1057.

Skinner, B.F. Operant behavior. In W. K. Honig (Ed.), Operant Behavior: Areas of research and application. New York: Appleton-Century-Crofts, 1966.

U. S. Bureau of the Census. Persons of Spanish origin in the United States: March 1978. Current Population Reports, Series P-20,

No. 328 (Advance Report). Washington, D.C.: U. S. Government printing office, 1978.

Uzgiris, I.C. Sociocultural factors in cognitive development. In H.C. Haywood (Ed.), Social-cultural aspects of mental retardation. New York: Appleton-Century-Crofts, 1970.

Valdez, R. The location of community mental health centers in Texas: Some descriptions and comparisons. San Antonio, Tx.: Intercultural Development Research Associaltion, 1980.

Waisbren, S.E. Parent's reactions after the birth of a developmentally disabled child. American Journal of Mental Deficiency, 1980, 84, 345-351.

Werner, E., Bierman, J., & French, F. The children of Kauai: A longitudinal study from the prenatal period to age ten, Honolulu: University of Hawaii Press, 1971.

White, R. The effects of teacher personality variables as measured by the achievement of mentally retarded students. Education and Training of the Mentally Retarded, 1970, 5, 194-202.

Young, C.L. Providing health and social services to illegal alien families: A dilemma for community agencies. Social Work in Health Care, 1979, 46, 301-318.