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IMPLICATIONS FOR EARLY INTERVENTIONISTS:

CROSS-CULTURAL AND LOW-INCOME FAMILY DIFFERENCES

By

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An Independent Study
submitted in partial fulfillment of the requirements for the
degree of:

Master of Science in Deaf Education

Washington University School of Medicine
Program in Audiology and Communication Sciences

August 6, 2010

Approved by:
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Abstract: This study examined the existing literature on current early intervention processes for children who are deaf or hard of hearing who are from low-income or minority families. The review of literature includes a framework of understanding the dynamics of low-income households and cultural differences among African Americans, Latin Americans, and American Indians.

Acknowledgements:

I would like to thank my advisor, Heather Hayes, Ph.D., for her encouragement and guidance throughout this process. I wish to also thank the faculty of the Program in Audiology and Communication Sciences at Washington University School of Medicine and the faculty at Central Institute for the Deaf. This has been a family-centered learning experience. Finally, I would like to thank my family, who have selflessly listened to, encouraged, and supported me.

Dedication:

This study is dedicated to the memory of Shelby M. Russell, who was dedicated to providing basic needs and counseling in the natural environment to low-income children and their families.

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Introduction:

The purposes of this independent study are twofold. First, I present a summary of the existing literature about low-income and minority families who receive early intervention services for children who are deaf and hard of hearing. Because minorities and low-income families have a higher incidence of children with disabilities, this study will discuss several factors that affect low-income families in relevance to early intervention with children who are deaf or hard of hearing. Furthermore, because minorities and immigrants are often low-income and over-represented in early intervention programs, a discussion is presented on cultural values among three groups: Caucasians, African Americans, Latin Americans, and American Indians. The variance of cross-cultural values may impact early intervention participation. The second goal of this study is to provide a framework of reference by which an interventionist may collaborate with families of minority or low-income status.

In order to discuss early identification and intervention in a specific population (families of minority or low-income status), it is important to describe the importance of these early services in general. The following section discusses the importance of early identification of hearing loss and the impact of early intervention for all children who are deaf. It also provides an overview of recent changes in early intervention.

Early identification and intervention:

Universal newborn hearing screening has led to an increase of early identification of hearing loss among infants and toddlers. Because of widespread use of newborn hearing screening, the average age of identification among children has dramatically

decreased throughout recent years. According to the 2007-2008 Regional and National Summary, a survey conducted by Gallaudet Research Institute, 41.8% of children who are identified as deaf or hard of hearing were identified at birth. The survey lists an additional 14.5 % diagnosed at age 2 and younger. The survey includes children who are deaf or hard of hearing from birth through age 12. Therefore the sample population may not accurately reflect the percentage of children currently being diagnosed earlier with newborn hearing screening, because children who are now 12 years old may not have had access to newborn screening procedures. Universal hearing screening has changed the scope of early intervention for children who are deaf or hard of hearing. Before universal hearing screening, the "age of identification and intervention often exceeded 2 yr of age." (Harrison, Roush, & Wallace, 2003, p. 94).

Approximately 1 to 3 per 1000 newborns is detected to have bilateral hearing loss. This number is significantly higher among children in intensive care neo-natal units (NICUs) (Task Force on Newborn and Infant Hearing, 1999). The number of infants with bilateral hearing loss among NICU patients is 2 to 4 per 100. Due to various factors, including poor prenatal care, infants born into poverty are at higher risk for being in the NICU. Therefore, infants born into poverty may be at higher risk for hearing loss, but can be identified with newborn hearing screening.

After receiving newborn hearing screening, a hospital is responsible for referral to an audiologist for further assessment. Follow-up procedures are crucial to the outcomes of infants that are detected to have hearing loss. The American Academy of Pediatrics (1999) has issued the guideline that:

> Intervention services should be evaluated on an ongoing and regular basis by the state department of health to ensure that sufficient expert services are available for children identified with significant hearing loss, that the services are accessible to the children in need, and that outcomes from interventions provided are effective. (Task Force on Newborn and Infant Hearing, 1999, p. 529).

The general purpose of early intervention is to improve long-term developmental and educational outcomes to children with disabilities. Early intervention has been established to reduce long-term educational costs, and to help families meet the needs of the individual with a disability, and to improve present levels during critical developmental years (Hebbeler et al., 2007).

According to the Joint Committee on Infant Hearing 2007 guidelines, there should be a model for intervention that occurs by 1, 3, and 6 months of age. A child with congenital hearing loss should be screened by 1 month, with an audiologic evaluation by 3 months, and early intervention services should be in place by 6 months of age. After identification, it is critical that professionals provide information about hearing loss to caregivers so the family has a comprehensive idea of what hearing loss means. The position statement includes the need for parents to be informed in a “culturally sensitive and understandable manner” (2007, p. 904). Based on a review of literature, many families are not receiving information regarding implications of hearing loss, resources available, and communication choices. Harrison and Roush (2002) report that parents often do not feel that they received enough information about hearing loss at the time of diagnosis. “When asked to restate the audiologist’s explanation of hearing loss and what

it would mean to their child, 40% were unable to do so and another 24% responded inaccurately" (Harrison & Roush, 2002, p. 233). There is likely a universal reason for parents not understanding the implications of hearing loss because 90% of children who are deaf or hard of hearing are born to hearing parents. If a family does not have enough information, they may not understand the urgency of following through with a referral with an audiologist and seeking intervention services.

Another example of miscommunication is presented by Steinberg, Bain, Li, Delgado, and Ruperto (2003). The authors surveyed Latin American families after having a child diagnosed as being deaf or hard of hearing. "The communication method chosen tended to be the one recommended by the professionals consulted, with little consideration of alternative approaches" (Steinberg et al., 2003, p. 301). Furthermore, the authors report that many Latin American families tend not to receive information on *all* communication options, including cochlear implants and learning spoken language.

After a child is identified with hearing loss or deafness, the child and family are eligible to receive early intervention services. The significance and impact of early intervention is nationally recognized, and is supported by federal law. The Department of Education implemented early intervention as part of the Individuals with Disabilities Education Act (IDEA) in 1986. Early Intervention Services for Infants and Toddlers with Disabilities is known as Part C of the IDEA law. New regulations were submitted as a result of the 2004 IDEA changes (accessible through the National Dissemination Center for Children with Disabilities at http://www.nichcy.org/Laws/IDEA/Pages/PartC.aspx). According to the law, early intervention must meet the needs of all children, birth to 36 months with one or more delay in areas of physical, cognitive, communication, social,

emotional, or adaptive development. Under part C, all states are required to provide services to families and children with such delays after assessment and determining eligibility. Part C mandates early intervention service provision, yet allows each state the right to determine eligibility standards and assessment tools. Early intervention services for children who are deaf or hard of hearing vary among states. Services for deaf or hard of hearing may include speech and language therapy, occupational therapy, physical therapy, auditory therapy, and coaching from a hearing specialist.

The extent and type of intervention services provided will be decided by a multidisciplinary team, and must include the family. The multidisciplinary team should discuss and monitor present levels of performance, goals and outcomes for each child identified as deaf or hard of hearing. This process is the Individualized Family Service Plan (IFSP), and is in accordance to Part C of IDEA. A service coordinator must be appointed to the family to direct the family to all possible resources and services outlined in the documented IFSP. Often, a teacher of the deaf is appointed to be the service coordinator for these families. After writing goals, a coaching method is most often used by the service coordinator or teacher of the deaf.

Typically, early intervention is family-centered and therapy may occur within the child's home, daycare, babysitter's home, all of which are referred to as the natural environment. The natural environment is considered to be the optimal setting for intervention services. This is particularly important for the development of language, because the child must first learn vocabulary and interactions that are most meaningful—those which are in that child's natural environment. Formerly, the interventionist working with a child whose family chose spoken language goals may have included bringing a

bag of toys or objects in order to elicit vocalizations or language development. A newer strategy is to assess a family's *routines* and incorporate those routines into the IFSF plan (McWilliam, 2000). An essential part of this process is also assessing the resources, including other family members that are available to families. Early intervention services may also take place in a center. In either setting, family involvement is recognized to be crucial to the process of intervention. With the help of a hearing coach, caregivers and family members learn how to facilitate language growth through everyday events.

Part C excludes coverage of a cochlear implant or the mapping of the implant (Department of Education, 2007). However, a hearing aid *may* be considered to be an assistive technology device and may be covered under Part C. Most states include providing a child with loaner hearing aids, but may not cover the costs for personal hearing aids. Attaining hearing aids may be difficult for those of low socioeconomic status who are uninsured and live in states where Part C does not cover the devices. The limitations of giving children who are deaf access to sound may have a greater impact on low-income families. Some low-income families and minority families may not have the financial resources to purchase hearing aids without the umbrella of insurance or Medicaid. Furthermore, many low-income families may not receive an initial hearing screening.

White and Muñoz (2008) report that more than 35% of children ages birth through 5 years are covered by Medicaid. The authors cite a report for the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program: Only 13% of children who are covered by Medicaid receive any hearing screening. Moreover, "the poorest children and those from minority families (which are the children most likely to acquire

hearing loss during early childhood) were disproportionately less likely to receive these services" (White & Muñoz, 2008, p.153). These families may lack awareness of services available, knowledge of hearing loss and the impact on language development, and families may be not have basic human needs being met.

For families who choose to have their infant or child amplified with hearing aids or cochlear implant, the Joint Committee on Infant Hearing Proposal (2007) suggests that a child be amplified within 1 month of a diagnosis. Harrison and colleagues (2003) conducted a survey study and investigated the timeline between newborn hearing screening, receiving audiologic confirmation, and children receiving hearing aids as part of intervention services. The sample study included 151 respondents. The authors determined that the median age in which babies with mild to moderate hearing loss received audiologic confirmation following newborn hearing screening was 4 months of age. Within this category of the survey sample, the median age in which the infants were first fitted with hearing aids was 6 months. In the severe-profound hearing loss range, causes unknown, the average age to receive audiologic confirmation was 2 months. The infants in the severe-profound range averaged their initial hearing aid fittings at age 4 months. This indicates a trend that when children in the severe-profound range and with causes unknown receive intervention within the parameters of the Joint Committee on Infant Hearing Proposal in 2000.

In their survey, Harrison et al. (2003) report that 55% of all children had not received hearing aids within a month of confirmation of hearing loss, a significant time lapse. The authors report that the most frequent response from parents describing the lapse in hearing aid fittings was problems in scheduling. The authors did not include

demographic information in their report, but did indicate that all respondents were fluent English speakers and literate. One could assume that this indicates a longer delay in services for non-literate English speakers.

According to 2007 data presented by the Centers of Disease Control and Prevention (CDC), roughly 46% of infants identified with hearing loss had a loss to documentation and follow-up for intervention. In the 2005 data the CDC published, the number of infants who did not receive documentation or follow up was 60%. This indicates a positive trend. The National Institute on Deafness and Other Communication Disorders (NIDCD) suggest that the goal for 2010 is that 85% of infants identified with hearing loss are enrolled in an appropriate intervention program by age 6 months (http://www.nidcd.nih.gov/health/inside/spr05/pg1.html).

Empirical research supports that early identification and early intervention are fundamental to successful language and speech development for children who are deaf or hard of hearing (Moeller, 2000; Yoshinaga-Itano, 2003). In short, the earlier the child is identified as deaf or hard of hearing, and the earlier the child and family participate in an early intervention program, the greater the success of language and speech development. Children who are identified as deaf or hard of hearing and receive intervention services within the first 6 months of life are likely to have language development similar to their hearing peers. According to Yoshinaga-Itano, Sedey, Coulter, and Mehl (1998) children who received early intervention *after* 6 months of age “had language development at 60% the level of children with normal hearing and typical development” (as cited inYoshinaga-Itano 2003, p.15). Yoshinage-Itano and colleagues (1998) also report that children who received early intervention before age 6 months “had language

development at 80% of typical development" (as cited in Yoshinaga-Itano, 2003, p. 15). Research strongly suggests that early identification and intervention are strong predictors of successful language and speech outcomes.

Another predictor of success may be the involvement of family during intervention services. Moeller (2000) concludes that high levels of family involvement in home-based early intervention programs are correlated to greater gains in language development, in conjunction with early identification and intervention. Moeller writes that parents who are actively involved in intervention "have been found to communicate better with their children and to contribute more to the child's progress than parents who do not participate in such programs"(2000, p. 2). Parent-child communication is fundamental for children who are deaf or hard of hearing. Family involvement in early intervention is therefore extremely influential in the language development of children who are deaf or hard of hearing.

For a child who is deaf or hard of hearing, several factors will predict successful language development. As mentioned above, the participation of the caregiver is directly related to communication with the child, and supports language growth. The development of spoken language is highly dependent on caregivers' commitment and participation to the goal of developing spoken language. For families who are low-income or minorities, the ability to commit depends on allocation of resources and the level of needs being met. Also, a family must have some knowledge and ability to receive all services related to early intervention. Socioeconomic status may have an impact on the *extent* to which a family can fully participate in early intervention. The discussion below will further describe poverty and the influence family income may have on early intervention.

Definitions of poverty and low-income status:

Current federal guidelines (2009) define poverty for the 48 contiguous states and District of Columbia for a four-person family to have an income of less than $22,050 per year (Department of Health and Human Services, 2009). A family of five is defined at poverty level with an income of $25,790. Essentially, basic needs may not be met for families that fall below those thresholds. Status of poverty level may be generational or situational (Payne, 2003). Situational poverty may be temporary due to a series of events or crisis. This includes the loss of a job, or spouse. Generational poverty is the continuum of poverty that spans two generations of a family. Regardless of type of poverty, early intervention minimizes the effects of poverty for children who need services (Yoshinaga-Itano et al., 1998, Moeller, 2000). However, the efficacy of intervention is dependent on family involvement, and training of all team members, including teachers of the deaf. Family involvement may be limited due to basic needs that are not met within a household. Below is a framework or hierarchy of needs to which a service provider may refer during the intervention process.

Hierarchy of needs:

As interventionists work with families that are living within poverty, it is important to understand the needs and values of those families. Often, a different set of priorities will exist among families in poverty than the priorities and values of middle-class families. Maslow's (1943) hierarchy of needs is a basic framework in understanding need and behaviors. The most basic needs that every individual must attain are physiological, such as food, water, and sleep. The next tier of needs describes security or safety. Family, employment, and resources such as transportation fall into this domain.

The middle tier of the hierarchical pyramid describes the need for social dynamics relating to love and belonging. Once these basic levels have been met, one can expect higher levels to be desirable and attainable. The next level is esteem, and includes self-esteem, self-respect, and respect of others. The most sophisticated tier of human need is categorized as self-actualization, and includes acceptance of circumstances, creativity, and problem solving. For families living in poverty, basic needs are not being met. Using Maslow's framework may be useful in understanding the priorities, needs, and behaviors of parents in poverty whose children require intervention services. For instance, if a parent is unemployed and does not have transportation, the motivation to seek follow-up services may be significantly diminished.

Prevalence of disability among low-income families and families in poverty:

In the discussion of low-income families, it is pertinent to understand the relationship between disabilities and income levels. The U.S. Census Bureau's 1996 panel of the Survey of Income and Program Participation (SIPP) conducted research regarding prevalence of low-income families and families receiving welfare benefits, or Temporary Assistance for Needy Families (TANF) that have children with disabilities. Low-income families are 50% more likely to have at least one child with a disability than families with higher incomes (Lee, Oh, Hartmann, & Gault, 2002). The SIPP reports that 11% of high-income families have a child with a disability. In contrast, approximately 20% of families receiving welfare benefits have a child with a disability. Among children who are deaf and hard of hearing, 53% of children diagnosed with hearing loss are of a household that earns $25,000 or less (Blanchfield, Feldman, Dunbar, & Gardner, 2001; Lenihan, Rice, & Voss, 2010).

Single mothers are also more likely to receive Temporary Assistance of Needy Families (TANF). Furthermore, single mothers receiving TANF are twice as likely to have a disability themselves (Lee, Sills, & Oh, 2002; Lee et al., 2004). TANF requires work participation of recipients, unless the mother is disabled or is otherwise exempt (Lee et al., 2004). For single mothers receiving TANF, the burden of working and meeting basic needs may influence their abilities to make scheduled appointments and remain involved throughout the process of early intervention for their child.

Healthcare among low-income parents:

Porterfield and McBride (2007) investigated the correlation between socioeconomic status and perception of healthcare. The authors used data from the 2001 National Survey of Children with Special Health Care Needs (NSCSHCN), which conducted 38,866 interviews. Among those interviewed in the survey, 96% of were parents of children with potential special needs. The multivariate analysis included information relating to family income, level of education of parents, race, native language, age of children, and insurance provision. Porterfield and McBride concede that services are often provided under IDEA, but many parents feel that services are inadequate. The authors found that low-income, less-educated, and single mothers were less likely to access healthcare, including therapy services for their children than higher-income families. As reported, lower-income families often do not perceive the need of services for children with special needs. Moreover, lower-income parents were more likely to report having a child with special needs, but were less likely to report the need for services. Kuhlthau, Nyman, Ferris, Beal, and Perrin (2004) report that African Americans and Latin American children with special needs were less likely to use

specialized healthcare or receive follow through referrals. This may reflect a lack of resources such as telephone service, transportation, childcare, and knowledge of how to access intervention services. The authors also suggest there may be a difference in perception of services needed and ability to access services for children with disabilities among those populations. For low-income and minority families, perception of availability of services may impact the outcome and participation of early intervention.

Accessing information on available resources can be a challenge for many families with a child who has been identified with hearing loss or deafness. As Maslow's (1943) hierarchy of needs suggests, basic human needs must be met in order for one to be committed to following through with referrals and establishing an IFSP. Thus, families who are not able to meet basic needs may not access services within the critical period, or the first 6 months. Once services are accessed, the perception of what is needed through those services varies among socioeconomic levels. It is important for professionals to know more about the families who receive early intervention services. In other words, what characteristics (e.g., socioeconomic levels, ethnicity) are associated with families who actually take advantage of early intervention services for their child? The National Early Intervention Longitudinal Study (NEILS) (Hebbeler et al., 2007) provides substantial data on families who receive early intervention services, including their socioeconomic levels and perception of needed services. Below is a review of this report.

NEILS 2007 Final Report:

The National Early Intervention Longitudinal Study or NEILS (Hebbeler et al., 2007) provides demographic information regarding which children (ages birth-to-3 years) and families have received early intervention services. The authors collected data

pertaining to types of services received, costs and outcomes when transitioning into kindergarten. They also conducted parent and caregiver interviews with a total of 3,338 families with one child per family receiving intervention services.

The framework for the study was designed with the notion that the "family [is] a system that is influenced by many factors, including its composition, the resources and supports available, the community in which it lives, and its beliefs and expectations" (Hebbeler et al., 2007). According to the study, intervention outcomes of children with disabilities are interrelated to several factors, including biological, social, environmental, and cultural.

Children who were identified as deaf and hard of hearing as the primary reason to receive services represented 1.9% of the total sample (Hebbeler et al., 2007). The number of children diagnosed by a professional, as reported by parents was 9 %. The report does not offer any reason as to why so few deaf or hard of hearing children received audiologic confirmation.

The final report reflects other research in that there is an overrepresentation of low-income families that require intervention services. In the study, 27% of the children entering early intervention were of families that earned less than $15,000 per year (Hebbeler et al., 2007). Furthermore, children entering early intervention services are more likely to be male, be in foster care, and have mothers that have not gone to college, and be of minority status. For instance, African Americans represented 21% of the sample study and represent 14% of the general population. In contrast, Caucasian Americans represented 53% of the sample, and 61% of the general population (Hebbeler et al., 2007).

The effect of socioeconomic status is highlighted in the NEILS report. Low-income and minority families "were more likely to report that a lot of effort was required to access the services" (Hebbeler et al., 2007, section 2, pg. 4). Scheduling was also reported to be a struggle for many families. Families may not receive the number of hours scheduled between the caregiver and service provider. Even in home-based visits, "23% of families were estimated to have missed 26% or more of those services" (Hebbeler et al., 2007, section 3, p. 3). Income levels of caregiver and cultural background may contribute to missing sessions.

The study reports that 98% of parents were generally pleased with the early intervention services. However, there seems to be a disparity among minorities. "For example, 59% of African-American families rated their therapy services as excellent as did 55% of Hispanic families, whereas 64% of white families saw the services as excellent" (Hebbeler et al., 2007, section 3, p.13).

Interventionists working with minority and low-income families must consider the inclusion of the family, regardless of background, throughout the entire early intervention process. The NEILS report underscores the need for all professionals involved in providing early intervention services must consider the needs and the values of the family. It is recommended that early intervention focus on the family and child. However, it is reported that 44% of all families within the sample received services that were directed merely toward the child. Parents report several areas they believed could have been helped by the early intervention professional. Among those services, the greatest areas of need were: accessing information for other agencies, knowing which recreational activities are most appropriate, and finding child-care (Hebbeler et al., 2007).

This means that some families with a child who is deaf or hard of hearing may not only want speech and language outcomes as part of the IFSP, but may also need help with other daily needs. If an interventionist were to include this as part of services provided, the family may gain a greater sense of autonomy.

The implication of not including families during the intervention process may also leave families unaware of procedures, such as the IFSP. Placing sole efforts on the child and not empowering the family may silently keep families, particularly those of low socioeconomic status, from accessing all necessary resources. Once the child is ready to transition to an IEP, the family may be ill-equipped to handle ongoing burdens and responsibilities.

Children with diagnosed conditions typically entered early intervention and developed an IFSP within the first year of life. Unfortunately, many parents were unaware of the IFSP. There seems to be a correlation between the level of a parent's education, minority status, and knowledge of an IFSP. Minorities and mothers who did not finish high school were also more likely to report not being aware of the development of the IFSP (Hebbeler et al., 2007). For instance, 37% of Hispanics reported being unaware of the IFSP. Of mothers who had lower levels of education, 31% were unaware of the development of the IFSP. Within the context of IFSP development, most families reported being satisfied with the level of involvement. However, low-income, minority, and less educated mothers were more likely to report a desire for more involvement during the process. Also, minority families were more likely to report that there was a lack of support and understanding of their respective cultures and values (NEILS Data Report No. 2, p. 7). The "dissatisfaction may come in part from cultural mismatches in

how parents are expected to and therefore 'trained' to interact with children" (Peña & Fiestas, 2009, p.79).

Intervention among other cultural backgrounds:

The role of the caregiver and the role of the provider may vary among cultures. Different values and expectations may alter the outcomes and intervention models provided to families from other ethnicities. For instance, within the Latino culture, a parent does not view the child as a playmate (Peña & Fiestas, 2009). Furthermore, the expectation that the child performs a task independently does not support Latino cultural values. Early intervention providers must have some understanding of the culture with which the family identifies. Discussed below are frameworks in which one can understand some values and dimensions of Caucasian, African American, Latino, and Native American cultures.

As mentioned earlier, there is an overrepresentation of ethnic minorities who receive early intervention services. Providers, including deaf educators, are typically white, educated, middle-class women. Luterman (2008) writes that there is a danger that "is ever present that we might impose our cultural values on others" (p.193). Therefore, one must understand the framework of culture from which the majority of service providers come and that norms are based on the white middle-class. In addition, building and establishing trust with families from other cultures requires the professional to be aware of certain values within those cultures.

Lynch and Hanson provide a framework for cultural differences and values in their book, *Developing Cross-Cultural Competence* (2004), some of which will be summarized here. For example, to cultural influence, Caucasian Americans place value

on the individual as opposed to the collective group. Individuals with Anglo-European roots also place emphasis on equality, assertiveness, informality, self-advocacy, and achievement (Lynch & Hanson, 2004). One particular cultural value that shapes the conduct of early intervention is the value of time. Caucasians often place less value on the past, and place most emphasis on the future. Within the context of time, Caucasians expect efficiency and organization and "time is seen as something that is used and must be saved" (Lynch & Hanson, 2004, p. 93).

Given the importance of timing in terms of early intervention and hearing loss, it is not surprising that one possible reason (in addition to numerous others) why some families do not get services immediately is related to views on time. Harrison & Roush (2003) describe the priorities of families and audiologists established immediately after diagnosis of hearing loss, and a few months later. The authors include information pertaining to potentially different goals of families, based on the severity of the child's hearing loss. Common responses, consistent in all domains include understanding causality of hearing loss, and setting realistic or appropriate timelines for learning language and speech. These priorities reflect the cultural value system of Caucasians in the emphasis of self-advocacy, orientation toward the future, and efficient use of time. However, these priorities may not befit other cultural norms and expectations.

Within African American cultures, there is a focus toward the situation rather than time (Lynch & Hanson, 2004). This opposes the mainstream value of time. In addition, African American values include collectivism vs. individualism and extended family bonds are highly valued. These variables may affect the approach that African American families may have toward appointments. For instance, if a mother's cousin needs

immediate help with childcare, the mother may prioritize assisting the family member, thus keeping a collective balance, rather than shifting focus on the individual child and upcoming appointment. In terms of poverty within the African American culture, Lynch and Hanson assert that in the African American home is not appropriate to "[a]ssume that poverty equates with dysfunction" (2004, p. 175). Abolishing one's own cultural bias may be difficult, but is necessary for the outcome of the child and family throughout intervention.

When working with African American families, establishing goals regarding wearing hearing aids or cochlear implants may differ for some families. Lynch and Hanson describe the view that high-tech medical care may be equated to trauma care for some families. "This observation is based on the reality that violence and accidental death and injury are at the top of the leading causes of morbidity and mortality in the African American community" (Lynch & Hanson, 2004, p.164).

Like the African American culture, Latino culture emphasizes the group or collective needs (Lynch & Hanson, 2004). In implementing collectivism as part of a cultural norm, "parents who value this perspective may focus on the family as a whole rather than on the individual child. Supporting the child's role may involve helping the child and encouraging siblings to provide support" (Piña & Fiestas, 2009, p.80). The Latino culture values time as being flexible. Generally, Latino families may not hold the same sensitivity to time that mainstream white Americans do. Both collectivism and values of time may influence a parent's recognition of achieving milestones, including language and speech development. Typically, in collective cultures, achieving individual milestones is not congruent with their cultural expectations.

A survey of 29 families with children who were deaf or hard of hearing explored the choice of communication mode and cultural influences involving families' decisions among Latin Americans. For Latin American families, "63% of the families reported that religious beliefs played a major role in determining communication mode" (Steinberg et al., 2003, p.299). According to the authors, Latin Americans may believe in using a natural faith healer to heal a disability. This notion will vary among Latin American cultures and families.

American Indian culture is diverse and varies among tribes. The concept of disability is significantly different in American Indian Culture, compared to white American cultural norms. American Indians view a disability as a disharmony with nature (Lynch & Hanson, 2004). In fact, in most native languages do not have a word for disability. Typically, the physical characteristics of a disability are not viewed as the defining marker of an individual. Considering cause of deafness may be less important among American Indians. However, the question of *why* the child has a hearing loss may be more relevant to the culture (Lynch & Hanson, 2004).

It is important to recognize the value of traditional ceremonies among American Indian groups. Ceremonies are often conducted in order to enhance therapy services. For the interventionist, this may mean allowing the family to conduct a ceremony before any appointments for referrals and home-visits are met. "Respecting family decision making may mean that the services are delayed until the family has had a chance to seek traditional medicine" (Pedersen & Vining, 2009, p.87). If the family has completed a healing ceremony, the child may receive markings on areas of the body to ensure healing. Lynch and Hanson (2004) note that it is important to consult with the family before

removing any objects placed on the child after a healing ceremony. This becomes relevant for a child who is receiving hearing aids.

American Indian culture tends to value time in the present dimension. There is less emphasis on future goals, and more emphasis on present needs and situations. This framework may be useful for the multidisciplinary team when discussing goals for an IFSP. The American Indian culture places emphasis on the group rather than the individual. In this framework, it is not unusual for American Indians to include non-family members into the family network. In regard to decision-making, grandparents tend to carry out the parental role (Lynch & Hanson, 2004).

Implications for early interventionists when working with low-income or minority families:

As there have been increases in early identification in recent years, more children will be entering early intervention services. This indicates that professionals must be prepared and trained to work with various cultures and incomes in the natural setting. However, "[o]nly a few existing preprofessional training programs throughout the United States provide extensive training in intervention for families and children from birth through early childhood period" (Yoshinaga-Itano, 2003, p.13). Therefore, there is a need to increase training of professionals on current practices of early intervention. Training should include addressing needs specific to low-income and minority families that may vary from the immediate agenda of many service providers.

The review of literature implies that there is a greater need for documentation and follow-up services after the referral process following newborn hearing screening. "Many state systems do not have a well-established link to early intervention services, especially

services specific to children with a hearing loss, leaving many families without the information and resources they need" (Sass-Lehrer, 2002, p.9). Follow-up procedures and documentation continues to be a challenge among low-income and minority populations. The recent recommendations are for states to have established task forces that focus on follow-up procedures and ensure all eligible infants and children are being served under Part C.

This literature review provides information that there is a lack of informing low-income and minority families of all communication choices, legal rights and services mandated by Part C, and the role the caregiver can have as a facilitator of language with a child who is deaf or hard of hearing. Therefore, the implication for any professional is to avoid inadvertently withholding information based on income levels or minority status. The beginning of providing services for families whose children have received either a late identification or late intervention means ensuring caregivers have all the information they need to make appropriate choices and goals for their children.

Professionals who provide early intervention are often cautioned to not enable families. Instead, the goal should be "to empower, and we do this best by not over-helping and by being there in a supportive way" (Luterman, 2008, p. 121). There are no clear guidelines as to what this implies for service providers working with low-income or minority families. Based on aforementioned surveys, it may be supportive for service providers to actually assist families with accessing basic needs. Once those needs have been met, the families are more likely to be able to follow through with scheduled appointments and ultimately fully participate in the intervention process.

"By listening to and valuing our clients, we will always respect their unique cultural heritage, and clients and families will tell us the best way for them to be taught" (Luterman, 2008, p. 193). As the review of literature indicates, many minorities do not feel satisfied with cultural sensitivity and the interventionists should have addressed other needs such as providing enough information, and assisting with arrangements for transportation and childcare. It is imperative that interventionists have some background knowledge of clients' cultural identities, and is sensitive to those value systems.

Assessing resources of a family is a strategy that should be implemented by a service provider. Explicitly asking about basic needs may be necessary for the early interventionists. As discussed, several important resources can be limited for low-income and minority families. For instance, social networks among minorities will vary and may affect meeting childcare needs. In one small sample study, Latin Americans were more likely to live with another adult than not (Domínguez & Watkins, 2003). Conversely, African American women were more likely to live with no other adult than not (Domínguez & Watkins, 2003). The service provider typically assesses who lives in the home. However, it is suggested that a service coordinator or early interventionists is informed of a peripheral network available to a caregiver. The purpose in collecting that information may become useful in understanding more about the family's routines as well as knowing if childcare or transportation would be available from outside the home.

As with any interview, IFSP meeting, and appointments, the needs and desires of the family must be assessed through attentive questioning *and* listening. Lynch and Hanson (2004) suggest several ways to consider involving the family during the IFSP, while maintaining culturally appropriate practices. Some suggestions may not be overtly

known by the average provider and include reducing the number of professionals available, and to encourage families to have spiritual leaders, other relatives, friends, and possibly an interpreter to be present. The inclusion of important members of one's community may strengthen the sense of autonomy for families from other cultural backgrounds. Lynch and Hanson also suggest incorporating "practices that are culturally comfortable, such as serving tea, taking time to get acquainted before beginning the more formal aspects of the meeting, or conducting the meeting in a highly formal manner" (2004, p. 461). This may seem contradictive to the agenda of most interventionists, because those practices may be viewed as a misuse of time during home visits. However, if the goal of early interventionist is to seek out the goals of the family and coach effective strategies for the development of the child who is deaf or hard of hearing, then taking the time to get acquainted with all members present may be necessary to move forward.

The correlation between high levels of family involvement and language development of a child who is deaf or hard of hearing supports the need for the interventionist to recognize the barriers that may diminish family involvement. Again, using the framework of Maslow's (1943) hierarchy of needs may be instrumental for an interventionist to assess if basic needs are met through questioning. One must not assume that the desire to help a child is less among low-income and minority families. Therefore, it is critical for any professional to understand how low-income families and minority families may struggle with meeting basic needs and often lack the resources to access information concerning services available to the child who is deaf or hard of hearing.

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