

**Module: Family-Centered Practices  
for Infants and Toddlers With Visual Impairments**

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**Session 1: Building Reliable Alliances**

**Session Notes**

**Introduction**

In Session 1, “Building Reliable Alliances,” of the *Family-Centered Practices* module, participants will acquire the knowledge, skills, and expertise required to demonstrate competence in building effective alliances with families. In addition, participants will be able to identify and describe the legal, theoretical, and research bases for family-centered early intervention. Finally, participants will recognize and implement recommended practices upon which reliable alliances are built—knowing themselves, knowing families, honoring diversity, affirming and building on strengths, promoting family choices, affirming great expectations, communicating positively, and warranting trust and respect.

**Objectives**

After completing this session, participants will

1. describe the legal basis for family-centered practices in the context of early intervention.
2. identify and implement the key features of family-centered practices: focusing on family strengths, promoting family choice, and collaborating with families and other professionals, while respecting and honoring diversity within the context of families, communities, and cultures.
3. describe the rationale for using family-centered practices and demonstrate the ability to initiate and sustain a reliable alliance with families based on effective help-giving practices.
4. describe their overall philosophy for working with families including the basic assumptions and principles that guide their approach. Participants will develop self-awareness of personal values, assumptions, and biases related to childrearing and interactions with families and understand how those affect relationships with families and children.

*Module:*   **Family-Centered Practices  
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**Session 1: Building Reliable Alliances**

**Major Points**

**A. IDEA Part C**

A family-centered, multidisciplinary approach to early intervention is supported by federal legislation.

In 1986, Congress passed Public Law (PL) 99-457 as an amendment to the Education of the Handicapped Act, PL 94-142 (passed in 1975) to extend downward to age 3 years the right to a free, appropriate public education to meet the unique needs of children with disabilities. Congress passed this amendment in recognition of “an urgent and substantial need” to

- enhance the development of infants and toddlers with disabilities,
- reduce educational costs by minimizing the need for special education through early intervention,
- minimize the likelihood of institutionalization and maximize independence, and
- enhance the capacity of families to meet their children’s needs.

In 1990, the law was revised, and the name of the law was changed to the Individuals with Disabilities Education Act (IDEA). The Individuals with Disabilities Education Act Amendments of 1997 (PL 105-17) were signed by President Clinton on June 4, 1997. The Final IDEA 1997 Regulations were released on Friday, March 12, 1999. Part C of IDEA provides the legislative support for family-centered early intervention services for infants and toddlers (newborn to age 3) with disabilities and their families. Family-centered support is a method of coordinating and delivering assistance, support, and services to families. It is based upon an understanding of the complexity that exists within families and upon recognizing that decisions and services will influence each member of the family and the unit as a whole.

Information on Part C of IDEA can be found at <http://www.ideapractices.org> and on the CD *Discover IDEA CD 2000* (Council for Exceptional Children, 2000). IDEA will be reauthorized in 2004, and final regulations will be issued following reauthorization. Be alert for changes in federal regulations that affect early intervention in 2004 and 2005.

IDEA Part C, Section 303.12 describes early intervention services and mandates that services should be provided in a family and child’s natural environments. Sixteen early intervention services are listed. They include

1. assistive technology,
2. audiology,
3. family training,

4. health services,
5. medical services only for diagnostics or evaluation,
6. nursing services,
7. nutrition services,
8. occupational therapy,
9. physical therapy,
10. psychological services,
11. service coordination,
12. social work services,
13. special instruction,
14. speech-language pathology,
15. transportation, and
16. vision services.

Vision professionals will be particularly involved in four of these services—assistive technology, service coordination, special instruction, and vision services—while working with other team members to provide comprehensive early intervention based on the family’s and child’s specific needs. In serving infants and toddlers with visual impairments, teachers of children with visual impairments (TVIs) and orientation and mobility specialists (OMSs) will work with professionals who have expertise in other disciplines.

IDEA Part C, 303.12 provides the following definitions.

**Assistive technology device** refers to any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities. Assistive technology service refers to any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include

- the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child’s customary environment.
- purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities.
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs.
- training or providing technical assistance for a child with disabilities or, if appropriate, that child’s family.
- training or providing technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

**Service coordination** refers to assistance and services provided by a service coordinator to a child eligible under this part and the child’s family that are in addition to the functions

and activities included under Section 303.23. Additional information on service coordination can be found in Session 2 of this module.

**Special instruction** may include

- designing learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction.
- planning curricula, including the planned interaction of personnel, materials, and time and space, that lead to achieving the outcomes in the child's individualized family service plan.
- providing families with information, skills, and support related to enhancing the skill development of the child.
- working with the child to enhance the child's development.

**Vision services** may include medical and educational/intervention services, including

- evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities.
- referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders.
- communication skills training, orientation and mobility training for all environments, visual training, independent-living skills training, and additional training necessary to activate visual motor abilities.

**Qualified personnel** for early intervention services include

1. audiologists,
2. family therapists,
3. nurses,
4. nutritionists,
5. occupational therapists,
6. orientation and mobility specialists.
7. pediatricians and other physicians,
8. physical therapists,
9. psychologists,
10. social workers,
11. special educators, and
12. speech and language pathologists.

Note that teachers of children with visual impairments (TVIs) are considered to be *special educators*.

Handout A, "Missions and Roles for Professionals from 12 Key Disciplines," describes the responsibilities of professionals from different disciplines. Professional organizations develop position papers to guide their members in working with young children with special

needs and their families. The Division on Visual Impairments (DVI) of the Council for Exceptional Children (CEC) developed a position paper on family-centered practices for teachers of children with visual impairments (Handout B). The Division for Early Childhood (DEC) of the Council for Exceptional Children developed position papers that describe recommended practices (Handout C) and a code of ethics (Handout D) for all early interventionists.

For a family with an infant or toddler with a visual impairment, TVIs and orientation and mobility specialists (OMSs) are critical members of the early intervention team. The early intervention team will determine the level of involvement of these professionals. Because it is not possible to separate development of infants and toddlers into discrete disciplines, the family and all service providers on the early intervention team must work together to provide information, learn new skills, share responsibilities, and respect one another. IDEA provides a legal basis for this kind of teamwork by requiring that professionals from more than one discipline assess young children who are eligible for early intervention. Although the term *multidisciplinary assessment* is used in the legislation, the intent is to ensure that more than one discipline is involved in assessment and intervention planning. In Session 2, multidisciplinary, interdisciplinary, and transdisciplinary approaches are defined and contrasted. Because professionals coordinate services to a greater extent in interdisciplinary and transdisciplinary approaches, those approaches, rather than a multidisciplinary one, are typically recommended by leaders in the field of early intervention.

*While working with the Pappas family, Margaret, the TVI, found it was necessary to develop a much greater understanding of switches and positioning for Clay, a 24-month-old with cerebral palsy (CP) and cortical visual impairment (CVI). The occupational therapist (OT) and speech and language pathologist (SLP) on the team were wonderful resources regarding assistive technology and positioning. However, Margaret quickly realized that the entire team needed assistance in adapting resources so that they were appropriate for Clay's visual functioning. Consequently, Margaret collaborated with the OT to identify positions in which Clay seemed to use his vision most effectively. She and the SLP identified switches and contrasting backgrounds that Clay was most responsive to visually. Although Clay currently is using a standard custom wheelchair, Margaret collaborated with the other team members to discuss future use of a power wheelchair for Clay. With the OMS, Margaret discussed Clay's need for independent travel.*

## **B. Theoretical bases**

Family-centered early intervention evolved from several theoretical bases, including family-systems theory, ecocultural theory, and the work of Turnbull and Turnbull.

The concept of family-centered early intervention was articulated during the late 1980s/early 1990s. The concept is based on an ecological model that views child development as a result of an interplay of biology (innate characteristics of the child) and society (the way the world treats the child). The ecological model proposes a reciprocal relationship between the child and environment: the child influences the environment, and the environment

contributes to the development of the child.

Each family forms a unique interactional system that can be described in terms of structural, functional, and developmental dimensions. By understanding family-systems theory, early interventionists can gain insight into factors that may influence whether or not intervention goals are congruent with family structure and values (Foster & Phillips, 1992).

- Family-systems theory provides a framework for understanding families and their challenges.
- Practitioners will be most effective when trying to understand problems within the context of each unique, individual family and crafting solutions that fit the family, rather than making the family adapt to the solution.
- Family-systems theory promotes the exploration of options that are based on a family's unique characteristics, rather than the imposition of options on a family.

The ecocultural model (Bernheimer, Gallimore, & Weisner, 1990) offers a theoretical framework for understanding how families make decisions (the authors call them adjustments or accommodations) in their lives based on the family's ecology (resources and constraints) and culture (values and beliefs).

Four central values characterize the concept of family-centered practices:

1. an emphasis on families' strengths rather than deficits,
2. the promotion of family choice, and control of and access to desired resources,
3. the development of a collaborative relationship between professionals and parents, and
4. a holistic view of the family—what is good for the child is good for the family and vice versa.

*Kristi Lee, a 13-month-old with ROP and high myopia, had been prescribed corrective lenses by her ophthalmologist. Her parents were very careful to make sure Kristi wore her glasses each day. The TVI/OMS, Joe, was concerned to see Kristi looking over the tops of her glasses most of the time. If her glasses were pushed back up, Kristi pulled them back down again and looked over them rather than through them. Joe checked to see if Kristi had any pressure points on her face from the glasses, thinking that perhaps the frame was uncomfortable. The frames seemed to fit well. Joe knew he was not an ophthalmologist and also that the Lees felt strongly that the doctor was the final authority on Kristi's vision. As he observed Kristi's functional vision with and without her glasses over time, Joe began to note when Kristi avoided using the glasses. Although he suspected that the correction simply wasn't right for Kristi, Joe wanted to share his concern in a respectful manner. Joe approached the situation cautiously and diplomatically. He finally suggested that the family check to see if the lenses had been made correctly according to the prescription the doctor had written. In addition, he suggested that the family mention to the ophthalmologist that Kristi avoided using the glasses in specific situations. Joe offered to accompany the family to the next ophthalmologist appointment. He provided a written log describing the tasks and times when he had observed Kristi looking over the tops of her glasses instead of through them.*

A set of practices, based on family-centered values and respect for diversity, has been refined and validated by research over the past 20 years. These practices are the basis for this module and early intervention personnel preparation around the country.

These practices represent a paradigm shift from child-centered services to family-centered support. Although Turnbull, Turbiville, and Turnbull (2000) have recently advocated a move from family-centered support to collective empowerment as the preferred model for family-professional partnerships in the twenty-first century, many agencies and professionals are still struggling to implement family-centered practices. Turnbull et al. provide an expanded description of assumptions underlying family-centered services.

- The family is recognized as the constant in a child's life.
- Families and professionals collaborate at all levels.
- Cultural, socioeconomic, racial, and ethnic diversity are honored.
- Family strengths are recognized and respected.
- Unbiased and complete information is shared continuously in a supportive manner.
- Networking and family-to-family support are encouraged.
- Expertise regarding the developmental needs of children and families is shared.
- When appropriate, comprehensive programs that provide emotional and financial support are implemented.
- Systems of care are accessible, flexible, culturally competent, and responsive to the strengths and needs identified by the family.

### **C. Reliable alliances**

Building reliable alliances with families is critical to effective early intervention.

Participants should understand that the most important goal for any professional is building trust and a reliable alliance with the family. Until that happens, their professional expertise is likely to be underused by the family. The term *reliable alliance* has been used by Turnbull and Turnbull (2001) to describe a dynamic relationship between families and professionals in which they experience individual and collective empowerment by sharing their resources in order to make joint decisions. In this session, *reliable alliance* refers to positive collaborative relationships between families and professionals that are characterized by trust, respect, and empowerment.

Reliable alliances involve eight obligations (Turnbull & Turnbull, 2001, p. 58):

1. knowing yourself,
2. knowing families,
3. honoring cultural diversity,
4. affirming and building on family strengths,
5. promoting family choices,
6. affirming great expectations
7. communicating positively, and

8. warranting trust and respect.

It is important to consider the potential impact of developing new relationships with a variety of service providers on the family and the ways that providers can best support the strengths and capabilities of a variety of families. Research suggests that certain specific professional behaviors enhance family-professional alliances (Dunst, 2000). Sharing information and professional expertise with families must be done with care, respect, and full appreciation for families' values, beliefs, and capabilities, and with knowledge of the ways that family members interact and function as a family unit.

*Diane, a TVI who was working with the Torres family, was distressed by how overwhelmed and fatigued Mrs. Torres seemed each week when Diane visited the home. Mrs. Torres managed all childcare for her seven children, aged 9 months to 9 years, as well as all work around the house. AnnaMarie Torres, the 16-month-old, had been diagnosed with microcephaly, CVI, and strabismus. Diane felt strongly that Mr. Torres should participate more in childcare, but Mrs. Torres gently explained that that was not how it was done in their family. Diane realized that supporting Mrs. Torres in finding activities AnnaMarie could manage briefly on her own or with a sibling, one of the family's IFSP outcomes, might provide Mrs. Torres with a break as well as benefit AnnaMarie and her siblings while respecting the family's values.*

Dunst (1997) and Dunst and Trivette (1997) found that family-centered practices such as sharing of information, facilitation of family/professional collaboration, having families make decisions, and building on family competence and confidence had a positive effect on families' belief in themselves and on their ability to maintain control over important issues. Other research that supports family-centered approaches in a variety of settings has been summarized by the Institute for Family-Centered Care (1998) and is described below.

- Family-centered care in neonatal intensive care units (NICUs) leads to better outcomes for infants born at risk.
- Providing parents with information they want leads to more efficient treatment of illness and enhanced parent-child interactions.
- Use of family-empowerment practices and parent-to-parent support leads to enhanced family outcomes that are associated with better outcomes for children.
- Parent involvement in program planning potentially leads to better early intervention programs for children.

#### **D. Parents' response to diagnosis**

An early step in building a reliable alliance can occur in supporting family members as they deal with the emotional responses that accompany the diagnosis of a visual impairment.

Many children with severe visual impairments are diagnosed within the first few months of life. Consequently, some families must deal with the realization that the perfect baby they were expecting has a potentially disabling condition. They may also have to cope with depression that may accompany the diagnosis of a disability. Additionally, parents of children with visual impairments have reported that the diagnosis of their children's visual

impairment was delivered in an insensitive, and sometimes even brutal, manner (Hatton & Waring, 1999). Dealing with the emotions associated with the diagnosis of a potential disability in an infant or toddler is even more difficult when it is delivered without sensitivity, understanding, or compassion (S. Potter, personal communication, September 16, 2002). The video *Breaking the News* (Chernus-Mansfield & Horn, 1991) addresses these concerns and helps increase awareness of professionals who work with families of infants and toddlers with special needs and visual impairments in particular. It provides insight into the grieving process that family members experience when they learn that their child has a severe visual impairment.

Early models of the grieving process typically depicted a series of stages through which one moves (shock, denial, anger, depression, and acceptance). Over the past 10 years, more complex and realistic models have been proposed in which individuals may experience a much broader range of emotions, including sadness, guilt, regret, longing, disbelief, fear, irritability, hopelessness, and powerlessness. These emotions may be experienced at varying intensities either sporadically and randomly or predictably—when triggered by an event such as a birthday, visit to the doctor, transitioning from one grade to another, or reaching a developmental milestone (Fazzi, Klein, Pogrund, & Salcedo, 2002).

Professionals should be sensitive to family members' emotional responses to the child's visual impairment. Maroney and Davis (2001) suggest that professionals consider the following when interacting with families who may be experiencing such stress.

**Listening.** Listen to parents without trying to make them feel better or solve their problems. Ask how they are doing and empathize.

**Educating.** Share information about the child's diagnosis, prognosis, and treatment options. This will help parents regain a feeling of control that may have been diminished when the diagnosis was received.

**Respecting.** Learning about a child's visual impairment (and possibly other disabilities) can be overwhelming. The most competent parent's coping strategies can be taxed in this situation. Early interventionists should withhold judgment about parents' reactions. Instead, they should support parents in viewing their reactions as normal and natural for the situation, in seeking counseling and additional emotional support, and in nurturing themselves.

**Empowering.** Support parents as they move from adjusting to and accepting their child's disability to seeing their child as a capable and independent whole being.

## **E. Diversity**

It is important to be aware of differences in cultures and to be sensitive to the challenges these differences may present. In addition to cultural diversity, families are also diverse in family structure, living conditions, religious beliefs and practices, and values. Aspects of family diversity include: single- versus two-parent families, parents of same or different genders, differences in socioeconomic status, differences in values, and differences in religion.

Socioeconomic status, educational levels, family values, and many other factors work in

combination to affect how families respond to their child's visual impairment. Additionally and as important, members of different cultures, religions, and nationalities may interpret and respond to visual impairment in different ways. TVIs should be sensitive to family backgrounds, preferences, and comfort levels when working with all families, including families whose cultural and ethnic backgrounds differ from their own.

The United States experienced significant growth in population and diversity during the 1990s; that growth will continue in the future. The 2000 Census counted approximately 281 million people in the United States, up from 249 million in 1990. Western states experienced the most growth, followed by those in the south. A band of counties stretching through the midwest, from the Mexican border to the Canadian border, lost population, as did a band of counties that stretched from the interior northeast through the Appalachian area of West Virginia and eastern Kentucky.

The Census Bureau makes the following projections of ethnic composition in the United States over the next 50 years.

|          | <b>1999</b> | <b>2020</b> | <b>2050</b> |
|----------|-------------|-------------|-------------|
| White    | 72%         | 64%         | 53%         |
| Hispanic | 12%         | 17%         | 24%         |
| Black    | 2%          | 13%         | 13%         |
| Asian    | 4%          | 6%          | 9%          |

Hispanic and Asian populations are expected to increase, while the percentage of the White population is expected to decrease between now and 2050. This increase in Hispanic and Asian families has implications for early intervention, particularly if English is not the primary language spoken in the home.

In a recent report of the characteristics of infants and toddlers referred for specialized services for children with visual impairments in nine states in 1998 and 1999 (AK, AZ, CA, CO, IA, MA, NM, NC, and UT), the following ethnic information was obtained (Hatton & Model Registry of Early Childhood Visual Impairment Collaborative Group, 2001).

|          | <b>Hatton et al.</b> | <b>Babies Count</b> |
|----------|----------------------|---------------------|
| White    | 57%                  | 60%                 |
| Hispanic | 26%                  | 23%                 |
| Black    | 5%                   | 8%                  |
| Other    | 2%                   | 9%                  |

Hatton et al. data collected in 1998 and 1999; Babies Count data collected in 2001 and 2002

More recently, in an analysis of data collected in 2001 and 2002 by the Babies Count Registry of the American Printing House for the Blind (D. Hatton, personal communication, September 16, 2002), similar percentages were reported. Other demographic characteristics reported by Hatton et al. (2001) that might impact service delivery indicate that 83% of the children came from two-parent homes and that only 14% of the mothers had less than a high school education, while 50% had some college or a college degree.

French demographer Jean-Claude Chenais writes of contemporary American society, "For

the first time in history, a single country has a population made up of all the world's 'races' ('white,' 'black,' 'yellow,' and 'red'), of all its religions (Christian, Buddhist, Muslim, animists, etc.), and of all its languages" (1999, p. 632). Language differences have the potential to affect significantly interactions between an interventionist and a family. In fact, the four-step process of establishing cultural reciprocity (discussed in Major Point G) may be impeded if the interventionist and family are not fluent in the same language. When differences in language are present, it is particularly important to work closely with interpreters and translators to ensure that they are facilitating, rather than impeding, communication. Chen, Chan, Brekken, and Valverde (2000) developed *Conversations for Three: Communicating Through Interpreters*, a video and accompanying booklet that describe the challenges of, and provide useful guidelines for, working with interpreters.

Milian (2000, p. 198) provides a comprehensive definition of diversity that summarizes its complexity:

Diversity has come to signify the heterogeneous nature of this society. It has a broad meaning that can refer to human characteristics, such as culture, language, race, class, disability, age, and sex; personal affiliations to religious and political groups or ideologies; or sexual orientation.

She suggests the following topics should be explored with families from minority cultures in order to identify issues that may affect intervention or education: medical issues, language spoken in the home, literacy activities, interactive play (social skills), and daily routines (Milian, 2000).

## **F. Cultural norms and VI**

Some cultural groups have specific and different responses to visual impairment.

Professionals in the field of visual impairment have encountered a variety of responses among families to visual impairment (Erin, 2002). The list below demonstrates the wide range of reactions in terms of cultural values and norms. Professionals must approach all situations without prejudice, knowing that they will be ineffective in supporting families and children with visual impairments if they try to impose their own biases and beliefs.

- Families from some cultural groups believe that the family should care for and support the child with a disability, and they do not see independence as an important value. This is especially true with regard to travel: many families do not expect or want their child to travel independently and believe the child's role is to receive assistance from others. Professionals often are unsure about whether to encourage independence for a blind child if the family does not expect the child to function without assistance.
- Some families come from cultures in which blind/visually impaired individuals are not expected to hold jobs, or they are expected to hold only certain jobs. For example, until recently, many Asian cultures prepared people with blindness mainly for careers in massage or fortune-telling.
- While the majority culture in the United States tends to trust written communication as the clearest and most consistent method of planning (e.g., IEP meeting), people from

some cultures tend to value oral communication. Information conveyed only by letter is not trustworthy for some families. Direct contact from school personnel is more important to them.

- Gender expectations vary across cultures. It is important to discover what toys are typically used by children of the same age as the child with a visual impairment and to incorporate these into learning activities so that the child is more likely to interact with peers.
- Some cultures look on specific types of visual impairments as having special meaning within the culture. For example, people with albinism are viewed as having special powers in some cultures, while in others they are seen as bringing bad luck. Professionals might ask parents how others in their community react to their child in order to find out about these perceptions.
- Many religious and cultural groups still connect the presence of visual impairment with the idea of retribution for sin. This belief tends to be more common among grandparents, but professionals often are concerned about how to react when a family expresses a belief like this. For example, professionals may struggle with the appropriate response: Should they disagree? Should they support the family's belief even though they feel that it is not founded in fact? Should they talk to the family about how this might affect the child?
- People in leadership roles vary within families. For some families, religious leaders and heads of families may be critical decision makers. For early intervention to be successful, it may be necessary to involve these leaders or at least gain their approval for the family's participation in an educational program.
- It is common for families to visit religious healers during their children's early years. Many families do not necessarily expect healing, but rather support, from their religious community. Professionals should be aware that this is common and does not necessarily reflect a belief that there will be a physical change in the child's condition but rather a family's effort to understand and accept the meaning of the disability.

For detailed insight into specific religious and ethnic interpretations of visual impairment, we recommend *Diversity and Visual Impairment: The Influence of Race, Gender, Religion, and Ethnicity on the Individual* (Milian & Erin, 2001). While the potential for cultural influence exists, it cannot be assumed that all families, even with very similar cultural backgrounds, will be influenced equally or in the same manner by cultural traditions, values, and histories.

### **G. Cultural reciprocity**

Cultural reciprocity refers to a two-way process, typically initiated by service providers, by which service providers and families from different cultures share information about values and culture to find mutual ground for effective communication.

Cultural reciprocity does not require TVIs to give up or change their values, but it does require openness, a willingness to learn and understand, and an ability to regard families in

a positive light. According to Harry (as cited by Warger, 2001), professionals may consider following a four-step process that will help them develop cultural reciprocity. The four steps to this process are described below.

- Step 1 Identify your own cultural values as you interpret a child's or family's challenges or as you recommend services.
- Step 2 Determine whether the family is aware of and values your assumptions—if not, how do your views differ.
- Step 3 Identify and respect cultural differences between you and the family—explain the cultural basis of your assumptions.
- Step 4 Determine the best way, through collaboration and open dialogue, to adjust your recommendations to match the family's values.

Bruns and Corso (2001) summarized issues that influence the relationships between professionals and families as including family structure, length of time since immigration, age, and cultural expectations related to services and outcomes. In addition, they identified several differences that could interfere with the development of effective relationships between service providers and families, including differences in expectations and roles, personality characteristics, cultural beliefs and acculturation, and background (age, education, etc.). Finally, they offer additional suggestions on respecting cultural and linguistic diversity that facilitate the development of effective relationships.

- Respect the uniqueness of individual families.
- Develop personal relationships.
- Communicate appropriately.
- Recruit staff who value diversity.
- Develop relationships with cultural guides.
- Evaluate outcomes and processes.

As noted by Santos and Reese (1999), families within cultures vary considerably due to differences in how connected they are to their traditional culture. Some of the factors that influence how strongly families are tied to their culture include

- primary language spoken in the home and community,
- educational levels,
- religious affiliations,
- country of origin,
- length of time family has resided in this country,
- degree of acculturation,
- current residence, and
- income.

Both Warger (2001) and Santos and Reese (1999) suggest that identifying and collaborating with a community leader from the same culture may assist early interventionists in establishing trust and effective relationships with families from

different cultures.

## **H. Cultural reframing**

Professionals bring their own biases, values, and past experiences to any new relationship with a family and their child. To be effective, practitioners must understand and be sensitive to family reactions to disability within the context of the family, community, and culture.

It is important to be aware of the biases, judgments, and assumptions we have about families. This is especially important because of the fact that early intervention professionals tend to be women from European American backgrounds (Dote-Kwan, Chen, & Hughes, 2001), and the families they serve are likely to be ethnically and linguistically diverse (Hains, Lynch, & Winton, 2000). Getting to know families entails learning about their perspectives, strengths, needs, and concerns. Professionals are just as influenced by their cultural background as are the families with whom they come in contact.

*June, a TVI and OMS, had been frustrated with how the Hamilton family used the materials she brought to their home. During the home visits, Mrs. Hamilton was as excited as June to see Jimmy, a 12-month-old with ROP, reach for and play with stacking cups, measuring spoons, seasonal decals, and shiny beads when these toys and objects were placed on the floor around him. June was happy to leave these materials in the home, and Mrs. Hamilton seemed glad to have them. However, in the following weeks when June visited the home, the toys and objects had become part of the other children's playthings; and often the stacking cups, measuring spoons, beads, and decals could not be found. It seemed that Jimmy had no opportunity to use the things June had left for him. Initially, June was angry at Mrs. Hamilton's apparent inability to control her other children and to keep the materials separate for Jimmy's use. When she realized her anger was not helping the situation, June made an effort to think about her beliefs regarding resources for children with visual impairments and to think about Mrs. Hamilton's needs and priorities regarding Jimmy and her other children. Finally, June talked with Mrs. Hamilton about her concerns. Together, Mrs. Hamilton and June were able to talk about how Jimmy might be given the opportunity to use the toys and objects with his siblings during the week in a way that fit in with the Hamiltons' daily routines.*

Armenta (1993), Kalyanpur and Harry (1999b), and Turnbull and Turnbull (2001) suggest that a first step in being able to establish a reliable alliance with families is knowing yourself. The second step is getting to know and appreciate families and their perspectives, strengths, needs, and concerns.

As individuals expand their worldviews (i.e., perceptions), they continue to develop sensitivity and respect for the different values and perspectives they encounter in intervention situations. An expanded worldview is something that comes from within each individual rather than from reading or being told about it. One approach to expanding worldview is through the nonjudgmental practice of cultural reframing—simply acknowledging that the way one normally perceives a situation is just that, a perception. It is not necessarily the objective, sole reality of the situation. Cultural reframing is an attempt to

see or explain a situation from another point of view. It takes the cultural components of a situation into account in a nonjudgmental manner, resulting in a different and possibly neutral, or even positive, interpretation.

We suggest several activities to increase awareness of one's own worldview and of others' worldviews. Activity A, "The Family Philosophy Project"; Activity D, "The Family Panel Activity"; Activity F, "Family Values, Beliefs, and Symbols"; and Activity G, "Cultural Reframing" offer opportunities for participants to experience development of self-knowledge and expand their worldview.

### References for Major Points

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