DOCUMENT RESUME

ED 380 223 PS 023 061

AUTHOR Fenichel, Emily, Ed.
TITLE Cross-Cultural Studies of Child Development: Implications for Clinicians.
INSTITUTION Zero to Three/National Center for Clinical Infant Programs, Arlington, VA.
REPORT NO ISSN-0736-8083
PUB DATE Oct 94
NOTE 33p.
AVAILABLE FROM Zero to Three/National Center for Clinical Infant Programs, P.O. Box 25494, Richmond, VA 23260-5494 (1-year subscription, $37).
PUB TYPE Collected Works - Serials (022)
JOURNAL CIT Zero to Three; v15 n2 Oct-Nov 1994

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Blacks; Book Reviews; *Child Development; *Cross Cultural Studies; Cultural Awareness; *Cultural Influences; Day Care; Emotional Development; *Family Programs; Foreign Countries; Hispanic Americans; Intervention; Professional Recognition; *Psychotherapy; Social Development; Social Science Research; Social Services; Videotape Recordings
IDENTIFIERS African Americans; Ireland; Jamaica; Japan

ABSTRACT

This theme issue contains six articles on the development of infants and toddlers: (1) "Cross-Cultural Studies of Child Development: Implications for Clinicians" (J. Kevin Nugent); (2) "Therapeutic Work with African-American Families: Using Knowledge of the Culture" (Cheryl Polk); (3) "Psychotherapy in Specific Cultural Contexts: Resources for the Infant Mental Health Clinician" (Cheryl Polk); (4) "The Critical Importance of Cultural and Linguistic Continuity for Infants and Toddlers" (Hedy Nai-Lin Chang and Dora Pulido); (5) "Professionalization as Culture Change: Issues for Infant/Family Community Workers and Their Supervisors" (Blanca E. Almonte); and (6) "Studying the Social and Emotional Development of Hispanic Children in the United States: Addressing Research Challenges" (Maria P. Fracasso). Each article includes a reference list. The journal also includes reviews of six books and ten videotapes on cultural awareness, diversity, and multicultural issues related to child development, child care, and social programs. (MDM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

94/2

October / November 1994 Volume 15 No 2

ED 380 223

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
X This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Marilyn Holt

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
E. Fenichel
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Cross-Cultural Studies of Child Development:

Implications for clinicians

J. Kevin Nugent,

Professor of Child Development, University of Massachusetts

Director of Brazelton Scale Training, Child Development Unit, Harvard Medical School

Cross-cultural studies of child development provide infant/family practitioners with three invaluable, if not indispensable principles which can serve to support and direct culturally-inclusive clinical reflection and practice. First, while studies of child development in different cultural settings contribute to our appreciation of the rich diversity of child rearing practices and belief systems across the globe, they also challenge our own assumptions about the very nature of child development and in turn help to free us from whatever residual nostalgia we may have for the primacy or superiority of our own cultural world view. Second, cross-cultural research reminds us that experimental-controlled studies are by no means the only source (or even the chief source) of data collection or information-gathering about child development. Studies conducted within the classic empirical tradition often tell the practitioner little about the dynamic nature of child-environment relations or the context of development and as such provide us with few reliable guidelines for working with families from different cultures. Third, cross-cultural research forces practitioners, program designers, advocates and policy makers to question the appropriateness of every program goal and the validity of

Continued on page 3

PS 023061

2 BEST COPY AVAILABLE

Editor's Note

We live in a multicultural country, but the landscape of this country can be seen as riddled with ravines, gullies, and man-made moats that separate and isolate cultures from each other. Fortunately, the contributors to this issue of *Zero to Three* have discovered ways to bridge cultural chasms. To do so, they use the fundamental tools of the infant/family field — research protocols, program design, staff training and supervision, therapeutic approaches, and consultation. They show us how these tools can be used to build cultural competence and what adaptations are needed to make them useful in cross-cultural work with very young children and their families.

Two themes in particular resonate among the articles in this issue and in the videotapes and publications included here as well. The first theme involves the recognition that daily caregiving routines for babies and young children reflect a culture's fundamental, deeply held values and beliefs: To understand any caregiving behavior, we must understand the values and beliefs on which it is based. The second theme is closely related: Because we absorb our own culture's values at such an early age, through our own experiences of being cared for, we may not be able to articulate our own beliefs without effort. To challenge our assumptions and biases, we must first recognize them. Introspection and self-awareness are therefore critical for anyone working cross-culturally — as they are for anyone working with infants, young children, and their families.

Contents

1 Cross-cultural studies of child development *J. Kevin Nugent*
9 Therapeutic work with African-American families *Cheryl Polk*
12 Psychotherapy in specific cultural contexts *Cheryl Polk*
13 Cultural and linguistic continuity for infants and toddlers *Hedi Nai-Lin Chang with Dora Pulido*
18 Professionalization as culture change *Blanca E. Almonte*
19 Studying the development of Hispanic children in the U.S. *Maria P. Fracasso*
27 Publications
28 Videotapes
30 Conference call
31 Reader survey

BEST COPY AVAILABLE

Zero to Three Staff

Editor, *Emily Fenichel*
Consulting Editors, *Jeree Pawl and Jack Shonkoff*
Assistant Editor, Videotapes, *Margie Wagner*
Assistant Editor, Publications, *Julia Bromley*

Zero to Three is the bi-monthly bulletin of ZERO TO THREE/National Center for Clinical Infant Programs. Unless otherwise noted, materials published in Zero to Three may be reproduced by health professionals or employees, officers or board members of non-profit education and social services organizations for non-commercial use, provided they acknowledge ZERO TO THREE/ National Center for Clinical Infant Programs as the source and copyright owner of this material.

ISSN 0736-8083

©ZERO TO THREE/National Center for Clinical Infant Programs 1994

2000 14th Street North, Suite 380, Arlington, VA 22201-2500
Tel. (703) 528-4300
Publications Orders: 1-800-899-4301

ZERO TO THREE/National Center for Clinical Infant Programs
Board of Directors
Kathryn Barnard, University of Washington
T. Berry Brazelton, Children's Hospital Medical Center, Boston
Maria Chavez, Department of Children, Youth and Families, State of New Mexico
Robert N. Emde, University of Colorado School of Medicine
Linda Gilkerson, Erikson Institute,Chicago
Stanley I. Greenspan, George Washington University School of Medicine
Robert J. Harmon, University of Colorado School of Medicine
Irving B. Harris, Pittway Corporation, Chicago
Asa Grant Hilliard, III, Georgia State University, Atlanta
Gloria Johnson-Powell, Harvard Medical School
Sheila B. Kamerman, Columbia University School of Social Work
Anneliese Korner, Stanford University Medical Center
J. Ronald Lally, Far West Laboratory, San Francisco
Bernard Levy, New York City
Alicia F. Lieberman, University of California, San Francisco
Samuel Meisels, University of Michigan
Dolores Norton, University of Chicago
Robert Nover, George Washington University School of Medicine
Joy Osofsky, Louisiana State Univ. Medical Center, New Orleans
Jeree Pawl, University of California, San Francisco
Deborah Phillips, University of Virginia
Kyle Pruett, Yale University School of Medicine
Arnold Sameroff, University of Michigan
Marilyn M. Segal, Nova University, Ft. Lauderdale, Florida
Rebecca Shahmoon Shanok, Jewish Board of Family and Children's Services, NYC
Jack Shonkoff, University of Massachusetts Medical School
Lynn Straus, Mamaroneck, NY
Ann P. Turnbull, Beach Center on Families and Disability, Lawrence, Kansas
Bernice Weissbourd, Family Focus, Inc., Chicago
Serena Wieder, Clinical Psychologist, Silver Spring, Maryland
G. Gordon Williamson, JFK Medical Center, Edison, New Jersey
Barry Zuckerman, Boston University School of Medicine

Life Members
Mary D. Salter-Ainsworth, University of Virginia
Peter Blos, Jr., Ann Arbor, Michigan
Peter B. Neubauer, New York City
Arthur H. Parmelee, University of California Medical Center, Los Angeles
Julius B. Richmond, Harvard University Medical School
Mary Robinson, Baltimore, Maryland
Pearl Rosser, Silver Spring, Maryland
Albert Solnit, New Haven, Connecticut
Edward Zigler, Yale University

Associate Directors: Carol Berman and Emily Fenichel

This publication was made possible in part by a grant from the American Express Foundation.

Florence Sharp

every assessment tool in the light of the cultural background of the children and families whom they serve.

The heuristic value of this field for the clinician, therefore, goes beyond the simple description or documentation of different patterns of child-rearing in strange or exotic cultures. The exposure to research from different cultures does indeed enable us to broaden our appreciation of cultural differences in the socialization process. Studies of child development in context can reveal the universals and the specifics of human behavior, what may be biologically based and unchangeable and what is environmentally induced and therefore by nature variable. They may tell us what is phylogenetically programmed and what is culturally programmed, what is "bred in the bone" and what is shaped by parents and society. They can extend our understanding of the clinical process since the goal of cross-cultural research is to expand the range of variability of what is considered to be normative behavior. Cross-cultural studies in turn help us identify the particular kinds of experiences that affect development, the role of mothers and fathers in the socialization process in societies where a larger family network is responsible for child care, and the role of different kinds of discipline or child-rearing practices; in general, they describe the range of settings in which development takes place.

However, cross-cultural research also serves to challenge the validity of our current assumptions about human behavior and to free us from our own unconscious ethnocentrism. This form of ethnocentrism can be called unconscious or latent because it is not readily accessible to our conscious reasoning and it plays a subtle and often unconscious role in our interactions with families from cultures other than our own. The clinical goal of cross-cultural research is to challenge our core assumptions about the nature of development, about what we think of as "good" or what is "optimal," what is "normal" or what is "abnormal." The concepts of normality and risk are therefore seen as cultural constructions which may not have validity in cultures other than in the one in which the concept was constructed. Garcia-Coll (1989) in her study of teenage childbearing in an urban Puerto Rican setting for example, demonstrated that the cultural environment of these young mothers was supportive and positive and concluded that adolescent parenthood does not necessarily constitute a negative life event for mother and child. In this case it was the cultural context, not the age or marital status of the mother, that constituted the major determinant in mediating positive or negative outcome for mother and child.

Cross-cultural studies also serve to challenge the hegemony of logical positivism and the traditional primacy of experimental-controlled studies in our efforts to study and understand the nature of child development and meet the needs of families from a wide range of cultural backgrounds. When T. Berry Brazelton points to the risk of "throwing out the baby when we throw out the bathwater" in our search for objectivity, he is suggesting that it may be the "bathwater" or the so-called interfering variables of the experimental paradigm that may well be the source of the most significant information on the cultural-environmental influences which shape the child's behavior. If we throw this out in our search for objective "generalizable" data, we may be left with little information on the specific environmental practices that influence the child's development (Brazelton, 1991). A cultural-contextual approach to clinical research forces us to examine behavior in context, to examine the ecology of development and to come to an appreciation of the historical and cultural antecedents of the behavior under study (Bronfenbrenner, 1979).

Cross-cultural research also has serious implications for infant/toddler/family programs in the light of the changes in the Individuals with Disabilities Education Act (IDEA), with its emphasis on respecting cultural diversity. In the absence of systematic information on different ethnic groups in North America, the ethnographic approach of the cross-cultural tradition has immediate applicability to the study of different cultures on the North American continent, about which we have little information. While there has been some systematic work with children and families from cultural groups within the United States (e.g. Chisholm, 1989; Muret-Wagstaff, 1989; Field, 1990; Rosser et al., 1989) there are still few ethnographically based studies of infants and toddlers and their families in North America (Lynch and Hanson, 1992). This means that many infant/toddler/family programs may be based on a priori goals that bear little relation to the cultural

BEST COPY AVAILABLE

background of the families in which the programs are set. By emphasizing the primacy of context, this approach leads us to question the appropriateness of program goals and to re-examine the kinds of assessment tools we use to evaluate children, in the light of the cultural background of the children and families in the program. From this perspective, the clinician becomes the data gatherer and each program must challenge itself to develop a set of strategies to meet the unique, culturally mediated goals of the population being served and ultimately to develop program goals that are inclusive and culturally comprehensive.

Approaches to cross-cultural studies

The classic cultural tradition guiding the study of child development has been the cultural transmission approach (Valsiner, 1989). It is an approach that has as its focus the description of socialization practices and examines the effects of different child-rearing practices on personality. However, while this tradition has provided a rich description of socialization practices in different cultures, it is essentially unidirectional in its thrust, with the child seen as a passive receptor of cultural messages. "Personality is culture writ large," Ruth Benedict wrote. Cultural practices shape behavior and child-rearing practices determine it. The underlying assumption is that the study of child-rearing practices is the key to understanding the child.

A more recent approach to the study of cultural differences in behavior has been to examine the contribution of the child to the developmental process and to examine development as a dynamic interaction between the organism and the culture in which it is embedded (Valsiner, 1989). The socialization process is seen as an active co-construction process in which the developing child reconstructs cultural messages from the very beginning. This perspective is bi-directional, and socialization is understood as an active reconstruction of the parent's culture by the child. We have reviewed a series of studies from a wide range of cultural settings which clearly demonstrate that the infant has a role in shaping and directing the socialization process itself from the very beginning (Nugent, Lester and Brazelton, 1989, 1991 and in press).

Chisholm's study of the Navajo culture and the effects of cradle-boarding on the child's development provides an illuminating example of this perspective (Chisholm, 1989). The cultural transmission approach would suggest that the reportedly shy, withdrawn behavior of Navajo children was the result of the custom of cradle-boarding. The "swaddling hypothesis" suggested that carrying the infant on a cradle-board served to inhibit her movements and this in turn was instrumental in promoting a quiet, shy, withdrawn disposition among Navajo children. Chisholm suggested that an alternative hypothesis could be that this view may rather be a reflection of the projection of Anglos, who would like to see the Navajo as a submissive people. Using the Brazelton Neonatal Behavioral Assessment Scale, Chisholm discovered that at birth the Navajo infants had a unique behavioral repertoire: they displayed well modulated state organization, they cried little, and they had generally low activity levels. These qualities were present at birth. These were the very capacities which made it easy for Navajo mothers to carry them on cradle-boards. In this case, it was the behavior of the child that contributed to shaping the behavior of the parent. This provides an example of socialization as a dynamic, interactive process from the beginning.

Guided by the notion of socialization as a co-construction, I will now briefly describe three studies which produced results that serve to challenge our assumptions about the nature of risk by yielding results that could be called counter-intuitive. These results in turn challenge our conventional assumptions about the nature of development itself. The studies were conducted in Jamaica, Ireland and Japan respectively.

Jamaica: The effects of maternal marijuana use on neonatal outcome

In a study of maternal marijuana use during pregnancy in Jamaica, which was conducted along with Melanie Dreher and Rebekah Hudgins (Dreher, Nugent and Hudgins, 1994), we examined the effects of maternal marijuana use on behavioral outcome in the newborn period. A series of studies conducted in North America demonstrated the deleterious effects of prenatal marijuana use on newborn outcome. Fried and Makin (1987) have reported that moderate levels of marijuana use in pregnancy were related to poorer habituation scores, higher irritability levels and more tremors and startles as measured by the Brazelton Scale. Similarly, Coles et al. (1992) found that infants whose mothers used marijuana in pregnancy demonstrated depressed Orientation scores at 14 days and had poorer Range of State at one month, compared to a matched group of unexposed infants.

Our study of 33 marijuana-using mothers and 27 non-users and their newborn infants was conducted in the southeastern part of Jamaica, where there is well-known and widespread use of marijuana. Consistent with the working class in other parts of Jamaica, residents in this community view marijuana not only as a recreational drug but also one that has ritual and medicinal value. It is valued for its health-promoting functions and is consumed as a tea by family members for a variety of illnesses and to maintain and promote health. Rastifarians endorse marijuana as a sacred substance and may smoke ritually on a daily basis. While women traditionally prepared marijuana in teas and medicines, female marijuana smoking is a new phenomenon. If smokers were Rastifarians they were called Roots Daughters, described as women with a purpose, who think, reason and smoke like a man (Dreher, 1987). They are considered self-reliant and dignified. Many of these women smoked marijuana on a daily basis and continued to smoke during pregnancy and the breast-feeding period. Marijuana use is not necessarily indicative, therefore, of a mother's lack of concern for

her baby. Supported by the folk belief that marijuana has health-giving properties, women use it to deal with the difficulties of pregnancy. Nineteen of the women in our sample reported that it reduced nausea, while 15 said that it reduced fatigue and improved their appetites during pregnancy. Post-natally they reported that marijuana helped alleviate post-partum depression. All reported it was good for themselves and their families. In general however, it should be pointed out that these women are a minority and most women in Jamaica refrain from smoking marijuana during pregnancy.

An ethnographic design, combining community and household naturalistic observations was employed. Field workers lived for up to two years in the parish and local midwives were part of the team and helped recruit the women. The final samples were matched and consisted of 33 users and 25 non-users. The users were divided into three groups:

Heavy users (n=10):smoked daily (21 cigarettes/week)
Moderate users(n=9):smoked 3-4 times/week (11-20 cigarettes/week)
Light users(n=12):used tea only or smoked less than 10 cigarettes/week)

In this study, marijuana use was uncontaminated by any other drugs.

Results revealed no differences between the infants of users and non-users on Brazelton Scale scores at three days. However there were differences at 30 days: babies of marijuana-users had better physiological stability and required less examiner facilitation to reach alert states. In the comparison of heavy users the results were more striking. The infants of heavy users were more autonomically stable at 30 days than the infants of the light users and the non-users. On the Supplementary items of the Brazelton Scale they showed better quality of alertness, they were less irritable, needed less examiner support, had better self-regulation and were judged to be more rewarding for caregivers.

Conventional wisdom and the existing data suggested that not only would the infants of heavy users be negatively affected by the maternal marijuana use, but that heavy users would be less likely to provide an optimal caregiving environment postnatally. In an effort to interpret these counter-intuitive results we were forced to look in more depth at our ethnographic data. In our post-hoc analysis of the data we found that the environments of these infants were in fact more nearly optimal, despite the fact that they were matched on global SES ratings. The SES rating did not, however, reveal significant but subtle differences which existed between the environments of the heavy-using mothers and the non-users. It seems that the heavy-users, the Roots Daughters, were better educated and their households had fewer children. In other words, they had more adults living in their households and fewer children to compete for parental attention.

Thus differences among infants may well be the result of environmental influences that overrode the drug effects. Marijuana use is but one of many variables that may influence the infant's life from the beginning. Thus the absence of any differences between the exposed and non-exposed groups suggest that the better scores of the marijuana-exposed infants are traceable to the cultural positioning and social and economic characteristics of mothers using marijuana that select for the use of marijuana but also promote neonatal development.

Ireland: The risk status of unmarried mothers and their infants

There has been a dramatic increase in the percentage of infants born to unmarried mothers in Ireland over the last decade. For the first fifty years of this century 2 percent of all registered births were to single mothers. In 1975 the figure had risen slightly to 3.7 percent. Within 10 years it had risen to 8.5 percent and in 1990 the figure stood at 14 percent. In a study of the contraceptive practices of Irish women, Sheila Greene, Marie-Therese Joy, Paul O'Mahony and I concluded that increased rates of sexual activity among unmarried couples, the lack of information on family planning, and the unavailability of artificial birth control contributed to this sharp increase (Greene, Joy, Nugent, O'Mahony, 1989). There is evidence to suggest that at least since the beginning of the middle of the last century attitudes towards unmarried mothers in Ireland have been overwhelmingly negative. There is a general consensus in the literature that infants born to unmarried mothers are at increased risk for negative developmental outcome (Baldwin, 1981; Garfield and McLanahan, 1986). Data on young single mothers suggest that these mothers are less responsive to their infants and are at risk for interactional failure (Culp et al. 1986).

We studied two hundred first-time working-class Irish (Dublin) mothers, half of whom were unmarried and half of whom were married. They were first interviewed during the third trimester of pregnancy (Nugent, Greene, Wieczoreck-Deering et al. 1993). Consistent with our social-historical analysis and consistent with results from similar studies in North America, our results demonstrated that during pregnancy, the unmarried mothers had significantly less social support than married mothers and they were significantly more depressed than the married mothers. On the basis of these findings, we expected that the unmarried mothers and their infants would be at risk for interactional problems.

One hundred and eight of these mothers and their infants were observed in their home settings at one month after delivery. We studied mother-child play in an effort to assess the quality of the mother-infant relationship and to assess the incidence of interactional failures. At the home visit, we compared the married and unmarried mother-infant dyads on Belsky et al.'s assessment of mother-infant play (Belsky et al. 1984). We found no differences in the quality of mother-infant play between the

two groups on the six global dimensions. In fact, on a closer examination of the patterns of interaction, we found that the unmarried mothers showed more positive affect than the married mothers, they stimulated their infants more and looked at them more during the play sequence. We found no evidence of interactional failure among the unmarried mother-infant dyads. In addition, we found that the unmarried mothers as a group were no longer clinically depressed in the post-partum period as they had been during pregnancy. We concluded that this counter-intuitive outcome was mediated by cultural factors. The disappearance of the depressive symptomatology in unmarried mothers may be due to the fact that the cultural rejection experienced by the unmarried mothers during pregnancy was replaced by a general cultural acceptance of mother and infant which characterizes Irish societal attitudes to mothers and babies.

These findings demonstrate that what constitutes risk in one setting may not in another. Definitions of risk are inevitably cultural constructions by virtue of the fact that they are derived from specific circumscribed empirical data sets that often have limited application across cultural settings. These results demonstrate the danger of using a priori categories of risk and the importance of collecting baseline data on the population with whom we work. Definitions of risk must be context-specific in order to provide appropriate guidelines for clinicians and policymakers who are trying to meet the needs of infants and families in at-risk settings.

Japan: The relation between sleep environments and sleep disturbances in infancy

While sleep disturbances are the most common concern among parents of young infants to-day in North America and in other industrialized countries (e.g. Brazelton, 1990; Dawes, 1989; Lozoff et al. 1985), sleep problems or night-waking are less commonly reported as clinical concerns in Japanese settings.

Over the past ten years T. Berry Brazelton and I have been working with Tomitaro Akiyama and Chisato Kawasaki on a longitudinal study of infants born on the Goto Islands off the coast of Nagasaki. Recently we have been studying the sleep arrangements of infants in two Japanese settings (Kawasaki, Nugent, Brazelton et al., in press). We found that up to three years of age, none of the infants in our rural Goto Islands sample (n=21), slept alone. Eighteen of the infants (86 percent) slept with their parents and the remaining three (14 percent) slept with their grandparents or siblings. In a study of 45 children between the ages of 4 and 28 months in Nagasaki itself, we found that 73 percent slept in the same bed as their parents. The remaining 24 percent slept in the same room but on a separate mat. No infant slept alone in either sample.

Sleeping arrangements and the management of sleep in young infants is one of the ways in which a culture attempts to achieve its goals for its children. In Japan, parents want their children to develop a sense of what can be loosely translated as dependence or obedience from the very beginning. Doi refers to this as AMAE and in a recent study of Japanese fathers and mothers, we found that parents valued this characteristic above all others as the primary goal of socialization (Doi, 1990; Takahashi, Nugent, Greene, Brazelton, 1994). The sleeping arrangements in Japanese society seem to have evolved to promote the development of AMAE in Japanese infants and to foster the development of a close, dependent relationship between children and parents, especially mothers. It is tempting to suggest that this sleeping arrangement, which provides the infant with continued close physical contact with the mother, also results in an absence of sleep problems. However, from a more dynamic constructivist perspective, we recognized that the interpretation must lie in an examination of the interactions of the infant with the environment. In fact, when we examined the Japanese infants on the Brazelton Scale, we found that these infants showed little state lability and were especially well able to deal with environmental perturbations while asleep (Akiyama, et al. in press). Together these two sets of data suggest that the behavioral repertoire of the Japanese newborn, with his capacity for shutting out negative stimuli while asleep as well as his ability to maintain robust alert states, serves as an enabling predisposition that reduces the possibility of problems with sleep or night wakefulness. We hypothesized that the behavioral disposition of the Japanese infants, combined with sleeping arrangements that promote extensive close physical contact with parents, together may result in fewer sleep problems.

The sleeping arrangements we observed in Japan challenged our assumption of what in Western societies is conventionally considered to be the "normative" or more optimal practice of having the baby sleep on her own from birth on (Brazelton, 1990). In the United States at least 89 percent of infants sleep alone in a separate room apart from their parents (Shand, 1981) and parents believe that this will facilitate the separation-individuation process in the young child, and will in turn promote the child's independence and successful adaptation in her society (LeVine, 1988).

It is clear that neither the Japanese or the United States approach is a better or worse strategy for child-rearing. Both practices are culturally based solutions to a specific child care issue and both are guided by separate cultural belief systems that have evolved over time in response to very different social environments, in two societies which have very different sets of goals for their children.

Conclusion

These three cross-cultural studies demonstrate that the notion of risk is a cultural construction. Thus we must always examine the validity of the data bases on which many of our at-risk categories and diagnoses are based.

Risk categories have to be contextualized. The only valid risk inventories are those that emerge from and are constructed from the communities which we serve. Listening to and searching for the authentic voices of these communities through ethnographic research is the first step for the culturally sensitive clinician (Finn, 1994).

Engagement with children and families from other cultures can have a disequilibrating effect on our clinical world view and may yield counter-intuitive feelings. These counter-intuitive feelings, in turn, may turn out to be our most sensitive gauge for action, because in our engagement with families from other cultures, we may find the opposite of what our previous experience led us to expect. Cross-cultural experiences can serve to challenge the very essence of our beliefs about what we are doing and the efficacy of our interventions.

Barbara Young

Intuition, often considered to be the hallmark of the "good clinician," can be defined as the ability to make clinical judgements based on relatively little information. It is often assumed that this ability to get to the heart of the problem with little information is no more than an unlearned "gut feeling" or something the good clinician is born with. However, on closer scrutiny, we can see that this facility is based rather on a capacity for observation that has been systematically honed and refined over the course of a lifetime of observations in similar or parallel situations. Specifically, it involves the ability to listen for and simultaneously integrate multiple sources of information and apply this information to the immediate situation. In terms of its usefulness as a tool for understanding other cultural viewpoints, intuition is constrained by our own experience and by the extent of our contact with other cultures. However, it can still be a powerful clinical asset since it is through extended contacts with people from cultures other than our own that our "intuitive feel" will be challenged and we will develop a sense of cultural competence.

In sum, cross-cultural examples challenge our assumptions about the nature of development. They urge introspection as they force us to examine our own belief systems, to unmask our own cultural biases by reviewing our attitudes towards children and towards families. It goes without saying that without an awareness and appreciation of our own culture or without a firm sense of identity with our own culture, it will be extremely difficult to be sensitive to or open to the nuances of another culture. It will be equally difficult to have access to our own biases and prejudices. Paradoxically, it is only in our engagement with other cultures that our understanding of our own culture is refined and our appreciation of other cultures is simultaneously enriched.

References

Akiyama, T., Kawasaki, C., Goto, Y., Tsurusaki, T., Ogi, S., Nakamura, M., Kawaguchi, Y., Brazelton, T.B., Nugent, J.K. (in press). The relationship between neonatal behavior and developmental outcome at seven years of age in a sample of Japanese infants in the Goto Islands. In J.K. Nugent, B. M. Lester, T. B. Brazelton (Eds.), *The Cultural Context of Infancy*, Vol 3. Norwood, New Jersey: Ablex.

Brazelton, T.B. (1990). Parent-infant co-sleeping revisited. *Ab Initio*, 2, 1, 1-2.

Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Cambridge, Mass.: Harvard University Press.

Belsky, J., Taylor, D.G., Rovine, M. (1984). The Pennsylvania infant and family development project, II: The development of reciprocal interaction in the mother-infant interaction dyad. *Child Development*, 55, 706-717.

Coles, C. D., Platzman, K. A., Smith, I., James, M. E., Falek, A. (1992). Effects of cocaine, alcohol and other drug use in pregnancy on neonatal growth and neurobehavioral growth and status. *Neurotoxicology and Teratology*, 14, 22-33.

Chisholm, J. (1989). Biology, culture and the development of temperament. In J. K. Nugent, B. M. Lester, T. B. Brazelton (Eds.). *The cultural context of infancy, Vol. 1*. Norwood, New Jersey: Ablex.

Culp, R., Applebaum, M.I., Osofsky, J.D., Levy, J.D. (1988). Adolescent and older mothers: comparisons between prenatal and mater-

BEST COPY AVAILABLE

nal variables and newborn interaction measures. *Infant Behavior and Development*, 11, 353-362.

Dawes, D. (1989). *Through the night: helping parents and sleepless infants*. London: Free Association Books.

Doi, Takeo, (1990). *The Anatomy of Dependence*. Tokyo: Kodansha International.

Dreher, M., Nugent, J.K. Hudgins, R. (1994). Prenatal marijuana exposure and neonatal outcomes in Jamaica: aa ethnogaphic study. *Pediatrics*, 93, 2, 254-260.

Dreher, M. (1987). The evolution of a roots daughter. *Journal of Psychoactive Drugs*, 19, 165-170.

Finn, C., (1994). Irish mothers' perception of parenting a handicapped infant. Presented at the 14th Annual Conference of the Society for Reproductive and Infant Psychology. Dublin, September 7-9, 1994.

Fried, P., Makin, J. E. (1987). Neonatal behavioral correlates of prenatal exposure to marijuana, cigarettes and alcohol in a low risk population. *Neurotoxocology and Teratology*, 9, 1-7.

Garfinkel, I., McLanahan, S. (1986). *Single Mothers and Their Children*. Washington, D.C,: The Urban Institute Press.

Greene. S., Joy, M. T., Nugent, J.K., O'Mahony, P. (1989). contraceptive practices of married and single first-time mothers. *Journal of Biosocial Science*, 21, 379-385.

Kawasaki, C., Nugent, J.K., Miyashita, H., Miyahara, H., Brazelton, T.B. (in press). The cultural organization of infants' sleep. *Children's Environments*.

LeVine, R. A. (1988). Human Parental Care: universal goals, cultural strategies and individual behavior. In R. A. LeVine, Miller, P., Maxwell, M. (Eds.). *New Directions for Child Development*, 40, 3-12.

Lozoff, B., Wolf, A. W., Davis, A. W. (1984). Co-sleeping in urban families with young children. *Pediatrics*, 74, 2, 172-182.

Lynch, E.W., Hanson, M.J. (1992). *Developing Cross-cultural Competence*. Baltimore: Paul H. Brookes.

Muret-Wagstaff, S., Moore, S. (1989). The Hmong in America: infant behavior and rearing practices. In J. K. Nugent, B. M. Lester, T. B. Brazelton, T.B. (Eds.). *The Cultural Context of Infancy, Vol.1*. Norwood, New Jersey: Ablex.

Nugent, J. K., Lester, B. M., Brazelton, T.B. (1989, 1991, in press). *The Cultural Context of Infancy, Vols. 1, 2 and 3*. Norwood, New Jersey: Ablex.

Nugent, J.K., Greene, S., Wieczoreck-Deering, D., Mazor, K., Hendler, J., Bombardier, C. (1993). The cultural context of mother-infant play in the newborn period. In K. Macdonalc (Ed.) *Parent Child Play*. Albany, New York: State University of New York Press.

Rosser. P., Randolph, S. (1989). Black American Infants. In J. K. Nugent, B. M. Lester, T. B. Brazelton (1989). *The Cultural Context of Infancy*. Vol.1. Norwood, New Jersey: Ablex.

Takahashi, S., Nugent, J.K., Kawasaki, C., Greene, S., Wieczorek-Deering, D., Brazelton, T.B. (1994). Parents' socialization goals and father involvement in caregiving in Japan and some comparisons with Ireland. Presented at the 14th. Annual Conference of the Society for Reproductive and Infant Psychology, Dublin, Sept. 7-9, 1994.

Now available from ZERO TO THREE

Diagnostic Classification of Mental Health and DevelopmentalDisorders of Infancy and Early Childhood (DC: 0-3)

Call ZERO TO THREE's Publications Department

1-800-899-4301 or 703/528-5693

Price: $25.00 plus $4.00 shipping and handling

Volume discounts available

Therapeutic Work with African-American Families:
Using knowledge of the culture

Cheryl Polk, Ph.D.

Infant-Parent/Daycare Consultant Program
University of California, San Francisco

Clinical interventions should resonate with the client's cultural experiences, and clinicians must use the strength of these experiences as the starting point for beginning therapeutic work. This application of sound cultural knowledge and enhanced cultural sensitivity is essential when working with families who have infants and toddlers. Most caregiving practices are soundly grounded in cultural beliefs, whether or not the parent is able to articulate the underlying rationale for his or her actions. Cultural beliefs greatly influence feeding, sleeping, and toilet training practices. The amount of independence a toddler is allowed, the use of discipline, and the quality and type of a child's play are all greatly influenced by the child's cultural background.

In African-American families, children are often taught to be independent at an early age. There is a push for autonomy and control of one's body and feelings. Toddlers and preschoolers, especially boys, are expected to be "tough" and are not encouraged to express their discontent. Too much cuddling or holding young children for extended periods of time is considered "spoiling" the child and deemed harmful for children's later growth and development (See Coll-Garcia, 1992 and Kelley, Power & Wimbush, 1992).

Three examples from my work in providing infant-parent psychotherapy and consultation to daycare staff illustrate the need for understanding the importance of culture.

One single mother with whom I worked had called a local parental stress line to complain that she was having considerable difficulty with her daughter's oppositional behavior as the child approached her first birthday. This mother wanted her child to be weaned and was fearful that she would be unable to accomplish this feat before the child turned one year old. At times, this mother could be sensitive to her daughter's distress over being weaned, but she was fearful that if she cuddled her daughter for too long, she was "just going to spoil her," and the child would be "good for nothing." The mother decided that she "guessed" her daughter would "just have to tough it out" and that this disappointment would "prepare her for the fact that life is hard. She is not going to get her way many times."

This young woman was fairly isolated and depended upon public transportation. We agreed that I would come to her home and see if we could figure out together how she could wean her daughter. We began by exploring why it was essential for her daughter to be weaned. This young woman desperately wanted to be a good mother and had followed her pediatrician's advice to breastfeed her child despite receiving conflicting advice from her grandmother and mother, who lived in a nearby community. When she began to wean the child, she once again received conflicting advice from the "experts" — her pediatrician and her maternal relatives. Her physician told her not to worry about it; her mother told her to cease nursing immediately and pointed out that if she had simply bottle-fed the child in the first place, she would not be "in this mess."

Marilyn Holt

In my weekly visits to this mother's home, we continued to "sort out" all the contradictory advice she was receiving about her baby. With considerable help, the mother was able to ask her own mother why being weaned by the first birthday was crucial. It turned out that this family, like many other African-American families, saw the ritual of being weaned from the breast (or the bottle) by the infant's first birthday as a transition into early childhood.

During our weekly meetings, this young mother and I continued to explore whether she had to embrace all of the cultural and family rituals suggested to her, or could she, after consideration, decide on a different course for her child? In my work with this mother I did not challenge or contradict the advice she was receiving from her maternal relatives. I focused, instead, on helping her gain additional knowledge to understand the reasoning behind this advice and on helping her decide whether she was going to embrace (or in some

Janet Brown McCracken

cases reject) these cultural expectations. Through a consistent, supportive, and yet non-judgmental posture, I helped her to realize that neither she nor her child had to "simply tough it out" and that there were other methods of coping available to her.

The next two examples illustrate this use of mental health approaches with daycare staff to help them become responsive to cultural influences on the behavior of young children.

The first request to our daycare consultation program came from the staff of a large, federally subsidized child care center. They were particularly concerned about the aggressive behavior of a two-and-a-half-year-old African-American boy, Kamal, who had been in their center for two months. He was, in their words, "beyond control."

I began this consultation by observing this child, with his guardian's consent. Kamal refused to participate in any small-group activities and rarely listened to the daycare providers. He simply ran around the classroom, with apparent glee. I approached Kamal while he was systematically and with considerable enjoyment destroying a toy garage, and inquired why he was doing this. Kamal, to my amazement, responded that he was "Bebe's Kids." Kamal was referring to an African-American group of cartoon characters created by the late Robin Harris. In Kamal's world, there was a clear explanation for aggressive (but not hurtful) behavior: he was imply imitating the behavior he observed in his favorite cartoon show. Kamal's behavior was, perhaps, culturally congruent with his neighborhood playmates, and yet it was totally unacceptable in the preschool setting.

There were two major, interrelated tasks in this consultation. One was to explore the daycare staff's perceptions of this child and to help them understand his behavior. The goal of this task was to increase their sensitivity and responsiveness to this child, whom they simply saw as a "problem." The director of the center, teachers in Kamal's classroom, and I met to discuss my observations. I shared with the staff Kamal's explanation for his behavior and explained the cultural reference (none of them had ever heard of "Bebe's Kids"). We began to explore how they could help Kamal become more comfortable in preschool and slowly help him make the transition into group activities. After considerable discussion, we agreed that a primary caregiver would be assigned to Kamal. Our reasoning was to help Kamal form a relationship with at least one person in the classroom and to later use the strength of the relationship to help him form other relationships at school. This primary caregiver, a Caucasian male, was given the assignment of "observing" Kamal throughout the next week, whenever he had the opportunity. He was to take special note of what occurred to precipitate aggressive behavior, what Kamal did during these aggressive periods, and how, after these bouts of aggression, Kamal was able to calm himself.

The next week, the staff and I met to discuss these observations. Interestingly, when Kamal's primary caregiver was able to focus on him for considerable periods of time, two trends emerged. First, Kamal enjoyed the attention and was better able to participate in group activities. Second, Kamal's seemingly random aggressive acts became more predictable. Whenever Kamal felt excluded or did not understand an activity, he disengaged from the group and began aggressive play. Kamal, who was not used to being in a multicultural setting or in a structured environment, had been unable to develop relationships with his peers and was unable to seek aid from his teacher when feeling distressed. In short, Kamal was miserable.

The second task in the consultation was to help Kamal's family understand his distress and to get them to work with the center's staff to make preschool a more successful experience for Kamal. This task was particularly challenging. Kamal's parents were young and were especially sensitive to complaints about their son's behavior. They were being monitored by the local child protective services social worker and were suspicious about the motives of school "outsiders" (none of whom was African-American) trying to tell them how to raise their child. Kamal's father was especially reluctant to meet the staff, and I decided that I would just "be there" one day when he picked up his son, to see if I could initiate a conversation about his son's adjustment to preschool.

I did "happen" to meet Kamal's father the next week at preschool and began describing his son's behavior to him. Before I could share with him Kamal s explanation for his behavior, Kamal's father stated to me quite proudly that his son was one of "Bebe's Kids." My immediate understanding of this cultural frame of reference lessened the father's anxiety about talking with me. I continued to "meet" this father for several weeks at Kamal's school to discuss his son's behavior. Kamal's father's anxiety prevented him from keeping regular appointments with school staff members, but he enjoyed our informal "chats" and genuinely seemed to want his son to "do well in school." The challenge of this work was helping Kamal and his father build trusting relationships in a culturally "foreign" environment.

Kamal's primary caregiver continued to observe his behavior. He shared his growing understanding of Kamal's behavior with the other staff members to help them to develop better methods to respond to Kamal's outbursts. This caregiver also began to join me in the "chats" with Kamal's father and was able to begin his own regular chats with the father. My work in this center mainly involved helping this family and preschool staff members recognize their respective cultural beliefs about behavior and helping them talk to each other regularly to avoid misunderstanding. We were, thus, able to form a bridge between Kamal's two worlds.

My third example also comes from a multicultural preschool setting.

I had been asked to come and observe one child, but while I was there another child, a three-year-old African-American boy, was asked to leave the reading circle because of his inability to sit still and refrain from playing with his peers. Clearly embarrassed by being excluded, he ran from the circle, pushing down chairs along the way. He rejected his teacher's attempt to comfort him, and ran under a nearby table, where he remained with his back to the group for several minutes. Shortly thereafter, he emerged, dusted himself off, and announced with great bravado that the was "too legit to quit."

This young boy was exhibiting what Ridley (1985) and others call "cool pose," or, in the words of a popular television commentator, "Never let them see you sweat." He was also using the title of a well-known rap song to announce to his classmates that he was now able to return to play. When I later discussed this incident with his teachers, I was able to explain this cultural reference to them. Increased knowledge of this young man's culture helped his teachers become more responsive to this child's coping strategies, while helping him to enlarge his repertoire of coping behaviors.

During the consultation we also discussed whether a large reading circle was the most successful strategy to facilitate learning and social development in children who were just becoming accustomed to a structured environment. Their attempts to become more responsive to this child's particular needs helped the staff to question the appropriateness of their approach to early childhood education. This center historically had a large population of Asian children who were used to sitting still for long periods of time without complaining. Their traditional reading circle approach was unsuccessful with the increasing African-American population entering the center. The African-American children were more verbal, more aggressive, and increasingly likely to be unresponsive to their caregivers' methods. This staff struggled to design a curriculum that responded to cultural diversity. In the process, they gained a curriculum that was developmentally more appropriate for most of the children in the center.

Conclusion

When working with most African-American families, a therapist is required to be extremely flexible and adaptive. Most African-Americans view psychotherapy with extreme distrust. Building working alliances can often take a considerable amount of time. Learning about cultural values and beliefs and taking a non-judgmental approach to the usefulness of culturally inspired coping behaviors are essential for good work.

One must recognize that it is the strength of the interpersonal relationship that the therapist is able to form with the adults in a family that will ultimately allow one to help an African-American child. Jenkins (1985) explained the steps involved in this process of doing cross-cultural work with African-American families. He observed that the family first "sizes up the therapist to see if she measures up." If this test is passed successfully, the family then becomes more involved and "opens up." Third, the family's loyalty to and personal regard for the therapist allows the family to continue to be involved in a therapeutic relationship. Lastly, if all of the aforementioned stages have been achieved, the family is able to engage in a viable treatment relationship. Clearly, knowledge of, and familiarity with, African-American families' cultural views and beliefs is a crucial first step.

References

Coll-Garcia, C. (1992). Developmental outcome of African-American infants. *Child Development, 63*, 583-593.

Jenkins, A.H. (1985). Attending to self activity in the Afro-American client. *Psychotherapy, 22*, 335-341.

Kelly, M., Power, T., & Wimbush, D. (1992). Determinants of disciplinary practices in low-income, black mothers. *Child Development, 63*, 573-582.

Ridley, C.R. (1984). Clinical treatment of the nondisclosing Black client. *American Psychologist, 39*, 1234-1245.

Psychotherapy in Specific Cultural Contexts:

Resources for the infant mental health clinician

Cheryl Polk, Ph.D.

Infant-Parent/Daycare Consultant Program
University of California, San Francisco

All mental health practices, including psychotherapy, occur within a specific cultural context (Ridley, 1985). Cultural values, morals, and norms greatly influence the definition of mental health/mental illness (Jackson, 1983). Cultural knowledge, therefore, provides a frame for the types of interventions which will be helpful for all clients (Sue& Zane, 1988; Ridley, 1985).

Several books and articles provide a helpful framework for understanding cross-cultural therapeutic interventions. Pinderhughes' 1989 work, *Understanding Race, Ethnicity and Power: The Key to Efficacy in Clinical Practice,* focuses on the beliefs, attitudes, and perceptions of clinicians. A particularly compelling chapter in this text discusses the power of the therapist as an important dynamic in cross-cultural encounters with minority clients who have historically been rendered powerless in society. Pinderhughes also devotes a chapter to describing her teaching methods for helping clinicians learn, through vivo experiences, how to become knowledgeable and comfortable in cross-cultural interactions.

Sue and Zane (1987) suggest that the role of cultural knowledge is to alert therapists to possible problems in their credibility when working with minority clients. They further suggest that cultural knowledge and culturally sensitive therapeutic strategies be linked to the basic processes of credibility and giving. *Credibility* is defined as the client's perception of the therapist as an effective and trustworthy helper. *Giving* is defined as the client's perception that something useful was received from the therapeutic encounter (p.40)

Psychotherapy with African-Americans

Several authors have pointed out particular challenges of which therapists should be aware when they are working with African-Americans. Ridley (1984) discussed the nondisclosing manner of many African-Americans, which is in direct contradiction to tenets of psychotherapy. Ridley emphasized the socialization process of blacks which conditioned them to "play it cool" and to exhibit "healthy cultural paranoia" (p. 1235). He described the manifestations of this behavior as: a) lack of trust in people; b) suspicion of the motives of others; c) lower degree of certainty about the sequence of events; d) a sense of individual powerlessness; and e) a sense that if one is not cautious, trouble will ensue (p. 1235). Ridley posited that the nondisclosing behavior of blacks was exacerbated in therapy, and, thus, the treatment of blacks was a paradoxical therapeutic enigma.

Block (1981) and Hines and Boyd-Franklin (1987) also stressed the historical prejudice and risk associated with therapy for many African-Americans. They suggested that clinicians must be sensitized to the cultural context of black life in America. Hines and Boyd-Franklin noted that color is the predominant distinguishing fact of life for African-Americans. They suggested that although this reality pervades African-American family life, the means of coping with racism vary from family to family. They stressed the importance of including extended family networks in treating black clients. They emphasized that the starting point of therapy with families should be based on an understanding and enhancing of their strengths.

Oler (1989) discussed the impact of the legacy of slavery on African-American consciousness. Oler posited that African-Americans go through four different stages of awareness of their history and their relationship with white Americans. These stages include: 1) preconsciousness of their black identity; 2) confrontation of racism; 3) internalization of positive values related to blackness; and 4) integration of the adaptive aspects of the preceding three stages. In order to successfully do therapy with an African-American patient, therefore, one must ascertain the patient's level of acculturation.

References

Block, C.B. (1981). Black Americans and the cross-cultural counseling and psychotherapy experience. In A.J. Marsala and P. Pederson (Eds.), *Cross-cultural Counseling and Psychotherapy.*New York: Pergamon Press.

Boyd-Franklin, N. (1987). The contribution of family therapy models to the treatment of black families. *Psychotherapy, 24,* 621-629.

Jackson, A.M. (1983). Treatment issues for black patients. *Psychotherapy, 20,* 143-151.

Oler, C.H. (1989). Psychotherapy with black clients: racial identity and laws of control. *Psychotherapy, 26,* 233-241.

Pinderhughes, E. (1989). *Understanding Race, Ethnicity and Power: The Key to Efficacy in Clinical Practice.* New York: The Free Press.

Ridley, C.R. (1984). Clinical treatment of the nondisclosing Black client. *American Psychologist, 39,* 1234-1245.

Ridley, C.R. (1985). Imperatives for ethnic and cultural relevance in psychology training programs. *Professional Psychology: Research and Practice,* 16, 611-622.

Sue, S. & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37-45.

The Critical Importance of Cultural and Linguistic Continuity for Infants and Toddlers

Hedy Nai-Lin Chang with **Dora Pulido**
California Tomorrow, San Francisco, California

Child rearing practice is a reflection of the values and beliefs of families and the culture of their community. The most basic acts of caring — feeding, toilet training, comforting, playing — reflect the values of the adult providing care. For example, an adult who has been raised to believe that early mastery of skills is important may use feeding time as an opportunity to encourage an infant to build specific motor skills. If a person was trained to emphasize autonomy and independence of young children, he or she might create situations where children feed themselves even if the results are quite messy. On the other hand, someone who grew up in a home where food was scarce may have a greater tendency to control how an infant eats in order to ensure food is not wasted. These examples illustrate that caregiving is both embedded in culture and a process through which adults convey their values and expectations to children.

As greater numbers of children spend time in care outside the home, greater attention is being paid to the importance of assuring continuity between what happens to a child at home and when he or she is under the care of another adult. In this case, the term "continuity" refers to the ability of the provider to understand, respect, and build upon the cultural as well as linguistic practices of the home to ensure a child's continued growth and development. Many believe that such continuity of care is particularly essential for young children. Ron Lally of Far West Labs explains,

Children between birth and two years of age are in the midst of forming the core of their identify. They are just beginning to acquire preferences and beliefs. The development of this identity occurs in large part by incorporating the views held by the adults who care for them. If the views of those adults are negative and inconsistent with the values of the family and community, the impact on a child's sense of identity could be devastating.

How such continuity can be assured, however, is a question which is still in the process of being answered.

This article explores various strategies for ensuring that caregiving is culturally and linguistically appropriate. It also identifies issues which merit further investigation and research. Strategies discussed include: employing caregivers of the children's cultural background, drawing upon the cultural expertise of staff, developing cultural sensitivity, and rethinking the language of care.

Substantial portions of this article have been adapted from *Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education.*

Employing caregivers of the children's cultural background

Some believe that placing young children in the care of a provider from the same cultural background is the most effective way of ensuring cultural continuity. The attributes of how a community rears its children can be very subtle. Culture influences everything from the body language an adult uses to convey affection or disapproval to how children are included in conversation. Readings, workshops or even discussions with parents cannot replace the understanding and expertise gained from growing up as a member of a particular community. Most of us cannot precisely explain why we do things a certain way — we just know that we do it and it seems to feel right. Usually, these attributes have grown up with us from childhood.

Consequently, it is easy for even the most culturally sensitive person to inadvertently teach a child culturally inappropriate behavior. Consider the experience of one infant/toddler caregiver who, despite her own bilingual (English/Spanish) and bicultural background (Mexican American), found she was unable to anticipate a cross-cultural issue which arose for a Korean toddler under her care. Employed at a university child care center, this caregiver often cared for babies of international students. One year she found herself responsible for an 18-month-old Korean girl who always allowed the other toddlers to take her toys away from her. Wanting the child to be able

Nancy P. Alexander

to stand up for herself, the provider patiently worked to teach the girl to be more assertive and to hold on to her toys. Just when the provider found she had successfully taught this new ethos to the girl, the parents came to visit the center. Watching their child exhibit this new behavior, they exclaimed, "What will we do when we return to Korea? Such selfishness is unacceptable!" In contrast, a caregiver who shares a cultural background with a child is much more likely to naturally engage in practices which are in harmony with those of the home.

Drawing upon the cultural expertise of staff

Whether or not children are placed directly under the care of a provider who shares their cultural heritage, employing caregivers from the cultural groups being served can help to increase the capacity of a child care facility to provide appropriate care. Caregivers can be important sources of advice about effective strategies for working with children from their own communities as well as how to avoid potential cultural faux pas.

Child care facilities must build supportive, safe climates where staff feel comfortable sharing diverse perspectives and raising concerns.

The mere presence in a child care setting of staff from various cultural groups does not, however, assure that others will benefit from their knowledge. Discussing issues of race and cultural differences is not always easy. Often staff are reluctant to share their views because they think their beliefs will be discounted or that co-workers will take offense. Child care facilities must build supportive, safe climates where staff feel comfortable sharing diverse perspectives and raising concerns. Sometimes, the most constructive learning occurs when a staff person from one cultural background observes a co-worker of a different ethnicity responding to a child in manner that s/he believes is culturally inappropriate. But learning only results if staff feel free to state their concerns and openly discuss them with co-workers. Creating specific opportunities for staff to share their expertise can also help to make it easier for staff to feel comfortable talking about issues of race and culture. Child care facilities can, for example, invite staff from different cultural groups to make presentations to each other and regularly set time aside during staff meetings to discuss the cultural appropriateness of various activities or policies. Often, such conversations allow staff to recognize values which are common across cultures as well as increase their appreciation and understanding for different perspectives and approaches.

It is important to note, however, that the lack of minority providers can present a significant barrier to utilizing this strategy. The results of California Tomorrow's survey of 434 centers in California call attention to this problem. This survey found that while most white children were in centers with at least one white caregiver, this situation was much less likely to exist for other children. For instance, more than 50 percent of the centers with one or more Asian children in their care did not have any Asian staff and more than 40 percent of the centers serving one or more African American children did not have any African American staff. While this survey used race as a proxy for culture, it is important to remember that any given racial category encompasses numerous ethnic groups. Matching by specific cultural background is probably even lower than reported through this survey. Drawing upon the expertise of diverse staff can only occur if significant resources are directed toward the recruitment, training and retention of staff from underrepresented ethnic groups.

Developing cultural sensitivity

Given the large numbers of children under the care of providers from a different ethnic group, another important strategy is teaching and encouraging providers to become culturally sensitive. (Gonzales Mena, 1993, Lally et. al, 1994, Mistry, 1990.) Cultural sensitivity can be viewed as an ongoing learning process which involves caregivers becoming aware of the values which underlie their own approaches to caring for children and understanding the beliefs of the families with whom they work.

Often, caregivers are unaware that how they interact with children is influenced by cultural values and beliefs which may be learned from their own childhood, their professional training or other social influences. Consequently, the first step towards developing cultural sensitivity is taking the time to reflect upon daily caregiving routines and analyze the underlying assumptions. For example, a caregiver should think about the way s/he handles putting a baby to sleep. Does s/he tend to put babies down and then leave them alone — even if they cry? Or does s/he usually soothe the child to sleep with cooing sounds or lullabies? Whatever technique a caregiver uses, s/he should analyze why s/he acts in this particular manner. What does s/he hope to achieve by acting in this manner? What are messages implicitly being transmitted to the child? This process of self-reflection increases a provider's understanding of how child-rearing is shaped by culture.

In addition to reflecting about oneself, being culturally sensitive requires learning about the different cultures and childrearing techniques of the families and communities of the children in their care. While workshops or books are one source of information, caregivers should be wary of over-reliance upon such materials because they tend to only provide information about general characteristics and behaviors. Although people from the same cultural group tend to share a common set of beliefs and traditions, tremendous individual variation exists within any group because of differences in personal history and experience.

Cultures are also subject to change and evolve as a result of a group's historical experience and exposure to ideas from other cultures.

Typically, parents or other family members are the most accurate sources of information about a family's child-rearing practices. Drawing upon their knowledge involves taking the time to ask parents about how they handle particular situations when they are at home and what are typical child-rearing strategies in their community. It also entails paying close attention when parents seem uncertain about or uncomfortable with how a caregiver handles a particular situation. Such discomfort is often a sign that the parents would normally approach the incident in a different way and could provide a caregiver with an opportunity to ask the parents about their beliefs.

Once a provider realizes the existence of differences, s/he must then be able to engage parents in an open dialogue about their respective caregiving practices and how they can work together to ensure their approaches are not in conflict with one another. In her book *Multicultural Issues In Child Care*, Janet Gonzales-Mena suggests that resolving cultural conflicts can result in one of four possible

> Pay close attention when parents seem uncomfortable with how a caregiver handles a particular situation.

outcomes. The first, **resolution through negotiation**, occurs when both parties are willing to modify their behavior in order find an appropriate solution. Another possible outcome is **caregiver education.** The discussion convinces the caregiver to modify his or her practice because the parent has taught him or her about another equally valid approach to caring for a child. On the other hand, the reverse effect, or **parent education**, could also be the result. The parent decides to adopt the teacher's approach because the discussion has helped him or her to understand an important concept in child development. The fourth possibility is that the parent and the provider never see eye to eye and the provider must adopt techniques for **on-going management of the unresolved conflict**. If this occurs, the key is for parents and provider to be able to maintain an open dialogue and respect each other's opinion.

Ensuring that caregivers and parents have opportunities to discuss and understand each other's habits, attitudes and traditions has implications for program design and policy. Programs can take a number of steps to create such opportunities. Parents could, for example, be encouraged to interview providers and discuss their respective child-rearing practices and philosophy as soon as they enroll their child or even while they are comparing child care options. Ongoing opportunities for parent/provider

Janet Brown McCracken

interaction (e.g. regularly scheduling parent meetings, conversing with parents during drop-off and pick-up, inviting parents to observe the program) are also essential. In multicultural settings, maintaining low staff/child ratios becomes even more important. Only having a small number of children means that a caregiver has more time to interact with the parents of each child and is more likely to have a manageable number of cultural groups.

Rethinking the language of care

Providing appropriate care is not just a matter of culture. Language is also a critical issue. The debate over what should be the language of care is a controversial topic which has received increasing attention in recent years. Some believe that early care and education programs should be used as an opportunity to expose children to English as early as possible. Advocates of English as the language of care believe that early exposure to English is an important strategy for preparing language-minority children for schools.

In contrast, a growing number of educators are finding that this emphasis on early acquisition of English may be harmful rather than helpful. The problem is that early care and education programs which emphasize English without paying adequate attention to the home language may be creating situations where children learn English at the expense of their home language (Wong Fillmore, 1991.) Programs which do not use a child's home language reinforce existing societal messages that a child's home language has a lower status. Keenly aware of status differences, children from language minority families will often refuse to speak the language of the home and cease to continue developing their primary language skills and ability.

BEST COPY AVAILABLE

The loss of the primary language is a tragedy for a number of reasons. First, language is a primary vehicle for transmitting culture. Many words and concepts do not easily translate from one language to another. Language is a critical source of a child's sense of identity and cultural heritage. Second, if language loss occurs and the parents do not speak English, the effects on family functioning can be even more disastrous. Unlike their children, language-minority parents are much less likely to have opportunities to learn English. Many are working several jobs just to survive and do not have time to take English as a Second Language courses (which often have long waiting lists anyway). Many are relegated to unskilled, low-paying jobs which do not require them to speak English. Children who speak only English cease to share a common language with their parents. Parents are in a sense "robbed" of their ability to parent — to pass on their values, advice, and knowledge or even help their children with their homework. Finally, a growing body of research (Ramirez et. al., 1991, Cummins 1989) demonstrates that the development of a child's primary language skills is integral to helping a child gain skills in English and succeed academically. Children who have developed basic skills in their primary language, such as identifying colors or learning to count, are easily able to transfer these skills to another language. Development of the skills in the primary language offers children the advantage of hearing about the concepts in the language they knows best and also makes it possible for parents who do not speak English to promote concept development while the child is at home.

> Children who develop basic skills in their primary language are easily able to transfer these skills to another language.

Although muc' of the language debate has focused on pre-school children, this issue has significant implications for infants and toddlers. Little is known about the impact of placing a child for long periods of time under the care of an outside caregiver who does not speak the home language. Some believe that placing very young children in English-only care is even more likely to lead to the loss of the home language, since children at this age are just beginning to develop sounds and form their first words. More research on this topic is clearly needed.

Being cared for by a caregiver who speaks a child's home language is also crucial for another reason. Sharing a common language is a prerequisite for strong communication between the parent and the provider. While parent/provider communication is necessary for all children, it is particularly crucial when children have not yet developed the ability to verbally express their needs themselves. The well-being of infants depends upon the adults in their lives being able to share information. Suppose for example, a caregiver notices that a baby keeps pulling his ear and thinks that this may indicate the baby may be suffering from an earache. The baby's health depends upon the caregiver being able to alert parents to this symptom so that they can take the baby to a doctor if he breaks out in a fever. Similarly, parents need to be able to talk to a caregiver about their concerns. Parents may want to find out if the provider has noticed their child has a lingering cough or whether s/he has also noticed a particular behavior, such as bullying other children or showing signs of timidity. But when parents and providers do not share a common language, conveying such information can be extremely difficult, particularly if the subject matter is not straightforward. A provider would, for example, have great difficulty adopting the culturally sensitive approach to caregiving described earlier if s/he could not easily communicate with the parents.

Language and culture have been discussed separately in this article because it is important to view them as related but distinct concerns. Sharing a cultural heritage does not guarantee that two people share a common language. Nor does fluency in a language spoken by a particular ethnic group necessarily indicate knowledge of that group's culture and traditions. On the other hand, the strong interconnections between language and culture should not be overlooked. As mentioned earlier, language is one of the primary vehicles through which culture is transmitted.

Unfortunately, many language-minority families do not have the option of placing their child in a facility which has caregivers who speak their home language. Again, California Tomorrow's survey sheds light on the current situation. It found that while nearly all of the child care centers surveyed could provide home-language support to their English-speaking children, only 55 percent had any staff person who could communicate with their Spanish-speaking children. More than two-thirds of the centers serving Asian children did not have a staff person who could speak the home language of their Tagalog, Chinese, Vietnamese, or Korean-speaking children.

Issues meriting further research and analysis

While the field has benefited from the information which has already been generated on this topic, further research and analysis on questions related to the provision of culturally and linguistically appropriate care is still very much in order. Described below are a number of key questions deserving further exploration.

How does the need for culturally and linguistically consistent care relate to the age of the child? Are the effects of culturally and linguistically inappropriate care in fact more devastating for infants and toddlers in the process of developing the core of their identity?

Do parents take issues of race, language and culture into consideration when making decisions about care? If

so, how? What types of materials can be developed to inform parents about the importance of these issues?

Why are certain language and cultural minorities underrepresented in the field of early care and education? What are the barriers to entry? What are effective recruitment and retention strategies for underrepresented groups?

Given that nearly all providers spend some time with a child who is ethnically different from themselves, what set of core principles and practices should be adopted by all child care workers? How can such a set of core principles be disseminated to the entire field?

Given the challenges of simultaneously working with multiple racial or linguistic groups and the scarcity of existing bilingual/ bicultural staff, is it appropriate for **some** early care and education programs to concentrate on meeting the needs of a particular ethnic or linguistic group with the understanding that children will eventually be placed in ethnically diverse settings? Under what situations would such "concentrated" programs be considered inappropriate because it would be preferable for children to be placed in a diverse setting? Is a concentrated type of program more appropriate or necessary for certain types of groups? What are the implications of such a strategy? For program eligibility regulations? For Civil Rights Law — given that segregation has historically been associated with discriminatory practice?

Conclusion

By the middle of the next century, experts predict the United States will no longer have any one dominant ethnic group. The demographics of the population of children under six are changing the most rapidly. As this country's ethnic diversity increases, the field of early care and education, like every other sector of our society, must grapple with the implications for their work and practice. And as with many other fields, the discussions of these implications are both complex and emotional. One reason this subject is so volatile is that many people believe that paying attention to particular languages and cultures will somehow lesson this country's sense of unity. The assumption of this article is diversity and unity are inextricably interwoven. The goal is for all children in our society to develop the skills needed to successfully negotiate the joys and challenges of living in a multicultural society. Grounding a child in a strong sense of identity and connection to family and community is part and parcel of achieving this overall goal. Children who have this foundation are more likely to have the self-confidence and sense of efficacy which allows them to be comfortable and successful in multicultural settings.

References

Chang, H. with Sakai,L. (1993) *Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education*. San Francisco, CA: California Tomorrow.

Cummins, J. (1989). *Empowering Minority Students*. Sacramento, CA: California Association of Bilingual Education.

Gonzales-Mena, J. (1993). *Multicultural Issues in Childcare*. Mayfair Publishing Company.

Lally, R. et. al. (1994). Caring for infants and toddlers in groups: Necessary considerations for emotional, social and cognitive development. *Zero to Three*, Vol. 14, No. 5. April/ May 1994.

Mistry, J. (1990). Culture and learning in infancy: Implications for caregiving. In *Infant/Toddler Caregiving: A Guide to Culturally Sensitive Care*. Program for Infant and Toddler Caregivers, California State Department of Education Child Development Division and Far West Laboratory for Educational Research and Development, December, 1990.

Ramirez, D., Yuen, S.D., Ramey, D.R. and Pasta, D.J.(1991). *Final Report: Longitudinal Study of Structured English Immersion Strategy, Early-Exit and Late-Exit Transitional Bilingual Education Programs for Language-Minority Children*. Aguirre International, submitted to U.S. Department of Education, February 1991.

Wong Fillmore, L. (1991). When learning a second language means losing the first. *Early Childhood Research Quarterly*, Vol. 6.

Professionalization as Culture Change:

Issues for infant/family community workers and their supervisors

Blanca E. Almonte, M.A.

Family Focus, Inc., Chicago, Illinois

Family advocates, resource mothers, home visitors, child care aides, family development specialists, and other paraprofessionals who work with infants, toddlers, and their families are often in a very uncomfortable situation. Although a paraprofessional may have been chosen for her position because she seems able to bridge cultures, once on the job she is likely to discover that the values and rules of the professional culture may be in conflict with the values and rules of other cultures to which she feels allegiance. One group values independence, another interdependence. One culture encourages open expression of feelings, another self-control. Moreover, some of these values and rules of behavior have been learned at such an early age and are so deeply ingrained that the paraprofessional is not conscious of them. Consequently, conflict between, for example, the culture of the service program and the culture of the community will not be experienced intellectually. Instead, conflict hits the paraprofessional as emotional upheaval, often coming without warning. She feels anxiety, or anger — a powerful sense that she is being asked to do things or to teach families to behave with their children in ways that are "just not right."

A supervisory relationship between a paraprofessional and a professional must address culture change and the feelings that accompany it.

I have felt this anxiety, and I have felt this anger. But when I was a paraprofessional "family life outreach worker" and tried to talk about these feelings with my supervisors, they told me to keep my "personal problems" at home. They suggested that I was emotionally unstable and criticized my "inability to keep my professional life separate from my work life."

I stopped confiding in my supervisor. I stopped telling her about the emotional upheaval my work was causing. But as I went on, became a social worker, and began to supervise paraprofessionals myself, I realized that the difficult feelings I had experienced were a normal, natural part of the process of professionalization. And I realized, too, that professionalization is inevitably a process of cultural change.

I have come to believe that a supervisory relationship between a paraprofessional and a professional **must** address culture change and the feelings that accompany it. The supervisor must recognize and convey to the lay worker that they are both going through a process of acculturation and adaptation, each learning from the other as they negotiate some predictable stages. The goal for each partner in the relationship is cultural competence. Each partner must be able to be "sensitive" to someone from another culture. Each partner must also be able to teach another what he or she needs to know in order to understand the expectations of a new culture and make choices about how to survive and flourish in that new culture.

In real life, learning about a culture is more like watching a three-ring circus than viewing a parade. The acts are appearing at the same time rather than marching down the street in an orderly sequence. However, in a printed essay, I am forced to discuss the following interrelated themes one after the other: 1) the importance of investing in reflective, mutually respectful and trusting supervisory relationships for paraprofessionals; 2) the aspects of culture and stages of acculturation that paraprofessionals and their supervisors need to explore; and 3) techniques supervisors can use for bridging cultural gaps. In real life, all these themes are intertwined and need to be considered together — as any reader who tries to apply the ideas raised in this essay to her practice will soon discover.

Investing in reflective supervision

The concept of reflective supervision must be "sold" to both paraprofessionals and administrators of infant/family service programs. In my experience, paraprofessionals are not initially eager to participate in something called "supervision." Many lay workers don't have a great deal of formal education and have not had very good experiences with teaching and learning through the written or spoken word. When I was a paraprofessional, for example, I saw record-keeping as a process used to check up on my performance rather than as a chance to help me reflect on what I was doing. And when I tried to talk about the feelings my work aroused, my supervisors discouraged me. We need to make supervision something much different. The supervisory relationship must become a comfortable way to teach paraprofessionals the information they need to provide their particular service, and — equally important — the boundaries of their role, especially when families face a multiplicity of problems. The supervisory relationship must also become an opportunity for supervisor and paraprofessional to teach and learn

This essay is excerpted from a presentation made at ZERO TO THREE's Eighth Biennial National Training Institute, held in Washington, D.C. in December, 1993.

from each other what each one believes about the development of young children.

In order to gain a commitment to reflective supervision from program directors and supervisors, these professionals need first of all to be clear about why they are hiring paraprofessionals to work with infants, toddlers, and their families. Often, professionals see the lay worker as someone who is able to change the behavior of the client population. But clients don't see the paraprofessional that way at all — they see her as someone who has access to the services they need. Expectations must be clarified. Paraprofessionals are often asked to work in dangerous neighborhoods (which may or may not be the neighborhoods in which they live). Professionals need to ask themselves: Are we hiring paraprofessionals because they understand the client population better than we do? Are we hiring them to do things that professionals are **unable** to do themselves or to do things that professionals are **unwilling** to do themselves? Are we hiring lay workers because they can do a better job, or because they can do a cheap job? A home visitor who is caught between conflicting expectations cannot do her job adequately. A home visitor who is aware of being used is angry; she cannot do her job adequately either.

Nancy P. Alexander

I believe that professionals should hire paraprofessionals because of what they know and the skills they bring. Training and supervision should build on paraprofessionals' potential but should never discredit their unique knowledge.

Moreover, a good supervisory structure must recognize that paraprofessionals who are really good need to move on after awhile. They need incentives to grow and a career ladder to climb. I helped administrators in one agency begin to think about the training and supervision of paraprofessionals as an aspect of service provision to the community. Knowing that we would lose them, we invested time and energy in the training and supervision of lay workers as a part of leadership development. We trained paraprofessionals with the expectation that they would move on and that we would recruit and train new community workers. (Of course, once a career ladder is in place, talented paraprofessionals often end up staying longer in an agency than they would otherwise.)

Once administrators, supervisors, and paraprofessionals make a commitment to training and supervision (which in most infant/family settings should probably occur both in group and individual sessions), it is crucial to build trust, reflection, and an ability to risk into the supervisory relationship. These elements make it possible to use the relationship to address the multiplicity of communication, teaching, and cultural adaptation issues which are involved in achieving cultural competence.

Using the supervisory relationship to teach and learn cultural competence

Providing culturally competent health, educational, and/or social services requires paraprofessionals and their supervisors to reach a common understanding of several key concepts and processes. Both the supervisor and the paraprofessional need to reach self-awareness and shared awareness of emotionally loaded material and ideas. The supervisory relationship must be sturdy enough to permit reflective exploration of difficult issues, especially since candid discussion is likely to reveal strong differences in perspective. Major issues that must be addressed on the journey toward cultural competence are: the phenomenon of multiple cultural allegiances; cultural determination of perception; and stages in cultural transition and ethnic identification.

Multiple cultural allegiances and differences in cultural values

Culture is the way that any group of people develops to manage its environment. Culture goes far beyond ethnicity and race. The primary goal of any culture is transmission of that culture; the process of "enculturation" is what the family and society use to teach us rules of

BEST COPY AVAILABLE

behavior that incorporate the values, or ideals, of the culture.

We all belong to a multiplicity of cultures, based on, among other things, gender, sexual orientation, socioeconomic status, religion, language, general level of education, and profession. We can become aware of the impact of multiple cultural allegiances by making a list of them and then asking ourselves, "Do we behave the same way when we are with members of all these groups? If not, why not?" It is certainly true, for example, that I dress, speak, and act differently when I am addressing a professional audience than when I am accompanying my elderly mother to church.

It is not always easy to recognize the values or ideals that lie behind culturally prescribed behaviors that we have learned through enculturation early in life. Consider, for example, what mainstream, middle-class American parents do to prepare for a new baby. They want the baby to have a room of his own, with a little crib for himself, and a little dresser, and his own toys, and a night light. When they bring the baby home from the hospital, they put him in his room, in his crib, and they turn on the night light and walk out of the room — maybe leaving the door open. In many cultures, this behavior would be considered child abuse. Many cultures believe that a very young child has absolutely no business being alone. A baby should sleep next to — if not in — the mother's bed, so that she can touch him every time he makes a sound. What are the values behind these behaviors? Mainstream, middle-class America values **independence**, and children are trained from birth for independent living. Other cultures — including the Mexican culture — value **interdependence**, and our childrearing practices are designed to fulfill this cultural goal.

In the supervision of paraprofessionals, it is important to convey the idea that differences in cultural values are simply differences — not reflections of cultural superiority or inferiority. At the same time, it is important to be clear that, usually, the paraprofessional's role is to offer insights about the expectations of mainstream American culture so that families can make choices about how to help their children survive and thrive in it.

Paraprofessionals raised in another culture often find their values in conflict. The process of **acculturation** has brought the lay worker to embrace some new "professional" ideas about child development, yet many of her feelings about "what is right" to do with children were acquired in the process of **enculturation** and are therefore deeply ingrained and not necessarily conscious. For example, the worker may understand intellectually the developmental significance of temper tantrums, but if she was raised in a culture that doesn't allow children's temper tantrums because they are seen as an invasion of other people's privacy, our advice about ignoring temper tantrums just doesn't feel right. Paraprofessionals who are mothers may find it painful to reflect on their own childrearing practices in the light of what they are learning about child development. I remember the anguish of a mother visitor who said to me, "I used to wash out my son's mouth with soap because he lied. Now you're telling me that kids that age cannot lie..."

Dealing with parenting issues always involves engaging in culture change. It's not possible to be "culturally neutral." For example, cultures differ tremendously in how they treat time. One pattern is not superior to another, but often in order to be successful in mainstream American culture, people do have to learn how to be "on time" and adhere to schedules. This, however, is an observation — not a moral judgment.

Perception

Culture shapes our view of the world. Each of us perceives the world differently, depending on what our culture has taught us to see, to pay attention to, to ignore willfully, or simply not to see at all.

What happens, then, when supervisors send paraprofessionals out "to observe behavior"? What the worker observes and notices, and the interpretation she gives to it, will be based on her cultural learning. If the paraprofessional observes parent-child interaction and relates her readings of behavior to the supervisor, who is then supposed to help her interpret her observations, everyone must recognize the difficulty of making judgments through a third person — especially across cultures. We are all likely to interpret other people's behavior on the basis of what that behavior would mean if **we** were the actors. But before making a judgment about a mother, a baby, or their relationship, the observer needs to know what a particular behavior means in the family's culture, and what that behavior means in terms of cultural goals for the child and family.

I have talked earlier about the importance of building trust, reflection, and an ability to risk into the supervisory relationship. It is essential for the paraprofessional to be able to trust the supervisor with her perceptions. The supervisor, for her part, must be able to help the paraprofessional reflect on her observations and interpretations and look at other possibilities. What did she see, and what did it mean? What else could it mean? How might the worker go about finding out what particular behavior means for this family? In discussing these questions, both the supervisor and the paraprofessional learn to look at behavior from a new perspective.

The notion of "secondary cultural characteristics" is important here. Primary cultural characteristics are those embedded in a culture. Secondary characteristics are those acquired by a group as a result of its contact with another culture. In order to survive discrimination by another culture, members of so-called minority groups sometimes develop secondary characteristics that may not continue to be useful strategies in different circumstances. People trying to communicate across cultures need to be alert to secondary characteristics. If a paraprofessional has distrust of the majority as a secondary cultural characteris-

tic, a supervisor from the majority culture may need to raise the issue of experiences of discrimination early in the relationship — and in more than a single question — so that the issue of trust can be discussed directly. If a family is described as "manipulative" or "untruthful," the supervisor needs to help the worker wonder about the meaning of the behavior involved and its possible usefulness as a survival strategy.

Stages in cultural transition

Supervisors and paraprofessionals need to recognize that they are involved together in a process of cultural learning and change, and that powerful feelings are a natural and expectable accompaniment to each stage of the process. Many models of cultural transition have been developed. I find that **euphoria, culture shock,** and **adaptation** are useful terms to describe culture change that involves class and professional status, as well as the bridging of cultures.

Euphoria comes with the paraprofessional's selection for her job. To be chosen in the first place, she has usually distinguished herself in some way — she is a program's best volunteer, or she has demonstrated remarkable strength as a parent. She sees her new job as a step up the social ladder, bringing her higher status, more money, and more recognition from her community. The supervisor is euphoric, too — here is a chance to help someone effect changes!

Culture shock, however, is the next predictable stage. The paraprofessional realizes that she is not talking the same language as the supervisor. The agency or program may not be about what she thought it was about. She wants to help, but the agency is telling her all the time that she doesn't know enough to help and that she is overstepping her bounds. She finds herself in situations that are frightening. There are difficult expectations (like written reports) and puzzling concepts (like "confidentiality"). The worst part is always getting put in the middle, between professionals who see her as able to make clients change their behavior and clients who see her as powerful to deliver goods and services.

Meanwhile, the supervisor is likely realizing that she doesn't know enough to help the paraprofessional. She doesn't know enough about the culture of the target population (this, of course, is why the paraprofessional was hired), but she also doesn't know enough about how the paraprofessional's cultural allegiances — her social class, her gender, her ethnicity — might be shaping her perceptions or coming into conflict with her new occupational role.

Adaptation follows, as the paraprofessional learns to communicate and behave appropriately both in the professional community and in her community of origin. Adaptation is not always a peaceful process, however. There is often anger. At times, the paraprofessional really believes that she "has it all together" and the supervisor knows absolutely nothing — if she knew it, she would be out there doing it; she can't deal with "my people."

In order for the paraprofessional to achieve adaptation, the supervisory relationship must allow the degree of introspection, reflection, and collaboration needed for the lay worker and supervisor to build trust with each other and to look at difficult issues in a non-threatening manner. The supervisor must put herself in the position of learner. She must recognize that in order to understand the paraprofessional's culture, she has to learn it from the paraprofessional. Reading will help, but there is no substitute for the insider's view.

Adaptation involves making peace with the losses involved in becoming a professional.

Adaptation involves making peace with the losses involved in becoming a professional. The lay worker is no longer "one of the girls." She has grown away from some of the people she has grown up with — not because she wants to, but because they perceive her differently and she perceives the community differently. There comes a time when the paraprofessional needs to make peace with the fact that she is no longer one thing or the other. I will always be too fully Mexican to be fully American, but I will also be too American to be fully Mexican. I have made the change from paraprofessional to professional, but to this day, when I am supervising a paraprofessional I need to be careful that my own experiences of acculturation and my own ethnicity do not interfere with the current relationship.

Some factors facilitate cultural transition. **Economics** makes a difference. If a job offers decent wages, benefits, and a career ladder, adaptation to the culture of the job is much easier. **Education** is a factor. If the paraprofessional has sufficient formal education to understand the language professionals use on the job, adaptation is easier. If not, the supervisor needs to teach concepts in a way the paraprofessional can understand. **Ethnic, language, and minority status issues** that affect cultural transition include not only similarities or differences between the paraprofessional and supervisor but also experiences with people in power. The paraprofessional's view of society as one to which she can adapt, assimilate, or reject will influence her reaction to the work and the supervisory relationship.

Supervisors should be aware of stages in ethnic identity development. The conceptual framework for looking at this process was developed during the civil rights movement by Edward T. Banks. Atkinson, Morten, and Sue (1980) identified stages through which an individual moves in a racist society, involving the individual's regard for himself, his own cultural groups, other minority groups, and society at large. The process is a developmental one and not the same for everyone; where someone starts has to do with family and community. The stages identified by Banks are:

- **conformity** (not with one's own group, but with the larger society), including a depreciating attitude toward the self and members of one's own group, a discriminatory stance toward members of other minorities, and appreciation for what members of the dominant group have.
- **dissonance**, involving conflict between self-depreciating and self-appreciating attitudes (many paraprofessionals are at this stage), conflict with members of the same minority, conflict between dominant-held views of minority hierarchy and feelings of shared experience, and conflicted attitudes toward members of the dominant group.
- **resistance and immersion**, a stage in which individuals start building appreciation of their own culture and empathize with members of other minorities, although ethnocentrism is common.
- **introspection**, a stage characterized by concern with the basis of attitudes and judgments of the self and others.
- **synergistic articulation and awareness**, a stage in which individuals appreciate themselves, members of the same minority, members of other minorities, and (selectively) members of the dominant group.

Just as supervisors need to assess where the supervisee is in the process of acculturation, the supervisor also needs to assess a worker's stage of ethnic identification. In some stages of cultural identification, a person may be very punitive toward members of her own group.

Techniques for bridging gaps between cultures

A supervisor may convey to a paraprofessional that the supervisor is trustworthy, and willing to learn as well as teach. But what specific strategies can help the supervisor make her relationship with a paraprofessional the most effective teaching situation possible? Concepts borrowed from the field of multicultural education are useful in thinking about communication and learning styles.

Cross-cultural communication

Attention to the style and content of verbal and non-verbal communication is critical. In working across languages, the emotional meanings attached to words are very important. For example, the English word "ambition" ostensibly means the same thing as the Spanish word "ambicion." But to call someone "ambitious" in the United States means to see him as a "go-getter," motivated, and thinking for himself. To call someone "ambicioso" in some Spanish-speaking cultures suggests that he is selfish, grasping, and out to get ahead at the expense of others. Because so much of our work is related to values, it is important to think about the concepts themselves, rather than single-word descriptions. And in this connection, it is important to remember that people learn social, interactive language much earlier than cognitive, decontextualized, abstract language. Someone who is very verbal in a second language at the social level may not yet be able to conceptualize in the second language. Simple descriptors, illustration, and rephrasing are helpful techniques.

Discussion modes — patterns of participation and listening — vary from culture to culture. In some cultures, it is permissible to interrupt, and people show interest in a topic by getting excited. In other cultures, this behavior can be interpreted as being over-emotional or rude.

Non-verbal forms of communication — body language, gestures, personal space, and touch — don't have the same meaning across cultures. Eye contact is a classical example. If one talks to a child and the child looks down, one cannot assume that the child is not paying attention. In some cultures it is out of place to look a person in authority in the eye.

It is crucial for a supervisor to understand how respect is shown in the culture of the paraprofessional. She may need to ask quite explicitly, "What does respect mean to you?" Trust is built on respect. If the supervisor engages in disrespectful behavior, no matter how unintentional, she may lose the chance to build a mutually trusting relationship with the lay worker. And a trusting relationship is the foundation for a shared awareness between supervisor and paraprofessional of another complexity of communication across cultures — differing perceptions of what is appropriate to be shared and with whom.

Ngoc-Diep T. Nguyen (1992) has observed that culture determines what kinds of information are considered **private** (confidential, restricted to a chosen few, and socially hidden), **shared** (held in common with members of a particular group, with rules for appropriate sharing often non-conscious), and **public** (shared by all, socially acknowledged). In infant/family work, perceptions of what is private, shared or public will have a lot to do with what families share with her and what she feels comfortable sharing with her supervisor. Again, the paraprofessional is often caught in the middle. What does "confidentiality" mean when a family asks a worker to "promise that she will not discuss (a problem) with anyone else" and the supervisor expects the worker to share and analyze her perceptions?

Through the trusting relationship, supervisor and paraprofessional can develop shared awareness that there are different ways of looking at information and communicative events. The supervisor says explicitly, "There are times when you might consider something private, and I may not — we need to know and be clear about it." Part of teaching and supervising is conveying the idea that a process of acculturation is underway that paraprofessionals are going through and that supervisors are going through.

A supervisor also needs to be sure that she understands a paraprofessional's style of communication and structuring information. Some cultures prescribe that one spend a great deal of time on social niceties before one can "get to the point." Similarly, cultural rules may require a paraprofessional to lay out a great deal of information before

she feels comfortable talking about what she thinks. These patterns may mean that the home visit is over before the "meaty" part of the interview begins, or the supervisor's attention wanders (and the paraprofessional notices, and is turned off) unless care is taken to allow extra time for cross-cultural information or to give clear signals 15 minutes before the end of the supervisory session that "we're almost at the end of our time."

Learning styles

I have found Edward T. Hall's work on the issue of cultural communication extremely helpful in understanding differences in people's preferred way of learning. Hall conceives culture and communication in terms of **high context** and **low context.** A high-context culture places as much or greater emphasis on understanding the environment as on the written or spoken word. People in high-context cultures speak with their hands, need lots of eye contact, like to work in groups, are colorful in their dress, and are noisy. High-context learners prefer visual and experiential learning. A low-context culture is more subdued and quiet, paying a great deal of attention to what people say, compared to what they do. The primary means of communication is verbal; meaning comes from the written and spoken word. In mainstream American culture, most formal education involves a low-context style of teaching and communicating.

Supervisors need to find out through observation whether their supervisees are high-context or low-context learners so that they can find appropriate ways to teach key ideas. Similarly, paraprofessionals need to devise ways of imparting information that suit the learning styles of the families they visit.

Conclusion

American society may be moving away from the myth of the melting pot and the expectation that "minorities" give up what they are in order to belong and be accepted. We are recognizing the contributions that we all have made and are making to the richness and variety of this country. We need to recognize also that this richness builds on a variety of beliefs about children and good ways to bring them up. We need to build trust — among cultural groups, within communities, and within relationships for learning — so that we can become aware of our own ideals and values, reveal them to each other, and disagree about them safely.

Resources for further study

Cultural adaptation and learning

Berry, J.W. (1980). Acculturation as varieties of adaptation. In: Padilla, A.M. (Ed.) *Acculturation: Theory, models and some new findings.* AAAS Symposium Series #39. Boulder, CO: Westview Press.

Culture and communication behavior

Gumperz, J.J. (1982). *Discourse Strategies.* New York: Cambridge University Press.

Hall, E.T. (1976). *Beyond Culture.* New York: Doubleday.

Nguyen, N.T. (1992). Elements brought into a communicative event: An observational exercise (unpublished). Des Plaines, IL: Illinois Resource Center.

Socio-cultural issues related to education and language learning

Atkinson, D., Morton G., and Sue (1980). *Counseling American Minorities: A Cross-Cultural Perspective.* Los Angeles, CA: University of California Press.

Cummins, J. (1989). *Empowering Minority Students.* Sacramento, CA: California Association for Bilingual Education.

Longstreet, W. (1978). *Aspects of Ethnicity: Understanding Differences in Pluralistic Classrooms.* New York: Teachers College Press.

Nieto, S. (1992). *Affirming Diversity: The Sociopolitical Context of Multicultural Education.* University of Massachusetts: Longman Publishing Group.

Cross-cultural learning and teaching

Banks, J.A. (1988). *Multiethnic Education: Theory and practice.* Second edition. Boston: Allyn and Bacon.

Banks, J.A. (1987). *Teaching Strategies for Ethnic Studies.* Fourth edition. Boston: Allyn and Bacon.

Damen, L. (1987). *Culture Learning: The fifth dimension in the language classroom.* Reading, MA: Addison-Wesley.

Resources for culture learning

Brislin, R., Cushner, K., Cherrie, C. and Yong, M. (1986). *Intercultural Interactions: A practical guide.* Beverly Hills, CA: Sage.

Pederson, P. (1988). *A Handbook for Developing Multicultural Awareness.* American Association for Counseling and Development.

Supervision

Fenichel, E. (Ed.) (1992). *Learning through Supervision and Mentorship To Support the Development of Infants, Toddlers, and Their Families: A Sourcebook.* Arlington, VA: ZERO TO THREE.

Studying the Social and Emotional Development of Hispanic Children in the United States:

Addressing research challenges

Maria P. Fracasso, Ph.D.

Assistant Professor of Psychology
Towson State University, Towson, Maryland

For the past 10 years, my research has been devoted to the study of normative development and individual differences in the development of minority children, specifically children from Spanish-speaking countries, living in the United States. I felt that it was important to study social and emotional development in an Hispanic population not only because of the continual desire for contextualism in child development, but also, and more importantly, because of the conspicuous lack of information about child development in minority populations such as Hispanics. Hispanics currently represent the most rapidly increasing minority population in the United States and by the turn of the century are expected to be the nation's largest ethnic minority (U.S. Bureau of the Census, 1986). Since most Hispanics have incomes far below that of Euro-Americans (U.S. Bureau of the Census, 1988) and live in disadvantaged areas, their circumstances make the Hispanic population quite distinct from the Euro-American middle class populations which are typically the focus of most child development research.

The social and emotional development of Hispanic children living in the inner city has remained virtually unexamined. Several challenges have confronted researchers studying low-income immigrant groups such as Hispanics. Undoubtedly, some researchers have been concerned about collecting data in Hispanic neighborhoods, which some researchers feel are dangerous environments. Moreover, differences in language and appearance between many researchers and Hispanic individuals make it difficult to recruit participants for research studies, obtain entrance to their homes, establish a relationship, and maintain involvement with these families. Finally, lack of familiarity with social science research may make some potential participants uncomfortable and reluctant to participate in studies which require data collection in a strange setting, such as a university laboratory. The purposes and/or benefits of the study are not clear to them.

In a study I conducted in New York City, we examined the attachment patterns in a population of economically disadvantaged Puerto Rican and Dominican mother-infant dyads and the relationship of these patterns to maternal parenting behavior, Hispanic cultural values, and level of acculturation. In a second study that I conducted in Washington, D.C., I sought to determine individual differences and normative development of infants born to mothers who had recently immigrated from Central America. On the basis of extended observations, I attempted to identify and describe the typical experiences of three-month-olds and their families, focusing on amounts of time spent engaged in discrete activities. In addition, home visits when infants were 4, 8, and 12 months old were used to observe mother and infant interactions during specific activities. Finally, a laboratory visit was conducted in order to assess the relationship of these interactions to attachment at the end of the infant's first year.

Despite the fact that the two studies with Hispanic children and their mothers were executed in two different cities with two disparate Spanish-speaking populations, the research challenges I encountered were similar. The first challenge concerned participation in the study. In each study, I needed to find and recruit mothers with infants of the appropriate ages, address mothers' concerns and questions about the study, and ensure that they stayed involved long enough to complete a number of home visits as well as a visit to the laboratory at the end of each study. I needed to appropriately inform participants, who were from a culture different from my own and potentially skeptical, about the importance of the study and the specifics of the research protocol. While explaining the study, I also needed to be able sensitively to support mothers' involvement and ensure continued participation.

The second challenge concerned study design in research with culturally and linguistically diverse groups. How should one develop and/or translate instruments, measures, and procedures in a culturally sensitive manner? I needed to make sure that before the study began, the staff was culturally sensitive, that the instruments were developed and adapted to be culturally appropriate, and that both materials and data were translated accurately. In this essay I will address each issue and describe the strategies I used to overcome specific problems.

Recruiting, enhancing, and maintaining participation of Hispanic mothers and infants in a research study

Some of the most difficult obstacles I encountered in both studies involved finding, approaching, and informing Hispanic mothers with infants of the appropriate ages about my study. Additionally, I was concerned about how to ensure and maintain participation of these dyads over time in order to complete the study.

A strategy that proved successful in finding mothers was developing a list of all agencies that served the Hispanic community, including medical clinics, community centers, legal services organizations, local churches, and religious associations, with the name of the director, telephone number, and address. Assisted by research assistants who were either bi-lingual or bi-cultural, I set up numerous appointments to discuss the details of the project with the directors and staff of these agencies in order to obtain permission to visit each center and talk with mothers attending the center. After such meetings, one of three things would happen. Staff would: 1) express no desire to have participating mothers take part in my study; 2) communicate information about the study to mothers and have interested mothers contact me; or 3) allow me to visit the center on a specific day(s), either to speak with mothers individually or to present the study to a group of mothers. During the recruitment period, my assistants and I would visit such centers repeatedly to discuss the project and answer mothers' questions. If a mother was willing to participate in our study, I recorded her name, address, telephone number (if the family had a telephone), the same information for a close relative or a friend, and the baby's name and date of birth. If a mother was interested but hesitant, I gave her a slip of paper with my name, telephone number, and brief information about the study.

A second technique that was successful in recruiting mothers was advertising in local Spanish newspapers. Advertisements in Spanish included the name of the project, the specific requirements for participating in the study (e.g., pregnant women or mothers with infants up to two months of age, recently migrated from Central America, etc.), whom to contact, and a telephone number.

By far the most successful recruitment technique was broadcasting public service announcements on local Spanish radio stations and discussing the project on the air during local community radio programs. Washington, D.C. has several Spanish radio stations. A disc jockey at one of these became interested in the study and invited me and an assistant to discuss on the air the details of the project, the purpose of the study, and the requirements for participation. Numerous mothers called in questions during the broadcast, and many interested mothers called our office both during and after the broadcast, volunteering to participate in the study.

In sum, successfully finding and recruiting mothers for the study involved soliciting help from organizations and agencies which served the mothers' community. Mothers seemed willing to participate in a social science research study if the study was condoned socially by people whom the mothers believed and trusted.

Once mothers and infants became involved in the project, the success of the study depended on their participation until the study was completed. Several strategies helped to maintain, enhance, and ensure mothers' participation. First, I made sure that only **one** Spanish-

Janet Brown McCracken

speaking research assistant maintained contact with each mother-infant dyad. This familiar person maintained frequent contact with the mother, telephoning in advance to remind the mother of an upcoming home visit, and calling in between appointments to ask how the mother and baby were doing and to keep abreast of planned family travel, relocation, etc.

In addition to keeping in touch by telephone, or when mothers did not have a telephone in the home, we sent letters, in Spanish, giving the exact date and time of upcoming home visits. These letters also included my name, the assistant's name, and the project telephone number. Mothers were asked to call us when they received the letter to confirm the date and time or to let us know if they had questions or problems concerning the future home visit. Occasionally, when I couldn't contact the mother, I would use the name, address, and telephone number of the close friend or relative that the mother had given us during the initial visit. The research assistant would call this person, identify herself as a friend of the mother, and ask the person to deliver a message to the mother, asking her to return our call. In order to maintain strict confidentiality, we disclosed no information about the study or why we were calling.

If we could not find the mother by either means, as a final strategy the research assistant and/or I visited the

BEST COPY AVAILABLE

neighborhood and inquired about the mother's current location from the tenants of her apartment or close neighbors. In both New York City and Wasnington D.C., we found that regardless of whether mothers moved from floor to floor in one building, from one building to a next-door building, or from a multiple-family home to a nearby residence, the neighbors were usually aware of the family's current location. If the neighbors knew the new location, we asked if they would please relay a message to the mother that we had stopped by, and we gave our names and telephone numbers.

The use of these strategies in both studies resulted in attrition rates of less than 5 percent. Maintaining participation involves consistent and frequent communication with mothers, using creative and resourceful strategies to do so.

I also found that providing the mothers with tangible incentives helped to ensure participation throughout the entire study. First and foremost, when we described the study to each mother, we told her that she would receive financial compensation for her time and effort in participating. In addition, at every home visit throughout the study, mothers were given token gifts specifically for their children, such as diapers, baby products, toys, and books. At the end of each study, mothers were asked to visit the university laboratory with their infants. If mothers indicated that they would not be able to come to the laboratory because they could not find or afford transportation, my assistant and/or I drove the mothers and infants to and from the lab, or cab transportation was arranged at no charge to the mothers. These extrinsic motivators greatly strengthened mothers' participation during the course of both studies.

Using culturally sensitive techniques for designing research studies and using research instruments with Hispanic mothers and infants

In addition to obstacles related to Hispanic mothers' participation in research studies, I encountered difficulties in designing the research study and using pre-existing instruments and procedures. Before the studies began, I was faced with specific questions about whether to use questionnaires that had been written and procedures that had been developed for other cultural groups; whether and how to use these questionnaires with a different cultural group; and how to interpret results in a manner that was both culturally sensitive and appropriate. Additionally, I was faced with how unobtrusively to conduct home and laboratory visits with culturally diverse assistants. Finally, because of the potentially dangerous environments in which the mothers lived, I was challenged with maintaining safety and protecting both participants and observers in these studies.

One of the first challenges that I confronted in designing these studies revolved around the cultural appropriateness of questionnaires and procedures that had been used previously with non-Spanish-speaking mothers. Since I decided to use well-established questionnaires that had been originally developed for a white, middle-class Euro-American group of mothers and infants, I used a number of techniques to approximate cultural equivalence of these instruments. Since these established questionnaires had been written initially in English, I employed the technique of translation and back-translation (Brislin, 1970) to limit linguistic differences. I had one "coordinate" bilingual speaker (one who has learned both languages at different periods of her life and separately in both countries) translate the English version into Spanish and a second coordinate bilingual to translate the Spanish back into English. By using back-translation, I was confident that the English questionnaires were accurately translated into Spanish. When there were differences between bilingual speakers, they discussed the discrepancy until they agreed on a correct translation. In addition to using back-translation, I asked several monolingual speakers to review the Spanish questionnaire, as a way to ensure complete understanding of individual words and meanings of sentences. Changes in translations were made when the monolingual speaker did not understand any word, sentence, or concept. Finally, I gave the Spanish version to additional bilingual speakers in order to evaluate the translated version of the questionnaire with respect to cultural appropriateness and accuracy.

Although the translations seemed linguistically equivalent and culturally appropriate, I was faced with the problem of ensuring accurate responding, interpreting, and reporting the results of these questionnaires. As a way to eliminate the possibility of a mother's responding inaccurately because she misunderstands the question, uses extreme response sets (e.g., does not differentiate between "strongly agree" and "agree"), uses acquiescent response sets (e.g., always saying "yes" or "no"), or simply does not answer the questions, the assistants or I read each question to every mother. This strategy removed the problems associated with imprecise result reporting and thus led to more correct interpretation of mothers' responses to these questionnaires.

In addition to the challenges involving questionnaires, I was apprehensive about conducting research with a paradigm that was initially designed for use with a white, middle-class, Euro-American group of mothers and infants. A successful strategy for ascertaining cultural appropriateness involved pretesting the procedure with mothers and infants similar to the dyads that were to be included in the study. By pretesting the procedures, I determined that the Hispanic infants' behavior in this paradigm was comparable to the typical Euro-American infant's. The paradigm was used in both studies, since the experience seemed similar for the Hispanic and Euro-American infants.

In addition to my concerns about employing culturally sensitive questionnaires and procedures, I was also concerned about the cultural and linguistic disparity between

the Hispanic mothers and the research assistants. In order to accommodate the Hispanic mothers who participated in each study, I employed culturally homogeneous, knowledgeable, sensitive, and bilingual assistants. Specifically, in the New York study, the assistants who observed mothers in their homes and conducted the laboratory visits were Puerto Rican and bilingual. In the study conducted in Washington, D.C., although the assistants employed were not from Central America, all were ethnically Spanish and spoke Spanish fluently; they were culturally knowledgeable and sensitive.

A final challenge to our research concerned the fact that many mothers lived in severely disadvantaged environments. Since visits to mothers' homes involved potential danger, I needed to take into account the safety of observers travelling in these areas. When physical safety was a concern, I insisted that observers visited homes **only** in pairs and **only** during daylight hours. Additionally, in order to reduce risks when visiting homes, observers were required to use their own cars rather than public transportation, to dress inconspicuously, and to carry **only** non-valuable materials. As a result of these precautions, neither observers nor participants were disturbed during the course of the study.

Concluding remarks

To my amazement and delight, our efforts to conduct research with Hispanic mothers and infants living in dangerous environments were successful. Although beset by numerous difficulties, both studies were successful, in part because of the development of effective strategies to overcome each challenge. Most importantly, however, I believe these studies could never have been accomplished without the genuine concern for and understanding of Hispanic mothers and their infants that I have developed throughout my many years of interactions with them. Despite cultural disparity, when a researcher is equipped with effective strategies to overcome obstacles and sincere regard for the individuals she or he wishes to study, even the most difficult circumstances in which research is conducted can be overcome.

Publications

Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education (1993) - Hedy Nai-Lin Chang, editor (California Tomorrow, Fort Mason Center, Building B, San Francisco, CA 04123) $14.00.

Based on a survey of 434 child care centers in California, *Affirming Children's Roots* documents the effects of demographic changes in the state on the context of child care. Ninety-six percent of child care centers surveyed serve children from two or more racial groups and 81 percent serve children from two or more language groups. While diverse settings offer children, parents, and caregivers an invaluable chance to learn about and benefit from the strengths of each other's cultures and languages, very little information or training about diversity is available to child care providers, and the field as a whole suffers from a shortage of language and cultural minority staff persons who could help to increase the awareness and responsiveness of a center to families from minority communities. In addition, although early childhood programs are in a unique position to foster strong partnerships with parents, parents from linguistic and cultural minorities are frequently left out of parent involvement activities and may discover early on that they have lost control over their children's socialization process.

The report describes strategies programs use to stress development in young children's home language, use an anti-bias curriculum, and emphasize respect for the position of the parent in a child's life. The report makes recommendations to state and federal government, professional associations, resource and referral networks, training institutions, and private foundations about ways to promote more culturally and linguistically appropriate care.

Culturally Diverse Children and Adolescents: Assessment, Diagnosis, and Treatment (1994) - Ian A. Canino, M.D. and Jeanne Spurlock, M.D. (The Guilford Press, 72 Spring Street, New York, NY 10012) $27.95.

This book offers clinical guidelines for mental health professionals who work with African-American, Latino, Asian-American, and American Indian children and adolescents who encounter multiple social stressors and whose families represent the nation's lower socioeconomic levels. The authors observe that health-seeking behaviors vary across culture and socioeconomic level; that the sociocultural context affects mental health and symptomatic behaviors; and that it is difficult to differentiate between behavior that is unique to a particular culture and behavior that is specific to socioeconomic level. They also note that depending on the circumstances, the stress a child experiences may either precipitate symptom expression or elicit adaptive responses. Canino and Spurlock offer concrete suggestions on how to elicit relevant history information (including cultural expectations of child development and behavior, the role of the extended family, family values, and protective factors within the family); how to use available diagnostic criteria, and how to intervene, with whom, and with which treatment strategies.

Exploring Family Relationships with Other Social Contexts (1994) - Ross D. Parke and Sheppard G. Kellam, editors (Lawrence Erlbaum Associates, Publishers, 365 Broadway, Hillsdale, New Jersey 07642) $59.95.

Drawing on the work of the Family Research Consortium, this volume works on the premise that outside influences affect families and that those influences affect the functioning of children and adults in their schools, work, child care, or peer group context. According to the editors, three important societal changes have created a new relationship between family and other institutions: the rise in maternal employment (from 24 percent in 1950 to 54 percent in 1990); increased use of child care (requiring attention to the role of peers in development of young children); and a rising divorce rate (more people are exposed to the legal system, through divorce, custody disputes, child support arrangements, and to welfare and other government supports).

The chapter on families and maternal employment during infancy reviews studies on children's responses to their mothers' employment during the children's early years, reflected in children's socioemotional and cognitive development. Authors observe that the impact of maternal employment must be studied in relationship to a child's experience in both family and child care settings. In other chapters, authors describe ways in which children's academic achievement and social competence are influenced by marital quality, life stress, parenting styles, and culture, as a regulatory context for shaping individual and family beliefs and behaviors.

Celebrating Diversity: Approaching Families through Their Food (1994) - Darby C. Eliades and Carol West Suitor (National Center for Education in Maternal and Child Health, Arlington, VA) Single copies available free of charge while supplies last from National Maternal and Child Health Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22102.

Published as a cooperative effort between the U.S. Department of Health and Human Services and the U.S. Department of Agriculture, this book is designed as a tool for communicating effectively with people from a variety of cultural backgrounds in order to promote the health of children and families. The book builds on the concept of food as common ground — a possible entry point for families into a system of care. It presents information about the food choices people make and how these choices relate to their cultural background. It also depicts strategies for using food as a communication tool, skills for communication in a multicultural or multilingual environment, and strategies for working within a community.

They're Never Too Young for Books (1994) - Edythe M. McGovern and Helen D. Muller (Prometheus Books Publishers, 59 John Glenn Drive, Amherst, NY 14228-2197) $14.95.

In this resource book, designed for parents, other family members, and professionals, the authors list books of distinction in various categories and identify criteria for selecting valuable books. For example, the authors describe *The Story of Ferdinand* by Munro Leaf as a book which "never preaches its theme, but makes the point clear instead through context; it has a main character with whom a child can identify and empathize; and it exemplifies the principle of text and illustration perfectly blended." The authors describe techniques for reading aloud to children and offer ideas for including children in creative dramatics and other activities that may enhance their enjoyment of books.

Making Sense of Federal Dollars: A Funding Guide for Social Service Providers (1994) -Madelyn DeWoody (Child Welfare League of America, Inc., 440 First Street, N.W., Suite 310, Washington, D.C. 20001-2085) $14.95.

This guide is designed to give staff of public and nonprofit agencies that serve children, youth, and families basic information on a range of federal funding programs which specifically serve this population. Sections on Medicaid, child welfare and social services, income support services, and federal funding sources for child care, nutrition, health, mental health, substance abuse treatment, juvenile justice, and education provide an overview of each program, a description of funding, and sources of further information.

Videotapes

Reaching the Family: Cultural competence for programs and Serving the Family: Cultural competence for staff. Produced by California Department of Education and distributed by RISE: Resources in Special Education, 650 Howe Avenue, Suite 300, Sacramento, CA 95825, tel: (800)894-9799. $15 per tape.

Reaching the Family (23 minutes) presents parents and professionals discussing the need for early intervention programs to be culturally competent, with practices that are consistent with the beliefs, values, and interaction styles of the communities they serve. The tape argues that achieving quality services across cultures demands patience, understanding, and competence and highlights the significance of achieving a staff that reflects the diversity of the community. Families, staff and community leaders identify the advantages of diverse staffing at all levels of a program. Specific techniques for recruitment, adjusting the hiring process, and providing support and training for all staff are suggested.

Serving the Family (40 minutes) was developed to increase awareness, expand knowledge, and build skills to meet the needs of culturally diverse young children and their families. Becoming culturally competent requires translating values, beliefs, attitudes, and knowledge into actions that result in providing non-judgmental, non-dis-

criminatory services to families of diverse cultures. Sam Chan, Ph.D., an authority on cultural dynamics, defines cultural competence and outlines the process of achieving successful practice. Families and service providers talk about their experiences in the process of gaining cultural competence. A series of training activities is provided that is designed to incorporate personal experiences and self-awareness into the process of developing cultural competence.

Finding the Balance and **Listen with Respect**. Produced by Southwest Communication Resources, Bernalillo, New Mexico and distributed by Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401, tel: (818) 994-0933. $150 for set of two tapes and *Culturally Responsive Services for Children and Families: A training manual*.

These two videotapes and training manual were developed to promote more cultural responsiveness in serving American Indian children and their families. The materials can be used to stimulate discussion of issues related to serving all cultural groups.

Finding the Balance (22 minutes) was produced to share with parents and professionals the experiences and views of two American Indian parents about the diagnosis and treatment of their young children with disabilities. These parents discuss the cultural differences and practices they experience as they try to obtain services for their children. The purpose of the tape is to promote increased understanding of American Indian parents and, through understanding, to improve communication.

Listen with Respect (13 minutes) demonstrates barriers that cultural differences can present to effective service delivery and recognizes the many opportunities for misunderstanding among cultural groups. This tape offers an overview of the frustrations many American Indian parents experience when they use "Western" medical services and identifies the traditions and values that shape their needs and responses. Specific techniques are offered that professionals can use to examine their attitudes and facilitate cross-cultural communication.

Culturally Responsive Services for Children and Families: A training manual is a 100-page volume that includes specific information about communication and interaction styles. The manual describes training activities to help professionals learn culturally competent communication skills.

Essential Connections: Ten Keys to Culturally Sensitive Child Care from the series **The Program for Infant Toddler Caregivers.** Produced by Far West Laboratory: J. Ronald Lally, Executive Producer and distributed by the California Department of Education, Bureau of Publications, Sales Unit, P. O. Box 271, Sacramento, CA 95802-0271, tel: (916) 445-1260. 36 minutes. $65.

Essential Connections: Ten Keys to Culturally Sensitive Child Care recommends ways to structure and run child care programs to strengthen children's connections with their families and their home culture. This video identifies culture as the fundamental building block of identity. Through cultural learning, children gain a feeling of belonging, a sense of personal history, and security in knowing who they are and where they come from. Families hand down beliefs, attitudes and ways of acting. Rules for living come from one's ethnic, regional and religious heritage. When young children are cared for by their parents and other family members, the process of cultural learning occurs naturally. However, when children are cared for outside the home, issues of cultural connections demand serious consideration and thoughtful planning by caregivers. Early child care that respects time-honored cultural rules helps children develop a secure sense of self. Culturally sensitive care is crucial for children to develop confidence, competence and connection. The ten key components of culturally sensitive infant toddler child care explored in this tape are: Providing cultural consistency; working toward representative staffing; creating small groups; using the home language; making environments relevant; uncovering your cultural beliefs; being open to the perspectives of others; seeking out cultural and family information; clarifying values; and negotiating cultural conflicts.

We All Belong: Multicultural Child Care That Works. Produced and distributed by Redleaf Press, 450 North Syndicate, Suite 5, St. Paul, MN 55104-4125, tel:(800)423-8309. 21 minutes. $29.95

We All Belong was originally produced by the Australian Early Childhood Association and filmed at the Sydney Lady Gowrie Child Care Center in Sydney, Australia, which serves a culturally diverse group of young children. A special introduction for North American audiences guides and facilitates viewing. The video demonstrates how to transform diversity into a creative force for children by integrating the daily cultural lives of children into an early childhood setting. The center is homelike, maintains mixed ages in all groups, and has low ratios of children to adults. The positive aspects of cultural diversity are embedded into every aspect of the program – curriculum, environment, choice of staff and relationships with families. The program is planned to mirror the children and their families, respecting and encouraging their diversity. This authentically multicultural program is guided by the assumption that the self-esteem of children is dependent on seeing themselves, and the values, beliefs and traditions of their families, reflected in the environment. This tape is designed for staff training, parent education, program planning and environmental assessment. A study guide for trainers is included.

Diversity: Crossing the lines (a video series). Produced by Bright Productions and distributed by Concept Media, Inc., P.O. Box 19542, Irvine, CA 92713-9542, tel: (800) 233-7078. Complete series, $700.

Diversity: Crossing the lines is based on the premise that prejudicial attitudes rooted in ignorance, primarily derived from stereotypes, can be changed. Work-place and school-based programs can have an impact on reducing the social unease experienced by individuals from diverse backgrounds. Strategies can be instituted that teach tolerance and understanding and generally reduce bigotry. Most professional and experts working in the area of multiculturalism acknowledge that their own celebration of diversity began with a small spark that someone helped ignite within them. This series and the instructional manual are designed to help ignite the spark of celebration and understanding in others. The series includes:

- **Make Contact** (24 minutes) illustrates both the historical and contemporary immigrant experience, helping viewers develop an appreciation of the difficulties and challenges of adapting to a new land with a new language and customs. It explores the roots of prejudice and stereotyping in the United States.
- **Make a Move** (30 minutes) examines the process through which individuals in a society acquire prejudices and the negative effects of these on others. The video uses dramatic vignettes and the words of those who have experienced prejudice, as well as archival film clips which illustrate stereotyping.
- **Make a Difference** (30 minutes) shows how prejudice and racism are tolerated by those in positions to make positive changes. The video illustrates the advantages of culturally diverse institutions and showcases communities and programs which have successfully increased understanding between diverse ethnic and cultural groups.

It's in Every One of Us. Produced by Wernher Krutein and distributed by ARK Media Group, Ltd., P.O. Box 410685, San Francisco, CA 94141, tel: (800)727-0009. 5 minutes. $29.95

It's in Every One of Us is a picture portrayal of individuals from the global family. Images depicting the commonalities of humanity combined with music and words celebrate the human spirit. The purpose of this tape is to promote respect and compassion across cultures; it is designed to be used as a tool to bring people closer together in training and seminar programs, parent/teacher education programs, family counseling services, furthering inter-cultural understanding and events and conferences promoting global awareness.

Conference Call

March, 1995

March 1-4: *Ken-Crest Services*, with support from the Administration for Children and Families,will sponsor a conference in Philadelphia, Pennsylvania on "Medically Fragile and Technology-Dependent Children: Care in the Community." Contact Judy Watman, Ken-Crest Services, 3132 Midvale Ave., Philadelphia, PA 19129, tel: (215) 844-4620.

March 3-4: The *Menninger Clinic*, Division of Continuing Education, will sponsor a conference in Topeka, Kansas, on Infant and Toddler Psychiatry. Topics will include attachment disorders, post-traumatic stress, eating and sleep disorders, after-effects of NICU experience, and intervention strategies for families and service providers. Klaus Minde and Alicia Lieberman will be featured speakers. Contact The Menninger Clinic, Continuing Education, tel: (800) 288-7377.

March 9-11: The *Children's Defense Fund* will hold its 1995 Annual National Conference in Seattle, Washington, with the theme, "Leave No Child Behind: Building and Strengthening Communities for Children." Contact Karen Seaver, Children's Defense Fund, 25 E Street, N.W., Washington, DC 20001, tel: (202) 628-8787.

March 27-29: The Ninth Annual *California Childhood Injury Control Conference* will be held in La Jolla, California, with presentations on injury epidemiology, public policy, and injury prevention strategies. Contact the California Center for Childhood Injury Prevention, Graduate School of Public Health/MCH Division, San Diego State University, 6505 Alvarado Road, Suite 205, San Diego, CA 9120, tel: (619) 594-36911.

March 27-April 1: The *Southern Early Childhood Association* will hold its 46th annual conference in Orlando, Florida, with the theme "Children Our Concern." Howard Gardner will be a keynote speaker. Contact SECA Conference, P.O. Box 56130, Little Rock, AR 72215-6130.

April, 1995

April 27-29: *Contemporary Forums* will present a conference in San Francisco, California on "The Child with Special Needs: Issues in Early Development - Birth to Five Years." A preconference addressing autism will be held on April 26. Contact Contemporary Forums, 11900 Silvergate Drive, Dublin, CA 94568, tel: (510) 828-7100, ext. 3.

April 30 - May 2: The *Michigan Association for Infant Mental Health* will hold its 19th annual conference in Ann Arbor, Michigan, on the theme, "Reflecting on Relationships: Internal Working Models, Inner Life of Model Workers, and Inside Models That Work." Daniel N. Stern, Charles H. Zeanah, and Joan Abbey will be plenary presenters. Contact University of Michigan, Conferences and Seminars, 541 Thompson Street, Room 112, Ann Arbor, MI 48104-1360, tel: (313) 764-5305, fax: (313) 764-2990.

Zero to Three Subscriber Survey

Reminder: ZERO TO THREE's publications ordering and subscriber services department is now under new management — **our own**. Publications specialists Mary Gannon and Marcella Usher are ready to answer your questions about *Zero to Three* subscriptions and renewals, and they can help you select other ZERO TO THREE publications to meet your information needs. **Call them at 1-800-899-4301** or **703-528-5693.**

To help us be more responsive to your interests and needs, please take a few minutes to complete the subscriber survey below. Mail or fax it to:

Joan F. Melner
ZERO TO THREE
2000 14th Street North, Suite 380
Arlington, VA 22201-2500

Fax: (703) 528-6848

Please check all responses that apply!

1. I am a
   - ❑ Direct service provider
   - ❑ Supervisor or administrator
   - ❑ Volunteer or advocate
   - ❑ Preservice or inservice trainer
   - ❑ Student
   - ❑ Other (please specify)

2. When I receive *Zero to Three*, I
   - ❑ Read it within a week
   - ❑ Put it in my "reading pile"
   - ❑ Scan it and route to others

3. After reading *Zero to Three*, I
   - ❑ Save all issues
   - ❑ Save selected issues
   - ❑ Share selected articles with others

4. I am interested in the following topic areas:
   - ❑ Child/family development
   - ❑ Health care
   - ❑ Infant/toddler child care
   - ❑ Infant mental health
   - ❑ New service programs
   - ❑ Policy-relevant research

5. I have read the following ZERO TO THREE publications:

   - ❑ *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)* - 1994
   - ❑ *Living and Testing the Collaborative Process: A Case Study of Community-Based Services Integration* - 1994
   - ❑ *A Welcome for Every Child: Care, Education and Family Support for Infants and Toddlers in Europe* - 1994
   - ❑ *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope* - 1994
   - ❑ *Learning through Supervision and Mentorship To Support the Development of Infants, Toddlers, and Their Families: A Sourcebook* - 1992
   - ❑ *Heart Start: The Emotional Foundations of School Readiness* - 1992

6. In addition to *Zero to Three*, I subscribe to the following professional publications:

_____ _____ _____

- ❑ Please let me know how I can provide *Zero to Three* to an infant/family professional from Eastern Europe, the Former Soviet Union, Central or South America, or a developing country in Asia or Africa.
- ❑ Please send me a complete ZERO TO THREE publications catalog.

Name: _____

Address: _____

_____

ZERO TO THREE

is published 6 times per year. Subscriptions cost $37 per year, $69 for 2 years and $99 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $20/auxiliary subscription/year. **Zero to Three**'s federal ID# is 52-1105189. Telephone orders may be placed by calling 1-800-899-4301 or (703) 528-5693.

☐ I would like to subscribe to **Zero to Three** for

___ 1 year ($37) ___ 2 years ($69) ___ 3 years ($99)

☐ In addition to my subscription, I would like to order ___ auxiliary subscriptions at $20 each per year. I understand all copies will be mailed to me.

☐ Please send me a complete **ZERO TO THREE** publications catalog.

☐ In addition to my subscription, I would like to contribute _____ to support the work of **ZERO TO THREE**/ National Center for Clinical Infant Programs. Contributions are tax deductible.

☐ Charge to

___ American Express ___ Master Card ___ Visa

Account No. _____

Signature _____

☐ Enclosed is my check for _____
Payable to **ZERO TO THREE**.

Send to:
ZERO TO THREE/National Center for Clinical Infant Programs
PO Box 25494
Richmond, VA 23260-5494

Name_____

Mailing Address_____

_____

City_____

State_____ Zip_____

Daytime telephone_____

Professional Discipline_____

_____

_____

ZERO
TO
THREE

2000 14th Street North, Suite 380, Arlington, VA 22201-2500

Non Profit Org.
US Postage
PAID
Waldorf, MD
Permit No. 47

Address correction requested

Moving ?
Be sure to notify **Zero to Three** of your new address.
Third class mail is not automatically forwarded.