Hmong Children and Their Families: Consideration of Cultural Influences in Assessment

Cheryl Meyers

Key Words: culture (sociology) • developmental therapy • school based occupational therapy

Occupational therapists assessing young Hmong children with developmental problems must consider their families' cultural beliefs as they affect the design of assessment procedures and practices. Choices that families make about health and educational services are influenced by their beliefs. Developmental status can be affected by unresolved medical problems and the child's general health condition. Assessment components based on cultural awareness may improve the effectiveness of early identification of Hmong children with developmental delay. Appropriate use of interpreters, creation of the most beneficial assessment environment, parental report, and observation of functional skills and play provide needed information when determining the child's eligibility for early intervention services. The author has found that trained interpreters provide the most reliable communication between family members and the therapist. Assessments in the home environment are encouraged due to the child's age and the need for family support and interaction. Parents are an excellent source of information about the child's current and past functional abilities. Observations of the child's interaction with family members, with objects and toys during play, and during functional daily living activities provides the therapist with valuable information about the child's need for intervention.

O ccupational therapists practicing with culturally diverse patient populations need to understand the history, religious practices, health beliefs, and family structures that will affect communication and treatment practices with members of the particular ethnic or cultural group receiving service. Such information is especially critical in the assessment of children, because family and social mores must be well understood to allow the therapist to integrate the family and child into the planning and implementation process. In addition, when working with young children, one finds that health conditions often affect developmental status. Understanding the basis for family decision making regarding health care and the family's concepts of illness will contribute to more effective assessment of the young child's development and to subsequent intervention.

One of the cultural groups that has grown rapidly in some areas of the United States is the Hmong population. In 1990 there were 110,000 Hmong living in the United States, with the highest population densities found in California, Wisconsin, and Minnesota. Since the Hmong began arriving in Minnesota a decade ago, they have grown to a population of 15,000 to 18,000, concentrated primarily in the St. Paul area. Although similar to other cultures of Southeast Asia, as with other ethnic groups in the region, the Hmong culture has unique characteristics. This paper reviews Hmong history, beliefs about health and illness, education practices and values, and family structure. It offers the therapist suggestions for consideration of these when developing procedures for communication, structuring the test environment, encouraging family participation, and choosing evaluation methods in occupational therapy.

History of the Hmong

The Hmong (pronounced Mong) moved from Mongolia to China around 2500 B.C. (Moore, 1989) and from China to the mountains of northern Burma, northwestern Thailand, northern Vietnam, and northern Laos in recent centuries (Westermeyer, 1982). In Indochina, the Hmong are known as Meo and in China as Miao. However, these are pejorative labels, and the Hmong people refer to themselves as Hmong, which means “free” (Koumann, 1979). The Hmong lived in unpopulated mountainous regions where migration was unopposed. In these areas, the Hmong lived peacefully and free of colonial rule (Koumann, 1979). Maize and dry rice were their principal food crops, with opium serving as their main source of cash revenue (Barney, 1979).

After World War II, war broke out between the French and the indigenous Lao independence forces. Hmong forces fought on both sides during this Laotian Civil War, and in 1954 the French left the country (Moore, 1989). The struggle continued between the Communist Pathet Lao and the Royal Lao Government. In 1961, Presi-
dent John F. Kennedy sent the first special forces to Laos to support the Royalists in their fight against the Pathet Lao. As the Vietnam War intensified, the Hmong were increasingly involved in that conflict. Hmong mountain strongholds became radar relay stations, and Hmong guerrillas regularly rescued downed pilots in North Vietnam and fought in battles (Moore, 1989). In 1975, along with similar political and military events in Vietnam and Cambodia, the Pathet Lao forces overthrew the Royal Lao Government. In December 1975, the monarchy was abolished and replaced by the People's Democratic Republic of Laos, which punished those Hmong who fought against them and who supported the United States in Vietnam. In the wake of this retribution, thousands fled to Thailand and subsequently to the United States.

Hmong Immigration

Two primary immigrant groups—the Lao and the Hmong—journeyed from Laos, via Thailand refugee camps, to the United States. Westerners frequently confuse the two, but in fact they are quite dissimilar in several aspects. The lowland Lao are from the cities, speak French, were exposed to many Western influences, and migrated early from Laos after the Vietnam War. The Hmong are from the mountainous areas with limited exposure to urban life, other languages, or cultures. They have had a written language only since 1954 (Faller, 1985). Two major dialects distinguished by color names are spoken by the Hmong: White Hmong and Blue/Green Hmong. These names reflect the color chosen by each group for articles of clothing and decoration (Koumarn, 1979).

Most Hmong refugees adopted their clan names as surnames when registering for immigration (Community Planning Organization, Inc., 1980). Because there are only 20 to 25 clans, many Hmong share the same patrilineal surname, for example, Her, Lor, Moua, and Yang (Hall, 1990).

Family

As with many Southeast Asian cultures, there is a strong sense of the familial self; family priorities and concerns take precedence over the individual. Family members gain status from their social role within the family structure (Nguyen, 1989). Although each clan monitors the social, political, economic, and religious interrelationships of its members, the sublineage family or household is the basic unit of Hmong social structure (Barney, 1979). It includes those persons under the authority of the household, who is the eldest male. A household may consist of more than one dwelling and often constitutes an entire village (Barney, 1979). Although the householder has the power to make decisions independently, the Hmong generally make decisions by consensus (Community Planning Organization, Inc., 1980). Although parents have primary responsibility for rearing their children, all members of the household are allowed to discipline and informally educate them. Barney (1979) stated that “one never observes corporal punishment of children but deep respect and obedience to parents and elders are characteristic of the Hmong” (p. 23). Women display deference to men and a reluctance to discuss intimate subjects in their presence (Faller, 1985). To the Hmong, it is of primary importance to save face and maintain social harmony (Walker, 1991).

Self-sufficiency of each household is expected and respected. Traditionally, each household was expected to have enough rice to feed the family and corn to feed the animals for 1 year. In actuality, they planned for 15 months so that if there was excess at the end of the year it could be used in emergency situations to assist a neighboring clan or household. A family experienced shame if they needed to ask for help. Hmong were essentially farmers until the early 1960s, when men were recruited by the United States for military purposes and paid with money. Commerce and trade then began to flourish for the first time (Koumarn, 1979).

Traditionally, women marry when their parents believe they are mature and able to manage a home, usually at 13 to 15 years of age. Marriages usually occur within the kinship group and women join their husband’s family. Hmong do not marry within the same clan, which is considered to be incestuous and is strictly forbidden (T. Yang, PharmD, personal communication, March 13, 1991). Hmong do not marry within the same clan, which is considered to be incestuous and is strictly forbidden (T. Yang, PharmD, personal communication, May 13, 1991), marry the widow and take over responsibility for the children. Thus, ties with the widow’s clan are preserved (Koumarn, 1979). Since the Hmong people’s immigration to the United States, many of their beliefs regarding polygamy, bride price, and age at marriage are changing to conform to laws and practices in this country (Meredith & Rowe, 1986).

Children are trained to be interdependent rather than independent and learn from an early age that they belong not only to a nuclear family but also to an extended family and clan system (Hall, 1990). Members are expected to turn to each other for help and to provide that help. Parallel cousins are called brothers and sisters (Hall, 1990).

Because newborns are thought to be especially vulnerable to “bad spirits,” during the first month of life a special ceremony may be held to protect the child. At the ceremony, strings are tied around the child’s wrist and neck while “blessings of good luck are expressed to the family” (Lee, 1986, p. 18).

Children are coddled until age 5 years and then are more strongly disciplined to fit into the mold of the family (Walker, 1991). The Hmong do not believe in develop-
mental traumas that Westerners associate with age, such as the "terrible twos" or adolescence (Barney, 1979).

Beliefs About Health and Illness

Because of their rural background and isolation in mountainous regions, the Hmong population has had great difficulty in adapting to Western health practices (Walker, 1991). Barriers to health care among immigrant Hmong include language, financial, structural, and cultural barriers (Walker, 1991). The Hmong often do not trust Western medical practices and frequently are in advanced stages of disease when they do seek out Western health care (Walker, 1990–1991). Noncompliance to medical advice is prevalent: Patients often refuse surgeries, stop or decrease their medications, and refuse to come back for follow-up visits (Walker, 1991).

As with any group, one hesitates to generalize beliefs because of individual differences within cultures. Variances due to time of migration to the United States and age at migration particularly influence Hmong perceptions and use of health care services. Many Hmong who have reached adolescence and early adulthood have become more acculturated to Western practices. However, even those who have lived in the United States for up to 14 years retain many of the traditional concepts about illness and health (Bliatout, 1990).

The traditional Hmong concept of health and illness reflects two general categories of beliefs. Illness is ascribed to either a natural, nonspiritual cause or a spiritual one (Thao, 1991). Recognizing the belief system operating within the family when a member is ill is helpful in understanding the choices families make regarding treatment and use of health care services. Families will most often choose traditional medical practice before considering use of Western medical services. Their acceptance of information from Western practitioners and their willingness to follow through with prescribed regimens and to follow-up with health care visits are all dependent on their operational belief systems. The Hmong believe that one can become ill due to exposure to the environment or as a result of age. Illness can be caused by drinking or eating unsuitable water and food. Changes in the weather can cause flu, colds, and various aches and pains (Bliatout, 1990). Although they do not understand the concept of germs, they do believe that some diseases are contagious, such as chicken pox and measles (Bliatout, 1990).

Spiritually based causes of illness fall into four major areas: mandate of life, loss of souls, ancestral worship, and animism. Traditionally, the Hmong believe that the life span of each individual is predetermined and that the time of death is inevitable and generally cannot be controlled. Their belief in reincarnation is strong, and one's corpse must be whole to reincarnate as a whole being. As a result, they generally do not accept autopsy, surgery, prostheses, dental fillings, or other invasive techniques that alter one's body. They fear that if the body is not whole at the time of death, the person may be reincarnated with a handicap or deformity in the next life (Cheon-Klessig, Camilleri, McElmurry, & Ohlson, 1988). In addition, they suspect that one may become weak after surgery and are suspicious that American physicians experiment with them because of their minority status. However unfounded, this fear is strong and pervasive in the Hmong community (Walker, 1991).

The Hmong believe that every human being has souls within, which govern the body. Souls inhabit various parts of the body, and all souls must be in the body to be healthy (Thao, 1991). Souls can be lost because of fright, depression, or loneliness, and loss can result in illness. Most of these symptoms would be considered a mental health problem by Western standards of medicine (Bliatout, 1990). A ceremony known as soul calling retrieves the lost soul and alleviates these perceived emotional difficulties (Thao, 1991).

Animism is the belief that spirits live in, on, and around a person. The Hmong respect this belief but do not practice it in any area other than health and illness. They believe that the world has good and evil spirits and that illness can result from offense to one of the surrounding spirits. When illness occurs due to individual offense of a spirit, one must perform an action of appeasement, such as a sacrifice of food, to regain health (Thao, 1991).

Traditional Health Care Practitioners

Traditional health care practitioners among the Hmong fall into two categories: Those who diagnose and those who heal. Because there are numerous methods of diagnosing and healing as well as persons who perform these functions, it can become quite confusing to those unfamiliar with Hmong health care practices (Thao, 1991). (See Table 1 for the variety of traditional health care practitioners and their roles.)

The healer whom one is most likely to hear about is the shaman. Shamans are not spiritual leaders but do have healing power. They may be men or women, and there may be many shamans within a sublineage family. A shaman may inherit the position or may be chosen. Shamans have different degrees of healing power and are aware of their limitations, thus they refer to other healers if appropriate (Thao, 1991).

Herbal medicine is frequently used by the Hmong to relieve organic illnesses. Although men and women can

The American Journal of Occupational Therapy

739
be herbalists, herbal medicines are made and administered primarily by women (Thao, 1991). Opium is traditionally used as a painkiller, particularly among the elderly (Koumarn, 1979).

Education

Koumarn (1979) reported that schools did not exist among the Hmong in the early 20th century. An oral tradition of learning was used to pass information from elder to child. Girls learned traditional housekeeping tasks and memorized poems and folk songs, which were then recited to their suitors at New Year’s festivals. Boys learned ceremonial songs, prayers, and blessings used at funerals, weddings, and other occasions as well as hunting and fishing. After World War II, those Hmong in relocation areas were exposed to French education. Many schools were built in the 1950s by the U.S. Agency for International Development with the support and encouragement of the Lao government (Koumarn, 1979).

The Hmong have had to adjust to a variety of life situations, because they have been forced to migrate from China to Indochina and now to the United States. In each area they have attempted to progress and adapt as necessary to achieve a better economic situation and social status (Yang, 1990). Currently, many Hmong have become technicians, engineers, teachers, and social workers. Private businesses have been established, including financial services, food stores, security services, and agricultural product cooperations. Hmong children adjust well to the educational system found in the United States and are able to compete with American children (Yang, 1990). Parents support their children’s educational progress, realizing that it provides them with the key to success in the United States (Yang, 1990).

Interacting With Hmong Families and Their Children

Background

With passage of the Education for All Handicapped Children Act (Public Law 94–142) (1975) and the more recent Amendments to the Education of the Handicapped Act (Public Law 99–457) (1986), children from birth to age 5 years who have an identifiable developmental delay or who meet specific criteria for being at risk for developmental delay are served through their local educational system in most states. In many localities, a centralized intake team functions to screen and evaluate those children who are referred to the school system for service. This interdisciplinary team generally includes occupational therapists. When the Hmong are included in the population served by the team, their cultural beliefs, family structure, and value of education for their children should be considered in the development of procedures and practices related to initial assessments. One needs to consider the most effective method of communication to overcome those communication barriers that exist, the most appropriate environment for testing, participation of the family in the process of assessment, and the type of testing procedures to use.

Because the team is developed under the auspices of a school rather than a health service system, many of the fears that the Hmong have relative to medical procedures are avoided. Education is valued among Hmong immigrants, because it provides the means for economic success and social status in the United States. They hold in high regard those who represent the educational system. However, because young children often exhibit medical conditions that affect their development, it is critical for occupational therapists to be aware of the family’s beliefs about health and illness.

Communication

The availability of Hmong interpreters plays a major role in the provision of occupational therapy services to these families. Because of cultural values that traditionally give males higher status, primary responsibility for decision making, and interaction with authority figures, men generally learn English before women. For these reasons, they may also serve as interpreters for the family. Because families immigrate within their clan or sublineage family, there are often other family members in the Hmong community who have arrived in the United States earlier and have learned satisfactory English to serve this purpose. An older child who has learned English in school may also have adequate English-speaking skills to serve as an interpreter. However, use of family members as interpreters is not recommended because of the lack of interpreter training, inconsistency in interpreting information, and the change in family dynamics that may be caused by placing a child in the role of liaison with an outside authority. A trained Hmong interpreter knowledgeable about policies and procedures and possessing the ability to develop rapport with children and their families is preferable. This person can provide an objective interpre-
tation of information between the family and the therapist.

A general training program for interpreters may include an array of content ranging from policies and procedures of the institution to information about community resources. In most settings, training is provided by staff other than the occupational therapist. The occupational therapist provides the trained interpreter with information about the assessment tools used, procedures used during the assessment, and clarification of terminology. Interpreters need to have information that will allow them to effectively communicate with the family about the purpose of the assessment, the process used, interpretation of findings, and recommendations by the therapist.

As the Hmong population grows and stabilizes, a pool of persons fluent in Hmong and English can be trained to interpret for the therapist in the areas of policy, rules and regulations, child development, family history, family concerns about the child, description of services available, and referrals to other agencies. It takes time to develop trust in the interpreter's ability to clearly convey the intentions of the therapist. Often, when listening to the interpreter and the length of conversation relative to the response that the occupational therapist receives in return, one wonders if the information the interpreter is providing is accurate. Because the Hmong may not have a word for concepts such as seizure or formula, the interpreter may use the English word or may enter into a lengthy description of the concept to convey the meaning. Therefore, it is difficult for the occupational therapist to determine on the basis of length of conversation and response what the content of the discussion includes.

Due to the size of the Hmong community and interrelationships among its members, the reputation and standing of an interpreter can be jeopardized by a request that is culturally inappropriate (e.g., demanding that a parent follow up on a medical request; requesting that a woman make decisions autonomously). The interpreter may need to accommodate Hmong cultural beliefs of harmony, saving face, and acquiescence to older members, which can conflict with the therapist's needs to obtain information or attempt to convince a family to follow through with a request. Although therapists may wish decisions to be made quickly, the Hmong parents may need to go to their elders for assistance in decision making. One needs to respect this process and allow time for it to occur so that parents are not pressured and are allowed to save face and the interpreter is not placed in a compromising situation.

Because written language is a recent addition to Hmong culture, illiteracy is common among the Hmong. To the Hmong, the numerous consent forms, individualized education plans or individualized family service plans, and permission forms that parents must sign when their child is in an early intervention program are alien and overwhelming. Illiteracy in Hmong or English or both further complicates the process of written documentation required by local, state, and federal mandates, even though English forms may be translated to the Hmong language. Direct communication by telephone or in person between the interpreter and the family when scheduling an assessment or other appointments is suggested to decrease the family's need to respond to additional written communication.

Several communication techniques addressed by Walker (1991) can be applied when therapists work with Hmong families. These include the following:

- Modulating the degree of emotion expressed. For example, raising one's voice or giving an ultimatum can cause the person to lose face and decreases the perception that the family has of the therapist as a respected professional.
- Adopting a quiet, unhurried demeanor. This reflects wisdom and good judgment in Eastern cultures and may enhance respect for the therapist.
- Accepting the use of traditional healing by the family if it is not harmful to the child.
- Understanding the symbols and interactions of healing that are meaningful to the Hmong.
- Encouraging and supporting use of Western medicines in a nonjudgmental and consistent manner. Dual systems of healing may be used simultaneously without harm.

Environment

When the occupational therapist is ready to assess the child with a suspected developmental delay, the assessment environment is considered. As with other young children, the preferred assessment environment is the home. When providing home-based services, the therapist will be confronted with uncontrollable variables, such as the number of persons present, siblings' interest in objects and materials, unexpected interruptions, and unforeseen events. However, young children tend to perform best in a familiar setting with familiar family members present. With the Hmong, the opportunity for extended family members to be present is particularly important. The presence of the family during the assessment creates an environment of support and comfort for the parents when dealing with a new situation in a strange culture. When budgets and personnel allotments do not permit a home assessment, the family can be encouraged to invite important extended family members to accompany them to the center-based assessment setting. This provides them with a greater sense of emotional security, and extended family members can be an additional source of information for the occupational therapist.
Family Participation

The family’s involvement during the occupational therapy assessment process benefits both parents and child, but often creates new challenges for the therapist. Public Law 99–457 mandates a family-centered approach to services, making families integral to the team. During assessments of Hmong children, there may often be 7 or more family members present. With the use of Hmong interpreters, all adult family members present during an assessment are acknowledged. The therapist, through the interpreter, identifies the family decision maker or decision makers as well as the person who is legally entitled and responsible for serving as the child’s guardian. Key members are questioned about their perceptions of the child before the child receives specific requests from the therapist. This serves to develop rapport with the family and gain helpful information from them. The interpreter helps the family understand the purpose of the therapist’s interactions with the child. The family can also contribute to the therapist’s assessment of the child with their comments and responses to questions. Thus, they become active participants in the assessment process.

Parental report is a reliable data source regarding a child’s development and present status. Hmong parents can provide reliable developmental information, particularly when asked to compare the specific child’s development and skills to those of other children of similar ages in the family. Parents may report that the child in question was not like their older children at the same age, that is, the child spoke less, did not walk, or did not interact similarly with others or with objects. Because of the extended family settings, even parents of a single child often have exposure to children of several ages to whom they can compare their child. Although normally one is cautioned against comparing siblings, the benefits of gaining insight into the child’s history, development, and skills may outweigh any negative effect of such a comparison. Information can be collected with the use of an interview format that addresses early development and health history. Health histories, as defined by Western medical standards, are often incomplete and vague because of the difference in interpretation of health and illness. Open-ended questions, such as “How does your child spend his or her day?” and “What does your child like to play with?” can provide valuable information about the child’s current levels of function.

Use of Standardized Tests

I know of no sensory integrative, developmental, or motor tests that included the Hmong population during their standardization. Therefore, one can not presume that the standardized norms of these tests hold true for Hmong children. This can pose a problem in situations where criteria for early intervention require the transformation of data to standard deviations or if administrators and therapists do not understand the implications of inappropriate interpretation of test data. Administration of standardized tests is not necessarily inappropriate if the information is used from the standpoint of item analysis and patterns of behavior that are also reflected in observable functional behaviors that the child exhibits during play, daily living activities, and interaction with others.

Functional Skills and Play

When evaluating the child’s functional abilities, one must consider the context of his or her family structure and home environment when determining the presence of any developmental delay. Consideration of these family variables gives the therapist information about family expectations, daily schedules, interactions between family members, and the child’s needs and strengths viewed from a family perspective. The child’s skills may be absent or not well-developed due to lack of family expectation, lack of exposure, or lack of experience and practice. Skill deficits need not be interpreted to mean that the child has an identifiable delay. Deficits may reflect the child’s lack of experience or lack of family expectation to complete an activity in the natural environment of the child’s home and community. For example, a child who is not independently spoon feeding may be allowed by his family to simply use his fingers. There is no family expectation of independent use of a utensil when eating. If the therapist suspects a developmental delay, observations over time permit the child to become comfortable with the therapist and interpreter and allow for accurate information gathering about the child’s functional abilities. Several observations provide an opportunity to see a pattern of behaviors reflecting normal or delayed development. The time needed for accurate determination of a delay in the child’s development will vary, depending on the therapist’s judgment about the child’s age and possible needs, the environment, and the family’s concern.

I have found that Hmong preschoolers tend to exhibit greater interest in fine motor tasks (e.g., paper-and-pencil drawings, small bead manipulation) than expected for their age group. They exhibit patience and perseverance in fine motor task completion to an extent unexpected for their age.

In contrast, I have found that Hmong children are often reluctant to participate with the therapist in gross motor skills that do not require interaction with an object, as opposed to playing catch or kickball. Their response is frequently one of quiet refusal. Therefore, if suspicious of a delay, the therapist can schedule more than one assessment period to interact with the child so as to observe a truer performance reflective of the child’s ability and skills.

Most Hmong children have few commercial toys. Their traditional play includes group games such as tag,
hide and seek, and spinning tops (Barney, 1979). Koumarn (1979) noted that their play and interaction often imitates adult roles. Older preschool children take care of younger children, including feeding, going for walks, and going to the local play area. Girls follow their mothers and assist them, and boys assist their fathers.

When assessing functional abilities and play behaviors, the occupational therapist uses toys and objects with which the child normally interacts as well as a variety of toys and objects that may be unfamiliar to the child. Toys and objects chosen with the child's age and probable developmental level in mind provides information about the child's skills with both familiar and unfamiliar objects, the child's interest in exploration, the types of toys and objects that motivate the child, and possible future application for use in intervention.

Summary

The Hmong, whose culture is rich and vital, are relatively recent immigrants to this country. Understanding their culture and valuing its differences contributes to effective, culturally relevant occupational therapy services. When assessing Hmong children, occupational therapists consider Hmong beliefs about health and illness, communication issues, the need for family participation, and selection of appropriate test environments and procedures. Use of trained interpreters is recommended due to the increased objectivity and effectiveness that will benefit the occupational therapist's assessment.

There is little information available that indicates expected Hmong performance levels on developmental checklists, standardized tests, or other evaluation tools currently used. Occupational therapists are encouraged to consider characteristics of the home environment, use observations over time of the child's functional and play skills, and use Hmong parental reports when gathering information about the child's abilities and needs and when determining the presence or absence of a developmental delay.

The following case study illustrates the effect of cultural influences on family beliefs and decision making surrounding a 3-year-old child with a seizure disorder. Strategies used when interacting with the family are discussed along with noted family outcomes at entry to elementary school.

Case Study

A 3-year-old was referred to the Early Childhood Assessment Team by a public health nurse due to concerns about his general development. He lived with his parents and five siblings. His medical history included the presence of seizures. Evaluation of motor development was determined to be necessary due to major difficulties noted during developmental screening. An in-home evaluation was scheduled with the boy's father by the Hmong interpreter. When the interpreter and therapist arrived, there were 16 persons in the living room–dining room area. The interpreter determined through questioning and introductions that those present were the paternal grandparents, a paternal uncle and his family, and the boy's parents and siblings.

Initial conversation was directed to the interpreter. Family members questioned the interpreter's knowledge of others in the Hmong community and his status within it. The interpreter directed his conversation to the father initially, but as the interview proceeded the three adult men joined in, with the adult women adding information indirectly through the male family members. Children sat quietly listening to the conversation, with interruptions coming only from the infants and toddlers.

The family reported that the boy had been ill as an infant in the refugee camp. They attributed it to karma or fate and did not express great dismay in regard to his seizure condition. They had no reason to think that he would improve or that his condition could be influenced. They appeared to accept his condition matter-of-factly. The seizure activity was diagnosed at a local international health clinic and medication was prescribed. Although the public health nurse and other health care providers made many appeals for consistent use of the medication prescribed, the family continued to use it sporadically. They viewed the medicine as "hot," which meant that it was quick acting and useful for conditions such as a fever or other acute symptoms. They did not believe that it would be beneficial to control the seizures.

The boy was expected to do little independently. Independence was not valued, and family members felt comfortable in caring for his feeding, dressing, and hygiene needs without encouraging any attempts at independence in these areas. No toys were in evidence, and independence in these areas was not valued. The family wanted him to do well for the "teacher" in school.

The family content to allow him to generally sit and watch them or be present. They brought him on all family outings, such as to the park or when visiting relatives.

During the therapist's interaction with the boy, the family wanted him to do well for the "teacher." Members often shouted directions explaining how to do something or words of encouragement. As blocks, balls, cars, finger puppets, and paper and crayons were presented to him, he explored them visually and manually. He was able to initiate spontaneous in-out, push-pull, and throwing play schemes. He imitated simple 1- or 2-step play behaviors. He was able to sit and crawl independently. Gross and fine motor delays were evidenced and included poor prehension patterns, lack of shoulder stability, poor trunk control, and no independent walking.

Following a review of all of the team members' assessment data, it was determined that the boy was eligible
for early intervention services. However, although his parents thought school would be fine for him because of their respect for the opinion and authority of school staff, they did not understand the concept of early intervention and the staff's belief that his development could be influenced by the intervention of others. They also did not understand the link between his seizure activity, his prescribed medication, and his ability to do activities.

For the first year of his intervention program, the boy attended school inconsistently. His family continued to give him his seizure medication sporadically and sent him to school only on his “good” days. The program provided the parents with some toys for the boy, and they began to develop an interest in watching him interact with these rather than being content to watch others. As the educational team, the public health nurse and physicians encouraged use of medications by pointing out the differences in the boy when medications were given consistently. The family began to use them more frequently and thus became increasingly aware of the positive behavioral changes the boy was demonstrating. It was important to them as their child became older that he do well in elementary school, and this provided an additional motivation. Thus, when the boy was 4½ years old, they consistently followed the medication routine.

As the family became more knowledgeable about the positive benefits of medication and its influence on the boy's development, they began to be a resource that staff used for new families in similar situations. They were able to point out the importance of early intervention for the child’s future education as well as allay some of the fears that other families had regarding Western medical practices.

Acknowledgments

I thank the members of the Early Childhood Intervention Services Team, whose shared experience allowed me to write this article. I also thank Ron Berkeland, MPH, OTR, for creating an atmosphere of unlimited possibilities and professional growth and Erica Stern, Ph.D, OTR, for her encouragement and assistance.

References


