



# the culture of a home visit in early intervention

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ABSTRACT

This article uses data from an ethnographic study that examined the delivery of home-based services in early intervention. Participants were families with a(n) infant or toddler with special needs, and professionals providing early intervention services to these and other families. The study examined an early intervention program that uses primarily a transdisciplinary approach to home-based service delivery. Perspectives on the delivery of services were elicited by ethnographic interviewing, participant observation of home visits, and the review of program structure, artifacts, and documents to determine what makes this program effective in the delivery of services. The data revealed that effectiveness of service delivery is dependent upon professionals creating a cultural environment that is similar in all homes during home visits. The discussion addresses the difficulty in defining and then implementing a family-centered service delivery model that takes individual differences into account.

KEYWORDS ??????????

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The practice of providing early intervention services to children with disabilities and families in the United States is the result of a series of laws passed over the past 40 years. The timeline of events leading to the current state of public law began with the Civil Rights movement of the 1960s and the Civil Rights Amendment of 1964. This was followed by Public Law 93-112, the Rehabilitation Act of 1973, Section 504, and Public Law 94-142, the Education for All Handicapped Children Act (EAHCA) of 1975 that are the foundation of civil rights to individuals with disabilities. These laws afforded disabled

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journal of **early childhood research**

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Vol 3(1) 51-76 [ISSN 1476-718X DOI: 10.1177/1476718X05051346]

individuals equal opportunities to education and employment. Since laying that foundation, several other federal laws have been passed to supplement, enhance, and improve the delivery of services to individuals with disabilities. For example, in 1986, all the rights and protections of EAHCA were extended to infants and toddlers with the passage of Public Law 99-457. Other similar public laws have resulted in the current state of service delivery to children with disabilities and their families called the Individuals with Disabilities Education Act (IDEA '97) Reauthorization of 1997.

The various public laws served different purposes. For example, Public Law 93-112, Rehabilitation Act, Section 504 of 1973 was passed to protect the rights of all individuals with disabilities in the workplace, but then was amended in 1974 with Public Law 93-516, Rehabilitation Act Amendments of 1974 and extended the protections of rights to individuals with disabilities not only in the workplace, but in all educational settings. Several legislative bills during the 1970s were passed to ensure the delivery of special education services to school-age children. In 1975, Public Law 94-142, the Education for All Handicapped Children Act, was enacted to assist states in providing a free and appropriate public education for children with disabilities. This legislation, however, did not include mandates for the delivery of services to infants and toddlers. Eventually, all the rights and protections of Public Law 94-142 were extended to infants and toddlers through the enactment of Public Law 99-457 in 1986. This new law focused on developing a service delivery model that addressed not only the needs of the child with a disability, but also the needs of the family in the delivery of services.

The passage of Public Law 99-457 in 1986 mandated the delivery of special education services to infants and toddlers from birth through two years of age and their families. This law and the subsequent series of legislative amendments culminated in the Individuals with Disabilities Education Act (IDEA) of 1991 and its reauthorization in 1997. The Individuals with Disabilities Education Act is the legislation that directly impacts the delivery of early intervention services to children and their families. The essential elements of PL99-457 (known as Part C of IDEA 97) remained unchanged except adding a provision for intervention services to be provided in a natural environment. In most instances, a natural environment could be interpreted to mean services provided in the family's home.

One of the primary intentions of the Individuals with Disabilities Education Act, and in particular early intervention services, is to provide services that are in the child's natural environment while being sensitive to the diverse cultures existing in American society. Clinicians, however, continue to provide services in a wide variety of settings using a wide range of strategies and techniques to promote child and family development.

The critical research problem in early childhood special education is

understanding the differential impact specific kinds of services have on infants and families (Shonkoff et al., 1988). Shonkoff and his colleagues feel that, in a field that emphasizes the importance of individual differences and recognizes the limitations of a 'one-size-fits-all' service delivery model, there is a critical need for greater understanding of interactions among children, families, cultural differences, and services available.

The goal of this ethnographic investigation was to uncover and determine the culture of the home visit in early intervention. An increased understanding of professionals' and families' perspective on the delivery of early intervention services in this setting means a better understanding for dealing with cultural issues of the home visit. In many instances the study provides confirmation for professionals' service delivery strategies. These issues are important for the need to better understanding the parent education component of early intervention (Mahoney et al., 1999) and the paradigm shift in family-centered philosophy (Baird and Peterson, 1997).

The primary purpose of this study was to investigate the phenomenon of the home visit in early intervention. The outcome of this investigation attempted to answer the question: what are early intervention specialists' and families' perspectives of the delivery of home-based early intervention services? The answer to this question resulted in a better understanding of how parents and professionals work together in providing home-based early intervention services.

## **early intervention research**

Research supporting the need for early intervention preceded the passage of Public Law 99-457 and Public Law 94-142. Most of the literature documenting the need for early intervention services was written during the mid-1960s to the mid-1980s. Since then, many literature reviews have examined the effectiveness of early intervention (Bailey and Bricker, 1985; Meisels, 1985; Ramey et al., 1985; Shonkoff et al., 1988). All these reviews agree on one major point. Early intervention has a positive impact on the development of infants and toddlers (Bailey and Bricker, 1985; Bronfenbrenner, 1974; Casto and Mastropieri, 1986; Dunst et al., 1989; Lazar and Darlington, 1982; Meisels, 1985). Once beyond this basic premise, there are several problems with the studies conducted examining the effectiveness of early intervention. The problems are related to the inability to control the variables affecting early intervention. Researchers have addressed these problems in a variety of literature reviews on the efficacy of early intervention (Casto and Mastropieri, 1986; Dunst et al., 1989), however, there continues to be a lack of research attempting to address the difficulties posed by efficacy studies in early intervention. The difficulties may persist because the traditional research

model is inadequate for meeting the required changes in efficacy research (Eiserman et al., 1995). Still, once researchers begin discussing the variables that affect the progress seen in children receiving early intervention services, the agreement is not so universal among them. A few of the variables affecting the success of early intervention services include: age of entry; intensity of involvement; degree of parent involvement; socioeconomic status; age of parents; and parental attitudes. Unfortunately, the literature is unclear as to what impact these and other variables have on the progress children make in early intervention. LeLauren and Wolery stated that, 'If investigators base their research on sound theoretical foundations, their independent variables may come from two sources: (a) predictions based on the assumptions of a relevant theory and (b) past research related to that theory' (1992: 277). The atheoretical nature of early intervention research and inability to identify independent variables accurately present difficulty in identifying what makes early intervention effective. Although it is true that applied research deals with practical, rather than theoretical questions, such research should be framed within existing theoretical approaches whenever possible (LeLauren and Wolery, 1992).

In early childhood special education, a more ecologically based research model is becoming more prominent (Bronfenbrenner, 1979). The change in early intervention theory and practices were influenced by PL 99-457 and have resulted in a change in the research methodologies for investigating the theory and practices. Traditionally, quantitative research methods have been used to investigate the effectiveness of early intervention and what variables make it effective. However, some researchers suggest that quantitative research may not be the appropriate methodology for investigating early intervention (Stainback and Stainback, 1984). These investigators are emphasizing the importance of studying early intervention in its natural context because this most closely matches the approach to and practices of early intervention. A methodology well suited to investigating some phenomena in its naturalistic context is naturalistic inquiry (Lincoln and Guba, 1985). More specifically, ethnographic methods can be used to uncover the culture of home-based early intervention services. Ethnography is a method of research used to discover the culture of a society.

This investigation used ethnographic methods to uncover and determine the culture of the home visit in early intervention and professionals' and families' beliefs, values, and opinions of early intervention services. How these beliefs, opinions and values match and differ from each other helped to define more accurately the *effectiveness* of services being provided.

The terms *discover* and *uncover* have very specific meaning and implications for this investigation. The intent of an ethnographic researcher is to discover the nature of a culture. If an investigation is taken one step further by

examining the organizational culture to uncover the values, beliefs, and underlying assumptions of the culture, then a contribution to the culture is provided. Ideally the researchers might set out to *discover* a culture, but functionally the researchers are *uncovering* the culture hoping to do something with the knowledge gained.

## **problems in research**

The scarcity of qualitative research efforts in early intervention (Hatch, 1995; Karnes and Johnson, 1988; Murray, 1992; Odom, 1988) and the limitations of quantitative research efforts in identifying variables that account for the effectiveness of intervention services (Dunst et al., 1989; LeLaurin and Wolery, 1992; Meisels and Shonkoff, 1990) were factors that influenced the selection of methodology for this study. The traditional paradigm of research, which was initially intended for use in the hard and life sciences only, includes research methodologies that are questionable in the social and behavioral sciences because of researchers' inability to control variables and manipulate the environment. Qualitative research methods can be used more easily to examine theories-in-use to find out what makes early intervention effective during a home visit and to describe the home visit culture from the perspective of the parents and the professional. Researchers must begin investigating early intervention from a holistic point of view rather than a fragmented and singular point of view where research variables might be examined in isolation and not consider the entire context.

Most of the research in early intervention has evaluated the impact of services for preventing or limiting developmental disabilities in infants and toddlers. Clearly, past research in early intervention using quantitative methods has been inadequate to identify what makes early intervention effective. Despite the literature devoted to improving quantitative research methods in early intervention (Dunst et al., 1989; Meisels and Shonkoff, 1990; Odom and Karnes, 1988), it is likely that difficulty will persist in using quantitative research methods. These problems, such as difficulty in identifying what variables make early intervention effective, will persist because the traditional research methodology is ill-suited for many early intervention investigations and program evaluations. Casto stated that:

Given the tentative nature of many current (quantitative) research findings, one may anticipate that ethnographic studies will be utilized to provide more qualitative data about certain aspects of the field, and to generate important research hypotheses for further study. (1988: 59-60)

A shift from quantitative to qualitative research methods is necessary for an increased understanding of, and theoretical basis for, early intervention. Qualitative methods are clearly useful in generating theory and identifying

variables affecting a study. In early intervention, this suggests that qualitative methods would be useful for preceding quantitative methods used to confirm the variables affecting early intervention services.

In conclusion, remembering that all research paradigms have limitations is important. Quantitative and qualitative research each has a place in investigating early intervention. Recognizing the strengths and weaknesses of each methodology and using the paradigms best suited for the proposed investigative question is important.

## **design of the study**

### **description of the program**

The Little Snowflakes Program was recruited for participation in this study because of its long history of excellence and effectiveness in providing services to infants, toddlers, and their families. The program was also recruited because of its focus and belief in providing home-based early intervention services using a transdisciplinary approach. The Little Snowflakes Program is located in an upper Midwestern community with a population of approximately 50,000 residents. The general philosophy of this program is to provide parent-training opportunities for families to help promote the child's development more effectively.

Families have other service delivery options available to them (e.g. consultation to day care facilities where an infant spends the day), but home-based service is the primary means by which this program provides services. The frequency of home visits ranges from once a week to once a month. The average time of a home visit ranges from one hour to one and a half hours. The program provides services to approximately 75 families. A full-time staff member is expected to have 15 families on her/his caseload.

### **participants**

The Little Snowflakes Program has seven professional staff providing individual services to families. One of these seven people is the program coordinator, two others are full-time staff members, and the remaining four members of the staff are all part-time ranging from 20 to 30 hours per week.

The professional staff members, included in the Little Snowflakes Program of seven staff, are two occupational therapists, two speech-language pathologists, two Early Childhood Special Education Specialists, and a social worker. The lengths of time employed in this program ranges from four months to 16 years. The program coordinator is also an occupational therapist and has been with the Little Snowflake Program for 16 years.

## **description of the parents**

Four families participated in this study. Each of the families had one child with special needs ranging in age from 10 months to two and a half years. Three of the children had a mother and a father in the home and the fourth child had a single parent. The children's disorders included cerebral palsy, Down Syndrome, severe hydrocephaly, and spina bifida. The parents ranged in age from 27 to 44 years old. As with the staff, each family provided its own unique contribution. All families were information rich, providing a wealth of insight into the delivery of a home visit in early intervention.

## **procedures**

Qualitative research methods were used to gather and analyse data in this study. Specific methods of gathering data included unstructured ethnographic interviews (Spradley, 1979), participant observations (Spradley, 1980), and examination of program documents. The data was then analysed to investigate early intervention culture in home visits. Provisions for the trustworthiness of the investigation were achieved through triangulation, thereby supporting the credibility, transferability, dependability, and confirmability of this study (Guba and Lincoln, 1982).

A variety of methods of data collection were used to achieve a better understanding of the participants, and to increase the credibility of the findings. The strength of the study design was dependent upon triangulation. The study included two types of triangulation. First, the study included methodological triangulation that uses multiple methods to study a single problem or program. Second, data triangulation that involves a variety of data sources in the study. The following section describes the three methods of data collection employed in this study.

1. *Observations*. Formal observation occurred during the home visits. Each of four families were video taped. All home visits were videotaped for later analysis. During and after each home visit, field notes were written.
2. *Interviews*. One important way to understand people is through their eyes and their voices. The study included a series of interviews using Spradley's ethnographic interviewing methods. Spradley outlined and discussed 12 steps in this Developmental Research Sequence (DSR): 1) locating an informant; 2) interviewing an informant; 3) making an ethnographic record; 4) asking descriptive questions; 5) analysing ethnographic interviews; 6) making a domain analysis; 7) asking structural questions; 8) making a taxonomic analysis; 9) asking contrast questions; 10) making a componential analysis; 11) discovering cultural themes; and 12) writing an ethnography. All 12 steps were followed to some extent during this investigation.

3. Interviews with all participants were done at their convenience. Permission was given to audio tape record the interviews, which were later transcribed for use in data analysis.
4. *Review of documents.* Reviewing program documents contributed to the understanding of the home visit. Many of these documents were photocopied for review, and later analysis.

Over the course of seven weeks (as seen in Table 1), parents and professionals were audiotape interviewed a minimum of three times each. Each interview began with a 'grand tour' question (i.e. Can you tell me all the things that happen during a home visit?) in an effort to have the participant identify those things that are most important to them when describing a home visit. This initial question and subsequent interviews were followed by a series of more detailed questions that resulted in a domain analysis (Spradley, 1979). All interviews were part of a much more complex analysis of interview data based on Spradley's (1979) developmental research methods. Most interviews lasted from one to two hours. Each family was also observed three times each during a home visit by the professional responsible for that family. These observations lasted from one to two hours. All observations were videotaped and reviewed at a later date. A constant comparative analysis of interviews and observations was conducted throughout the duration of the investigation.

**table 1** time lines for fieldwork investigation

Date	Activity
Week 1	Met with program coordinator to outline the nature of the investigation and scheduled first set of five staff interviews.
Week 2	<b>Conducted first set of five staff interviews.</b>
Week 3	<b>Transcribed, analyzed, and developed structural questions for first set of staff interviews.</b> <i>Conducted first set of three parent interviews.</i>
Week 4	<b>Conducted second set of staff interviews.</b> <i>Transcribed, analysed, and developed structural questions for second set of parent interviews.</i> <i>Video taped first set of three home visits.</i>
Week 5	<b>Transcribed, analysed, and developed contrast questions for third set staff interviews.</b> <i>Conducted second set of parent interviews.</i> <i>Video taped second set of three home visits.</i>
Week 6	<b>Conducted third set of staff interviews.</b> <i>Transcribed, analysed, and developed contrast questions for third set of parent interviews.</i> <i>Video taped third set of three home visits.</i>
Week 7	<i>Conducted third set of parent interviews.</i>

## **an explanation of data analysis**

Transcribed interviews, field notes from observations, and program documents were analysed in a general sense using the constant comparative method (Glaser and Strauss, 1967). This method is a non-mathematical procedure designed to identify themes and patterns in qualitative data. The analysis led to a number of salient themes and patterns emerging from the participants and program under investigation. This means that during the course of the fieldwork and after its completion, the investigators continually reviewed the data to identify trends and themes as they emerged in the data. As these tendencies in the data continued to emerge, a general theoretical framework was formed to explain and interpret the data, eventually leading to the five underlying assumptions that represent the essence of this investigation.

A constant comparative methodology for qualitative research was central to this investigation; however, several more specific data collection and analysis procedures were used. As a means of analysing the data, two kinds of inductive data analysis occurred. The first kind of analysis involved ethnographic and qualitative methodologies that were conducted while in the field and immediately after returning from the field. Spradley's (1979, 1980) qualitative research methods for gathering interview and observation data were used in this study. The second kind of analysis involved examining the three levels of organizational culture present in this early intervention program. The levels of organizational culture were uncovered and identified in the data by using Schein's (1992) three levels of organizational culture.

## **diagnosing organizational culture**

Schein (1992) has identified three levels at which culture can be analysed. These levels include artifacts and observable behaviors, espoused values, and basic underlying assumptions. Each level of organizational culture builds on the previous level.

The three levels of organizational culture were used as the *frame* of analysis for this investigation. The remainder of the information that follows was organized using these three levels of organizational culture. Level 1, artifacts, includes descriptive information about the program, staff, and families participating in the study. This also includes information about habits, patterns of behavior, norms, rites, and rituals as described in the typical day and the typical home visit. Level 2 is espoused values which in this case consist of program-stated strategies, goals, and philosophies. These are the espoused justifications for what it is the staff do on a daily basis. It is conceivable that Level 2 as the true organizational culture. This level of organizational culture often yields espoused values, that is *what people will say* rather than values-in-

use, which can be used to predict *what people will do* (Ott, 1989). Because of the large number of behaviors left unexplained at this level, Schein stated that, 'To get at that deeper level of understanding, to decipher the pattern, and to predict future behavior correctly, we have to understand more fully the category of basic assumptions' (1992: 21). Level 3 represents the basic underlying assumptions, which are the fundamental beliefs, values, and perceptions that have become so taken for granted that one finds little variation with a cultural unit (Schein, 1992). In essence, the basic underlying assumptions represent the findings of this investigation.

## **results**

### **level 1 of organizational culture: the typical home visit**

Families and therapists in the Little Snowflakes Program were asked to describe a typical home visit. The families' and therapists' responses to this request were at the same time, different and similar. The responses were similar in that all parents and therapists mentioned the same general components of a home visit, but different in that all responses included a different perspective of the general components.

The typical home visit consists of eight parts:

1. planning;
2. greeting;
3. activities;
4. observation;
5. demonstration;
6. sharing knowledge;
7. follow-up; and
8. scheduling.

A summary of the eight parts are provided in Table 2. Before, during and after each home visit, these eight parts of a home visit were observed. Each home visit was preceded by a period of time to plan for the session. The clinician would then arrive at the home and greet the family members. This was followed by a period of time where the professional, parents, and child with special needs would engage in an activity related to the child's development and included opportunities for observation, demonstration, and sharing of knowledge. The observation, demonstration, and sharing of knowledge were parts of the home visit to help educate and/or train the parent in how to effectively promote the child's development. In addition to these parts of the session, the home visit also included time for follow-up on the previous home visit. During this time, the professional determined the kind of progress made by the infant/toddler and/or the extent to which family members have

**table 2** components of a home visit

Components of a home visit	Description
1. Planning	Review of notes from previous home visit. Gathering and packing treatment materials. Reviewing old and establishing new activities.
2. Greeting	An important part of every home visit, but the kind of greeting is individualized for every family.
3. Activities	Things done on a home visit that directly promote child development. A means of determining how much a parent has worked with a child.
4. Observation	Observation is a critical means by which learning occurs. Parents observe the therapist and their child to learn how to do an activity or exercise. Therapists observe to assess the child, document progress in the child, and assess how parents interact with the child.
5. Demonstration	Parents and therapists demonstrate activities intended to promote child development. Demonstration acts as the seed from which learning and understanding grows in parents and therapists.
6. Sharing knowledge	The single most important aspect of a home visit. Sharing knowledge is the process by which therapists and parents gain knowledge from one another.
7. Follow-up	Follow-up is a way to make sure therapists meet the needs of the family on a regular basis. Both parents and therapists are responsible for follow-up. Examples of follow-up include: parents working on an activity for child development during the course of a week or therapists checking back during the week to see if the child's ear infection has cleared up.
8. Scheduling	Scheduling the next home visit. The most collaborative task that parents and professionals engage in.

engaged in promoting the child's development. The final element of all home visits was a short period of time for scheduling the next home visit.

The consistency with which these elements of a home visit were present was remarkable. The diversity and individuality of each professional was seen in how they each incorporated these parts of a home visit into her own session. When the professionals spoke of individuality in the delivery of services to families, they were primarily referring to how they individualized the eight components of a home visit.

Despite the overwhelming evidence that home visits are nearly identical from one home to the next and one professional to the next, the early intervention professionals strongly believe in the individual differences of one

home visit to the next. These individual differences presents difficulty in describing home-based early intervention services at Level 1 of organizational culture, but enough similarity exists between what parents and therapists said and did to provide general descriptions. The similarities in a home visit from one appointment to the next was nicely summarized by Patty, the program coordinator, when she said:

. . . the thing that I think is real important in working with families is that there is a sense of continuity, because if you are only seeing a child once a week you want there to be some continuum, some growth, and some ongoing change. That you are not just going in and doing this one week and another area another week and another area, and it feels like a real hit and miss to the family.

Patty's comments illustrate the importance of continuity in home visits. The therapist's continuity in providing services is represented by the consistent series of events that occur during a home visit. This series of events is consistent with what Hershberger (1991) described as the structure of a home visit.

## **level 2 of organizational culture: analysis of the espoused values and beliefs of professionals providing home-based services**

The Level 2 analysis of the home visit's organizational culture consists of the parents' and professional's perception of what goes on at Level 1. Level 2 of organizational culture consists of the staff's values and beliefs, as well as the philosophies, ideologies, ethical and moral codes, and attitudes (Ott, 1989). Level 2 represents the sense of 'what "ought to be" as opposed to what is' (Schein, 1987: 56). It is during a Level 2 analysis that the nature of reality concluded in the Level 1 analysis is either confirmed or placed into question based on the participant's espoused values and beliefs. During the course of the investigation a number of patterns emerged which questioned the congruence of Level 1 and 2. This incongruence was most evident by examining the communication interaction between parents and professionals.

During a home visit, therapists espouse a collaborative relationship with the parents. This collaborative perspective of family centeredness was not evident in interviews, observations, or documents reviewed. Despite the therapists' ability to articulate the espoused position of collaborative interactions with families, the majority of what was occurring during the home visits was educational in nature and involved very little collaboration. Therapists espouse a collaborative style of communicative interaction, but in reality it was not occurring.

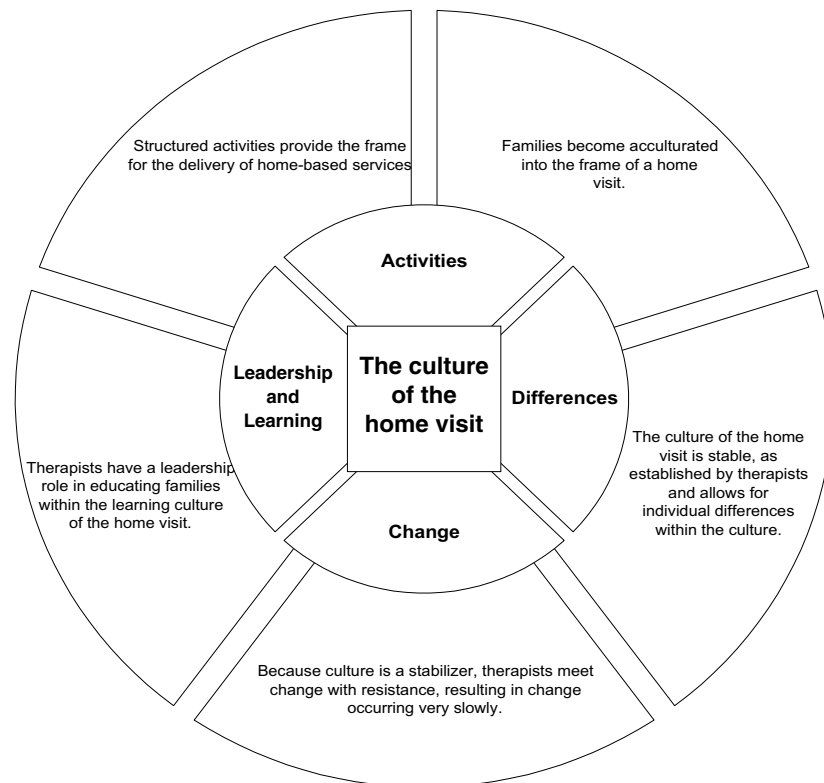
As the prior example illustrates, many of the staffs' values and beliefs are congruent with what they do and some are not. In essence, the Level 2 analysis revealed that what was discovered at Level 1 is not consistent with

what professionals and parents espouse in Level 2. The inconsistency makes it necessary to examine Level 3 of organization culture to determine the basic underlying assumptions of this program.

**level 3 of organizational culture: basic underlying assumptions that guide staff and the program philosophy**

A Level 3 analysis of the organizational structure in this Early Intervention Program attempt to clarify and explain the general data described in the Level 1 and 2 analysis. The Level 3 analysis provided an explanation for the discrepancies between Level 1 observations and Level 2 beliefs about what happened. Level 3 of organizational culture uncovers the implicit assumptions that describe how staff perceive, think about, and feel about things (Schein, 1992). These basic assumptions are what staff have come to believe at a conscious and unconscious level of what really works in the delivery of home-based early intervention services. Basic assumptions, as Schein defined this concept, 'have become so taken for granted that one finds little variation

**figure 1**



within a cultural unit. In fact, if a basic assumption is strongly held in a group, members will find behavior based on any other premise inconceivable' (1992: 21-2).

The Little Snowflakes Program staff have created a cultural environment from which they conduct home visits. All basic assumptions operate within this frame. These assumptions are strongly held values and beliefs that have evolved over an extended period of time and are difficult for them to articulate.

Through an analysis of the descriptive data, several basic underlying assumptions that contribute to understanding the theoretical basis of transdisciplinary home-based early intervention services have been identified. The assumptions are what guide the behaviors of the staff in this program during a home visit. Each of these assumptions contributes to the cultural environment within which parents and professionals operate during a home visit. The assumptions in no particular order of significance are as follows:

#### **assumption 1 – activities frame a home visit**

Structured activities provide the frame for the delivery of home-based services and serve as the means by which a family becomes acculturated into the frame of the home visit. The use of toys, demonstration, and observation provide the frame of reference necessary for therapists to deliver services while families learn the culture of the home visit.

#### **assumption 2 – recognition of differences among each other**

Differences exist in therapists, parents, homes, programs, treatment techniques, etc. but all within an established framework for the delivery of home-based services. The culture of the home visit is stable, as established by therapists and allows for individual differences within the culture.

#### **assumption 3 – change as a constant variable**

The delivery of services to families in early intervention is in a constant state of change requiring therapists to become *perpetual learners* (Schein, 1992). Because culture is a stabilizer, therapists meet change with resistance, resulting in change occurring very slowly.

#### **assumption 4 – professionals as leaders in the home**

Therapists have a leadership role in educating families within the learning culture of the home visit.

### **assumption 5 – family focus and professional control**

Each therapist has a personal definition for family-centeredness. Individual definitions of this term are necessary so that what a therapist does during a home visit is consistent with a personal definition.

## **discussion/implications**

### **the home visit culture**

The results of this investigation clearly indicate that there is a home visit culture. The Little Snowflakes Program provides home-based services within a pre-existing frame (the eight components of a home visit) established by therapists that is acculturated into the homes of families. It was evident through interviews, observations, and document review that therapists create a cultural environment for the delivery of early intervention services. This cultural environment is necessary for therapists to have a frame of reference from which to operate in the delivery of early intervention services. In essence, it is not the therapists that are learning a new cultural environment, but rather the parents are adapting their home to this newly introduced culture of an early intervention home visit.

The families' learning of the home visit culture occurs because parents and families are new members of the early intervention team and culture. For example, in this investigation, families reported that initially they had no preconceived expectations regarding what would happen in early intervention and actually expressed concern about the expectations that program staff members had of them. The expectations that therapists had of families were based on the therapist's frame of reference or perspective on how the home visit should be conducted.

The therapist's perspective on the delivery of early intervention services in the home was also evident in the Individual Family Service Plan (IFSP) meeting. During this meeting, therapists expect parents to come up with goals for the child and family. Parents indicated that this was an unrealistic expectation when first becoming involved in early intervention. The therapists also acknowledge that parents have difficulty with the first and/or second IFSP meeting, but once the parents get to the third one, they are very good at contributing and coming up with their own goals for the service plan. This example clearly illustrates that a period of time is required to learn the early intervention culture. It appears that professionals need time to educate and teach parents the way to participate in an early intervention program.

It is evident that the therapist's acculturation of families in this home visit culture and early intervention in general is what allows professionals to function on a daily basis. Without some frame of reference for working in the

home, therapists would have difficulty providing services in the home. The therapist's frame of reference is what provides the stability for delivering early intervention services. The cultural environment is necessary for stability and the successful delivery of early intervention services from one home to the next.

Therapists create an environment in which family acculturation into the home visit is a slow and natural series of events that occurs unintentionally. This teaching of the home visit culture to parents is not a conscious effort by therapists. Parents are taught the home visit culture through experience with the process of a home visit, not through direct instruction of the process.

The following assumptions describe what most significantly contributes to understanding a home visit in early intervention. The underlying assumptions provide support for the general notion that there is a home visit culture created and maintained by therapists that permeates all families and homes participating in the delivery of early intervention services.

### **assumption 1 – activities**

Structured activities provide the frame for the delivery of home-based services and serve as the means by which a family becomes acculturated into the frame of the home visit. The use of toys, demonstration, and observation provide the frame of reference necessary for therapists to deliver services while families learn the culture of the home visit.

As mentioned previously, the Little Snowflakes Program therapists engage in a series of events that occur on all home visits. No matter whom the therapist, the kind of family, or child's disability, all home visits move through these series of events. Therapists make individual accommodations for each step when necessary to meet the different needs and priorities of families, but only to the extent that they fit into the existing frame from which therapists work.

### **assumption 2 – differences**

Differences exist in therapists, parents, homes, programs, treatment techniques, etc. but all within an established framework for the delivery of home-based services. The culture of the home visit is stable, as established by therapists and allows for individual differences within the culture.

Differences are evident in every aspect of a home visit. Therapists do not know what to anticipate during a home visit, except that each home visit will be different. Parents and therapists discussed a multitude of differences during their interviews. Therapists frequently mentioned that every family is different. The extent to which parents and therapists talked about differences

appeared to be an illustration of their understanding of cultural diversity in the delivery of services. Therapists acknowledged cultural diversity by discussing differences in the delivery of services. After closer examination of the data, however, the differences that families and staff refer to are those involving strategies, techniques, and methods of service delivery, not cultural diversity.

Therapists acknowledge that families are all different, but they do not talk about making personal cultural adaptations to individual families. Therapists provide individualized services to families that fit into a pre-existing frame established by the therapist. The therapists' lack of cultural adaptation to individual families is supported by the various interviews. Therapists did not talk about the cultural values and beliefs of families during the investigators interviews despite attempts to broach this subject on several occasions.

In summary, the differences that staff and parents talk about and accommodate for when describing the delivery of home-based services are partially examples of their cultural sensitivity. Therapists' accommodations to differences are examples of their ability to change. Therapists refer to differences within the context of adapting to change. In broad terms, change represents a move from a child-centered delivery of services to a family-centered delivery of services. The therapists' recognition and accommodation of the various differences are the result of increased awareness provided by expert opinions of best practices.

### **assumption 3 – the issue of change**

The delivery of services to families in early intervention is in a constant state of change requiring therapists to become *perpetual learners* (Schein, 1992). Therapists, however, meet change with resistance, resulting in change occurring very slowly.

This assumption is based on the concept articulated by Schein (1992) that the constant change in the delivery of services to families means that organizations and their leaders will have to become perpetual learners. Schein continued by stating that the issue of perpetual learning in the context of cultural analysis is a form of a paradox. He explained the paradox in the following quotation:

Culture is a stabilizer, a conservative force, a way of making things predictable. Does this mean, then, that culture itself is increasingly dysfunctional, or is it possible to imagine a culture that by its very nature is learning oriented, adaptive, and innovative? Can one stabilize perpetual learning and change? What would a culture that favored learning look like? (Schein, 1992: 361)

The questions posed by Schein illustrate the paradox between the stability of a culture and the instability or constant change inherent in perpetual learning.

The questions by Schein also suggest that a culture can potentially exist where perpetual learning and change are part of the culture.

The individual staff members of the Little Snowflakes Program have established a cultural framework from which they deliver home-based services. Experts in the field of early intervention, however, are promoting change in the delivery system. As individual Little Snowflakes Program staff attempt to adapt to these changes, a conflict in the team is created. The conflict exists because *experts* are not just asking early intervention programs to change, but also individual therapists and their individual cultural framework. As the team members in the Little Snowflakes Program discussed the changes, they expressed concern in how to deal with the change. One therapist's existing frame may not require much change, while another therapist's frame may need to be altered a great deal. Each therapist acknowledges that his/her frame of reference is different from other therapists, but each therapist also struggles to develop a frame of reference in the delivery of services that is similar to other therapists and that of best practices. The desire to develop a universal frame of reference in the delivery of home-based services is a desire to create more stability in the early intervention program culture.

The members of the Little Snowflakes Program have many years of experience and, thus, a stable and mature organizational culture. They are stable because of the success they have had over the years. And so, when change is introduced, the effects of changing the culture are limited or superficial because they have such strongly held beliefs and values. Therapists are able to maintain some program stability because *what they do as a group* does not have to be a reflection of *what they do as individuals* in their respective homes providing services. It is the maturity of the program and staff that enable them to maintain stability as a group and be perpetual learners. The paradox of change and cultural stability is possible because of the maturity of the organization. The more mature the organization and professionals associated with it, the more a person can adapt to change. Change in the case of early intervention is perpetual learning.

#### **assumption 4 – leadership roles and learning**

Therapists have a leadership role in educating families within the learning culture of the home visit.

Assumption 4 is a broad overview of early intervention and its relationship to home visits and the belief that therapists must be leaders in educating families. First, parents and professionals can have different kinds of role relationships that have a direct impact on the learning that occurs during a home visit. Second, the home visit is a 'learning culture that contains a core

shared assumption that the environmental context in which the organization exists is to some degree manageable' (Schein, 1992: 364).

During the first year of involvement with early intervention, parents need a lot of support, guidance, and most of all direction. They need to be told what to do, where to look, and how to choose. They do not have the knowledge base to be the leader on the team, and professionals should not approach them in this manner during the first year. Parents acquire the knowledge base of early intervention slowly. As a result, the amount of directiveness can decrease and the support can increase as the amount of time in early intervention increases.

Therapists appear to recognize and acknowledge that initially parents' are unable to take on the role of collaborator during a home visit. When families begin receiving home-based services, the therapist takes the role of leader. Therapists guide the communicative interactions between themselves and parents in the initial stages of service delivery. It is only after an extended period of time enrolled in the program that parents have enough knowledge, which therapists have provided, to act independently and collaboratively with therapists. The achievement of a collaborative relationship between therapists and parents is the result of therapists' influence over the parents. Therapists modify parents' values and beliefs so that they are aligned with the policy advocacy or best practices model of how parents should act as a parent in early intervention. Therapists may explicitly describe parents as interactive when they participate at the 'level of their capability', but in an ideal home visit, therapists are looking for parents to be interactive and to share in all aspects of the home visit, because that would satisfy their definition of family-centeredness.

### **assumption 5 – family centeredness**

Each therapist has a personal definition for family-centeredness. Individual definitions of this term are necessary so that what a therapist does during a home visit is consistent with a personal definition.

The therapists' goal is to achieve a service delivery model that is family-centered which includes the individualistic delivery of services. Because family-centeredness is so individualistic, defining it is difficult. The lack of a definition for family-centeredness makes it difficult for therapists to develop a frame from which to work when providing services. Consequently, they attempt to provide family-centered services from the existing cultural frame they have established for themselves to function in the various/different homes. Therapists achieve family-centeredness by providing families with options that are available within the existing frame.

To most people, a home is where families live, eat, sleep, and socially

interact. To early intervention professionals, however, it is a place to conduct therapy with a child and educate parents. The goal of the professional is to provide families with knowledge about the home-based early intervention program. Families learn much of this knowledge slowly because therapists do not speak explicitly about much of what they teach families and over time parents will learn the tacit knowledge. Once they acquire this knowledge, the assumption is that parents will be active participants and leaders in providing services to their children.

## **summary**

Qualitative research methods (Lincoln and Guba, 1985; Maykut and Morehouse, 1994; Patton, 1990) can be useful for researching and examining various aspects of early intervention and other highly dynamic intervention service delivery models (Stainback and Stainback, 1984). The intent of this study was to use ethnographic methods (LeCompte and Preissle, 1993; Spradley, 1979; Spradley, 1980) to describe and examine the home visit in early intervention. The examination and description of a home visit led to discovering themes and patterns (Glaser and Strauss, 1969) in the delivery of services as well as uncovering the organizational structure (Ott, 1989; Schein, 1992) of an early intervention program.

The use of ethnographic methods to examine an early intervention program and analyse the program in terms of organizational culture provided insight into the nature of early intervention that considers the organization and its influence on the delivery of services to families. The Little Snowflakes Program's organizational culture was analysed at three levels:

1. visible artifacts and observed behaviors;
2. espoused values, rules, and behavioral norms; and
3. tacit, basic underlying assumptions. (Schein, 1992)

To understand and make sense of the artifacts, espoused values, rules, and behavioral norms adequately, the investigators uncovered the basic underlying assumptions. The investigators uncovered the basic assumptions and revealed the essence of the culture and what really happened or occurred in this culture.

The identified patterns and behaviors revealed five basic underlying assumptions that contributed to understanding the culture of Little Snowflakes Program organization and uncovered the patterns that Schein stated, 'explain the behavior and the success of the organization in overcoming its external and internal challenges' (1992: 47). A summary of the assumptions are as follows:

1. *Activities*: Structured activities provide the frame for the delivery of home-

based services that are necessary for therapists to teach families the culture of the home visit.

2. *Differences*: Differences exist in all aspects of the delivery of home-based services, but within an established framework for the delivery of services. The culture of the home visit is stable as established by therapists and allows for individual differences within the culture.
3. *Change*: The delivery of services to families in early intervention is in a constant state of change requiring therapists to become perpetual learners.
4. *Leadership Roles and Learning*: Therapists have a leadership role in educating families within the learning culture of the home visit.
5. *Family-Centeredness*: Each therapist has a personal definition of family-centeredness. Individual definitions are necessary so that what a therapist does during a home visit is consistent with a personal definition.

This investigation has only described certain elements of the culture of the Little Snowflakes Program as they pertained to the nature of a home visit. One should not assume that these elements describe the whole culture or that these same elements are operating in every part of the Little Snowflakes Program organizational structure. As Schein stated, 'the generality of the assumptions is itself something to be investigated and determined empirically' (1992: 47).

With the use of qualitative research methods and the analysis of the organizational culture operating in the Little Snowflakes Program, a deeper and more comprehensive understanding of what these professionals do in delivering early intervention services was uncovered. This knowledge and understanding will enable professionals to reflect on how they provide services to families in the home and potentially alter the practices that they use with families. Early intervention professionals should give consideration to what it means to provide services based on best practices and what it means to provide family-centered services. This study did not identify specific variables that make early intervention effective, but rather provided insight into why and how certain variables are deemed important for the delivery of early intervention services.

## **implications**

This qualitative investigation has identified three broad conclusions that have implications for the delivery of home-based transdisciplinary early intervention services. First, the organizational structure of the Little Snowflakes Program team is in a constant state of change. Early intervention teams seek cultural stability and so those who propose change must recognize and acknowledge that change will be met with varying degrees of resistance.

Second, professionals will continue to struggle to define intervention

philosophy as long as it is based on policy advocacy and best practices and not on empirical data. Clearly, the Little Snowflakes Program staff could articulate the present state of best practices in early intervention, but they had much more difficulty in providing the services that they espoused. In some instances, the staff was unaware that what they did was inconsistent with what they said they did. The therapists had the knowledge of best practices, but the implementation of these practices varied from therapist to therapist.

A broad underlying assumption of early intervention is that if early intervention professionals are educated adequately in terms of the knowledge base required as outlined in PL 99-457 and current revisions to IDEA, then therapists will provide appropriate services to families and children with disabilities. In the case of the Little Snowflakes Program, this has not occurred. New knowledge and potential change may create instability within a team.

The third conclusion that has implications for early intervention is related to difficulty in defining family-centeredness. The difficulty that professionals have in defining family-centeredness may be due to this model of service delivery not being well suited for all families. The Little Snowflakes Program staff were doing many things with families that did not fit into a traditional definition of family-centeredness, but it was what worked most effectively with those particular families. Ironically, the therapists justified what they were doing by saying it was family-centered. While it was family-centered in the sense that the therapists provided for the family what they needed, the actual model of delivery would not be considered family-centered because it was based on what the therapist felt the family needed. The therapists felt it was family-centered because the family wanted the therapist in control of service delivery.

The things that therapists do while providing services to families are dependent upon family needs and priorities. In some instances, alternative service delivery models should be considered for some families. Therapists should and do consider what parents need instead of what they want. Professionals should use their expertise and determine with parents what kinds of services are appropriate. In some instances, parents may be incapable of this decision and so it is the professional's responsibility to decide this.

The pendulum of family-centeredness appears to have swung too far in one direction. Professionals should again, acknowledge their expertise and use it in providing services to families. Professionals need not give up the knowledge that precedes changes in early intervention, but rather use the changes to supplement what they already know. In the broadest sense, family-centeredness means having cultural sensitivity to families. Professionals can be culturally sensitive to families without having to relinquish their expertise.

## future directions in research

Past research in early intervention using quantitative methods has been inadequate to answer the various questions posed by the field of early intervention. Despite the literature devoted to improving quantitative research methods in early intervention (Dunst et al., 1989; Meisels and Shonkoff, 1990; Odom and Karnes, 1988), it is likely that difficulty will persist in using quantitative research methods. These problems will persist because the traditional research methodology is ill-suited for many early intervention investigations and program evaluations. Casto stated that:

Given the tentative nature of many current (quantitative) research findings, one may anticipate that ethnographic studies will be utilized to provide more qualitative data about certain aspects of the field, and to generate important research hypotheses for further study. (1988: 59-60)

Both quantitative and qualitative research methodologies have a role to play in the continuing evolution of early intervention. This study has shown that qualitative research methods are useful in identifying what it is that professionals do when providing services to families and children with disabilities. Future research should include the analysis of the organization providing services. An analysis of the organizational structure will enable researchers to examine what they do and how they go about doing it.

The question is, 'How can therapists possibly accommodate the many different styles of communicative interaction and families in early intervention?' The answer to this question may be found in what Friend and Cook describe as a number of prerequisites for effective interactions. The first and only one that seems relevant to this discussion is *the frame of reference*.

Every individual enters each life experience with a unique perspective. Your past experiences, acquired attitudes and beliefs, personal qualities, past and present feelings, and expectations for others affect what and how you observe and perceive, and ultimately how you respond and act. What you bring to the situation, independent of the situation itself, is called your *frame of reference*. It is your predisposition to respond in some particular manner to a particular situation. (1992: 35)

The notion of therapists having a frame of reference in which they engage in communicative interactions suggests that each therapist has a style that is specific to how s/he might be successful in interactions with parents. Each of the therapists in the Little Snowflakes Program brings a slightly different frame of reference to the home visit affecting the interaction between him/her and parents. Over time, however, best practices and policy advocacy positions held by experts in the field of early intervention have modified the various therapist's frame of reference to more closely match those of the other therapists which is collaboration. If, in fact, the therapists have a frame of

reference that encourages a collaborative communicative interaction style, then any other kind of style would be breaking the frame from which therapists are operating.

Therapists have a way of communicating with parents. This communication style is their frame of reference. By establishing a frame of reference for interacting with families, the therapists are essentially creating a cultural environment in which a pattern for the delivery of home-based services is consistent from one home to the next. Their frame of reference influences the communicative interactions that occur in each of the homes in which they work. As Samantha stated, ' . . . generally families that we've worked with, over time they learn the way we do things'. Samantha's statement suggests that she has a frame of reference for interacting with families and then the families learn this frame of reference through the communicative interactions that occur.

Therapists use a frame for the delivery of home-based services so that they can maintain an internal sense of stability from one home to another. The frame consists of the parts to a home visit. The consistent patterns of activities and ways of interacting represent the frame for therapists to provide families with early intervention services.

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