



The Language We Use: Providers' Perceptions About Families

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Abstract

Implicitly-held unconscious associations and attitudes may not align with the beliefs we hold outwardly or explicitly but can affect our professional perceptions, decisions, and actions. In a phenomenological study identifying strategies used to support families in vulnerable circumstances, we conducted nine focus groups to examine how early interventionists (EIs) described families and children, the language they used, and how they used it. Thematic qualitative analysis revealed three themes about families: perceptions of parenting, perceptions of capability, and perceptions of priorities. How EIs characterized families and their interactions with families were both reflective of and counter to family-centeredness and, at times, indicative of implicit bias. This study addresses a critical gap in the field, given the lack of empirical research available about implicit bias in early childhood intervention professionals. Implications for personnel preparation and practice change are discussed to begin the necessary work of moving the field toward more culturally sustaining practices.

Keywords Part C · Early childhood intervention · Family · Vulnerability · Bias

Introduction

Since 1993, the Division of Early Childhood (DEC) has recognized family-centeredness as the recommended model of service delivery for early intervention services for young children with disabilities and developmental delays (McLean & Odom, 1993). As both a philosophy and theoretical framework (Bruder, 2000), family-centeredness includes respecting family members' rights, roles, and abilities in family-related issues. Thus, this approach treats the family

as a service unit, respecting the family's culture and valuing the family's strengths and input (Allen & Petr, 1996). Implementing family-centered practice has been shown to increase families' satisfaction with intervention services (Xu et al., 2020). However, despite the professional emphasis on family-centered practice, families have not always described their experiences with early intervention professionals (e.g., developmental specialists, related service providers, service coordinators) in ways that are theoretically coherent with family-centeredness (Lietz, 2011). Likewise, researchers

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have reported that family-centered approaches are inconsistently applied when working with families who have children with severe emotional disturbance (Kilmer et al., 2010), children with disabilities (Wright et al., 2010), children within the welfare system (Michalopoulos et al., 2012; Smith & Donovan, 2003), and children and families experiencing poverty (Corr et al., 2020) and homelessness (Kim & Kim, 2013; Powers-Costello & Swick, 2011). Additionally, when the expectations and values of EIs are seemingly incongruent with a family's culture, families are less likely to implement intervention recommendations and may discontinue services (Long et al., 2015). When EIs act in ways that are inconsistent with family-centeredness, they may be demonstrating implicit bias toward families.

Implicitly-held unconscious associations and attitudes may not align with the beliefs we hold outwardly or explicitly (Beachum & Gullo, 2019; Staats, 2014), and can affect our professional perceptions, decisions, and actions in ways that favor one group or social identity over another (Staats, 2014). Unconscious actions and implicit bias have gained greater attention in our current sociopolitical climate, and discussion of these topics has entered daily discourse. Implicit associations cause people to have attitudes about others based on age, race, gender identity, sexual orientation, dis/ability, socioeconomic status, religion, immigration status, weight, and appearance (Annamma et al., 2018; FitzGerald & Hurst, 2017; Godsil et al., 2014; Staats, 2014). These may affect a person's actions even when they are unaware or when they think they are not biased against another group. In fact, most of us are not aware of our own implicit bias nor do we question its source; it can be invisible when left unexamined or unquestioned. For example, if someone associates poverty with minimal education, questioning the family's capability to make sound decisions for the child, particularly if those decisions are in conflict with the person's beliefs reflects implicit bias. While explicit bias tends to be noticeable, implicit bias is often harder to expose and may not align with our stated beliefs (Staats, 2014).

EIs may, as many professionals do, struggle with implicit bias, often in ways that can unconsciously perpetuate racism, ableism, classism, etc. (Blanchard et al., 2021; Gilliam et al., 2016; Tomlin & Viehweg, 2016). These biases can influence a professional's perceptions and practices, especially when they may lack cultural awareness or when their life experiences vastly differ from the social identities of the children and families with whom they work. Of concern are implicit biases that negatively impact interactions with families and further disadvantage those who are experiencing vulnerability (e.g., minority ethnic populations, immigrants, those living in poverty, those that are homeless). The presence of implicit biases among healthcare professionals (FitzGerald & Hurst, 2017; Zestcott et al., 2016), early childhood educators (Davis et al., 2020; Gilliam et al., 2016; Rausch et al.,

2019) and among K-12 educators (Chin et al., 2020; Quinn, 2017; Starck et al., 2020) are documented. However, a dearth of literature exists in the fields of home visiting and early intervention.

This lack of research warrants an in-depth qualitative approach to understand the perceptions of EI providers when working with families, and whether those perceptions include the presence of implicit biases. Therefore, the overall purpose of this study was to identify the language used by providers when describing families. The following questions guided the analysis: (1) What language did EIs use to describe families with vulnerable circumstances; and (2) How did their language use reveal possible implicitly biased perceptions and views about families?

Methods

Participants

Eligible participants included all early intervention professionals (e.g., developmental specialists, related service providers, service coordinators) in one state's Part C early intervention system. Representing nearly 60% of the state's Part C workforce, the 67 participants described themselves as White ($n=66$, 98%) and predominantly female ($n=65$, 97.0%). See Table 1 for participant demographic information. Participant demographics are reflective of the field at large (Hebbeler et al., 2007) and of the families served in the northeastern state where 94.4% of the population identified as White (United States Census, 2019).

Procedures

The current study was part of a larger phenomenological project exploring the family-centered strategies EIs in one state reported using when working with families experiencing vulnerable circumstances (e.g., homelessness, poverty, disability, foster care). The larger study, approved by the Institutional Review Boards at each of the lead researcher's institutions, included nine focus groups, representing each region of the state. Focus groups ranged in size from 2 to 16 participants, with an average of seven, and all focus group participants contributed data to the current study. Focus groups were comprised of intact teams, who were familiar with one another. Facilitators established rapport with introductions, shared that we wanted open discussion, assured participants that their voice and experiences were valued, and reminded them that their responses would be anonymized before information was shared. Participants' supervisors were not present, and participants were assured that information would not be shared with their supervisor.

Table 1 Focus group participants

Participants' characteristics (N=67)	n (%)
Gender	
Male	2 (3.0)
Female	65 (97.0)
Current position in early intervention system	
Service coordinator	15 (22.3)
Early childhood special educator	14 (20.9)
Occupational therapist	10 (14.9)
Speech language pathologist	9 (13.4)
Special educator, other than ECSE	9 (13.4)
Physical therapist	4 (6.0)
Educational technician	2 (3.0)
Teacher of deaf/hard of hearing	3 (4.5)
Licensed clinical social worker	1 (1.5)
Educational level attained	
Associates degree	2 (3.0)
Bachelor's degree	25 (37.3)
Master's degree	38 (56.7)
Doctoral degree	1 (1.5)
No response	1 (1.5)
Years worked in profession for which prepared	
Less than 1 year	3 (4.5)
1–3 years	6 (8.9)
4–6 years	4 (6.0)
7–12 years	14 (20.9)
13–18 years	13 (19.4)
19–24 years	13 (19.4)
25–30 years	8 (11.9)
30+ years	6 (9.0)
Years worked in early intervention profession	
Less than 1 year	8 (11.9)
1–3 years	14 (20.9)
4–6 years	10 (14.9)
7–12 years	13 (19.4)
13–18 years	5 (7.5)
19–24 years	7 (10.4)
25–30 years	6 (9.0)
30+ years	4 (6.0)

Lead researchers facilitated each of the focus groups using a semi-structured protocol. Participants responded to the primary question, “What family-centered strategies do you use to support families experiencing vulnerability?”. Facilitators used non-judgmental prompts and expanded on participants' responses as needed to learn more about strategies used for specific vulnerabilities, as well as EI processes such as identifying a primary service provider or determining when to call child protective services.

Analysis

The research team conducted a thematic qualitative analysis (Miles et al., 2014) with a multi-step, collaborative analysis process (Cornish et al., 2013). Using Dedoose software for data management, researchers identified four transcripts for initial analysis, representative of each facilitator and different areas of the state (e.g., rural, urban, north, south). The lead researchers and a minimum of two additional team members independently read each of the four transcripts, identified segments for units of analysis, determined codes for each segment, then met to discuss the segments and reach agreement about the code for each segment. After the four transcripts were coded in this manner, the research team discussed the identified themes and adopted a four-component coding scheme, indicating (1) the focus of the segment as the family, the professional, or the intersection between the family and professional systems, (2) what was being influenced (i.e., practice, priorities), (3) whether the segment described a strength or area of concern, and (4) a descriptive code (Saldana, 2016) that provided specific context for the segment, such as “competing priorities” or “building rapport.” Using this coding scheme and consensus process, the first four transcripts were reanalyzed, along with the remaining five transcripts, for a total of 1328 segments.

The codes were grouped into 20 overarching categories through pattern coding (Saldana, 2016) and segments were assigned to one of the 20 categories. Using collaborative analysis (Cornish et al., 2013) across focus groups, a minimum of three team members individually coded transcripts and then small groups met to discuss segments for assigned categories until 100% agreement was reached. The lead researchers met and reviewed the results of the collaborative analysis, consolidated several of the categories, and defined the final seven themes.

This current study explored the theme of *perceptions*, defined by the research team as “how EI's perceptions of families are revealed through ways in which providers talk about and reference families with whom they work, either in positive, neutral, or negative ways.” How participants described families seemed, at times, at odds with the key elements of family-centeredness and we felt it was important to analyze this phenomenon more closely. The team reviewed the 156 segments in the *perceptions* theme, identified three sub-themes (perceptions of parenting, perceptions of capability, and perceptions of priorities), and assigned each segment to one of the sub-themes based on the context and content of the segment.

Quality Indicators

Trustworthiness and credibility of data were ensured through utilization of several strategies (Brantlinger et al., 2005).

Collaborative work, intercoder agreement, and investigator triangulation, through the use of two facilitators and a larger analysis team, ensured that multiple perspectives were included throughout the study design, data collection, and analysis. The team also engaged in reflexivity conversations during the data collection and analysis process, and used memoing to capture thoughts and feelings during the study. Data were collected from a large sample and sufficient quotations are presented to provide evidence of recurrent findings.

Research Team

The research team was comprised of eight women and one man, eight of whom identified as White and one who identified as Black. The lead researchers were two PhD faculty members with experience working in and researching early intervention. The remainder of the team consisted of one PhD faculty member, two doctoral students, three master's students, and one undergraduate student, all with interest in the topic and experience working with populations from vulnerable environments. The team included early childhood special educators, early childhood educators, and social workers.

Reflexive Statement

As early interventionists and researchers, we hold fundamental beliefs as to the nature of the work with families. We believe that all families should have equitable access to high quality, supportive services that meet the individual needs of each child and family. We believe that these services should be provided in a way that supports the autonomy and individual priorities of each family. We believe that all families, including those experiencing vulnerable circumstances, are entitled to support free of bias and judgment, and that honors and respects families' priorities. We believe that all early interventionists are entitled to a working environment that provides sufficient support (financial, emotional, mentoring, time, etc.) in order to do their daily work.

During the data collection and analysis phases of this study, each research team member reflected on their own beliefs and how these beliefs impacted the way they heard and understood the participants' experiences. When personal beliefs and values did not align with the data presented, team members held conversations to reflect and set aside their own beliefs to hear the lived experiences of the participants. As a multidisciplinary team, we pushed each other to recognize our own biases, strengths, and beliefs, and allowed for opportunities to learn from one another. We complemented each other's perspectives, held each other accountable, and

pushed each other to see and interpret the words through a different disciplinary and professional lens.

Results

We present researcher-selected segments from the analysis of the "perceptions" theme that are representative of the nine focus groups. The quotes shared have been de-identified and we use types of trees to represent each group, with letters indicating the speaker when multiple participants are included in the same quoted segment (i.e., Maple A and Maple B). Based on analysis of the data, three themes about families emerged: (1) perceptions of parenting, (2) perceptions of capability, and (3) perceptions of priorities.

Perceptions of Parenting

A key element of family-centeredness is to recognize and build upon family strengths. Many participants acknowledged that parenting a young child with a disability while also experiencing other vulnerabilities can be difficult, and that parents were doing their best. For example, one participant stated "Sometimes with families if they're really in a vulnerable place, I'm just happy they let me in the door and they scheduled the next visit and kept it. And that's as good as it gets and I'm OK with that" (Pine). However, other participants contradicted such empathetic statements with those that interjected their own ideas about 'right' parenting and what they observed in families, for example, "because sometimes we go into families' homes we're only there for an hour and we are exhausted, we couldn't imagine actually being in that house 24/7, that would send any kid over the edge" (Ash). Some judgment about parenting and family life was overt, such as, "yeah, well, she is not very good and her pierced nose" (Palm) and "I think a good portion of our parents had less than ideal upbringings" (Willow). Additional statements connected family composition with focus of EI session, "very few of my families have, you know, two stable parents in the home that I can just walk in and we know we can talk about everything else for two or three minutes and then get into the nitty gritty" (Oak). Other participants questioned parenting choices regarding feeding practices, "like if they do breakfast and just do snacks, and the rest of the day there are no meals, is that okay?" (Willow). One participant also shared her apprehension about parenting ability for parents with mental health concerns, "and if they don't address their mental health needs they certainly can't raise typically developing children; it's like this horrible circle that you can't get out of, like on a loop" (Ash).

When discussing families living in poverty, several participants seemed to equate poverty with chaos, making

statements such as “people survive in levels of chaos that I definitely could not” (Elm), and:

I think when the families are in poverty, or sometimes they're just chaotic families that don't know how to organize anything, they collect toys by the side of the road or at thrift shops and they're not developmentally appropriate and they're not complete or purposeful, it's just a bunch of plastic pieces (Willow).

One participant theorized that this perceived chaos could be indicative of abuse or neglect:

This has never been clear to me either, there never has been an incident, it's just pure chaos every week and you're just wondering how they're surviving through the week and you know there's no money for food there's no, there could be emotional abuse, there could be domestic abuse, but I have no proof (Elm).

Another participant further expressed frustration with families and their lifestyle:

What's been a big thing that I see since I've been in this is going into homes where that a good percentage of these people are very unorganized - they cannot organize their thoughts, or their life, or their house, anything. And that's where I have trouble with it all being family directed because I think in many cases they have to change if they want to get out of some of the situations they're in, they're going to have to be willing to change and that doesn't come (Willow).

In additional statements about families living in poverty, multiple participants suggested that parents did not know how to play or interact ‘properly’ with their children, for example, “that's exactly what I'm saying, for our families in poverty, some guidance on how to play” (Willow). This was echoed by another participant, who then also looked for validation from peers, “I think the big thing is parents don't really get on the floor and play or at a table or they don't have a table, am I right?” (Willow). In contrast, some participants were able to empathize and articulate the instability and changing nature of the difficulties families may face:

I think it's really a difficult thing keeping in mind that definition of a crisis as anything a family doesn't see coming and maybe having an unexpected bill and now they're back to nothing and it's a crisis more often (Ash).

Perceptions of Capability

While the stated purpose of early intervention is to build a family-professional relationship with families to support their child with a disability or developmental delay

(Workgroup on Principles and Practices in Natural Environments, 2008), many participants mentioned that they did not feel that the families on their caseloads were capable. The following is an example of a comment about perceived capability for a child with specific medical needs:

Or that family who does love their child who has a very high, high medical need child and they don't understand the importance of medical follow ups and going to doctor's appointments and doing them nor can they get there, are they neglecting their child? No. They love their child, but they don't have the capacity and the group hug around them to help them. It does take a village for some of these kids (Willow).

However, most of the comments referred to the participants' judgements of parental capability for supporting a child with a disability. For example, one participant stated, “She didn't have the skills, though, to follow through with any of it. It was too overwhelming” (Elm). Another participant in the Elm group stated, “yeah, you just need to accept that this is how people function, and they can't get out of the pattern that they're in because they don't have the skills.” When discussing specific strategies to support the children, participants also shared comments such as, “right but our families don't know how to do that” (Willow). Discussion that centered around parents with disabilities also included statements regarding perceived capability:

Parents who have cognitive disabilities, very, very challenging because trying to figure out how to help them read their child's cues, trying to help them understand how they support learning and development, motivation. Because I find often times they are less motivated. Motivation is also part of our cognitive development as much as it is our emotional development. They can't see the goal that will come of their efforts. Um, they, it's harder for them to change their own behavioral patterns (Oak).

When talking about how they defined vulnerable circumstances, participants frequently mentioned parents with mental health needs. This construct of mental health as a vulnerability led to participants' sharing a sense of unease or discomfort in working with certain families. For example, when asked, “What do you do differently with parents who have mental health concerns?”, some responses were sarcastic, such as, “don't be the only person in the room who's not, you know, unbalanced, who's not crazy [laughter]” (Pine).

When asking the same question about supporting parents with mental health needs in the Willow group, a participant responded, “park facing out.” The group laughed, and a second participant added “clear a path to the door.” In a follow-up question, the facilitator asked about building trust

or rapport, and participants replied in a cascade with several deficit-based statements,

(Willow B) “it may take longer,”

(Willow A) “or it may take no time at all because they’re so needy,”

(Willow C) “those are the scary ones,” and.

(Willow E) “that’s a good sign of mental illness”.

As the participants each added to this conversation, they laughed as they encouraged one another; however no one presented positive information about working with parents with mental health concerns or responded to the question of how they build trust or rapport. Instead, more cascading statements and negative statements ensued,

(Willow D) “I think sometimes it’s a dilemma ... something that I feel that I have to say as a professional but they’re not gonna want to hear”

(Willow F) “that can be a challenge”

(Willow D) “and the parents can really get upset”

(Willow E) “that’s when they usually close down.”

In the Ash group, a participant echoed this sense of vulnerability in supporting parents with mental health needs:

Yeah that’s my biggest challenge... I feel most vulnerable going into homes with adults that have mental health concerns and it depends, there’s been times that I didn’t feel safe because I felt like the adult or one of the adults in the home was unpredictable and then I’ve had other families with mental health concerns that I could identify with so I felt more compassion for them.

Participants also expressed frustration with using the coaching model with families in vulnerable circumstances. For example, a participant stated “we’ve had this ongoing thing where coaching doesn’t work for every family; the ones out in the trenches feel that and some families we say aren’t coachable” (Ash). In this instance coachable seemed to equate to capable. Some participants expressed the idea that even with support, families are not capable, “it is not that I don’t believe in what we do because I do but, I mean, 25% or less of our families are even success stories because of all the mental health, the drugs, the poverty” (Maple).

Perceptions of Priorities

Participants frequently alluded to theoretical frameworks to demonstrate that they understood that families in vulnerable circumstances had many issues other than early intervention services to consider, and that families are often navigating multiple service delivery systems. As a tenet of family-centeredness, parents make choices regarding how they spend their time and resources, and sometimes EI services may not be at the top of the priority

list. Several participants discussed the difficulty that can arise for families as well as the multiple needs of families, for example, “she was raising two babies that had special needs and for her to even phone call shelters, that was a really big problem for her” (Elm). We recognize the provider’s empathy in this statement and others. Another participant discussed a strategy to support a family in similar circumstances,

Having a gentle conversation about are they able and willing to access resources. Do they know where they are? Can they get to them? Sometimes that’s as far as it goes because you know some families are just so proud or unable to get to the point where they can [ask] (Pine)

Additionally, some empathetic statements were made that directly referred to basic needs within family systems:

I always think of Maslow’s hierarchy of needs and how if housing is a daily problem, the food is a daily problem, and relationships are a daily problem. ... You know it’s really hard to get to a point where you work on a specific problem for your child. (Pine)

Several participants did recognize the importance of family priorities unrelated to their early intervention services. During a discussion regarding strategies to support families living in poverty, one EI stated, “being understanding that sometimes it can be [that] they cancel; it seems trivial but if they get a ride somewhere [then] they need to get that when they can,” followed by another participant elaborating with, “I’ve been more understanding of that because they can’t help their child if that need isn’t met so that day the food bank was open and they needed to get there that’s priority over me” (Ash).

However, empathetic statements often included or were followed by statements of frustration that a parent was not following through with a strategy or topic previously discussed. For example, one participant appeared to express frustration at a parent’s response to their suggestion related to behavior management. After sharing a story about a specific family, the participant went on to say:

You have to kind of ask, is this a priority for you? If this is not a priority for you... but they’ll say this isn’t the strategy that we would use or can use. This isn’t how we’re going to do it. So then I just have to move on to the next thing because I can’t think of anything that’s going to help you stop this behavior. But they just can’t or won’t do it cause it’s not built in to how they think about how to help the kids. (Pine)

Two participants had additional comments related to how families choose to prioritize how they spend money, for example:

(Maple A) I feel like as far as the poverty [for] a lot of families it's priorities. They are going to have their money for their cigarettes, their weed, they are going to have alcohol, they are going to have a four-wheeler, but they are not going to buy a vehicle for their family.
 (Maple B) They just can't plan.

Statements of this type were often made when discussing family choices overall and not in relation to how the family engaged with early intervention. Participants also discussed the complex nature of the challenges that families face, but with frustration, such as “then eventually if you are in the home long enough you can sometimes get to those issues that actually have to do with the kids” (Maple). While family-centered practices rely on a parent stating their goals and the EI supporting those goals, participants made comments related to judging how they felt a parent should engage with early intervention or stated their dissatisfaction with families' choices. “I feel like we can usually tell pretty quickly how involved the parent is or is not” (Linden). Participants also discussed their priorities for families, and expressed frustration when those priorities did not align with the families' actions:

(Pine A) “and I was thinking I have to wrangle this person in,”

(Pine B) “and I think it's just sometimes, sometimes it is a constant wrangling,”

(Pine C) “and sometimes you can't wrangle”.

Discussion

During these focus groups, participants were asked to share openly and honestly about their experiences when working with families in vulnerable circumstances. As researchers, we intended to set up a safe space where participants felt comfortable sharing their experiences, thoughts, and feelings. We feel reasonably assured this goal was met because of the participants' candor and the ease with which they shared their thoughts. Across all focus groups, participants described family strengths, provided images of resilience, and acknowledged the complex lives of families beyond participating in early intervention services. As we listened to the language that occurred, we were mindful that the EIs participating in the study did not set out to be malicious or to intentionally speak ill of families. However, as researchers, we could not ignore the EIs' deficit-based descriptions about families.

Why Did These Perceptions Emerge?

In this study, we asked participants to reflect on experiences and strategies used when supporting families in vulnerable

circumstances. We found language used in focus group settings both reflective of and counter to the prevailing discourse of family-centeredness. We noted some of the ways in which EIs' statements and interactions may be read as judgmental, including beliefs about what, for some participants, constitutes “normal” or ideal family composition (e.g., two-parent families). These types of beliefs can be said to reflect dominant cultural norms of Western societies, which tend to favor nuclear families with two parents. This is similar to findings by Fleming et al. (2011) in which EIs indicated that it was easier to work with “good” families and more difficult to work with families that are less similar to themselves in income or education.

The perceptions of families that emerged may also be a reflection of participants' own upbringings and experiences and rooted in cultural understandings (Derman-Sparks & Edwards, 2010; Lynch & Hanson, 2011). Questioning whether dietary choices and meal timings are indicative of neglect may reflect a difference in lived experiences and show a lack of multicultural understanding of some families' practices around eating and nutrition. Given what has historically been and is still a predominantly monocultural (i.e., white, female) field (Hebbeler et al., 2007), it is not surprising that these would both reflect dominant narratives and be similarly or commonly experienced within the focus groups. It is puzzling that these underlying beliefs emerged and were vocalized despite knowing they conflicted with the professional discourse emphasizing family-centered (i.e., relational and capacity-building) and culturally relevant and responsive practices (Bradshaw, 2013; Lynch & Hanson, 2011). Based on IDEA, eligibility criteria for EI is built on a deficit-based, medical model where children are eligible for EI if they meet predetermined criteria demonstrating that they do not have typical development. This deficit-based approach to eligibility can set up the relationship between the family and the professional as one that is based on a power and “need” relationship (Blanchard et al., 2021). This can lead to EI as having a stigmatizing rather than supportive nature for families. EIs must be intentional to employ an equity-focused, non-hierarchical, and relational approach, and not allow their practice and discourse be influenced by this power and stigmatizing structure. While the philosophy of EI is to support the family in achieving their goals for their child, and the EI assists with strategies to achieve those goals, beginning the relationship from a deficit lens can make it difficult to switch to a family-centered balance of competence and trust.

In addition to what participants said, how they said it was also significant. We observed a cascade or snowball effect around many of the responses in which participants were quick to agree with each other, finished another participant's statement, or elaborated with additional details through sharing their own anecdotes or by using humor or sarcasm. In many instances this was accompanied by

nonverbal body language such as nods, head shaking, or laughter. In short, they lost their professional register. There also was little pushback from other participants within a focus group when problematic statements were shared, with additional participants validating statements with “yeah exactly” and “yeah” rather than questioning the assumptions that were made. While seemingly innocuous or harmless in isolation, the pattern of deficit-based language used to describe families within and across focus groups is of concern. Participants were fairly quick to agree and elaborate, relating to the ideas and opinions expressed. We wondered if this was an indicator that they shared common experiences, possibly in their own lived experiences or in their professional experiences working with diverse and/or populations from vulnerable environments.

These verbal and nonverbal language patterns were observed when EIs were asked what they do differently with parents who have mental health concerns. Of the several responses given, all were sarcastic and stereotypically represented individuals with mental health needs as “scary”, “crazy”, “needy”, or needing to be fled from. These were not isolated responses, and were found across multiple groups. Responses like these could possibly indicate implicit ableist views and a similar lack of strengths-based thinking around individuals with mental health needs (Young et al., 2019).

Although we agree with the need for personal and professional accountability when recognizing and addressing implicit bias, we also believe not all of the root causes are located within the individual. We speculate that many of these reactions, the cascading deficit-based responses, loss of professional register, and lack of pushback, may also have their roots in compassion fatigue. Compassion fatigue is the gradual build-up of intense emotional and physical exhaustion that those in the helping professions have been shown to develop over the course of their careers (Mathieu, 2012). Left unsupported in the workplace, it can cause chronic fatigue, irritability, loss of empathy, bitterness at work and at home, disrespectful stance toward clients, and change in career (Mathieu, 2012; Potter et al., 2010). When exposed to high levels of or prolonged stress, professionals who might consistently act without bias otherwise may revert back to stereotypical, inequitable, exclusive, and unjust thinking, almost as if running on “autopilot” (Beachum & Gullo, 2019). We suggest that chronic fatigue without support may be playing a role in magnifying implicit biases, causing participants in our study to step outside professional discourse, and obscuring the need to interrogate their own problematic use of language and what it represents. In other words, the fatigue removed a failsafe of sorts and served as a catalyst for existing, perhaps deeply hidden, biases to reveal themselves.

Why are these perceptions an equity issue?

Engaging in discourse that adversely describes families who may not have the same background as the EI can lead to troubling assumptions and reinforce deficit-based attitudes, particularly regarding historically underserved populations (Artiles et al., 2010). The absence of discourse may signal implicit bias and discomfort with certain topics, including socioeconomic status, race, disability, and cultural practices. Specifically, the absence of discourse around race could be an indicator of color-evasiveness, or avoiding substantive discussion or acknowledgement of race, particularly if participants were using other “-isms” as proxy (Annamma et al., 2017). In the state described in this study, the most current racial demographics of children receiving Part C services included approximately 86% children who were white, while 14% of children were considered to be non-white or multiple races (U.S. Department of Education, 2020). While there were no participant statements that directly addressed a child’s or family’s race, nor read as overtly racist, there may be elements of racism present that the research team did not understand due to their own positionality.

Deficit-based attitudes and adverse statements regarding families also may influence service delivery, particularly when participants do not share similar identities to the families they support. Implicit bias can reinforce explicit bias such as resource discrimination and undermining families’ ability to become independent (Amodio & Devine, 2006; Dovidio et al., 1997; Park & Judd, 2005). Families can also internalize oppressive thoughts and behaviors toward them, impacting their capacity to believe in changing behaviors and continuing cycles of oppression. This conflicts with a key principle of early intervention that states, “All families, with the necessary supports and resources, can enhance their children’s learning and development” (Workgroup on Principles and Practices in Natural Environments, 2008, p. 2). Given this, recognizing and addressing implicit bias is essential to our work in the field and is one of the priority issues for DEC (2020b).

Implications for Personnel Preparation

The tenets of family-centered practice emphasize that EIs must value the family’s input, preferences, and strengths, *and* respect the family’s culture (Bruder, 2000). Preservice students often lack the knowledge and skills needed to interact with families in culturally responsive ways, focusing on “diverse” families only in terms of ethnic and linguistic diversity (Bruder, 2004). We advocate for preparation programs to expand the lens of diversity and focus on families of many different backgrounds by providing opportunities for students to work with and learn from families who do not have the same backgrounds as them (Meek et al., 2020).

Learning experiences can build upon the intersection of family-centered practices and culturally responsive actions. One such opportunity is experience-based learning, in which preservice students are provided real-world experiences to acquire critical cross-disciplinary competencies (Bruder et al., 2019) throughout their preparation program. Other examples of experience-based learning include partnering with families from the start of the preparation program, shadowing families in their daily routines, and participation in immersion-based coursework. Another approach might be the use of role plays helping students react positively to a variety of family situations paired with constructive feedback. Ideally all of these activities are co-created with family members who may have experienced the marginalizing effects of implicit bias.

Applying a critical lens inward can inform and strengthen family-centered practice. With support from faculty, supervisors, and mentors, students can be helped to critically examine their beliefs and attitudes toward working with families, their own viewpoints and the viewpoints of others, and their professional dispositions. Bradshaw (2013) encourages providers to increase cultural competence and reflection by specifically examining their own cultures and acquiring greater knowledge of family cultures. “Many providers assume their beliefs and practices are correct and applicable to all children” (Bradshaw, 2013, p.6), while in contrast, culturally responsive providers recognize that their professional perceptions and practices are shaped by their own cultural experiences (Bradshaw, 2013; Durand, 2010; Rogoff, 2003). Pre-service EIs can learn to engage in these reflective practices prior to their work in the field. Intentional recruitment of students from a variety of backgrounds into EI programs can also help enrich classroom discussions around cultural experiences, specifically centered around families whose cultures have been historically marginalized or ignored. All of these experiences have potential to move the field towards being more diverse and inclusive of family structure, ethnic, income, and ability diversity.

Implications for Practice Change

A much-needed shift to more culturally responsive practices is emphasized among many professional organizations for practicing EIs. The Division for Early Childhood (DEC) priority issues (DEC, 2020b), the DEC Code of Ethics (2009), and other statements from the organization have addressed the critical need to address bias, stating: “We all have a role and responsibility to become consciously aware, change behavior and ultimately eliminate the impact of these biases by supporting each other through, and holding each other accountable to, our unconscious actions” (DEC, 2020a).

The way practicing EIs talk about their roles and beliefs about children and families, how they write developmental

plans and goals, and the ways they act toward children and families are all discursive practices. That is, they reflect the discourses of educational institutions they attended (e.g., their professional preparation) and of current workplace culture (e.g., on the job training, expectations, and professional development). Therefore, EIs must take a critical, reflexive stance toward deficit perspectives they encounter in workplace discourse, be skeptical, and work toward change, especially where they serve as co-constructors of that discourse. EIs can also critically “self-check” the language they use that may perpetuate deficit-based discourse by reflecting on the language they use to describe families. In turn, this can lead toward more culturally respectful language and attitudes.

EIs must seek to understand parents’ values and priorities to provide strategies that align with parent priorities, even when in conflict with the EIs personal choices. Keilty frames this idea as “support[ing] the family in parenting in the way they want to parent” (2017, p. 28), describing an important principle of family-professional partnership. Such practices might involve asking parents more frequently about their priorities and with what topics they would like support. Parents are more likely to share their true priorities and goals, rather than saying what they believe the EI wants to hear, when care is taken to avoid perceptions of judgment. Shifting the social power to the family and providing information in a non-biased way affords the family greater agency in informed decision-making and co-construction of goals (Keilty, 2017).

EIs in the field need time and space to discuss and debrief about culturally responsive practices, especially when their experiences may be novel or challenging. After each focus group concluded, many participants indicated they lack opportunities to talk deeply with teams or supervisors about their work, as early intervention team meetings are typically focused on specific Individualized Family Service Plan (IFSP) concerns using the state’s early intervention model. Dedicated time is needed for team discussions about critical issues, such as experiences and concerns when supporting families. By cultivating a critically reflective space for practitioners, thinking can shift from “now it’s time to talk about diversity” to “this is our lens and part of our practice”. Likewise, EIs might experience less compassion fatigue if they had time and space to talk through and process stressful and difficult situations. Incorporating strategies such as reflective supervision or consultation (Gilkerson & Imberger, 2016; Tomlin & Viehweg, 2016; Watson & Gatti, 2012) or Facilitating Attuned Interactions (Cosgrove et al., 2019), similar to what is utilized in infant mental health work and other home visiting programs, may be beneficial to support EIs. These reflective strategies would allow EIs to understand their own positionality and how their experiences and beliefs may be impacting their interactions with

families, particularly as they work in situations that they may find difficult or novel. These strategies may also help to mitigate compassion fatigue and promote a collaborative working environment.

Limitations

This study contributes to the literature by highlighting how EIs describe families and their interactions with families in ways that may suggest implicit bias. We recognize that there are limitations to this study. Although the participant sample widely represented the early childhood workforce in the state Part C system, the participants' views and opinions are those of early intervention professionals residing in a single state. Because Part C systems vary in personnel and structure by state, the extent to which the findings can be generalized is limited. Additionally, the majority of participants were white, female, and highly educated. While these demographics are reflective of the field at large (Hebbeler et al., 2007), this study does not provide insight on perceptions of families from providers who do not share the same identity or region. Additionally, while we hoped to establish a safe space for participants to share their true thoughts, there was potential for social desirability because focus groups were with co-workers rather than with individuals that they did not know. The majority of the research team were also white and female, with advanced degrees. During the analysis process, we had to wrestle with what we heard and recognize our own biases and backgrounds. The fact that we were surprised by some of the perceptions expressed by the participants could be part of our privilege that we have to acknowledge and wrestle with—how are we part of the systemic bias that occurs within the field?

As critically conscious researchers, we were disturbed by the lack of pushback from participants when deficit language was used. Although we had made a commitment to remain neutral and not interfere in the research process or to influence participants' responses in any way, we also questioned: *when does neutral mean harm?* In allowing those interactions to take place, in what ways were we contributing to the reproduction and reification of harmful norms and stereotypes? We continue to reflect on the role of the researcher in redirecting deficit language as part of our professional obligation toward anti-bias practices.

Future Directions

We recognize that there is a need for further research examining the language used by EIs. Future studies could apply critical discourse analysis when examining how professionals in helping professions describe their work, or large

scale studies that employ mixed methods and/or quantitative methods could further investigate this issue. Additionally, research is needed to determine whether this is a widely-occurring phenomenon, and to examine the types of interventions or pre-service strategies that are most effective in mitigating negative discourses. If interactions with children and families are to become truly anti-bias and equitable, then we must examine how EIs participate in discipline-specific discourse and whether those narratives are harmful or supportive. Future research should extend beyond culturally relevant and responsive considerations to help identify evolving culturally sustaining practices that can be implemented within home visits (Alim & Paris, 2017). What makes the intersection between family-centered practice and culturally sustaining pedagogy potentially hopeful are the areas of overlap that advance asset-based, anti-biased, socially just practices. These practices cannot be advanced in Early Intervention without examining professional discourse and implicit bias.

Declarations

Conflict of interest There are no financial disclosures.

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