Barriers and Facilitators to Cultural Competence in Early Hearing Loss Services: A Qualitative Analysis

Obstacles et facilitateurs à la compétence culturelle dans les services précoces offerts aux enfants ayant un trouble auditif : une analyse qualitative

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KEYWORDS

CULTURAL COMPETENCE

EARLY HEARING DETECTION AND INTERVENTION

QUALITATIVE INQUIRY

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Abstract

Increasing diversity in Canada has direct implications for early hearing detection and intervention. Efforts to improve cultural competence in early hearing detection and intervention should be informed by evidence on how cultural differences can affect services; however, there is limited empirical research in this area. The objective of this study, therefore, was to explore the experiences of practitioners in pediatric hearing loss services in providing care to families of minority culture backgrounds. To address this objective, a qualitative research design with semi-structured interviews was used to gain insight into practitioner perceptions of barriers and facilitators to the provision of culturally competent care. A total of 19 practitioners participated in this study. Three themes emerged from the interview data: characteristics of a culturally competent practitioner, barriers to service provision, and facilitators to service provision. Practitioners encountered barriers throughout the process of service delivery with language barriers affecting every stage. Practitioners also reported using various facilitators, such as communication strategies, to mitigate many of these challenges. This study contributes insight to a field that has received little attention in early hearing detection and intervention.

Abrégé

L'accroissement de la diversité au Canada a des répercussions directes sur les services de détection et d'intervention précoces des troubles auditifs. Les efforts visant à améliorer la compétence culturelle des praticiens fournissant des services de dépistage et d'intervention précoces des troubles auditifs devraient être guidés par des données probantes qui indiquent comment les différences culturelles peuvent affecter les services offerts. Or, les recherches empiriques dans ce domaine sont limitées. L'objectif de cette étude était donc d'explorer l'expérience de praticiens travaillant auprès d'une clientèle pédiatrique ayant un trouble auditif et offrant des soins à des familles issues des cultures minoritaires. Un devis de recherche qualitatif et utilisant des entrevues semi-structurées a été sélectionné pour mieux comprendre les perceptions des praticiens quant aux obstacles et aux facilitateurs à la prestation de soins culturellement adaptés. Au total, 19 praticiens ont participé à cette étude. Trois thèmes sont ressortis des données des entrevues : les caractéristiques d'un praticien culturellement compétent, les obstacles à la prestation de services et les facilitateurs à la prestation de services. Les praticiens ont rencontré des obstacles tout au long du processus de prestation de services, la barrière linguistique affectant chaque étape. Les praticiens ont également indiqué avoir eu recours à divers facilitateurs, tels que des stratégies de communication, pour pallier à plusieurs de ces difficultés. Cette étude contribue aux connaissances d'un domaine des services de détection et d'intervention précoces des troubles auditifs qui a reçu peu d'attention.

Increasing diversity in Canada has direct implications for pediatric hearing loss services. The latest census projects that by 2036 almost half of Canada's population will be immigrants or children of immigrants (Statistics Canada, 2017). In such a multicultural population, cultural differences can create challenges for health care systems, which are typically tailored to meet the needs of the majority population. Culture can influence values, beliefs, and health-related practices, and can impact all aspects of health care service delivery (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

Consideration of culture is of importance in pediatric hearing loss services as culture can influence how families respond to services at various stages in the process, from identification to intervention. For example, hearing loss is stigmatized in some cultures and can be seen as the fault of the parents and a source of shame (Jackson, Traub, & Turnbull, 2008). Having a child with permanent hearing loss can even result in family relationships being severed (Jackson et al., 2008; Yucel, Derim, & Celik, 2008). In some situations, parents may refuse interventions to conceal their child's hearing loss. In addition, concerns have been raised about the additional stress multicultural families may experience when their cultural norms differ from those of practitioners and the interventions they use (Phillips, Worley, & Rhoades, 2010). Thus, practitioners who provide early hearing detection and intervention (EHDI) services should be aware of cultural differences and practice culturally competent care.

In their literature review, Betancourt et al. (2003) defined cultural competence in health care as

> ...understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (p. 293)

Efforts to improve cultural competence in EHDI programs should be informed by evidence on how cultural differences can impact services; however, our scoping review identified limited empirical research in this area (Grandpierre et al., 2018). In addition, available literature is dated, anecdotal, and possibly reflects stereotypes (Ball & Lewis, 2014; Eriks-Brophy, 2014). Although there is extensive research on cultural competence in other rehabilitation fields which detail the perspectives of practitioners and patients of minority culture backgrounds (i.e., Al Busaidy & Borthwick, 2012; Centeno, 2009; Dogan, Tschudin, Hot, & Özkan, 2009; Dressler & Pils, 2009; Drolet et al., 2014; King, Desmarais, Lindsay, Piérart, & Tétreault, 2015; Lindsay, King, Klassen, Esses, & Stachel, 2012; Yang, Shek, Tsunaka, & Lim, 2006), one source of untapped information is the viewpoint of practitioners in pediatric hearing loss with respect to their experiences providing services to cultural minorities. Therefore, the goal of this study is to contribute empirical data to address this research gap.

Context

Most provinces in Canada have implemented Newborn Hearing Screening services. In Ontario, the main context of the study, each infant is screened at birth for hearing loss. If a referral is required, infants will then receive diagnostic assessments. The confirmation of a hearing loss diagnosis will lead to intervention discussions with audiologists regarding technological options as well as language therapy options. Language therapy options typically include spoken language approaches (oral), visual approaches (sign), and total communication approaches (oral + sign). In the context of this study, auditory verbal therapists who participated reported to prescribe to spoken language approaches. All services are publicly funded, excluding the purchase of hearing technology.

Objectives

As part of a larger program of work that investigates cultural influences on EHDI programs from the perspectives of both practitioners and families of minority culture backgrounds, the objective of this study was to explore the experiences of practitioners in the provision of services to families of minority culture backgrounds.

Method

Participants

Practitioners in the field of childhood hearing loss (e.g., audiologists, listening and spoken language therapists, itinerant teachers of the deaf and hard of hearing, speech-language pathologists) were eligible to participate if they provided (a) early hearing detection and intervention services to children with permanent hearing loss and (b) services to families of minority culture backgrounds (e.g., not the dominant culture in Canada: English and/or French Canadian).

Health care practitioners offering services to children with permanent hearing loss were recruited from the Children's Hospital of Eastern Ontario (CHEO), a tertiary care hospital located in Ottawa. The Professional Practice Leader of Audiology in CHEO's Audiology Clinic was approached regarding recruiting her team for the study.

Upon approval, all team members were approached for recruitment. Recruitment also occurred at a local conference in Ottawa (i.e., the Dual-Language Learning conference held in 2017), which was open to practitioners in the fields of audiology and speech language pathology. During scheduled breaks, practitioners were approached about their interest in participating.

Recruitment and data collection was informed by Thorne, Kirkham, and MacDonald-Emes's (1997) Interpretive Description method. Interpretive Description draws strongly on features of grounded theory, ethnography, and naturalistic inquiry and attempts to gather a meaningful account of a clinical phenomenon of interest and make it accessible to clinical understanding. This can be achieved by drawing on data collected from small samples through methods such as interviews. A convenience sample of 12–20 participants was therefore anticipated to be suitable for obtaining relevant information. This study received ethical clearance from the research ethics boards of Children's Hospital of Eastern Ontario Research Institute (16/01X) and the University of Ottawa (A10-16-01).

Procedure

Data were collected through individual interviews conducted in English. Prior to the interviews, participants were asked to complete a brief form to record demographics and job-related information. This included data such as profession title, practice setting, years of experience, and percentage of time working with patients of minority culture backgrounds. A semi-structured format was used to guide the interview from a pre-determined list of questions developed by the lead researcher (see Appendix). The interview protocol was informed by findings in our scoping review (Grandpierre et al., 2018). The interview consisted of open-ended questions on cultural sensitivity training (if received, from where, etc.), and general experiences with service provision to families of minority culture backgrounds. Prompts to seek new leads or request clarifications were incorporated into the interview protocol. Seven interviews were conducted over the phone due to distance (e.g., five were located outside Ottawa, two participants were not available to be in Ottawa at the time of the interview). Live interviews took place at practitioners' offices in CHEO. Field notes were taken by the researcher (VG) during interviews. All interviews were conducted by the researcher (VG).

Analysis

Interviews were audio recorded and transcribed verbatim. In addition, field notes were recorded and consulted during analysis. All data were entered into NVivo (version 10.1.2), a qualitative software program used for coding and qualitative research analysis. Demographic information was entered into Excel.

Analysis of transcripts occurred concurrently with data collection (DiCicco-Bloom & Crabtree 2006). In the Interpretive Description method, inductive data analysis techniques are often used to highlight thematic patterns and commonalities to help characterize the topic of interest (Thorne et al., 1997). Inductive techniques are typically used in qualitative methods where data, such as transcripts, are analyzed to generate ideas (Thorne, 2000). Transcripts were analyzed using a coding process known as the *constant comparative method* based on Strauss and Corbin's (1990) open, axial, and selective coding methods, an approach that fits well within the Interpretive Description methodology (Thorne, Kirkham, & O'Flynn-Magee, 2004). Open coding involves reviewing and assigning labels to each passage. Axial coding involves a comparison of characteristics for each label among interviews. In selective coding, concepts become further refined by examining similarities of labels and collapsing these categories into major themes.

Abiding by qualitative research practices, the concept of trustworthiness (Krefting, 1991) was used to ensure quality and transparency in this study. Components of trustworthiness are credibility, transferability, dependability, and confirmability. Credibility was evidenced by data collected from various participants in different fields within audiology. Transferability was demonstrated by the collection of in-depth data with detailed descriptions of the setting and the participants. Dependability was achieved with a clear description of the research process. Reflexivity is an additional component to ensuring trustworthiness which enables transparency (Korstjens & Moser, 2018). In this study, reflexivity was achieved by the researcher documenting reflexive notes during the interviews, as well as the interview setting. In addition, peer debriefing with the coauthors occurred throughout each stage of the study. Finally, confirmability was evidenced using detailed field notes to help ensure neutrality of the data. Consulting coauthors with expertise in qualitative research, health sciences, and medical research about the decision-making on the research process also contributed to achieving confirmability.

Results

Participant Characteristics

A total of 26 practitioners responded to the invitation to participate; the study protocol was reviewed for feasibility.

As this topic is underexplored, all 26 respondents were elected to be interviewed; however, only 19 participated. Of those, 14 practitioners were recruited at CHEO and five from a local conference; the latter group practiced at centres (e.g., public and private health care facilities) in various cities in two Canadian provinces (Ontario and Nova Scotia). One participant provided written feedback to the interview questions but did not participate in an oral interview. **Table 1** provides a description of participant characteristics.

To gain multiple perspectives from practitioners in different roles within pediatric audiology, a diverse sample of various professions was selected. Practitioners were audiologists, auditory-verbal therapists, an auditory-verbal educator, itinerant teachers of the deaf and hard of hearing, a hearing resource teacher, a case assistant worker in audiology, and speech language pathologists who work in audiology clinics. Experience in these fields ranged from 3 to 40 years.

Most of the practitioners had reported receiving prior education on cultural sensitivity in the form of training and/or lectures, varying from 1-hour lectures to a series of workshops. The majority were French and/or English speakers with Canadian and/or Francophone (Canada,

Table 1

Participant Characteristics

	All practitioners
Number (%)	19[a] (100)
Sex, *n* (%)	
Male	1 (5.2)
Female	18 (94.7)
Languages[b], *n* (%)	
English	19 (100)
French	16 (84.2)
American Sign Language	2 (10.5)
Arabic	1 (5.2)
Spanish	1 (5.2)
Cultural backgrounds[b], *n* (%)	
European	10 (52.6)
Francophone (Canada, France)	7 (36.8)
Canadian	7 (36.8)
Asian	1 (5.2)
Australian	1 (5.2)
Position, *n* (%)	
Audiologist	7 (36.8)
Speech language pathologist	3 (15.7)
Therapists/teachers/case worker	9 (47.3)
Years of experience, median, (range)	17 (3–40)
Received cultural sensitivity education, *n* (%)	12 (63.1)

Note. [a]One participant provided a written response to the interview protocol (e.g., was not available for an oral interview); [b]Many practitioners were multilingual and multicultural.

France) cultural backgrounds. Practitioners serviced a large variety of cultures, mainly consisting of Canadian Indigenous, Asian, and African.

The purpose of the interviews was to explore practitioners' experiences providing services to families of minority culture backgrounds. Three themes emerged from the interview data: barriers to service provision, facilitators to service provision, and characteristics of a culturally competent practitioner. It is important to note that most of the practitioners (74%) commented on the difficulty of attributing their patients' families' responses to cultural differences as opposed to typical stress responses. The results, therefore, represent when practitioners felt confident that their experiences with families reflected cultural differences.

Barriers to Service Provision

Practitioners described various barriers to care. Barriers were encountered throughout the care process, such as during audiological testing, diagnosis, amplification, language assessments, and interventions.

Language barriers. Language barriers affected every stage of treatment and were noted to be problematic even when professional interpreters or someone who could translate (e.g., colleagues or extended family members) were available: "Language barriers can be the biggest impediment for the family I think. In terms of making sure…let's say, often…we have one parent who speaks English and…they are acting as the interpreter for their husband which really is not ideal" (Participant 22). Another participant noted,

> I think the hardest thing when working with families is when French or English is not their first language and they are working with an interpreter. What happens is that when an interpreter is working with you, you don't know how much filtering is going on because you don't know that other language, so when you are working with a family to get informed consent for something like a CI [cochlear implant] surgery you really want to make sure that parent really understands and certainly we've had families with English as a second language where you're hoping that the parent is saying that this is what they want and you are trying to make sure they have all the tools needed to make the right choice, with that interpreter. (Participant 7)

Language barriers also occurred in service provision when parents' interaction with their children at home was minimal. The level of parent–child interaction varies with culture and can affect services (e.g., spoken language development) that depend on family engagement for optimal outcomes. For example, auditory verbal therapists typically promote ongoing verbal communication in families to support language development; however, if there is minimal parent–child interaction in a culture, this can reduce the effectiveness of the intervention:

> So how do the parents interact with the kids because… they may not talk to their child as much or interact in the same ways we might expect so I think there has to be some sensitivity around what our expectations are for interacting with their kids…there's not only the nonverbal but the verbal…. In terms of nonverbal, I've worked with – it was actually the Indigenous population in Canada where eye contact was very different. So they don't give direct eye contact when they communicate. So being aware of that was really important as a clinician. (Participant 10)

Cultural challenges during audiological testing. In addition to language barriers, challenges to audiological testing were noted when caregivers were not comfortable receiving services because of the practitioners' gender (e.g., families sometimes preferred male practitioners). Practitioners described instances where families were not receptive to the information provided. Sometimes male practitioners were requested to relay the information. Other situations were more delicate, such as requesting the removal of children's religious attire during audiological testing.

> When a child is coming in for a hearing assessment and we have a 30 minute time and from a clinical perspective it would be very lightly touched on if a child came in and for example, they wear a hijab and you had to ask them to remove it and there was a male audiologist at the time, he would be asked to change [to leave] at that time because that would be appropriate. (Participant 7)

Cultural challenges during discussions of hearing loss diagnosis. Almost all practitioners commented on surprising reactions when diagnoses were communicated, which were attributed to cultural differences. They discussed how, in some cultures, disability is stigmatized and seen as something shameful. This perception sometimes led to caregivers denying the hearing loss or refusing amplification for their children.

> …when I worked in [Canadian province], I worked with many Asian families. And it was seen within…at least the family group of one of the patients that I worked with… the family was embarrassed about the diagnosis and so it was very challenging to get them to accept that

> the hearing loss was in fact a permanent thing and to get them to accept that if they wanted a listening and spoken language mainstream-schooling outcome, the way to achieve that was through regular hearing aid use and therapy. One family in particular, they sought out alternative medicine to try and cure the hearing loss. (Participant 10)

> I have experienced two middle eastern families where the parent made it very clear, that when they went back to [home country] to visit, that they took the hearing aids off. And the mother said "I don't even wear my glasses when I go back to Lebanon. I wear glasses now because I need them - but if I wear glasses as a young woman, I never would have found a husband." (Participant 12)

Cultural challenges during administration of standardized language assessments. Standardized language assessments also presented challenges for practitioners. Specifically, the assessment content was not always reflective of everyday environments. Most of the practitioners commented on how these assessments were normed on majority populations and that culturally inappropriate items affected scoring.

> ...having the proper assessment tools, [it is] very important. For example, you cannot use – immigrant families coming to Canada, [they have never seen] the Christmas tree and they never see snow, and they don't have any [idea of] what the snow looks like, they [have] never seen it in their country, so it would be like "what".... It's not appropriate to talk about snow without them experiencing it.... I cannot assess them with snow. Like I'm talking to a Canadian child about the desert and camel, they [have] never seen a camel and I cannot mention a camel in my first assessment because they don't have any experience with the camel, what it looks like, what sounds it makes, you know? So this knowledge is very important. (Participant 15)

Cultural challenges during language interventions. Many practitioners commented on barriers encountered when providing interventions to families of minority culture backgrounds. A variety of reasons were indicated, such as language barriers, limited culturally sensitive materials, differences in expectations between practitioner and parents regarding who will do the therapy, and differences in language output expectations between practitioner and parents: "I have to say, some of our books are white-centric, but I have newer books that I've bought for the little ones that have more different racial groups represented" (Participant 13). Another participant noted,

> In some families...a few African families – no toys at home. And so we had to either provide some toys to show the mom what we wanted to do with them and modify our expectations in terms of sort of seeing what the mom did do with the kids and maybe building routines around or building language into daily routines and you know, dressing, and having the child help you know with food, meal time and that kind of thing. Um so ...I guess the cultural expectation of what a parent does in terms of how much do they actually play with their child or talk to their child – that would come into play. (Participant 12)

Facilitators to Service Provision

Although many challenges were noted, practitioners proposed a number of strategies to overcome barriers. Facilitators included communication strategies, learning about cultural differences, and strategies throughout the process of intervention.

Communication strategies. Communication strategies included ensuring comprehension by asking caregivers to repeat what was said. Using simple language, learning key phrases in the caregivers' language, speaking slowly, and using visual aids (e.g., writing key words or showing pictures or videos) were also seen as useful.

> When we ask people if they understand what we are saying, and we know they have a different first language, initially when people nodded I assumed they were getting along ok. I learned over time that this is good in counselling but this is particularly important when there is a language barrier is that you need to get them to repeat back to you what they think you've said. Sometimes you see that there are huge gaps. (Participant 5)

> I find written communication as a backup, even if I'm there in person, so I always have "what we do," "what we did" in writing so that they can go [to] somebody and say what exactly does this mean or, those kinds of things. So I would certainly use simpler speech, vocabulary, or I would show them what I'm talking about through either a picture or I would Google it or I would show them physically something in their home. I would say in English, you know, what do you refer this for example a sofa or couch, what would you call that? (Participant 19)

Strategies to learn about cultures. Many practitioners stated that learning about cultural practices was an important facilitator to culturally competent service provision. Strategies to learn about cultural differences included attending lectures, workshops, or training and

asking families questions about their daily routine, religious holidays, cultural traditions, and practices. Some stated that asking families about how disability was perceived provided helpful feedback on how to approach interventions. In addition, home visits were considered invaluable for learning about differences to better tailor care to meet the needs of the family.

> If they've come from a country where this is viewed as a stigma then the first question to ask is how is hearing loss viewed in your culture...I try to get the info from the family, how do you feel about this. Then I can address their concerns, will he struggle wearing the hearing aids, do they show?... If they are obviously immigrants or refugees then I will ask them about their country. (Participant 5)

> I think doing a home visit is a really good way of [taking] a peek into the culture. I think home visits are generally a good idea, when you are first meeting a family. But I think particularly when you have a family from a different culture, you can learn a lot when you go to their home. So being respectful of their traditions, doing a home visit to find out more about their traditions. And also, I think home visit puts them at ease so they can talk a little bit more about themselves. (Participant 9)

Strategies during intervention. Strategies for different stages of the intervention process were proposed. These included explaining the health care system and modifying standardized language assessments and interventions. Describing the health care system involved not only explaining the services the practitioner provides, but also what is generally available to families from the health care system (e.g., coverage funding for hearing aids). Health care models vary across cultures, and immigrants may not be aware of what they can access.

> It's really a learning experience to go and understand that here [in Canada] you can actually push and that you have rights to ask for more different things. So when the medical team is in front of you, they have no idea that you would not go and look for other options... So knowing that some people may not go look, it's important that they will be informed of every kind of choice they would have. And I think this is part of what is lacking in terms of being sensitive to the culture. Because here [in Canada], [if] they have little information, they [can] go look and they connect with other people. This is definitely not what would be done in some other cultures. If I look at an African family I have on my caseload - the kid is falling through the crack. The parents didn't ask [about what they have access to] and they were just following the system and the kid had barely any support. And I think it is pretty typical of what could happen with [an] immigrant, they come and trust what is happening and then if the kid falls through the crack, they won't see it. (Participant 18)

When practitioners encounter challenges with standardized assessments, they use various strategies to overcome these challenges. This includes adapting standardized assessments by administering a subset from a battery of tests, informing caregivers and recording that the score does not present an accurate assessment of competencies, or using non-standardized checklists or vocabulary lists to gain insight into language abilities.

> I will have them fill out like a 50-word beginning words that we have. And I'll have them fill out their understanding in their own language as well as English so that I have an idea of how the child is doing overall, you know, is the child learning a language – period? And then, you know kind of combining the two gives me an idea of how well the child is doing. (Participant 9)

Challenges in interventions were overcome by making an effort to use culturally sensitive materials and by tailoring the content to reflect family home environments. This included making decisions on the content of the therapy and even on the décor of the office.

> You know I do a little garden with pudding and cookie crumbs and then those gummy worms when we're talking about gardens...this is a fun kind of activity of mine and again I would check with the families, tell them what I'd like to do, this has gelatine in it, are you okay with that, if they aren't, I'll find something else to do. (Participant 19)

> I'm sensitive to using themes that are appropriate to the family. When I decorate the room I try to make sure that I...you know, I want to observe North American cultural preferences but I don't want to make them such that they are uncomfortable for something else.... Even asking parents, oh you know I understand Eid is coming, could you bring in some stuff and we can share it together. (Participant 13)

Characteristics of a Culturally Competent Practitioner

Practitioners described various characteristics of a culturally competent practitioner, with **Table 2** listing those described by all practitioners. The most common characteristics included being respectful of culture and language, having knowledge of cultural practices, and self-reflection.

Table 2

Characteristics of a Culturally Sensitive Practitioner
Respects culture, languages
Knowledgeable of cultural practices
Reflects on own cultural identity, values, prejudices, biases, and assumptions
Open-minded
Modifies sessions (e.g., appointment times, content) when needed
Explains sessions to families in advance to determine if content is culturally appropriate
Engages in cross-cultural encounters (e.g., multicultural events)

Be respectful of culture and language. Many practitioners commented on the importance of being respectful of cultural practices. Respect involves acknowledging and accepting different cultural practices, thereby creating a safe space for families to receive services.

> I think being respectful of cultural differences and value differences. I have a couple of adolescent Muslim girls who wear a hijab, respectful of practices, closing the door to the room when asking them to remove their hijab to work with the device. And I also realised that because that is their dress, garb, when I'm doing assessments in terms of hearing, I always do my assessments with them wearing their hijab because that's their typical wearing option. (Participant 7)

> Well I think respect for the other cultures you're dealing with, as with any family, respect and trust have to be the basis of the relationship because we are asking them to buy in to the fact that their child with hearing aids or cochlear implants is going to learn to speak, and that is a leap of faith for most people, and if you've come from a culture or country where people who have hearing loss don't learn to speak, then it's even more of a leap. And so for them to believe you and to do what you are asking them to do at home, there has to be a foundation of trust in the therapist and so I try as hard as I can to create that trust and I think that begins with respecting their traditions and being open to whatever they want to tell me. (Participant 9)

Being respectful of the home language was also considered vital to culturally sensitive care. Practitioners noted on several occasions that they should be aware of a family's preferences to preserve their home language. Advocating for this approach was seen to help establish trust.

> Also, respecting their language in terms of teaching it to the child. So most times, parents want their children to learn their own language. Because there's grandparents involved – because the parents themselves are very attached to their language. So they go ahead and do that and we do the therapy in English and they will translate to the child's language. I think it works well when there can be someone who speaks English and then another speaks the native home language so that the child really has a bilingual kind of setting. So to be respectful of their language. I mean, in our situation, because it's a language-based program – that's HUGE! (Participant 9)

> So just to respect their culture and their language, because I don't want them to lose that as well, right? Cus I know that when I speak to parents they'll be like, oh we want them to...even if they don't understand fully the language they speak at home even if they are somewhat exposed to it. (Participant 17)

Have knowledge of cultural practices. Many practitioners also noted the importance of having some knowledge of their patient's cultural background prior to proceeding with service delivery in order to be sensitive to their needs. Strategies for learning about cultural practices include asking families about their day-to-day routines or describing the content of the therapy session in advance to see if everything is appropriate.

> Culturally sensitive [care] would mean that you would want to have some knowledge of what the cultural practices are for that particular family. You would want to know their religious observances.... It would be being able to incorporate those things into the therapy, asking families you know "I'm doing it this way, how would you do that at home, what would be more appropriate as something I could help you with at home." (Participant 13)

> I might also discuss with the families – well we do this anyways but – what are their routines at home, what types of toys they have and that's a big one because depending on the culture, they may or may not have the toys you expect them to have, so that the variety or the group of toys they may have could look very different... the types of songs they might sing or the types of play and routines they have could look very different too... so just not making assumptions around the fact that they are playing at home with the games and songs that I would expect to have in my house. (Participant 10)

Self-reflection. Nearly half of the practitioners commented on the importance of reflecting on personal cultural identity, values, prejudices, biases, and assumptions. Performing self-reflection was believed to help increase relationship-building opportunities and also establish trust.

> If you're entering into the relationship without your own cultural biases...you're working with a family and you're accepting them...you're willing to listen to what their expectations are, what their needs are what they want to get out of the services that you're providing. What they see as their priorities. Not your priorities. It's really very key to that work. (Participant 16)

> I always have to be mindful that my own culture...that's a bit different from the culture here...I have to be mindful that what I think could be pretty normal for me [but] may not be for everybody because we don't have exactly the same background.... (Participant 18)

Descriptions of other characteristics of culturally competent practitioners included being open-minded, flexible with appointment scheduling, modifying sessions when needed (e.g., appointment times, content), explaining sessions to families in advance to determine if content is culturally appropriate, and engaging in multicultural events (e.g., cultural festivities) to increase experiences with cross-cultural encounters.

Discussion

The aim of this study was to explore the experiences of practitioners with providing services to families of minority culture backgrounds. Practitioners encountered barriers throughout the process of service delivery with language barriers affecting every stage. Gender issues, lack of culturally sensitive materials, and Westernized language therapy programs occasionally presented challenges in service provision to families of minority culture backgrounds. Disabilities are also stigmatized in some cultures, which can present additional challenges to care provision. Differences in child-rearing practices can also present challenges for family-centred services.

Research in the field of rehabilitation services has described barriers to providing care to families of minority culture backgrounds similar to what we found in the field of pediatric hearing loss. For example, language barriers have been noted to impact rehabilitation service delivery (Centeno, 2009; Dogan et al., 2009; Drolet et al., 2014; King et al., 2015) and male patients from some cultures sometimes explicitly request male practitioners (Al Busaidy & Borthwick, 2012; Dressler & Pils, 2009). Finally, cultural differences in language (verbal and nonverbal), play, independence, family structure, and perception of disability can also affect service provision (Al Busaidy & Borthwick, 2012; Cochrane, Brown, Siyambalapitiya, & Plant, 2016; Dressler & Pils, 2009; Lindsay et al., 2012; Pidgeon, 2015; Yang et al., 2006). Practitioners were able to mitigate these barriers with communication strategies, learning about cultural differences, explaining the health care system, and tailoring standardized assessments and therapy-based interventions when required.

Facilitators and strategies described by the participants in this study align with an international consensus paper on best practices in EHDI programs (Moeller, Carr, Seaver, Stredler-Brown, & Holzinger, 2013). This document states practitioners should be supportive of differing cultural beliefs and practices. Additionally, the document recommends practitioners to be reflective of personal discomforts and cultural biases as well as knowledgeable regarding how differing cultural practices can impact care.

Similarly, studies in rehabilitation have identified facilitators to culturally competent care that are consistent with our study. Practitioners seeking to learn about different cultural practices felt that asking patients about their values, beliefs, and daily routines helped to appropriately tailor care (Kinébanian & Stomph, 1992; Lindsay et al., 2012; Maul, 2010; Pidgeon, 2015; Stedman & Thomas, 2011). Although learning about cultures through education (e.g., attending lectures, workshops, or training) was noted to be a facilitator, it should be noted that this is not sufficient to becoming a culturally competent practitioner, especially with Canada's rapidly changing diversity. Training is limited as it cannot account for all cultures present in Canada. As a result, it is up to practitioners to go beyond what may be available at work, taking up more time and resources in an already busy schedule. Although we cannot offer a solution, future research on this important topic is warranted.

Existing literature supports modifying care to ensure cultural competence practices such as informal

assessments, translated materials, and considerations for material selection and culturally meaningful treatments (Cochrane et al., 2016; Pidgeon, 2015; Rhoades, 2014; Williams & McLeod, 2012).

This study also uncovered some key characteristics of a culturally competent practitioner. Key characteristics include practitioners being respectful, knowledgeable of cultures, reflective, open-minded, and tailoring care when needed. These characteristics align with the values of family-centred care, which advocates for partnerships between practitioners and diverse families (Rhoades, 2017).

Although culturally competent practices can help to improve patient experiences and outcomes, little information has been available about the barriers and facilitators that practitioners working in pediatric hearing loss have encountered in providing services to families of minority culture backgrounds. To the best of our knowledge, this is the first study to contribute to research on culturally competent care in EHDI services. Our study is not without limitations. It is possible that some examples described in this article may not accurately portray the values, intents, and practices of an entire culture. However, the goal of the paper was not to describe the culture but instead to portray how cultural differences can affect treatment. Other limitations include the study location; Canadian health care is publicly funded and therefore cannot represent global views. In addition, the setting of this study uses one particular service model, whereas other locations use different models. These limitations provide directions for future studies investigating cultural competence from the perspective of practitioners in pediatric hearing loss.

Increasing diversity can create challenges for EHDI services which are typically tailored to meet the needs of the majority population. Our study provides insight into barriers practitioners may encounter when providing services to families of minority culture backgrounds. Additionally, the findings in this study offer strategies that can be used to help overcome cultural challenges experienced by practitioners in hearing loss services. Future research in different provinces utilizing various service models across Canada may also help provide sufficient data to inform a knowledge-to-action intervention seeking to improve and maintain culturally competent practices in EHDI services.

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Acknowledgments

This work was supported by the Ontario Graduate Studies grant.

We would like to thank all the participants for their contributions and everyone at the Child Hearing Lab at the Children's Hospital of Eastern Ontario Research Institute for their resources and assistance with this study.

Disclosures

No conflicts of interest, financial or otherwise, are declared by the authors.

Appendix

Interview Protocol

Clinician Interview Protocol: Pediatric Hearing Loss Practitioners' Encounters with Cultural Minority Patient Families.

Purpose of Interview

I am meeting with practitioners who are or have provided services to minority culture caregivers of children with hearing loss in order to better understand service needs. I am defining *minority cultures* as any cultural groups that are not representative of the majority culture in Canada (e.g., caregivers that do not identify as primarily French or English Canadian). I am interested in learning about your experiences with servicing minority culture families. For example, I would like to hear about whether the delivery of care to this population is a smooth process or whether there are challenges. I would also like to hear about if/how you tailor care to suit the needs of minority culture families.

Procedure

I will ask you questions to guide our conversation but feel free to talk about your experiences and to add any information you feel is relevant and important. Please don't hesitate to ask questions. I'm going to start off by asking you some background questions, then I'll ask questions about your interpretation of culturally competent care. I'll then move on to asking you about your experiences servicing minority culture families and strategies that you might use to help improve service delivery.

Definitions

Cultural competence in a health care context has been defined as "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 297).

General Information

Location of interview: Clinic Other: _____

Gender: ☐ Male ☐ Female

Informant: ☐ Audiologist ☐ AVT Other: _____

Education: _____ Years of practice: _____

Background Questions

What is your position title?

How long have you been working in this field?

Please tell me about your cultural heritage and the languages you speak.

Cultural Competence Questions

I'm looking for some information on the proportion of cultural minority families you service. In your current caseload, how often do you work with minority culture families? (e.g., most of the time, half of the time, some of the time, etc.)

Prompt: In the past year, what percent of your patients are cultural minorities? What are the most common cultural groups serviced? Again, cultural minority families are defined here as any cultural groups that are not representative of the majority culture in Canada.

What does the phrase 'culturally sensitive care' mean to you?

Prompt: In your opinion, what are key characteristics of a culturally sensitive practitioner?

Have you attended any courses or training on cultural competence?

Prompt: Did you receive any training in your degree? From your job?

Questions on Servicing Minority Culture Families: From Diagnosis to Intervention

Note: Some of these questions might be more relevant for a particular position in Audiology – if it's not part of your job, please describe any relevant encounter.

Did you encounter surprising reactions to the diagnosis? If you have, tell me about it.

Prompt: Did some cultural minority families perceive disability as something to be ashamed of or something to be concealed or as a gift?

Did you encounter challenges when discussing amplification options? If you have, tell me about it.

Prompt:

Did you have to use any strategies for hearing aid use? Did you feel that you had to do anything differently?

Were some opposed to amplification for cultural reasons?

Are there difficulties with achieving consistent amplification use?

Do some families seem to feel they need more guidance with amplification usage?

Did you experience challenges when providing therapy? If you have, tell me about it.

Prompt: Were some aspects of the therapy not applicable to the child's home environment?

Did you encounter challenges when filling out language assessment questionnaires? If you have, tell me about it.

Prompt: Were some aspects of the questionnaires not applicable to the child's home environment?

Personal Strategies for Working With Minority Culture Families

What are some of the methods you use when providing services to minority culture families?

Prompt: Do you modify standardized assessments such as administering a subset as opposed to a complete battery of assessments?

Prompt: Do you tailor therapy sessions in order to better reflect the patient's home environment?

Do you use any methods to help improve communication with minority culture families? If so, what are some examples? If not, please explain why.

Prompt: Did you try different strategies to improve communication like simplifying language?

What would you say is the most important factor in culturally appropriate care?

Prompt: Here are some examples: knowledge of cultural differences, knowledge of culturally sensitive practices, having culturally appropriate assessments and interventions, etc.

Is there anything you'd like to discuss that I haven't covered?