So What Does ‘Chulcha’ Have To Do With Disabilities???

Reflections by a Gringa from Baa-stin

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Act Early Texas!
LoneStar LEND Program and
the Texas State Autism Planning Grant

Professor of Pediatrics
Children’s Learning Institute and the Division of Child & Adolescent Neurology
UT Health Science Center at Houston
New England + NY + NJ + PA = only 62% of Texas
Texas could be the 40th largest country in the world...
42% of population lives in Houston and Dallas-FW
Texas’ Hispanic/Latino Population

Percent Increase of Hispanic Population Between 2000-2010

- Sherman/Denison: 82.0%
- Tyler: 84.9%
- Longview: 94.2%
- College Station/Bryan: 61.0%
- Beaumont/Port Arthur: 62.3%
- Austin/Round Rock: 64.2%
- Houston/Sugar Land/Baytown: 55.1%
- Killeen/Temple/Ft. Hood: 59.1%
- Midland: 53.2%
- Dallas/Ft. Worth/Arlington: 56.8%

Source: U.S. Census 2010, Hobby Center for the Study of Texas at Rice University.
# El Paso Demographics

<table>
<thead>
<tr>
<th>Category</th>
<th>El Paso County 2014</th>
<th>Texas</th>
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<tbody>
<tr>
<td>White</td>
<td>92.1%</td>
<td>80.0%</td>
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<tr>
<td>Black</td>
<td>4.0%</td>
<td>12.5%</td>
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<tr>
<td>American Indian/ Alaska Native</td>
<td>1.0%</td>
<td>1.0%</td>
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<tr>
<td>Asian</td>
<td>1.3%</td>
<td>4.5%</td>
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<td>Native Hawaiian/ Pacific Islander</td>
<td>0.2%</td>
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<td>Two or More Races</td>
<td>1.4%</td>
<td>1.8%</td>
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<td>Hispanic or Latino</td>
<td>81.2%</td>
<td>38.6%</td>
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<td>White alone, not Hispanic or Latino</td>
<td>13.3%</td>
<td>43.5%</td>
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<td>Houston 2012</td>
<td>Texas 2013</td>
<td>US 2014</td>
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<td>2 El Salvador</td>
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<td>2 India</td>
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<td>3 Vietnam</td>
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<td>3 China</td>
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<td>4 Vietnam</td>
<td>4 Philippines</td>
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<td>5 Honduras</td>
<td>5 Philippines</td>
<td>5 El Salvador</td>
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<td>6 Philippines</td>
<td>6 China</td>
<td>6 Vietnam</td>
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<td>7 China</td>
<td>7 Honduras</td>
<td>7 Cuba</td>
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<td>8 Guatemala</td>
<td>8 Guatemala</td>
<td>8 Korea</td>
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<td>9 Pakistan</td>
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<td>10 Colombia</td>
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<tr>
<td>11 Nigeria</td>
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<td>14 Taiwan</td>
<td>14 Germany</td>
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<td>15 Venezuela</td>
<td>15 Colombia</td>
<td>15 United Kingdom</td>
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Texas’ Vietnamese Population

2000-2010
US Vietnamese population ↑ 39%

• Texas has the 2\textsuperscript{nd} largest Vietnamese population in US

• Houston-Sugar Land-Baytown Metropolitan Area has the 3\textsuperscript{rd} largest MSA Vietnamese population

• Vietnamese are the 6\textsuperscript{th} largest foreign-born group in the entire US
### Nativity of Domestic Migrants to Texas 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Foreign-Born</th>
<th>Native-Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>1,827</td>
<td>17,097</td>
</tr>
<tr>
<td>Colorado</td>
<td>2,296</td>
<td>16,843</td>
</tr>
<tr>
<td>Arizona</td>
<td>2,263</td>
<td>17,188</td>
</tr>
<tr>
<td>New York</td>
<td>3,860</td>
<td>17,269</td>
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<tr>
<td>New Mexico</td>
<td>3,054</td>
<td>18,995</td>
</tr>
<tr>
<td>Louisiana</td>
<td>2,123</td>
<td>26,334</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>3,777</td>
<td>25,129</td>
</tr>
<tr>
<td>Illinois</td>
<td>4,400</td>
<td>26,272</td>
</tr>
<tr>
<td>Florida</td>
<td>6,264</td>
<td>27,057</td>
</tr>
<tr>
<td>California</td>
<td>16,412</td>
<td>45,974</td>
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</tbody>
</table>

Source: U.S. Census Bureau ACS 1-Year PUMS Data, 2013
Culture

is an integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, or social group and the ability to transmit the above to succeeding generations.
Topical Culture consists of everything on a list of topics, or categories, such as social organization, religion, or economy.

Historical Culture is social heritage, or tradition, that is passed on to future generations.

Behavioral Culture is shared, learned human behavior, a way of life.

Normative Culture is ideals, values, or rules for living.

John H. Bodley, From Cultural Anthropology: Tribes, States, and the Global System, 1994
An Anthropological Perspective of Culture

Functional Culture is the way humans solve problems of adapting to the environment or living together.

Mental Culture is a complex of ideas, or learned habits that inhibit impulses and distinguish people from animals.

Structural Culture consists of patterned and interrelated ideas, symbols, or behaviors.

Symbolic Culture is based on arbitrarily assigned meanings that are shared by a society.

John H. Bodley, From Cultural Anthropology: Tribes, States, and the Global System, 1994
What Shapes Culture?

Race
Ethnicity
Gender
Spirituality/ Religion
Literacy
Language
Sexual Orientation
Status/ Caste
Culture

➤ Stereotypes

• Boston
• New York
• Philadelphia
• Los Angeles
• San Francisco
• Mississippi
• Dallas
• Houston
Barbecue

- Missouri [Kansas City]
- Texas
- Tennessee [Memphis vs Nashville]
- Alabama
- North Carolina
- South Carolina
- Kentucky
- Illinois
- Georgia
Latino

- Cuba
- Mexico
- Dominican Republic
- San Salvador
- Costa Rica
- Colombia
- Venezuela
Cultural Competence

Requires providers, at a minimum, to:

- Acknowledge cultural differences
- Understand your own culture
- Engage in self-assessment
- Acquire cultural knowledge & skills
- View behavior within a cultural context

Require providers to modify approaches to:

- Assessment and diagnostic protocols
- Treatment & interventions
- Medication protocols
- Health education & counseling
- Consulting with traditional / indigenous practitioners & natural healers

Providers must have the capacity to:

• Address stereotyping, bias, discrimination, prejudice, and other ‘ISMs.’
• Work toward health and mental health equity and social justice.
• Advocate for these principles among peers and within professional societies.
PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

_____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

Tawara D. Goode - Georgetown University Center for Child & Human Development
University Center for Excellence in Developmental Disabilities Education, Research & Service
COMMUNICATION STYLES

6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

9. I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English proficiency.

10. I use bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

   - limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
   - their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
   - they may or may not be literate in their language of origin or English.

12. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

14. I understand the principles and practices of linguistic competency and:

   - apply them within my program or agency.
   - advocate for them within my program or agency.

15. I understand the implications of health literacy within the context of my roles and responsibilities.

16. I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.
### VALUES AND ATTITUDES

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<tr>
<td>17.</td>
<td>I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.</td>
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<td>18.</td>
<td>In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.</td>
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<td>19.</td>
<td>I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.</td>
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<td>20.</td>
<td>I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.</td>
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<tr>
<td>21.</td>
<td>I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).</td>
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<tr>
<td>22.</td>
<td>I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.</td>
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<tr>
<td>23.</td>
<td>I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).</td>
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<tr>
<td>24.</td>
<td>I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).</td>
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<tr>
<td>25.</td>
<td>Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.</td>
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<td>26.</td>
<td>I recognize that the meaning or value of medical treatment, health and mental health care, and special education may vary greatly among cultures.</td>
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<td>27.</td>
<td>I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.</td>
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<tr>
<td>28.</td>
<td>I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.</td>
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<td>29.</td>
<td>I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death.</td>
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<tr>
<td>30.</td>
<td>I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.</td>
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</table>
31. I understand that traditional approaches to disciplining children are influenced by culture.

32. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

34. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

35. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

36. I advocate for the review of my program’s or agency’s mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

How to use this checklist
This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.
Other Considerations

• Age at ASD diagnosis varies as a function of ethnicity and socio-economic status (SES).\(^1,2\)

• ASD prevalence increases with increasing SES in a dose-response manner and differs significantly \((p<.001)\) across low, medium and high SES groups.\(^3\)

• The mean age-at-diagnosis in Medicaid-eligible children was considerably higher than the 2010 US average at 65 months.\(^4\)

At their first specialty care visit, Medicaid-eligible Black children were:

• 2.6 times less likely than white children to receive an ASD diagnosis
• 5.1 times more likely to receive a diagnosis of adjustment disorder
• 2.4 times more likely to receive a diagnosis of conduct disorder
• ADHD was the most common diagnosis

• Many referrals to child neurologists or DB Peds are “for ADHD” instead of ASD because of the lower recognition of ASD symptoms in nonwhite children, especially of lower SES.

Other Considerations

PCP or specialty MD perception +/- ID may affect whether or not a physician conducts further analysis to confirm a diagnosis of ASD.

• 58% 2,586 eight-year-olds ASD+
• Data adjusted for gender, IQ, birth weight, and maternal education

*Black, Hispanic, Asian, and other ethnicities were less likely than White children to have a documented diagnosis of ASD.*

Q: What are some of the struggles you’ve faced as the parent of children with autism?

A: My daughter didn’t sleep alone until she was 5. She would be in my arms for hours before she fell asleep. Meals were always hard. It takes three hours to feed her each meal. My son was a bit different. He would sleep, but was aggressive and would throw things when angry or emotional. I was always busy taking care of my kids: I would give one a bath, and then the other; feed one, and then the other; take one to the washroom, and then the other. It was tiring.
Q: Why do you think it’s important to have a center that focuses specifically on the South Asian community?

A: Because of the additional support that’s available based on experiences that are unique to certain groups. For example, some in my community believe that when you have a child with a disability, it’s because of your karma. This belief becomes the reason for our situation, and if we went to another organization, they would not understand.

There are also language barriers that prevent us from seeking help, and a culture specific center opens more doors. When I decided to place my son in a group home, and because I had support from people within my community, it was easier to deal with.
Q: How do others in your community react to your decision to put your son in a group home?  
A: The friends and family I have here support and accept my decision, but they are worried. On the other hand, my husband and his family do not support my decision at all. They think my son is not receiving proper care. I want to let others know about my situation. The people in my community hide disability, and do not speak openly about it.
Q: What additional barriers do you perceive in raising a child with autism as a South Asian woman?

A: As a South Asian woman, I did not have time to get to know my spouse, we had our kids right away, and did not understand each other. My husband did not do his part and I dealt with the difficulties on my own, because of the cultural expectation of hiding marital problems. When you get married, both individuals are responsible for the work. You need to help each other when you have children especially when both children have autism. You cannot do it alone. In my community, it is believed that the mother is responsible for everything at home and if anything goes wrong, the mother is always blamed. It is very difficult, I get blamed for the way my children are.

https://www.psychologytoday.com/blog/talking-about-trauma/201404/cultural-barriers-treating-autism
Other Considerations

- In France, as recently as 2004, ASD was seen as a form of schizophrenia rather than a developmental disorder.

- Today in South Korea, children with autism are frequently diagnosed with a condition called Reactive Attachment Disorder — often associated with child neglect.

- Among the Efe pygmies in Central Africa, a child who begins exhibiting autistic behavior is understood to be under attack by the family’s ancestors and is sent to another village far away where he will not have contact with blood relatives.
• a form of punishment.
• cursed by God or the Gods
• Sinned
• violated a taboo
• others may seek to distance themselves from those who have incurred such "evil."
• the child with a disability is tangible evidence of divine displeasure
• prolonged public and private discussions about what wrongs the family may have committed
• victim of witchcraft

Chronic Illness & Disability

- Inherited disorders caused by a family curse or as "running in the blood."
  - clinician's desire to determine who is the carrier may be interpreted as an attempt to discover who is “at fault”....
- product of intermarriage among close relatives
- product of an incestuous relation
- in societies where belief in reincarnation is strong, a disability is frequently seen as direct evidence of a transgression in a previous life
- disabled are frequently avoided or discounted because of their past lives

A teacher instructs the class to draw an image of a lion. When all the hand-drawn images had been collected, the teacher held up an incredibly detailed drawing of a lion.

The teacher then criticizes the artist for being self-indulgent... having drawn an image that the rest of the class did not have the talent to draw themselves.

So, to discourage future displays of individual talents in her classroom, the teacher showed the class the “proper” way to draw a lion- a rudimentary stick-figure image of a lion that could be easily drawn by everyone in her class.

Chinese government continues to monitor what websites people are allowed to visit, with no access to Facebook permitted.

自閉症 is autism in Chinese, literally meaning “the loneliness disease”

Children with ASD are rejected from both the mainstream and special education systems-

• Even today, individuals’ unique talents are not sought out or encouraged- there is no such thing as “the individual”

• Everyone in China is still expected to perform at the same level- no special classes for “math whizzes” or “artsy kids” or musically inclined. Differences are still frowned upon.

• If children with ASD cannot work in the classroom like other students, they must not be in the classroom. Period. If they stand out in any way, they are a distraction to the other students and hinder their learning.

In North America:

*The squeaky wheel gets the grease.*

In Japan:

*The nail that sticks out gets pounded down.*
• Traditional values that lead parents to feelings of shame and guilt are being replaced by a motivation to spread awareness and understanding of autism.

• Autism has significant implications to parents but they are willing to make extensive sacrifices to ensure the success of their children.

• The new generation is more proactive, well-informed and determined to make sure their children are successful.
So How Does this Affect Screening & Diagnosis?

• Screening is the first step in the process of identification.

• ESPECIALLY CRITICAL for clinicians to understand and communicate this concept when working with families from diverse backgrounds.

• Particularly when their primary language is not English or when they have different views on child development since it may require more persistent follow-up to keep families engaged.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
So How Does this Affect Screening & Diagnosis?

- The concepts of screening, early identification and early intervention may be unfamiliar for families from diverse backgrounds.

- For many families, these concepts can be culturally bound

  - they may perceive that their children will be stigmatized in their communities if they participate in these practices.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• In some families, questions about a child’s skills may go unanswered since they may feel it is intrusive.

• Or their answers may ‘miss the point’ over and over throughout the evaluation.

• Some families may view screening as “looking for trouble” or feel that things clinicians think are problems are not an issue.

• Still for other families, their responses may shed light on their ability, background or resources.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• Thus, communicating slowly and clearly while LISTENING carefully and fully engaging families produces the best results.

• It can take multiple conversations, EVEN SEVERAL VISITS, to discuss concerns with families and work toward referral.

• It is also essential that clinicians do not become frustrated with the “denial” or “deflection” by the parents and/or grandparents, otherwise the possibility of engagement may be permanently lost.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• It is equally important to ask questions about the family’s understanding of and expectations for [general] child development.

• This could provide a wealth of information and set the stage for effective communication about child development in general and their child’s development specifically.

So How Does this Affect Screening & Diagnosis?

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• Consider whether parents understand the screening questions in addition to other possible language barriers because terms used in screening tools may have somewhat different meanings once translated.

• **CONSIDER LITERACY LEVEL**, as well as language and culture. *Literacy may be the prime factor in “non-compliance.”*

• Interpreters and cultural liaisons (who are proficient in distinct cultural issues) can assist greatly since written screening tools may be difficult for some families to complete, and for clinicians to interpret.

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Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
It’s More than Translation

• When working with families from diverse backgrounds, having thorough and clear conversations about the screening questions is critical to being certain that families understand and answer questions accurately.

• It is important to consider that some terms may not exist in a target language.

• In addition to translation, it may be equally important to develop new materials in the target language as well.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
When discussing screening concerns, miscommunication can often be avoided by starting with the families’ perspective.
• Ask questions as an invitation for parents to tell you what they are thinking, such as:
  • “Do you have any concerns about your child’s development?”
  • “What do you think is the cause of this concern?”
• Clinicians should express their concerns only after the family’s perspective has been shared, but they should also be mindful that families may not see a concern, especially if they are first time parents.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
Ask Questions!

- What do you call your child’s problem?
- What do you think caused it?
- Why do you think it started when it did?
- How severe is it?
- Will it have a short or long course?
- What are the chief problems your child’s problem has caused him/her and you?
- What do you fear most about it?
- What kind of treatment do you think your child should receive?
- What do you expect from this treatment?

http://www.autismgateway.com/c_cultural.html
• Targeted questions about the child’s behavior, communication, play, and interactions with other children and adults help clinicians probe further.

• When the issue is a failed or positive screening test, it is important to emphasize that it identifies only that a child is at higher risk for ASDs or other developmental delay(s). *It is not a diagnosis.*

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• Be cautious about the word “autism” if families do not ask you about it specifically. If they do, it is critical to ask:
  • “What have you heard about autism?”
  • “What does the term “autism” mean to you?”

• Reassure parents that when a child has problems with talking, interacting, or behavior, there are many things that can help a young child develop these skills.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
Don’t Go It Alone

- Enlist the collaboration of interpreters, cultural liaisons, nurses, community agencies, social workers, or others in supporting the family through the referral process.

- Identifying an available person in your practice or community with cultural and linguistic knowledge, and professional experience in ASDs, can make a positive difference to families in a successful identification and intervention process.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit
• Discuss the family’s comfort with speaking and understanding English and offer an in-person interpreter to assist at all visits, making sure that the interpreter is available free of charge.

• Schedule a follow up visit for one or two weeks after the specialty evaluation to talk through what happened at the visit.

Elaine Gabovitch, MPA Massachusetts Act Early: Considering Culture in Autism Screening Kit

Don’t Go It Alone
1. to review the analysis of culture and its relationship to society, the economy, and politics;
2. to outline the representation of disability in mainstream culture;
3. to explore the generation of disability cultures;
4. to examine the development of the disability arts movement and its implications for disability culture.

A sighted man named Nuñez falls into a long-isolated mountain valley where everyone has been blind for generations, and has adapted their social customs and other senses to being blind. Nuñez immediately assumes he will soon be king, but to the locals he seems incompetent.

Nuñez falls in love with a villager. When he asks for her hand in marriage, he is turned down by the village elders because of his "unstable" obsession with "sight". His attempts to prove he can see things they cannot go badly and he underestimates what they can sense via sound.

The claim isn’t that a person with a powerful new insight could never prove it to others. Rather, the point is that someone with a new insight could easily fail by arrogance, assuming his insight offers more than it does, and underestimating what can be done, and how things look, without it.

Nuñez could have succeeded by carefully mastering the usual skills and practices of the blind, and then carefully seeking simple clear ways to show how his new ability could give advantage, in the context of their usual practices. Assuming instead that his new “insight” excuses him from the need to follow the usual social paths, or to learn the usual insights and skills of the blind, is a recipe for failure.

http://www.overcomingbias.com/2010/07/do-one-eyed-rule-blind.html#sthash.0yNzrx5e.dpuf

1. Disabilities are approached best as a cultural fabrication, *e.g.*, an apparent disability-deafness- in a cultural context in which it does not count as a disability.

2. Focus on the recent popularity of disabilities in the United States as a good example of American culture at work.

3. Theories of culture and theories of disability similarly formulated with the materials of American culture, and show their relevance to currently popular accounts of school failure.

4. How two fairly new disabilities-- learning disabilities and illiteracy-- have been institutionalized as an active part of American education.

*Anthropology & Education Quarterly* 26(3):324-348.
It is about the powers of culture to disable.

how those now treated as disabled are the most telling example of such an elaboration.

In cultural terms, the difficulties people in wheelchairs... face with curbs and stairs tell us little about the physical conditions requiring wheelchairs or carts, but a great deal about the rigid institutionalization of particular ways of handling gravity and boundaries between street and sidewalk as different zones of social interaction.

Consideration of how such small matters can be turned into a source of social isolation and exclusion is a good way to ask about the nature of culture as disability.

*Anthropology & Education Quarterly 26(3):324-348.*
Recommended Readings

http://nccc.georgetown.edu/
The Spirit Catches You And You Fall Down
A Hmong Child, Her American Doctors, and the Collision of Two Cultures
Anne Fadiman

Winner of the National Book Critics Circle Award

With a new afterword by the author
Recommended Reading

"A wise and compassionate book." — ANDREW SOLOMON, author of *The Noonday Demon*

Unstrange Minds

A Father, a Daughter, and a Search for New Answers

Remapping the World of AUTISM

Roy Richard Grinker