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A relational-exploratory study : how attitudes towards deafness affect quality of behavioral health services provided to the deaf/deaf/hard of hearing client

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Ann Haseltine Tarmey
A Relational-Exploratory
Study: How Attitudes Towards
Deafness Affect Quality of
Behavioral Health Services
Provided to the Deaf/deaf/Hard
of Hearing Client

ABSTRACT

This study utilized a relational-exploratory design in an attempt to develop a clearer understanding of how attitudes towards deafness are related to potential quality of services rendered. It was hypothesized that amount of contact or level of knowledge of deafness might affect attitudes. It was inferred that attitudes that are more positive would result in more appropriate services, and attitudes that are more negative would result in less appropriate services.

The sample was compromised of students at the undergraduate and graduate level as well as experienced clinicians recruited from a community mental health center in rural New Hampshire (N=86). Participants either completed an online survey or filled out a hard copy survey. The Attitudes Towards Deafness Scale was the instrument utilized to measure attitudes of subjects. Demographic and additional questions designed by the researcher were incorporated into the survey. The purpose of additional questions was to attempt to substantiate amount of knowledge of deafness and level of contact in order to correlate results of the attitude survey.

Results of the data analysis showed significant difference in the attitude score between those who had served a deaf person and those who had not. Additionally, results also showed a significant difference between those who had received training and those who had not.

A RELATIONAL–EXPLORATORY STUDY:
HOW ATTITUDES TOWARDS DEAFNESS AFFECT
QUALITY OF BEHAVIORAL HEALTH SERVICES
PROVIDED TO THE DEAF/deaf/HARD OF HEARING CLIENT

A project based upon independent investigation,
submitted in partial fulfillment of the requirements
for degree of Master of Social Work

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2007

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I long to accomplish a great and noble task, but it is my chief duty to accomplish small tasks as if they were great and noble.

Helen Keller, n.d.

I dedicate the work on the following pages to my children, Signe and Olivia. Through laughter, tears and sacrifice we have made this journey together. I am deeply grateful to you both, for your patience and understanding. You have given my life true meaning, I love you two girls heart and soul.

Signe, you are the inspiration for this project. Though your years are young, you have humbled me and taught me much. Your sensitivity touches me every day and I admire your enthusiasm for life and your silly sense of humor. Through your eyes, you do not perceive others as “broken” or that something is “wrong.” I hope as you grow this value grows with you, from seed to blossom. I believe you will help transform the dominant “hearing” world into a more tolerant and accepting place of existence.

Olivia, you are a constant force in my life. You are spirited, determined and complex. You too, have the ability to accomplish great things. Your mind is resolute, quick and witty. You already possess the capacity for critical thinking; I hope you continue to cultivate this ability. My wish for you is that you continue to hold onto your core beliefs and values, but not forget to embrace change and transition. You have gracefully allowed this project to be a focus and I thank you for your patience and encouragement.

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CHAPTER I

INTRODUCTION

Deaf people have lived an uneasy existence due to unfair treatment since the beginning of time. Historically, sign language, the primary mode of communication of deaf people, had been deemed barbaric and not a viable form of communication. It was thought, mainly by the dominant hearing majority, that deaf people did not possess the capacity to be educated. Once it was determined in the early 1800s that deaf individuals possessed that ability, schools opened. These schools were mainly in the form of boarding schools, where it was necessary for children to leave home in order to gain an education. However, fierce debate over how to educate the deaf became a focus. Two schools of thought evolved surrounding communication modalities, oralism versus sign language. It was believed by some hearing teachers of the deaf, that deaf individuals could be trained to speak and hear. On the other side of the argument, a movement began that argued sign language was a viable form of communication. The debate between oralism and sign language still exists today.

Prior to the 1980s, there was no scholarly information surrounding deafness. Burch (2002) points out that deafness has been defined by hearing doctors, policymakers and educators. Though recent legislation has been enacted to protect the rights of deaf/Deaf/hard of hearing people, this population still faces unfair treatment and discrimination. As Pollard (in Raifman & McCay, 1996) notes, “It would be most desirable if these changes could come about in a proactive and enthusiastic manner,

through ADA education, enhanced disability awareness, and commitments to the civil rights ethic, rather than begrudgingly and protractedly through litigation” (p. 378).

Deafness is sometimes categorized as an “invisible disability” because it is not easily visible or readily understood. Further, socially constructed definitions of deafness have a propensity to pathologize deafness. Historically, Deaf/deaf/hard of hearing individuals have been marginalized in this country, which has resulted in limited power and status for these individuals. Members of the deaf population and Deaf culture possess different linguistic, language and communication needs, which are largely not understood by the dominant hearing culture. As a result, Deaf/deaf/hard of hearing individuals are less likely to access health care. A fear exists among this population that communication barriers are too costly in behavioral health settings; if miscommunication occurs the result could lead to misdiagnosis and inappropriate treatment.

Currently there exists little literature defining what factors might determine attitudes towards deafness in the behavioral health profession. Cooper, Rose & Mason (2003, 2004) have published the most appropriate information based on deafness and the behavioral health field.

The inherent goal of this study is to determine how attitudes towards deafness, which are likely socially constructed, are related to realistic and obtainable services by members of this diverse population. It is hypothesized that amount of contact with Deaf/deaf/hard of hearing people, level of knowledge of deafness, or a combination of both could be potential factors that determine attitudes towards deafness. It is inferred that attitudes towards deafness will affect the quality of behavioral health services provided. Less knowledge and contact will potentially result in attitudes that are more

negative and as a result, quality of services could be compromised. On the other hand, increased knowledge and contact could result in attitudes that are more positive, potentially yielding better quality of services. The research question guiding this study is: How do attitudes towards deafness affect quality of behavioral health services provided to Deaf/deaf/hard of hearing clients?

A relational-exploratory design was employed to determine how amount of contact, knowledge, or a combination of both, affect attitudes toward deafness. Prior to the data collection approval from the Human Subject Review Board was received (Appendix A). A recruitment email was sent targeting sample groups: experienced workers in the behavioral health field and undergraduate and graduate students with the intention of future work in the behavioral health field (Appendix B). This researcher designed a survey incorporating: screening questions, informed consent, demographic and additional questions, and finally the Attitudes Towards Deafness Scale (Appendix C). Permission was asked and granted to use Cooper, Rose and Mason's Attitudes Towards Deafness Scale (Appendix D).

For the purpose of this study, Culturally Deaf people are defined as those individuals who identify with Deaf culture and use American Sign Language (ASL) as their primary mode of communication. This population does not pathologize deafness; instead, it is considered part of the human element. Throughout this study, this population will be acknowledged with a capital "D" (Deaf). Also included in this study are those who do not identify with Deaf culture, but identify as deaf (small "d") or hard of hearing. Members of this group typically utilize assistive devices, such as hearing aids

or cochlear implants to hear. Degree of hearing loss does not constitute affiliation with either group.

It is the hope of this study that the findings will inform the field of social work by bringing greater awareness to the issues of this population within the context of the behavioral health field. It could be hypothesized that if attitudes towards deafness prove to be negative, and if little knowledge or training about deafness informs the work of behavioral health care workers, that there exists an increased probability that communication and cultural misunderstandings might occur. Consequently, oppression of individuals of the Deaf/deaf/hard of hearing will be perpetuated. Furthermore, clients will likely be misassessed and misdiagnosed, resulting in ineffective and inappropriate treatment.

CHAPTER II
LITERATURE REVIEW

The Historical Context of Deafness

The intent of this research is to argue that attitudes toward the Deaf/deaf/hard of hearing population are a result of a social construct that has evolved since the origin of humanity. It is clear this population has experienced a history of marginalization and oppression. As civil rights have evolved, the doors to equal rights have swung open. Though recent legislation has been enacted to protect the rights of deaf/Deaf/hard of hearing people, this population still faces unfair treatment and discrimination. The purpose of this research is to show that attitudes toward this population have been constructed by the dominant hearing population since the origin of deafness.

The history of deafness and how it has been perceived is long and complicated. Branson and Miller (2002) point out that there has been “a cultural construction of deaf people as disabled (p. 3). As a result, this population has been marginalized, pathologized, and oppressed. Deaf people have been impacted, socially, economically, politically and educationally.

In an attempt to better understand the social challenges that deaf people in our country have faced historically, it is necessary to understand the beginning of their social history and the many transitions this population has experienced.

In Colonial times, it was considered by the standards of those with hearing that those who lacked normal hearing were damned. It was believed that people were born deaf by an act of God and therefore were viewed as a lesser people. As Berman states, “their dehumanization was a necessary precondition of their maltreatment” (as cited in Branson & Miller, 2002, p. 24). This perception holds true through the early 1800s. For example, in New York, deaf people were not allowed to vote, and many states enacted laws to prevent carnivals from bringing deaf people into a town to combat the threat that they might be abandoned (Jankowski, 1997). Sign language, the primary mode of communication of deaf people, was considered savage, barbaric, primitive, and lower on the evolutionary scale. As a result of the social nonacceptance of deafness, there exists a period in history where oralism triumphed over manual language. Branson & Miller point out that during this time “the devaluation of deaf people’s natural sign language signaled and promoted the cultural construction of deaf people as ‘other’” (Branson & Miller, 2002, p. 161). The eugenics movement can also be considered a component of the cultural construction of deaf people as disabled (Branson & Miller, 2002).

It was not until later in our history when a shift in thinking occurred and instead of believing the deaf were incapable of being educated, it was thought they might possibly possess the capacity to be educated. Once this movement was established, schools opened. Modality of communication—oral versus sign language—evolved as a passionate debate among the hearing and the deaf community.

In 1817, Thomas Hopkins Gallaudet opened the first school for deaf children, The American Asylum for the Deaf in Hartford, CT (Van Cleve, 1987). It was a large step for the deaf community, however, it was slow to catch on because it was not until 1843 that

the next school for the deaf was established, this time in Indiana. These schools were comparable to boarding and vocational schools and one can posit that it was most likely only privileged children who could afford to attend them.

Education of the deaf cannot be discussed without mentioning the passionate debate regarding chosen mode of communication. On one side of the debate, oralists who were primarily hearing people believed deaf people could be integrated into society by teaching them how to lip read and use spoken language. However, proponents of a manual system of communication, primarily deaf people, with some support from a small group of hearing people, passionately supported sign language as a primary method of communication. Not only does a schism exist between the deaf and hearing communities, but also friction develops within the deaf population regarding modality. Debate over method of communication still exists today.

While deaf people were negotiating a troubled existence in our country, disability rights began to emerge. These forces were parallel but did not converge until much later in our history. Disability rights came into being after the Revolutionary War when policy was enacted to compensate the disabled for their service. This belief to give back to those who could not hold positions for wages continued into the Industrial Revolution. Workers who sustained on the job injuries, and as a result became disabled, would receive monetary payment from government. Policymakers believed that compensation for the disabled was necessary to combat poverty, maintain order, and promote economic and social stability. There was no concrete plan or policy; therefore, it was common that men received compensation over women, some disabilities over others, and employed

disabled workers who had paid their debt to society over unemployed disabled workers (Dell Orto & Marinelli, 1995).

The deaf experience in the first three quarters of the 1900s was comparable to that of immigrants. Deaf adults were mostly uneducated, challenged to communicate with the hearing world, and were treated with shame and repugnance. Because of this forced isolation, they began to live together in the same areas, just as immigrants did, and began to intermarry. As Theodore Roosevelt states: “We have room for but one language here, and this is the English language; for we intend to see that the crucible turns our people out as Americans, of American nationality, and not as dwellers in a polyglot boardinghouse” (Burch, 2002). From this statement, the weight of oppression and marginalization deaf people faced in our country is clear.

Another factor that affected the perception of the deaf during the early 1900s was the effect of Francis Galton’s Eugenics Movement. During this time, the forces of Social Darwinism and the Progressive Movement combined to put forth the notion that some classes of people were a detriment to the future of society. The result was denial of basic rights and grossly unfair treatment. As Burch explains, although the deaf were not necessarily slated for sterilization they were considered “dangerous, afflicted, socially inadequate and unfit” (2002). This kind of judgment added to the resistance of acceptance among mainstream America.

Social Policy

As quoted by Lane, The history of the deafness field is largely a history of hearing people and what they have done to, rather than for or with persons who are deaf (Pollard, 1996, p. 393).

Social policy surrounding deafness was largely non-existent until our recent history. In the 1930s, the Parents Movement, consisting mainly parents of children with cerebral palsy and mental retardation, began to organize. This organization began to advocate and lobby for children with all types of disabilities and is largely responsible for creating programs at all levels of the government. In 1975, riding on the momentum of the Parents Movement, the passage of Education for All Handicapped Children established that children with disabilities have the right to free and appropriate education in the least restrictive environment. This law positively impacted deaf children so they could essentially receive fair treatment in education. It is important to note that in sharp contrast the Social Security Act of 1935 provided legislation for “crippled” children, the Randolph-Shepard Act of 1938 allowed rights to the blind, and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 was passed for the mentally retarded (Pelka, 1997). However, legislation to benefit the deaf was not passed until the 1970s. Furthermore, prior to the 1980s there was no scholarly information on deaf people; as Burch points out, deafness was defined by hearing doctors, policymakers and educators (2002).

It is evident that fair and just treatment of the deaf has taken a long time to develop and grow and is still evolving today. The Deaf Community has lived through social persecution due to the belief they were damned, and they lived through isolation because of societal misperceptions that they were unable to be educated. Later, deaf people faced stigmatism associated with being a target of the Eugenics Movement. This community did not always receive fair treatment from policymakers due to the perception that their deafness was not worthy of compensation versus others with different

disabilities. Legal rights for the deaf did not exist until the Rehabilitation Act of 1973, which was considered the “Bill of Rights” for disabled people (Turkington & Sussman, 1992, p. 113). This legislation ensured that disabled people cannot be discriminated against and that employment, health, welfare, and social services are accessible. In 1990 the Americans with Disabilities Act was enacted to guarantee equal access to information and services. This included access to a statewide telephone relay system provided by states at no extra cost to deaf consumers. In addition, all television sets sold in the United States possess closed-captioned broadcast capabilities.

In terms of education, the Education of All Handicapped Children Act was enacted in 1975. Congress amended the law in 1990 and renamed it as The Individuals with Disabilities Education Act. Mainstreaming all children into the public school system became the norm, not the exception. This law was reauthorized in 2004 and was renamed once more as The Individuals with Disabilities Education Improvement Act.

In 1990 The Americans with Disabilities Act was passed. This law provides antidiscrimination protection for all people with a physical or mental disability that limits at least one life activity (McEntee, 1995). In terms of mental health care for deaf/Deaf/hard of hearing people as quoted by Glickman & Gulati (2003) the law prescribes “qualified interpreters and other effective services” (p. 8). This legislation insures a person’s right to equal access to psychological services. As a result, an agency must be equipped and able to provide access to communication for deaf/Deaf/hard of hearing clients at the expense of the agency. This could be in the form of assistive devices or sign language interpreters. However, as Raifman & McCay (1996) point out, “implementing the newly accorded equal access rights to persons with disabilities,

especially deaf persons, poses many of the same pitfalls as does racial minority access, including problems of cultural identity, stigma, ideological versus pragmatic strategies, limited resources, and political resistance” (p. 372). Resistance to the rights of deaf/Deaf/hard of hearing people still exists. As Pollard notes “it would be most desirable if these changes could come about in a proactive and enthusiastic manner, through ADA education, enhanced disability awareness, and commitments to the civil rights ethic, rather than begrudgingly and protractedly through litigation” (Raifman & McCay, 1996, p. 378).

Deaf people have historically struggled in this country, not unlike immigrants and other ethnic groups. Beginning with damnation, moving to an uneasy, apprehensive acceptance, and finally receiving equal treatment *most* of the time, deaf people still face challenges imposed by today’s society.

*The Case for Culturally Affirmative Mental Health Care
The Story of Jan DeVinney
(Glickman & Gulati, 2003).*

People who are deaf and partially hearing, and are seeking or receiving mental health services, routinely confront a stunning lack of accessibility and inappropriate treatment, as stated by Pollard (DeVinney & Murphy, 2002, p.304).

In 1996, a late deafened woman, Jan DeVinney, experienced a reoccurrence of a Major Depressive Episode. Her hearing had deteriorated over several years and her deafness had recently moved into the profound range, where she would have difficulty hearing a large truck drive by, the roar of a lawnmower, or even a telephone ringtone. Her hearing aids were of little help to her now. Jan was the program coordinator of a community support program for deaf people and she was working towards her Master’s degree.

As described by Harvey (1998), many persons with moderate hearing loss “develop good oral skills, lip reading skills, use of residual hearing, and a command of English” in order to “pass” in the hearing world (p. 66). As Jan’s hearing deteriorated, many of the devices that helped her accomplish this were of not use to her and she suddenly felt shut off and isolated from a world where she felt she had once belonged.

Jan had experienced a Major Depressive Episode four years prior. Currently, Jan was contemplating suicide and she understood the gravity of her condition. She tried to call a crisis hotline. Although it was supposed to be accessible to the Deaf/deaf/hard of hearing population, she was repeatedly hung up on. She realized her situation was desperate and she finally drove herself to the emergency room. When she arrived, she explained that when her name was called, it was likely she would not hear it. Though she had explained what accommodations she needed in order to effectively communicate, such as a place where lip reading would be easier, her request was ignored. She was led to a room where the bed was bolted to the wall. “I was struck by the irony that it was the purpose of my job to help eight deaf clients avoid the situation in which I now found myself in” (Glickman & Gulati, 2003).

The next morning, Jan, through written communication with a nurse, requested a TTY so she could contact her husband. After a series of failures to locate a working TTY, three hours later Jan was able to contact her husband. Jan was still not offered an interpreter; she was communicating via lip reading and written communication. Jan was angry and a few days of aggressive and assertive behavior landed her in an anger management group, without the use of an interpreter. Situations like this can be extremely difficult for a deaf person, unable to lip read all that is said while the rate of

conversation moves quickly. Additionally, for those who can hear, hearing does not require the use of muscles. To lip-read requires constant attention and the use of eye movement, which can be very tiring (Jackson & VandeCreek, 2001). A group therapy situation can be a nightmare for someone who relies on lip reading for receptive communication. It should be noted, and has been well documented, only about “30%-40% of English sounds are visible on the lips making speech reading unreliable and ineffective” (A. G. Steinberg, Wiggins, Barmada, & Sullivan, 2002).

Finally, an interpreter entered Jan’s room. Initially Jan was relieved, but after only a moment of signing Jan realized the interpreter’s skills were inadequate. Jan inquired about the interpreter’s experience. The interpreter was a sign language volunteer who had taken few classes. As Basil explains, there are not only issues of ethics and confidentiality when an interpreter is utilized, in therapy situations there are issues surrounding transference and countertransference (Jackson & VandeCreek, 2001). Furthermore, a sign language interpreter must be fluent in the grammar, syntax, and nuances of American Sign Language (ASL). Fluency is even more necessary in a therapeutic situation where complicated emotional issues are communicated.

Jan was misdiagnosed with Adjustment disorder instead of a relapse of Major Depression. The diagnosis of Adjustment disorder was a result of what therapeutic professionals perceived as Jan’s difficulty in adjusting to the most recent drop in her hearing. As a result, she was not being treated for depression and medications that had worked in the past were not prescribed.

The story of Jan DeVinney is disturbing. This did not occur in a remote rural area where resources are limited. This occurred in Portland, Maine a little over 10 years ago.

Jan was well aware of her rights; however, the more she advocated for herself, the more discriminated against and oppressed she felt by the staff and the facility. Jan sought litigation and in 1998, Maine Medical Center responded with 38 pages of changes they agreed to make to help ensure future deaf patients had access to appropriate services and accommodations. However, Maine Medical Center stood by their argument, that the facility need not offer an apology because it had done nothing wrong.

The Medical and Cultural Models of Deafness

Understanding the complexities of this population can be difficult. As quoted by Mitchell, there are about 11,000,000 individuals over five years of ages in the United States who are Deaf/deaf or hard of hearing (McCay, 2006, p.816).

Historically, deafness has been treated as a deficit or disease that must be prevented or cured. This school of thought can be referred to as the medical or pathological model of deafness. In an extreme form, this model implies a deaf person is incomplete, that deafness must be fixed or cured in order for an individual to become complete (Moore, 2001). Concepts like “handicap” are usually associated with this model.

Another perspective is the cultural model. This model posits deafness is not a deficiency or a limitation but part of the human condition (Moore, 2001). The most important aspects of the cultural perspective of Deaf identity is the attitude and acceptance of oneself as Deaf, not disabled. Additionally, fluency of ASL and knowing the social rules of the culture are integral components of Deaf identity (Glickman N. & Harvey M., 1996). It is here where these models diverge and the population splits.

Deaf/deaf and hard of hearing identities can be formed based on type and degree of loss, chosen communication modality and knowledge of Deaf culture. Those with

hearing loss, who have been primarily affiliated with the speaking and hearing world are generally aliens in the Deaf Culture (Luey, Glass, & Elliott, 1995).

Advances in technology have offered many options for this population. TTY capabilities, closed captioning, hearing aids and cochlear implants are the most common assistive devices and there exists a myriad of other assistive devices that can aid some deaf people. In many cases, these technologies link the Deaf/deaf/hard of hearing people to the hearing world. However, it is safe to say that within the dominant hearing culture there is little known about these technologies, not to mention the utilization of them. Depending on the severity of the loss and type of loss, not all deaf people can utilize hearing aids. Cochlear implants can be an option for others and embracing Deaf Culture is yet another choice for others.

*Recent Social Implications of Deafness
The Medical Model*

In terms of disability, deafness is the most common disability present at birth. Every year in the US, 24,000 babies are born with hearing loss; 12,000 with a moderate to severe hearing loss; another 12,000 with a lesser hearing loss (Brody, 2000).

An infant with hearing loss looks and acts like any other baby. There are no outward cues but hearing loss can be detected through infant screening. If screening does not occur, it is not until the child experiences a delay in talking that hearing loss might be suspected. This delay could result in long-term effects on the child in the areas of development, language, and cognition.

Awareness of the impact of childhood hearing loss grew in the early 1990s, as the social, developmental and educational implications of deafness became better understood. Infants not identified with hearing loss, or children who were identified

later, were missing out on a critical time frame where language development occurs at a rapid pace. When an infant or child is identified with any degree of hearing loss, it is difficult not to contemplate taking action when a child is identified with hearing loss. This situation makes a valid argument on the side of the medical model of deafness.

A study of profoundly deaf infants found that those who received family intervention scored significantly better in family stress, level of development, and communication ability than members of a comparison group who received a less systematic intervention (Greenberg, 1983). As the implications of childhood hearing loss gained more attention, the importance of infant screening became a priority. Research showed that infants who were identified with hearing loss by six months and began receiving intervention possessed expressive and receptive language skills within normal limits as compared to those who were identified later and did not receive early intervention (Yoshinaga-Itano & Apuzzo, 1998).

As a result of the increase of information surrounding childhood hearing loss, the importance of early identification was significant enough that in 1993 the National Institute of Health highlighted this concern, by recommending that all newborns undergo a hearing screening before discharge from hospitals. In response to this recommendation, legislative mandates increased across the nation. By 2000, 17 states established systems for newborn hearing screening, audiological assessment and intervention (Gallagher, Easterbrooks, & G, 2006).

As a direct result of legislation, there has been an increase of babies identified with hearing loss. Due to the recent increase in identification of deaf and hard of hearing

children, this population has evolved and, in a sense, come into existence in the recent past.

Social Implications of Deafness
The Cultural Model

Information about deafness has been limited to modern times. As quoted by VanCleve, “as recently as 1970 Deaf history did not exist (Moore, 2001, p. 29).

As Basil (2001) explains, Deaf culture makes up of nearly one percent of the population (Jackson & VandeCreek, p. 369). As Basil (2001) further points out, “deafness as a category has been dropped from the census because, although such persons may have an audiological defined “severe” or “profound” hearing loss, they may not necessarily call themselves “deaf” or “Deaf” but prefer the label “hard of hearing”” (Jackson & VandeCreek, p. 374). This illustrates the tension that exists between the hearing and Deaf worlds and results in even less acceptance and understanding of this culture.

Deaf culture does not perceive deafness as pathological or something that needs to be fixed or repaired. Unlike some other cultures, Deaf culture does not have a distinct cuisine, dress or religion. The most notable characteristic of Deaf culture is that it experiences sign language as primary language (Glickman & Gulati, 2003). Deaf culture does have schools for the Deaf and recreational sports and activities for the Deaf. Deaf culture is distinctive in that many cultures are passed from parents to children; however, Deaf culture is not necessarily transmitted this way. As noted in Glickman & Gulati (2003), “nine out of ten deaf children are born to hearing parents (p. 42). When a deaf child has hearing parents, communication can become difficult. When this occurs, many

deaf children can develop closer relationships in schools for the deaf and as a result will likely begin to identify with the Deaf community.

The Deaf community has a unique perspective on psychosocial development, mother/infant communication, family communication, and dynamics. Regardless of whether these perspectives are perceived as strengths or weaknesses, they are all different from experiences of hearing individuals (Jackson & VandeCreek, 2001).

Previous Studies Surrounding Measurement of Attitudes Towards Deafness

Deafness has been called the “invisible disability” because it is not easily seen or readily understood. Therefore, adopting a measure for deafness based on other disabilities could lack reliability and validity.

In terms of measurement, the first published and widely used scale, The Attitudes to Deafness Scale, was established in 1967 (Cowen, Bobrove, Rockway, & Stevenson, 1967). This scale was adopted from a scale designed to measure blindness. Until the recent past, this scale was widely used in determining attitudes towards deafness. Other instruments were designed for the purpose to measure attitudes towards other disabilities such as the Disability Factor Scales and Attitudes Toward Disabled Persons (as cited in Berkay, Gardner & Smith, 1995, p. 105). These measures did not specifically measure attitudes towards deafness.

More recently, The Opinions about Deaf People Scale was developed in an attempt to assess hearing adults’ beliefs about the capacities of deaf adults (Berkay, Gardner, & Smith, 1995). The authors of this scale proposed that hearing adults who believe deaf adults possess equal capabilities would also believe deaf people possess equal intelligence and skill level. This scale helped to facilitate research in the area.

Kiger (1997) looked further into how attitudes are affected by stereotypes, values and emotions. This research looked at these characteristics as separate and individual components of attitudes. The results of this research “suggest that the structure of attitudes toward person who are deaf are systematically different from the structure of attitudes toward persons with other disabilities” (Kiger, 1997, p. 557).

To this point, none of the research is specific for measuring attitudes within the mental health field. As awareness increased, the need for research specific to this area has evolved. The aim of one study sought to examine the level of hearing mental health professionals contact and knowledge of deaf issues as a factor in determining attitudes towards deaf people (Cooper, Rose, & Mason, 2003). The results of this study found that mental health professionals’ contact with deaf people of equal or higher status correlated to more positive attitudes toward deaf people as a group (Cooper et al., 2003). In addition, those who had received training in deaf issues reported more positive attitudes toward deaf people.

In a follow-up study, Cooper, Rose & Mason designed the Attitudes To Deafness Scale (2004). The purpose was to develop a reliable measure, specific to the mental health field, that could assess attitudes toward those who are deaf (Cooper, Rose, & Mason, 2004). Overall, Deaf people have been diagnosed at higher rates of mental illness than the hearing population (McCay, 2006). This leaves the question; does mental illness affect the Deaf population at increased rates? Alternatively, are Deaf people diagnosed with mental illness at increased rates because of lack of understanding of their culture? It is hypothesized that attitudes toward the Deaf/deaf/hard of hearing population are based on three components: contact, knowledge, or a combination of both.

Mental Health Issues Within in the Context of Deaf Culture

Because psychological and psychiatric work depends so much on accurate communication requiring minimal assumptions in order for correct diagnoses and treatment to be offered, anything that interferes with accurate communication can have dramatic and detrimental effects, as quoted by Basil, (Jackson & VandeCreek, 2001, p. 374).

Communication

As previously noted, whether one identifies with the Deaf culture, is pre-lingually deaf, or becomes deaf later in life, can result in different circumstances and situations. Therefore, mental health issues surrounding this population can be complex. As Basil notes, “to even begin to consider offering the complex and critical mental health services we have been trained to offer, considerable training is required in the variety of nuances involved in sign language, Deaf culture, and the deaf perspective on living in both the physical and in the social world of the hearing community” (Jackson & VandeCreek, 2001).

Viable communication is critical for all aspects of the therapeutic process. The chief concern for Deaf clients is the language barrier (Williams & Abeles, 2004). ASL is a visual language that does not translate word for word into spoken English. ASL uses visual gestures, handshapes and facial expression to express thoughts. Additionally, ASL possesses a different grammatical structure and syntax than spoken English. The number of psychologists proficient in sign language, or knowledgeable about hearing loss, is small (Feldman, Kluwin, & McCrone, 2005/2006). As a result, Deaf people report negative experiences, or avoid health care largely based on inadequate communication situations (A. G. Steinberg et al., 2002). On the side of the Deaf client, there exist

feelings of frustration, mistrust and avoidance of health care systems. Furthermore, when a Deaf client seeks treatment, Steinberg et al note, “deaf adults report suboptimal communication with their health care providers, including a reliance on speechreading and written communication” (2002, p. 731). As Basil explains, “just having an interpreter present in sessions does not mean full understanding has been achieved between the client and the clinician, nor that even adequate communication and mutual understanding of the concepts exchanged have been achieved” (Jackson & VandeCreek, 2001, p. 370). Finally, a clinician must understand there may be a stark difference in how a Deaf client receives and conceptualizes information.

Assessment

To ensure the highest level of sign language, professionalism and competence, national certification should be required. A sign language interpreter should possess fluency in both ASL and English. Furthermore, the interpreter should have a familiarity with clinical assessment or have a general understanding of medical or social services (Williams & Abeles, 2004).

It should also be understood that a person communicating in sign language will maintain intense and constant eye contact, may touch a listener, stomp, or wave an arm in order to gain the attention of another person (A. Steinberg, 1991). Non-verbal signs could be mistaken as intrusive, breaks in boundaries, or even abnormalities. In the therapeutic realm, this could be diagnosed as an inappropriate effect resulting in misdiagnosis and ineffective treatment.

Transference/Countertransference

It is imperative the interpreter maintain confidentiality in order to gain the trust of the Deaf client. This relationship between and among the clinician, client and interpreter can become convoluted. As Basil points out, the client might internalize the interpreter's words and form attachments, associations and transference with the interpreter (Jackson & VandeCreek, 2001). A Deaf client may either experience the interpreter as an intruder, or as the helping professional with the hearing therapist becoming the outsider (Williams & Abeles, 2004). Finally, countertransference may be placed on the interpreter by the clinician (Jackson & VandeCreek, 2001).

Furthermore, if a change in interpreter is made and the same one is not utilized each time with a client, this can too affect the therapeutic relationship. The period of understanding the subtleties of communication between and among client, therapist and interpreter will recommence, compromising the efficiency of treatment. In addition, the period of trust building will have to begin again.

Psychological Assessment

Historically, children who were Deaf/deaf/hard of hearing scored in the mentally retarded range on IQ tests. This helped reinforce the stereotype that children with hearing loss possessed less cognitive abilities. It was later determined that these tests were not measuring IQ; rather, they were measuring the language deprivation as a result of their deafness ((McCay, 2006). In terms of psychological evaluation, appropriate norms may be scant or non-existent (Cohen & Swerdlik, 2005).

For example, a frequently used measure, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), posits, "people are talking behind my back." Obviously, for a

Deaf person, this is a common occurrence. This illustrates how some psychological testing is inappropriate to utilize with the Deaf culture.

Mental Health Issues Within the Context of deaf/Hard of Hearing Population

Helen Keller observed that blindness cuts one off from things, deafness from people (Glickman & Gulati, 2003, p 8).

Communication

Most people who are deaf or hard of hearing will not identify with the Deaf culture. Therefore, many of these clients will be able to use spoken English combined with lip reading and assistive devices such as hearing aids and cochlear implants in order to communicate.

Age of Identification

There is a critical distinction between prelingual and postlingual deafness (Halgin & McEntee, 1986). Prelingual hearing loss can interfere with language acquisition, and this can have an effect on a person's social, cognitive and emotional development. As previously noted, many deaf children are born to hearing parents. Though it is recommended these parents learn sign language, they are less likely to become fluent in ASL (Glickman & Gulati, 2003). Since the ability of a deaf child to hear spoken language is compromised, and if parents do not sign, combined with the time frame in which capacity of learning language is optimal, the possibility of a child acquiring and mastering language can be greatly impacted. As Glickman and Gulati (2003) state, "those with first exposure to usable language after very early childhood develop permanent cognitive damage and permanent language deficits" (p.43).

Those who have experienced hearing loss after spoken language has been acquired face different challenges than those pre-lingually deaf. For this population, language has typically been acquired, which can facilitate communication. However, there is often a sense of isolation and frustration that can translate into communication problems. For example, a late deafened person might employ a strategy called “pretense” where he or she will pretend they heard and understood the speaker by seemingly agreeing (Halgin & McEntee, 1986, p. 471). Obviously, this can result in miscommunication.

A vignette illustrates the frustration of a person who does not affiliate with the Deaf community, but also has difficulty fitting in the hearing world. “Hearing people often think I am hearing because my speech is good; deaf people often think I am hearing because my signs are bad...we are caught between incomprehensible speech on one hand and incomprehensible signs on the other. If only those hearies would talk more clearly! If only those deafies would sign more slowly! Whose[sic] taking care of us?” (Harvey, 1998).

A person who utilizes a hearing aid or cochlear implant is often contending with the amplification of all sounds, for example the noise of fans in ventilation systems. This can be very distracting and impede communication. Additionally, a person utilizing these aids is also likely to be relying on speech reading. If the room is poorly lit, or if a therapist has a beard or mustache, the quality of communication can be impeded.

It is important to note that regardless of age of onset of deafness, the language and thinking of a deaf or hard of hearing person can be significantly different than what a hearing person might perceive (Halgin & McEntee, 1986).

A clinician working in the mental health field must be aware of the complexities of working with this population. A deaf or hard of hearing client, seeking counseling should not feel responsible to inform a clinician of the complexities of their hearing loss. Effective and appropriate assessment, diagnosis and treatment will be compromised if clinicians are not adequately trained in issues of deafness.

The Case for Culturally Affirmative Training

We are remarkably ignorant about deafness...ignorant and indifferent (Sacks, 1990, p.1).

It is the hope that in light of the argument put forth, it is clear our society will benefit from a strong effort to make culturally affirmative training an integral part of education and agency policy. It is likely hearing members of our society do not understand the Deaf culture, or even understand there exists a difference between Deaf/deaf/hard of hearing. It is more common for hearing people to think of Deaf people as disabled than to think of them as belonging to a cultural minority (Baynton, 1996).

Cultural affirmation includes one possessing cultural competence, knowledge and skills pertaining to Deaf/deaf/hard of hearing issues and a relevant self awareness (Glickman & Gulati, 2003). Without culturally affirmative training, or by holding a neutral stance, one actually endorses oppressive social processes (McGoldrick, 1998). Deafness must be understood as a multifaceted phenomenon that has both cultural and sensorial implications (Leigh, Corbett, Gutman, & Morere, 1996).

Furthermore, as Glickman & Gulati (2003) point out, conflict often arises in cross- cultural situations (p. 28). Training mental health workers to understand that this is normal and to be expected would greatly benefit them.

The passing of The Americans with Disabilities Act has brought greater awareness of issues of deafness. However, there still exists a resistance of the dominant hearing world surrounding acceptance of the deaf/hard of hearing population and Deaf culture. Further, as has been illustrated, in terms of mental health care, there still exists the need for awareness, knowledge and understanding of this population and culture.

CHAPTER III

METHODOLOGY

The purpose of this study was to understand how attitudes towards deafness are related to realistic and obtainable services received by members of this population. It was hypothesized that amount of contact with Deaf/deaf/hard of hearing people, or level of knowledge of deafness, or a combination of both, could be potential factors that determine attitudes towards deafness. Furthermore, it was inferred that more positive attitudes would correlate to better quality of behavioral health services being delivered to clients.

A quantitative research method was utilized because the goal of the research was to obtain objective data. The relational-exploratory research method was chosen as the most effective way to structure the research in order to explore how level of contact or knowledge might correlate with attitudes. The goal this study was to determine whether attitudes towards deafness were systematically associated with characteristics of contact with Deaf/deaf/hard of hearing people, knowledge of deafness, or a combination of both.

The study proposed drawing relationships between attitudes towards deafness, the dependent variable (DV), and the independent variables (IVs) of level of contact and level of knowledge. It was hypothesized that the IVs would directly correlate to attitude score. Questions were formulated by the researcher to determine amount of knowledge and level of contact.

Once approval was received from the Human Subjects Review Board the researcher began the data collection phase of the study (Appendix A). A recruitment email was sent to potential participants (Appendix B). Participants were required to meet screening criteria in which there were few limitations (Appendix C). The only criteria was to recruit participants either currently working in the behavioral health field, or those with the intention of working in the field. There were no age or demographic limitations. It was hypothesized that not limiting screening criteria would allow for a viable sample size that would be representative of the population of current or potential mental health care workers. This included participants who were students at undergraduate and graduate levels with the intention of working or practicing in the behavioral health field in the future, including those with the intention of becoming a Counselor, Therapist, Clinician, Case Manager, Substance Abuse Counselor, Social Worker, Psychologist, Psychiatrist or Nurse. Permission was received to recruit undergraduate students enrolled in Psychology classes at Keene State College, Keene, NH (Appendix D). Graduate students included students enrolled at Smith College, School for Social Work.

Also included were those who had experience or were currently practicing in the behavioral health field in any of the previously stated occupations. Agency approval was received to recruit at this researcher's placement (Appendix E).

A survey was designed by this researcher that first included screening criteria pertaining to whether participants had experience or intention of working in the behavioral health field. Next, respondents were required to read and agree to the informed consent before proceeding further (Appendix F). What followed was a series of questions including demographic inquiry and questions that attempted to measure level of

contact and knowledge of deafness (Appendix G). After these series of questions, the Attitudes Towards Deafness Scale followed (Appendix H). Permission was granted to utilize this scale (Appendix I).

Researcher bias was controlled to an extent purely by design. Utilizing a fixed method forced the research into a closed system; bias was taken into consideration and controlled for from the beginning of the research. By snowball sample and mass emailing, this researcher had little contact with participants; because of this little contact, interviewer bias was eliminated. However, due to the experiences of the researcher and the nature of the subject it is inevitable that within the questions the researcher designed, bias was inevitable. Beyond the demographic questions, the purpose of the questions was to draw upon amount of contact and knowledge of participants; specific details of questions are related to the experience and knowledge of the researcher.

Survey

It was determined that a survey would be the most efficient and effective data collection method for measuring attitudes towards deafness. This form of data collection would minimize respondent burden and maximize response rates. One purpose of utilizing a survey was the belief that participants would answer difficult or sensitive questions more accurately and honestly via online or anonymous hard copy survey. Additionally, data analysis of this survey would allow the researcher to make inferences describing the target population. Analysis of the data would result in the ability to measure how attitudes towards deafness might influence quality of mental health services.

The survey consisted of four sections. The first contained the screening questions. If participants did not meet screening criteria, the survey was designed to thank participants for their interest, and they would be exited from the survey. Once screening criteria was met, the participants were required to read and agree to the Informed Consent. Once this was agreed to, participants read an explanation of terms used in the survey. Included in the next section were a series of 26 questions designed by the researcher. Most questions in this section were multiple choice. One question, asking a participant's age, was open-ended. This line of inquiry asked a series of demographic questions. Also included were questions surrounding identification, experience, training, level of contact, and level of knowledge of the target population. In this section, the survey was designed to require a response for these questions. If a question was not answered, the survey would prompt an answer from the participant.

The final section included the Attitudes To Deafness Scale, a 22-question, six-item Likert Scale (Cooper, Rose and Mason, 2004). This section began with informing the participants that the scale was used with permission from the authors of the scale. This scale was authored and designed by researchers in England. This researcher took into consideration the possibility participants in the United States might possess different interpretations of the wording of the survey. As a result, it should be noted the researcher revised some of the language used in this scale. Throughout this study, the researcher has made a clarification between the terms "Deaf" and "deaf," including the term "hard of hearing" with those who identify as "deaf." However, the published scale utilizes only the term "deaf." This researcher added "Deaf" to each question in an attempt to capture attitudes about the entire population.

Other changes were made and are noted as follows. In the survey published by Cooper, Rose and Mason (2004), question number 4 states: “Deaf schools and deaf clubs create deaf ‘ghettos.’” This researcher felt the use of the word “ghetto” within the context of this research carried a negative connotation and as a result, potential negative responses to this question could skew the results. This question was deleted from the survey.

Statement number 16 in the published survey asserted: “Training more professionals to work with deaf clients would be a waste of time.” The corresponding statement in this researcher’s survey is question number 44. The wording was changed, and the statement read: “Training more professionals to work with Deaf/deaf clients is not necessary.” It was felt by the researcher that the original wording was strong and again responses could potentially be skewed. The edited statement conveys a less strong meaning allowing participants to respond to the question, not the language.

Finally, statement number 20 in the published survey declared: “I would like to see more deaf people at the clubs/societies I attend.” The corresponding statement in this researcher survey is number 47, stating: “I would like to see more Deaf/deaf people in the community.” The edited wording seemed more appropriate and reflected current terminology. This changed also intended to negate possible respondent bias.

Sample

Research subjects were recruited through a non-probability convenience sample (N=86). Participants were chosen because they met the selection criteria and were easily accessible. A snowball method of recruitment was also incorporated. A recruitment email was sent by the researcher to potential participants who met screening criteria,

including peers at Smith College School for Social Work. Additionally, a recruitment email was sent to all employees at West Central Services. This agency consists of four locations serving 34 towns and three counties, employing over 160 mental health care workers and administrative positions in the central and southwestern region of New Hampshire. Finally, a recruitment email was sent to a Psychology professor at Keene State College, a liberal arts college that is part of the University System of New Hampshire. Enrollment is just over 4,500 students. Students enrolled in upper level clinical and counseling classes with the intention of working in the behavioral health field were asked to participate. For those who chose to participate, the professor allowed seven extra credit points toward the participant's final exam.

Data Collection

Data collection was based on self-report. An online data collection management resource ("SurveyMonkey.com") was used to host this study. The method of data collection was advantageous because of the ease, convenience, and cost effectiveness of using an online data collection service. The survey was accessible from any computer with internet capability. Throughout the process of completing the survey, subjects could change answers to questions and use the "back" button on their web browsers. Responses were required for the survey questions. Once a questionnaire was completed, respondents could not withdraw from participation. Upon completion of the survey, participants were thanked for their participation and routed to the "SurveyMonkey" home page.

Participants had the option of requesting hard copy surveys. A small number of participants at the agency requested hard copies. When these were returned, if Informed

Consent had been agreed to, this document was stored in a separate envelope from the completed surveys to ensure anonymity. If Informed Consent had not been agreed to, the survey was destroyed. Once all hard copy surveys had been returned, the data was manually inputted to the online survey.

To determine which students at Keene State College participated in the survey for extra credit, hard copies were distributed to the class by the professor. When the surveys were returned, extra credit was given. The professor did not review the contents of the surveys. It was requested that completed surveys be returned within one week to the professor. The researcher then retrieved the completed surveys and manually entered the data from the hard copy surveys into the online survey.

Because careful and conscientious steps have been taken to insure data is anonymous and confidential, publication of data will not identify participants. Data will be stored in a secure place for three years as required by Federal regulations, after that time, data will be destroyed or kept secured until it is no longer needed.

Feedback surrounding the survey was conveyed to the researcher. Two participants felt that combining the terms “Deaf” and “deaf” in the same study resulted in their difficulty in answering questions. “Deaf” individuals identify with the cultural model of deafness. Those persons who identify as “deaf” are considered to represent the medical model of deafness. This divides the population. Therefore, these participants felt combining these terms made responding to the survey difficult.

Four respondents felt uncomfortable responding to statement number 34. “Deaf/deaf people are handicapped.” These respondents reported that they were uncomfortable with the term “handicapped” but felt that Deaf/deaf individuals were

disadvantaged to some degree. These participants expressed discomfort responding to this question, as the term “disability” is currently used more widely in the United States.

One respondent pointed out that in the section that gathered demographic information, not all degrees were represented. J.D was inadvertently left out of the survey.

Instrument

Besides the 26 questions designed by the researcher, permission was granted to use a recent, previously published scale. The Attitudes to Deafness Scale, a 22-question, six-item Likert scale was incorporated into the survey to measure attitudes (Cooper, Rose and Mason, 2004).

The instrument was chosen because it possesses strong content validity. This instrument adequately measures attitudes representative of those working in the behavioral mental health field. Questions were developed to produce a balanced range of statements based on the attitude construct.

The design and construction of this scale is built upon the previous research by Cooper, Rose and Mason (2003). This research examined mental health professionals’ attitudes towards deaf people in relation to contact and knowledge. This study served as a foundation for the later Attitudes to Deafness Scale utilized in this research.

The Attitudes to Deafness Scale also utilized the research of Kiger (1997) that explored how attitudes towards deaf persons are based in hearing people’s “affect, cognition and stereotyping.” The purpose of this research was to examine the intricacy of the structure of intergroup attitudes. This research suggests the structure of attitudes

towards deaf people is different from the structure of attitudes towards those with other disabilities.

Data Analysis

The data to be analyzed was downloaded directly onto a spreadsheet from the “SurveyMonkey” website. Data was analyzed to determine how the (DV) attitude score related to the (IV) amount of contact and level of knowledge. Descriptive statistics were used to describe some basic features of the data. With the help of the research analyst utilizing SPSS, a frequency distribution for responses to each question or statement from the survey was constructed. The relative frequency distribution illustrated proportion of the total number participants response for each interval. Much of the data was analyzed and interpreted from the frequency distribution.

A Pearson Correlation Coefficient was run to summarize and describe the overall relationship between the DV and selected IVs. It was determined there was a weak, but positive correlation between participants’ perceived knowledge and attitude.

Inferential statistics were also used to assess group differences. T-tests were run to compare attitudes to level of training and knowledge of deafness. Significant difference was found: as amount of knowledge and level of training increased, so did attitudes. These results are discussed in more detail in the following chapter.

CHAPTER IV

FINDINGS

The operational research question guiding this study is: How do attitudes towards deafness affect quality of behavioral health services provided to Deaf/deaf/hard of hearing clients? The goal of this project was to determine how attitudes are related to realistic and obtainable quality of services rendered by workers in the behavioral mental health field to clients in the Deaf/deaf/hard of hearing population. The findings of this study are based on the raw data and the summary statistics provided by SurveyMonkey.com and further statistical analysis guided by the research analyst at Smith College.

Demographic Data

Ninety-four participants responded to the survey. However, due to missing values of some questions, 86 surveys were included in the final data analysis. The majority of participants identified as female (82.6%) with a mean age of 39.58. Most of the respondents were from New Hampshire (59) and Maine (17). The majority of participants held a master's degree (47.7%), 12.8% held a bachelor's degree and 19.8% had a high school education. Only 1 participant identified as a nurse, while 3 participants identified as case managers, 3 as substance abuse counselors, 4 identified as counselors, 5 as graduate students, 6 as psychiatrists, 6 as psychologists, 10 as clinicians, 11 as social workers, 17 identified as therapists, and 21 identified as undergraduate students.

The majority of those surveyed did not identify as Deaf/deaf/hard of hearing (97.7%). Additionally, 94.2% of respondents reported no family members that identified as Deaf. Yet an increased number of participants reported family members that identified as deaf or hard of hearing (37.2%).

Most participants (61.6%) reported interacting with people who are deaf/Deaf/hard of hearing “sometimes” and 18.6% stated “never” interacting with the population. A majority of the respondents reported at one time serving a deaf/Deaf/hard of hearing person in their profession (60.5%), while the mean number of people served per participant was 5.82.

Characteristics of Participants

When asked “What is your level of American Sign Language (ASL) fluency?” most participants (75.6%) responded “none.” Not one participant responded as “fluent.” A majority of respondents (82.6%) reported a willingness to treat a client who utilized ASL, 12.8% were “unsure” and 4.7% said “no.” In addition, the majority reported they would employ the use of an interpreter (87.2%), and most knew it would be the agency’s responsibility to obtain an interpreter (66.3%). However, 26.7% were unsure whose responsibility it would be to obtain an interpreter and 7.0% believed it is the client’s responsibility.

In terms of rating to what degree the therapeutic relationship would be compromised by utilizing an interpreter, 45.3% participants reported the relationship would be “somewhat compromised” and 30.2% reported the relationship would be “moderately compromised,” where 12.8% felt it would be “not compromised.” Just over sixty-nine percent (69.1%) stated it would be important to know if someone was pre-

lingually deaf or became deaf later in life. Nearly three quarters of participants (74.5%) stated that the probability of miscommunication with a client who utilized assistive devices such as hearing aids or cochlear implants still existed. Half (50.0 %) believed a deaf or hard of hearing client did not understand spoken English the same way hearing people do and half (50.0%) reported they would include a deaf/Deaf/hard of hearing client in group therapy, and (41.5%) were “unsure.”

Most participants (69.8%) reported never receiving culturally affirmative training, while the balance of participants (30.2%) reported having received training surrounding deafness. Of those who responded they had received training, 11 received training within the last two years, 3 reported training within 3-5 years, 4 within 6-9 years and 9 over 9 years.

In terms of how competent participants felt about serving this population, most participants reported “unsure” (47.7%), while 33.7% reported not feeling competent and 18.6% reported feeling competent. Finally, respondents were asked to rate their knowledge of the population, using this rated scale: 1 equal to “none,” 3 equal to “some,” 5 equal to “moderate,” and 7 equal to “much.” The majority of participants rated knowledge between 1 and 3 (77.9%), illustrating little knowledge about this population.

Results of Statistical Tests

Based on the key, all the statements that reflected a “negative/undesirable attitude” were reverse scored. As a result, all statements with higher scores (6 or above) indicated more positive attitudes. Next, to assess internal reliability of the attitude scale, a Cronbachs Alpha was performed to measure how well the attitude statements go

together. An acceptable cutoff is .6. For the Attitudes Towards Deafness Scale the alpha was .781, indicating moderate internal reliability.

Pearson Correlations revealed a weak positive correlation between participants' perceived knowledge (question 29) and results to the Attitudes Towards Deafness Scale ($r=.226$, $p=.039$, two tailed). As participants' perceived knowledge increased, the score on the attitude increased as well. This data suggests that people who feel more knowledgeable also have a more positive attitude.

T-tests revealed there was a significant difference in the mean score on the attitude scale and those who had not served a deaf/Deaf/hard of hearing person ($t(82)=2.694$, $p=.009$, two tailed). Those who had served a deaf/Deaf person had a significantly higher mean score on the attitude scale ($m=4.305$) than those who did not ($m=3.980$) in response to question 14.

There was also significant difference in the mean attitude score between those who had received training and those who had not ($t(82)=3.296$), $p=.001$, two tailed). Those who had received training had a significantly higher score on the attitude scale ($m=4.462$) than those who had not ($m=4.050$).

Outcome of Attitudes Towards Deafness Scale Based on Analysis of Frequency Data

As a result of this study, it appears overall attitudes towards people who are deaf/Deaf could be considered positive. Respondents were asked 19 attitude statements and were to rate their level of disagreement or agreement with the statements on a 6-item Likert scale where 1 was equal to "strongly disagree," and 6 equal to "strongly agree." To obtain an overall positive or negative attitude, questions were scored based on the frequencies the data provided. Responses to questions 1-3 were considered to possess

general disagreement, and responses to questions 4-6 general agreement. Rating of the responses and corresponding attitudes was based on the key provided by the authors.

Upon analysis of the frequency data, some generalizations can be argued. Participants reflected positive attitudes when statement(s) could potentially be interpreted as invasive or private. For example, 95.2% responded with strong disagreement to this statement: “Deaf/deaf couples should receive genetic counseling to avoid having children with hearing loss.” Additionally, respondents rated the statement “All Deaf/deaf people should be offered corrective surgery” with overall disagreement, 61.0% responded between 1-3 on the Likert scale, leaving 39.0% agreeing with this statement by responding between 4 and 6 on the rating scale. Though the result of this statement reflects an overall positive attitude, the gap between the two percentages is small and offers insight to the neutrality of respondents feeling about this issue. The statement “Deaf/deaf people should automatically receive help in their home environment” was also translated to reflection of a positive attitude because 72.6% of respondents disagreed with this statement.

Statements that potentially reflect attitudes toward current policy, or lack of, also echo positive attitudes. The statement “Interpreters should be available for Deaf/deaf people at work” showed that 88.8% responded between 4 and 6 on the scale towards “strongly agree,” the balance of response rates (12.2%) fell between 2 and 3, and no one responded “strongly disagree.” “Training more professionals to work with Deaf/deaf clients is not necessary” was also responded to with significant disagreement (94.0%) reflecting a positive attitude.

Statements where respondents were required to rate level of disagreement/agreement surrounding language and communication resulted in overall positive attitudes. It should be noted that within this set of data, a pattern begins where survey respondents report responses increasingly in the middle of the Likert scale, resulting in responses that are more neutral.

Overall, respondents disagreed with the statement “Deaf/deaf children should learn to speak to communicate with hearing parents” (75.1%), implying a positive attitude. Ninety-four percent disagreed with “Deaf/deaf people should learn speech rather than sign language,” also implying a positive attitude. Out of the entire attitude survey, this statement illustrated respondents’ strongest opinion. The majority of responses (75.0%) fell between 1 and 2 on the scale. Nineteen percent gave this statement a rating of three, the balance (6.0%) gave a 4 rating, and no one responded with 5 or 6 on the scale.

Response to “Deaf/deaf children should be taught in sign language” resulted in 66% responding between 4 and 6 on the scale towards “strongly agree,” also resulting in a positive attitude. No one responded “strongly disagree” and nearly one third of respondents rated the statement between 2 and 3. Showing a disparity, but overall reflecting a positive attitude to the statement “Deaf/deaf people should learn to lipread,” 34.5% of participants gave a rating of 3. Overall, 42.9% responded with “strongly agree” and 22.6% responded with “strongly disagree.”

Responses Resulting in Negative Attitudes

Out of 19 attitude questions, 3 statements were responded to in a way that, based on the key, yielded negative attitudes. The statements that indicate less positive or

desirable attitudes include statements about perceptions of physical disability and personal opinion.

Over half of respondents (51.2%) rated the statement “I would like to have more Deaf/deaf friends” towards “strongly disagree,” implying a negative attitude. Just over 40% of respondents gave this statement a rating of 3, illustrating mild disagreement. This result could indicate survey respondents’ lack of knowledge or contact with this population. As previously noted, over 90% of participants did not identify as Deaf, or report a Deaf family member. Only 2.3% identified as deaf or hard of hearing, and only 37.2% reported having a deaf or hard of hearing family member. Lack of contact, combined with participant response that 69.8% have not received culturally affirmative training, could all be factors contributing to a negative attitude.

Also reflecting a negative attitude are responses to: “More research should be done to find cures for deafness.” The majority (79.6%) rated this statement between 4-6 toward the “strongly agree” margin. This result, when compared to participant self report that interaction with Deaf/deaf persons were on a minimal level, 18.6% stated “never” and 61.6% stated “sometimes.” Only 15.1% reported “consistent” interaction and only 4.7% reported “daily” interaction. As a result, it is possible a negative attitude could imply the hearing majority identifies, whether knowingly or unknowingly, with the “medical model” of deafness, possessing the belief that hearing loss should be repaired.

The final statement only slightly suggests an overall negative attitude. Respondents rated “Deaf/deaf people should not be viewed as ‘impaired,’” with 49.1% agreeing and 50.1% disagreeing. Four participants skipped this statement.

Responses Resulting in Positive Attitudes but Offer Ambiguous or Contradictory Information

The frequencies of three additional statements are considered, though reflecting positive attitudes, and illustrate responses that fall in the middle of the scale, reflecting more neutral responses, and those responses appear to be contradictory within a data set.

Slightly over 45% of respondents reported mild to strong disagreement to the statement: “I would like to have more Deaf/deaf colleagues.” The majority of respondents (38.3%) reported a rating of 3, illustrating mild disagreement. Another statement where data splits down the middle refers to whether respondents agree with the statement “Deaf/deaf people are safe drivers.” Just under half (48.8%) disagree, and 51.2% agree. Responses to “I would like to see more Deaf/deaf people in the community” did not yield strong results: 40.2% disagreed and 59.8% agreed. Responses to these statements appear to illustrate less strong feelings or indifference on the part of the respondents.

Another statement that offered more ambiguous results, where most responses fell with a rating of 3, was “I would like to see more Deaf/deaf people in the community.” Though responses to this statement overall reflect a positive attitude (59.8%), the balance of participants (40.2%) reflects a negative attitude. Responses to “Having a Deaf/deaf friend would be difficult” reflected disparity. Overall attitudes were positive for this statement. However, the rating that received the majority of respondents was 3 (27.4%). It appears it might have been difficult for participants to respond to these statements.

Responses to the following statements resulted in contradictory attitudes on the the subject of disability: “Deaf/deaf people are physiologically impaired,” “Deaf/deaf

people should not be viewed as ‘impaired,’” and “Deaf/deaf people are handicapped.” Statements 1 and 3 reflected positive attitudes. As previously noted, the second statement, though results were nearly split, resulted in an overall negative attitude. However, results for the first statement illustrate that the majority (72.0%) strongly disagreed with this statement. Finally, results for the last statement illustrate a positive attitude, with 61.9% disagreeing with the statement.

Comparisons of Data Groups Based Frequencies

Based on the data from the attitude scale, results were correlated to earlier demographic questions. Two principals were looked at: level of knowledge of deafness and contact with the population. Comparisons are solely based on data the frequencies provided. Additional results of inquiry surrounding communication provided interesting data.

Responses to the set of questions designed to measure knowledge offer mixed results. Inquiry surrounding ASL fluency illustrated none to little knowledge (95.4%). On the other hand, most respondents (66.3%) knew it was the agency’s responsibility to obtain an interpreter and 26.7% were unsure. Response to the statement “Please indicate how much or how little you feel you know about this population” yielded results that illustrate participants do not feel knowledgeable of Deaf/deaf/hard of hearing clients. On a 7-item scale with 1 equal to “none,” 3 equal to “some,” 5 equal to “moderate,” and 7 equal to “much,” 77.9% responded between “none” and “some.” Only 18.6% reported feeling competent to serve this population, 33.7% said no and 47.7% were unsure. Most respondents (74.4%) reported that it was important to know if someone was prelingually deaf or became deaf later in life. Though overall attitudes were considered positive to

questions that measured knowledge, upon analysis of this data set a pattern of contradictory results begins to appear. Responses in some cases appear to conflict with other responses within the same line of questioning.

The next set of questions attempted to measure amount of contact with the Deaf/deaf/hard of hearing population. As previously stated, an overwhelming majority (over 90.0%) did not identify as Deaf/deaf/hard of hearing or report a Deaf family member. Though less extreme, 62.8% reported no deaf or hard of hearing family member. Overall, 61.6% of participants reported interacting with a Deaf/deaf/hard of hearing client only “sometimes.” Most did report experiences serving a client in this population (60.5%). Participants were asked an open-ended question inquiring how many served the population. Thirty-six percent of respondents answered that they have served two people in their therapeutic careers. It is statistically difficult to compare attitudes to level of contact because so little contact with the Deaf/deaf population is reported.

The data from the survey implies that most participants possess positive or desirable attitudes towards this population. In addition, it has been determined that in terms of knowledge, results are mixed and contradictory. It has also been determined that participants share a limited amount of contact with this population. That being said, responses surrounding communication revealed the most interesting results. Most respondents (54.7%) replied that a deaf or hard of hearing client would not understand spoken English the same way hearing people do and 34.9% were “unsure.” A large percentage of respondents (81.4%) understood assistive devices would not end the probability of miscommunication. Contradictory to these responses, over half of

participants (53.5%) responded that they would include a Deaf/deaf/hard of hearing person in group therapy and 45.3% were “unsure.” Though an overwhelming majority reported a significantly low level of ASL fluency, 82.6% reported willingness to treat a client who utilized ASL and 87.2% would utilize an interpreter. Due to the disparity, the researcher wished to examine if there was a relationship between participant response to the low level of ASL fluency (N=83) and high percentage of participants who responded they would utilize an interpreter (N=76), it was not statistically possible to examine the data.

Finally, when asked to what degree, if any, the therapeutic relationship is compromised by employing an interpreter, 12.8% reported “not compromised,” 45.3% reported “somewhat compromised,” 30.2% reported “moderately compromised” and 11.6% reported “greatly compromised.” As a result, responses surrounding communication offer mixed and contradictory results.

Summary

The major conclusive findings of this study illustrate that participants with higher levels of contact with the Deaf/deaf/hard of hearing population possessed more positive attitudes than those with less contact. In addition, there was significant difference between participants who had received training surrounding deaf issues than those who had not. Respondents who had participated in training possessed more positive attitudes than those who had not received training. The results of this data makes a strong argument that to meet the needs of Deaf/deaf/hard of hearing clients, training of workers in the behavioral health field is necessary and ethical response to this data.

CHAPTER V

DISCUSSION

Overview

The purpose of this study was to gather data about how attitudes towards deafness might affect quality of behavioral health services provided to deaf/Deaf/hard of hearing clients. It was hypothesized that amount of contact or level of knowledge might impact or affect attitudes. It was also hypothesized that more positive attitudes would result in more appropriate services, while attitudes that are more negative would result in less appropriate services. The study utilized a relational-exploratory design in an attempt to develop a clearer understanding of how attitudes towards deafness are related to potential quality of services rendered.

There were several motivations for this study. 1. The complex world of deafness touched this researcher when her daughter was identified at four years old with bilateral, moderate to severe conductive hearing loss. 2. As an adult, this researcher witnessed and experienced the assumptions made by hearing adults toward her child. In some cases hearing adults pathologized the child and in other cases adults tried to make the child “normal” by measuring her abilities/differences by standards imposed by the hearing world. 3. This researcher witnessed institutional oppression of her child by those in power, mainly professionals in education. These professionals made assumptions seemingly based on lack of knowledge of deafness and limited contact with this population. 4. Finally, this researcher is motivated to bring awareness to these issues.

Study Findings

As noted in Chapter 4, the results of data analysis showed significant differences in the attitude scores in two areas. The first illustrated a statistically significant difference in attitude score between those who had served a deaf/Deaf person and those who had not. This data strongly implies that amount of contact with anyone from this population directly correlates to attitude. As level of contact increased, attitudes were more positive. This information implies that behavioral health workers who have less contact with the deaf/Deaf/hard of hearing population will possess attitudes that are less desirable. With this knowledge, it can be inferred that clinical services for individuals in this population might not be effective and/or appropriate.

Secondly, data that also showed statistically significant results that illustrate that professionals within the behavioral health field who had received training surrounding deafness, including Deaf Culture, had more positive attitudes than those who did not. This result makes a strong argument that training must be required for those working in the behavioral health field. Glickman and Gulati (2003) state: "...working with deaf people requires special knowledge and skills as well as thinking about what it means, culturally, and historically to be hearing and deaf" (pg. 8). This information underscores the responsibility of agencies to provide culturally affirmative training.

Based on the data gained by this research, it can be argued that mental health workers with less contact and no training will possess less positive or desirable attitudes towards their Deaf/deaf/hard of hearing clients. As a result, it can be inferred that services may be less accessible, less effective, appropriate or a combination of all three.

As a result, services rendered will be at a great cost and will do a great disservice to the Deaf/deaf/hard of hearing population.

There exists a systemic mistrust of institutions and workers in the behavioral health field by the Deaf/deaf/hard of hearing population (Steinberg, Sullivan and Lowe, 1998). The inability to obtain equitable mental health care is a product of the social construction or alternatively, social deconstruction of Deaf/deaf/hard of hearing people in this country. Steinberg et al. (1998) explain that many members of the Deaf culture are fearful of obtaining mental health care due to the mistrust of providers. Moreover, McCay points out that Deaf people have been diagnosed at higher rates of mental illness than the hearing population (2006). The fear of being misunderstood or misdiagnosed is too great; therefore, members of this population are less likely to seek services due to the mistrust of mental health care systems and the professionals working in these systems. If services are obtained through a clinician that has not received training, or has had little contact with this population, it is likely that assessment, diagnosis and treatment could be ineffective and inappropriate. The case of Jan DeVinney (ie: see p.11) clearly outlines the discrimination and unfair treatment that results when untrained and unknowledgeable behavioral health workers treat a deaf client. In addition to unfair treatment, due to inaccessibility to viable modes of communication, DeVinney was the victim of a misdiagnosis that perpetuated her deeply disturbing circumstance.

Other Considerations

Other findings of this study show that a little over half of respondents (54%) stated they would include a deaf/Deaf/hard of hearing person in group therapy, and 44.8% reported they were unsure. However, as Steinberg et al. (1998) point out that

deaf/Deaf/hard of hearing clients “overwhelmingly preferred all-deaf/hard of hearing groups over integrated deaf and hearing groups, even with interpreting services” (p. 982). Due to the group therapy dynamics, often several people will speak at once and there are rapid exchanges. A Deaf/deaf/hard of hearing member will usually follow only one person at a time, needing extra time to speech read and process what is being said. In addition, it can be a challenge for an interpreter to keep up with the discussion. As a result, group therapy can present major challenges for Deaf/deaf/hard of hearing members.

In addition to respondent disparity surrounding inclusion in group therapy, there exists other troubling data. Communication is a theme that consistently comes up throughout research among the Deaf/deaf/hard of hearing population. Although level of knowledge or training and amount of contact were the variables targeted for study, communication falls under the umbrella of these variables. As a result of this study, a large number of participants reported little or no ASL fluency (N=83); however, a large percentage of participants responded they would treat a Deaf client who utilized sign language (N=72) and a large number of subjects reported they would utilize an interpreter (N=76). This data illustrates a few points. First, it shows a willingness by members of the behavioral health field to engage in work with all clients, an important objective of social work. However, it is troublesome that the vast majority of hearing behavioral health professionals may not be taking into consideration the vastly different communicative and linguistic differences of spoken English and ASL. As Glickman and Gulati (2003) point out:

Many deaf persons seen in mental health settings do not have intact sign or spoken language systems. Hearing clinicians working with deaf people for the first time generally have no reference for what it means to be an adult who never acquired a full language (p. 9).

This phenomenon is relevant and is worthy of future study. The implications of communication or miscommunication are also worthy of future study.

Effective and appropriate therapy embodies and is dependent upon trust and a reciprocal communicative relationship between client and therapist. When this is compromised, or when a hearing therapist does not understand or consider there might exist a compromised communicative relationship, the role of dominant hearing professional over oppressed Deaf/deaf/hard of hearing client is created. In a sense, for some clients lifelong experiences are perpetuated and played out within the realm of therapy. As Glickman and Gulati (2003) state, “Majority clinicians who have not been cross culturally trained inevitably repeat the offenses historically inflicted on the minority group” (p. 26).

Shortcomings of Study

Those who identify with the cultural model of deafness (Deaf) and those who identify with the medical model of deafness (deaf, hard of hearing) were included in this study. The purpose of including both groups was an attempt to be representative of the entire population. However, some problems arose in trying to do this. The experiences of each group can be vastly different. Deaf individuals are likely to be associated with Deaf Culture and communicate mostly with sign language. Individuals who identify as deaf or hard of hearing typically use assistive devices to maneuver through the hearing world. As a result, there can exist a passionate difference of opinion within the collective

population surrounding communication modality and identity. Some of the statements adopted from the Attitudes Towards Deafness Scale were specific to Deaf Culture. Because the terms “deaf” and “hard of hearing” were included in the statements, some participants reported difficulty rating the statements.

In addition, as previously stated, the review of literature illustrated that Deaf people are diagnosed with emotional or mental health needs at increased rates compared to their hearing counterparts. It would have been advantageous if additional questions had been designed by the researcher to inquire about this phenomenon.

Researcher Bias

With any research study that is completed it is assumed that there are numerous methodological and personal biases that become parts of that study. There are personal biases as this researcher’s daughter identifies as deaf. In addition, there are methodological biases in using a standardized survey for a research study. Requiring participants to choose answers based on fixed responses or on a scale limits or forces subjects’ responses. Predetermined answers may have limited the variation of information.

Implications of the Research

The outcome of this research addresses concerns about effective treatment at the individual level; it also illustrates a need in the field for training at the macro level. The data the researcher provides is relevant to the field of Social Work because it illustrates a need in this profession that training surrounding deafness and culturally affirmative training become the norm, not the exception. The social worker’s role is meant to help people in need improve quality of life and to address social problems. Deaf/deaf clients

should not feel that effective, fair and informed mental health care is inaccessible.

Clients of this population should not fear cultural and communicative misunderstandings as a fundamental concern. If this occurs, the potential for mis-assessment, misdiagnosis, ineffective treatment, inappropriate treatment and inadequate services looms. Deaf/deaf clients who do obtain mental health services should not be further subjugated due to a clinician's lack of knowledge and negative attitude as established by the results of this research.

Recommendations for Further Research

Because there exists a paucity of research surrounding attitudes towards deafness within the therapeutic realm, there is a need to expand research on this issue. A viable therapeutic relationship is dependent upon establishing a relationship of trust and communication between clinician and client. If a therapist does not possess a fundamental knowledge of sign language and does not understand the implications of Deaf culture, but still chooses to utilize an interpreter, the result can be a greater injustice to the client. Clinicians must understand that sign language does not translate word for word into spoken English. Hand-shapes and visual gestures, eye contact and facial expression all combine to convey information. In addition, clinicians must understand how assistive devices help or hinder deaf or hard of hearing people. As this research shows, workers in the behavioral health field lacking training in or contact with the Deaf/deaf/hard of hearing population will likely have less positive or desirable attitudes towards these clients. Further research surrounding issues of communication would benefit the Deaf/deaf/hard of hearing community. It is the hope that further research

would bring greater knowledge and awareness to this population and would greatly and positively impact Deaf/deaf/hard of hearing individuals who seek treatment.

Summary

Since the beginning of civilization, people who are Deaf/deaf/hard of hearing have lived among us. For a much of that time, deaf individuals have been defined and pathologized by the dominant hearing culture. Deaf/deaf/hard of hearing individuals have faced discrimination and unequal access to resources and isolation. Not until the recent past has literature begun to identify this population as both a marginalized and cultural population. Though there appears to be a shift towards more awareness, knowledge and understanding of this population, there still exist many barriers in terms of discrimination and accessibility. The most humane and ethical response to this dilemma is that behavioral health agencies and institutions provide culturally affirmative training for workers in the field. This training would include: 1) Hiring of Deaf staff, or individuals competent in and knowledgeable about services for those who are deaf at all levels of the organization. 2) Communication excellence, which includes trained, professional interpreters, ASL fluency by hearing staff, TTY services, knowledge of assistive hearing devices, closed captioning for any videos utilized, and consultation with other agencies or state programs that possess expertise in this field. 3) Training surrounding Deaf Culture, including Deaf history. 4) Training specific to issues of deaf and hard of hearing clients. 5) Training surrounding issues of transference and countertransference when an interpreter is utilized as well as training around the potential differences of meaning communicated by both sign language versus spoken language and the issues of potential misinterpretation when using interpreters. 6) Training

surrounding appropriate assessments and effective treatment of Deaf/deaf/hard of hearing individuals.

Just as social workers are becoming more aware of the importance of cultural competence and sensitivity, the need for cultural and linguistic competence in potential work with Deaf/deaf/hard of hearing clients is an ethical responsibility that the field must increasingly embrace.

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Appendix A

Human Subjects Review Board Approval



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 20, 2007

Ann Tarmey
209 Sam Putnam Road
Charlestown, NH 03603

Dear Ann,

Your second set of revisions has been reviewed and the recruitment and screening processes are now clearly spelled out. We are now able to give final approval to your materials.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study.

Sincerely,

A handwritten signature in blue ink that reads "Ann Hartman D.S.W.".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

Cc: Claudia Bepko, Research Advisor

Appendix B

Recruitment Email

Hello –

I am currently conducting a research study to fulfill my thesis requirement for Smith College School for Social Work. My research focuses on how attitudes towards deafness influence therapeutic services.

I am now in the data collection phase of this project and have posted a survey online. I am looking for participants who are currently working or practicing in the behavioral health field, or those who plan to work or practice in the field in the future. Total time for taking this anonymous survey is about 10 minutes.

If you have received this communication, I hope that you fit the criteria or know someone who might. I would appreciate it if you would take the time to fill out the survey and/or forward the link of the survey to those you know who may fit the criteria.

The survey can be found at: <http://www.surveymonkey.com/s.asp?u=691893077724>

Your participation is anonymous and your answers cannot be connected to you.

Thank you in advance for your participation.

Sincerely,

Ann Tarmey

Appendix C

Screening Criteria

- 1) Are you currently a student with the intention of working in the Behavioral Health Field in the future? (For the purpose of this study, Behavioral Health Field includes: Counselors, Therapists, Clinicians, Case Managers, Substance Abuse Counselors, Social Workers, Psychologists, Psychiatrists, Nurses)

Yes No

- 2) Do you have experience, or are currently working or practicing in the Behavioral Health Field? (For the purpose of this study, Behavioral Health Field includes: Counselors, Therapists, Clinicians, Case Managers, Substance Abuse Counselors, Social Workers, Psychologists, Psychiatrists, Nurses)

Yes No

Appendix D

Keene State College Approval

FROM : FRIEDERIKA

FAX NO. : 16177429444

Feb. 15 2007 02:25PM P1



Department of Psychology
Rhodes Hall

Keene State College

229 Main Street, Keene, New Hampshire 03435-3400
603-358-2503 Fax 603-358-2184
www.keene.edu

February 15, 2007

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

I give permission for Ann Tarmey to locate a portion of her research at our institution, Keene State College. Keene State College requests that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) review the research proposed by Ann.

In addition, as chair of the Keene State College Human Subject Review Board, I have reviewed Ann Tarmey's proposal. Her research qualified for an expedited review and is approved. Presuming that similar approval is granted by the SSW HSR Committee, Ann is cleared to collect her data at Keene State College.

Sincerely,

A handwritten signature in cursive script, appearing to read "Anthony Scioli".

Anthony Scioli, Ph.D.
Professor of Psychology
Keene State College

Chair
Institutional Review Board for the Protection of Human Subjects
Keene State College

Appendix E

Permission West Central Behavioral Health

WEST CENTRAL BEHAVIORAL HEALTH

 DARTMOUTH-HITCHCOCK

Counseling Center

February 11, 2007

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

West Central Behavioral Health gives permission for Ann Tarmey to locate a portion of her research in this agency. We request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Ann. West Central Behavioral Health will abide by the standards related the protection of all participants in the research approved by the SSW HSR Committee.

Sincerely,



Joseph A. Bousquet, MSW, Ph.D.
West Central Services

Appendix F

Informed Consent

Hello:

My name is Ann Tarmey. I am conducting a study of attitudes towards deafness to learn more about the existence of this phenomenon within the therapeutic relationship. This study is being conducted in partial fulfillment of the requirements for the Masters of Social Work degree at Smith College School for Social Work. I am asking you to participate if you have in the past, present or will potentially in the future work in the behavioral health field. As a subject in this study you will be asked to answer questions relevant to the research.

Your participation in this research would add knowledge to the field of social work. Currently, little research exists about how attitudes towards deafness influence the therapeutic relationship. Your contribution would allow many professionals to understand their clients and to provide more appropriate and effective therapy. Your participation is voluntary. You will receive no financial benefit for your participation. Because this study is voluntary, you are free to refuse to answer specific questions and to withdraw from the study at any time. If you decide to withdraw, all data describing you will be immediately destroyed.

One of the potential risks of participation in this study is the possibility that you might feel uncomfortable emotions while talking during the survey.

Strict confidentiality will be maintained, as consistent with Federal regulations and the mandates of the social work profession. Confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of three years. Your identity will be protected, and you will never be associated with the information you provide in the survey. The data may be used in other educational activities as well as in the preparation of my Master's thesis.

If you have any questions, you will be able to contact me. I am best reached by email at atarmey@smith.edu ; you may also contact me by phone at 603 826 3264.

By participating in this survey, you are indicating that you have read and understand the information above and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

Online:

Agree _____

Disagree_____

Hard Copy:

Signature of Participant

Date

Please keep a copy for your records.

Appendix G

Demographics and Additional Questions

For the purpose of this study, the term “Deaf” denotes those who identify with Deaf Culture and use American Sign Language (ASL) as their primary mode of communication.

The other group includes those with hearing loss that identify as “deaf” or “hard of hearing.” In many cases, people in this group utilize residual hearing combined with assistive devices such as hearing aids or cochlear implants for hearing. Throughout the study, these latter two terms can be used interchangeably.

- 4) Age: _____
- 5) Gender:
Male Female
- 6) Do you identify as “Deaf”?
Yes No
- 7) Do you have at least one “Deaf” family member?
Yes No
- 8) Do you identify as “deaf” or “hard of hearing”?
Yes No
- 9) Do you have at least one “deaf” or “hard of hearing” family member?
Yes No

10) What is the highest level of education you have completed?

- _____ High School Graduate
- _____ Associates Degree
- _____ Bachelors Degree
- _____ Masters Degree
- _____ PhD
- _____ Post Doctoral Training

11) What is your current profession?

- _____ Counselor
- _____ Therapist
- _____ Clinician
- _____ Case Manager
- _____ Substance Abuse Counselor
- _____ Social Worker
- _____ Psychiatrist
- _____ Psychologist
- _____ Nurse
- _____ Student/Undergraduate
- _____ Student/Graduate

12) Please list the state in which you are employed or currently enrolled as a student:

CT MA ME NH NY RI VT Other

13) How often do you interact with anyone who identifies as “deaf”/”Deaf”/”hard of hearing?”

Never Sometimes Consistently Daily

14) Have you ever served a “deaf”/”Deaf”/”hard of hearing” person in your profession?

Yes No

15) If yes, approximately how many?

- 16) Do you feel competent to serve a “deaf”/”Deaf”/”hard of hearing” person?
Yes No Unsure
- 17) What is your level of fluency of American Sign Language?
1 2 3 4 5 6
None Moderate Fluent
- 18) Have you ever received training surrounding deafness including Deaf culture?
Yes No
- 19) If yes, was the training within:
____ 0-2 Years
____ 3-5 Years
____ 6-9 Years
____ Over 9 Years
- 20) Would you include a “deaf”/”Deaf”/”hard of hearing” person in group therapy?
Yes No Unsure
- 21) If a client utilizes assistive devices (hearing aids, cochlear implants) does this end the probability of miscommunication?
Yes No Unsure
- 22) Do you feel that a client who is “deaf” or “hard of hearing” understands spoken English the same way hearing people do?
Yes No Unsure
- 23) Would you be willing to treat a client who utilized American Sign Language?
Yes No Unsure
- 24) If so, would you utilize an interpreter?
Yes No Unsure

- 25) Whose responsibility is it to obtain an interpreter?
 The Client The Agency Unsure
- 26) To what degree, if any, is the therapeutic relationship compromised by employing an interpreter?
 Not Somewhat Greatly Totally
 Compromised Compromised Compromised Compromised
- 27) A Deaf/deaf/hard of hearing person could be competent to work in a position of power, such as President of the United States.
 Yes No Unsure
- 28) Do you think it is important to know whether someone was pre-lingually deaf or became deaf later in life?
 Yes No Unsure
- 29) Please indicate how much or how little you feel you know about this population.
 1 2 3 4 5 6 7 8 9 10
 Very little Moderate Very Much

Appendix H

Attitudes Towards Deafness Scale

Used with permission from Cooper, A., Mason, O., Rose, J. (2004). Measuring the attitudes of human service professionals toward deafness. *American Annals of the Deaf* 148 (5), 385-389.

- 30) Deaf/deaf couples should receive genetic counseling to avoid having children with hearing loss.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

- 31) Deaf/deaf children should learn to speak to communicate with hearing parents.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

- 32) I would like to have more Deaf/deaf friends.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

- 33) Deaf/deaf people should learn speech rather than sign language.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

- 34) Deaf/deaf people are handicapped.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |
- 35) More research should be done to find cures for deafness.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |
- 36) Deaf/deaf children should be taught in sign language.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |
- 37) Hearing children of Deaf/deaf parents are at the risk of emotional deprivation.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |
- 38) Deaf/deaf people are safe drivers.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |
- 39) I would like to have more Deaf/deaf colleagues.
- | | | | | | |
|----------------------|---|---|-------------------|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
Disagree | | | Strongly
Agree | | |

46) Deaf/deaf people should not be viewed as “impaired.”

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

47) I would like to see more Deaf/deaf people in the community.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

48) Having a Deaf/deaf friend would be difficult.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

49) Deaf people have their own culture.

1 2 3 4 5 6

Strongly
Disagree

Strongly
Agree

Appendix I

Permission to Use Attitudes Towards Deafness Scale

Ann,

Thanks for your enquiry. We are very happy for people to use the scale as long as they note the original source.

We would be interested to hear how you get on with the research.

Best Wishes & Good Luck,

John Rose

Date sent: Wed, 01 Nov 2006 11:46:36 -0500
From: "Ann Tarmey" <atarmey@email.smith.edu>
To: <j.l.rose@bham.ac.uk>
Subject: a question re: Attitudes to Deafness Scale

Hello:

I am a social work graduate student at Smith College in Northampton, MA., USA. I am currently beginning research for my Masters Thesis. I would like to ask permission to use this scale within the context of my thesis.

I am hoping to utilize your scale as I begin a qualitative study.

If you have any questions, please let me know. I look forward to your response.

Regards,

Ann Tarmey