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2007

Deaf and in need : finding culturally sensitive human services

Colleen M. Moore
California State University, Monterey Bay

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<u>Deaf and in Need:</u>
Finding Culturally Sensitive Human Services

INTRODUCTION

     Imagine that you are unable to provide food for your family or must obtain housing, health care, psychiatric services, child care, family planning services or any other human service; you are unable to gain access to these things due to any number of difficult life circumstances. You must go to the local Department of Social and Employment Services (California), apply for aid, surrender private information and face the potential emotional backlash or shame that, for some, accompanies the decision to ask for help. Now imagine that you are a member of a cultural group that uses a language, customs and social mores unknown to most people. The fear of being misunderstood, disrespected or ignored would most certainly cause anxiety or fear for a person seeking human services under these circumstances.

     For the deaf, obtaining culturally sensitive human services has been an ongoing problem not only in the United States, but worldwide. The sense of identity that accompanies the Deaf culture is not a new development, but has reached a level of acknowledgement in academia in terms of its relevance to the well-being of those who claim Deaf identity. Like every cultural minority, the deaf have faced discrimination, pity, ignorance and dismissal; the worst offense of which is acknowledged by Glickman and Gulati (2003) as "disempowering them around communication, resulting in communication isolation" (p.3). Social isolation is exacerbated by the deficit of appropriate social services for the deaf and can result in difficulties far worse than that for which a consumer originally sought services. In addition, misdiagnoses of mental retardation, autism, schizophrenia and low intelligence have resulted from a lack of qualified, culturally informed personnel.

Promoting diversity and multiculturalism requires helping professionals to become acquainted with and proficient in matters of tradition as well as the new developments in world cultures. For example, the National Association of Social Workers developed a Code of Ethics in 1996, the mission of which is to promote service, strive for social justice, focus on the dignity and worth of each person, and to sanction professional competence and integrity. Although intent to serve all cultures exists in the helping professions, the prevailing attitudes toward deafness are that of disability and weakness, not identity.

It is critical to the advancement of social services, for the deaf and for all that the nature of its accessibility, roadblocks, biases and impact become a larger part of the humanitarian discourse. In the course of this paper, the history of the deaf will be explained as a primer for understanding the development of the Deaf psyche. The concept of Deaf cultural identity and its collective history will be revealed; the difference between "Deaf" and "deaf" will be explained as an internal cultural distinction. The importance of this study will be illuminated in the context of three Major Learning Outcomes (MLOs) of the Liberal Learning major, tying the relevance of cultural awareness, second language proficiency and social work with synthesis of modern literature and discussion of current social services for the deaf:

- <u>LL MLO B2</u> – Single Ethnic/Cultural Group Awareness
- <u>LL MLO B4</u> – Second Language Communication Competence
- <u>LL MLO C11</u> – Subject Area Emphasis in Social Work

MLO B2 and B4 are intimately linked in this paper, inspired by the depth of study I have done in American Sign Language and of Deaf culture. Because I am dedicating

my life to social service and have had extensive experience working with adults and children with disabilities, I am fascinated with the emerging Deaf culture and how social service delivery is perceived among the Deaf. Because we are living in the age of multiculturalism, it is more important than ever to acknowledge and empower those who have not traditionally had a voice, both figuratively and literally. It is through this body of work that I wish to use my knowledge of Deaf culture and ASL to discover how social service delivery can be improved for the Deaf.

MLO C11 (Social Work) is the subject matter of one of my minors and it will be the focus of my graduate studies. The training that social workers must complete before earning an MSW degree includes many areas of cultural, political, legal, ethical and social competency. The importance cross-referencing social work and service delivery for the deaf in this study is critical and will demonstrate the need for change in the traditional delivery style. It will also demonstrate that conventional definitions of the word 'disability' should be challenged and replaced with culturally sensitive delivery models.

The purpose of this study is to examine the availability, quality and cultural appropriateness of human services for the deaf, as well as exploring the implications of poor quality services for the deaf population. A thorough discussion of the history and proliferation of Deaf culture will precede a review of modern professional literature pertaining to these issues and provide a context in which the study's questions can be answered.

Primary question:

- What is the availability and quality of social services for the deaf?

- What are the implications of poor service to this population?

- Is acknowledging Deaf cultural identity pertinent to service delivery?

- How does the notion of deafness as a disability impact deaf children and adults?

DEAF HISTORY: A PRIMER

The existence of deafness and its implications can be traced back as far as 360 B.C. in Plato's *Cratylus,* wherein Socrates ponders a type of sign communication that was used by deaf people at the time (Marschark & Spencer, 2003, p. 9). Although deafness was viewed as an illness or affliction, it is apparent that the effect of deafness on a person's psyche and development was of interest to philosophers. It has also been discovered that Greeks and Romans condoned infanticide to rid its societies of disabled citizens who could not contribute to the advancement of the whole (Marschark & Spencer, 2003,). In fact, prior to 1750, the deaf were primarily isolated, were forced into menial labor, and were often socially isolated from their families who viewed their rudimentary gestures as pitiful and embarrassing. It was nearly impossible to gauge the intellectual capacity for the deaf at this time, as they were seen as "…little better than imbeciles – the lot of the deaf was manifestly dreadful (Sacks, 1989, p. 12). The most significant oppression was felt by the prelingually deaf (becoming deaf before speech is developed, or deaf at birth), as no academic or social movement had offered evidence that that intellectual capacity was not dependent on the ability to hear.

The development of education for the deaf truly began in France in the early 1760s. Charles Michel Abbe de l'Epee, a student of theology and law, became

interested in matters that affected the poor and afflicted in the slums of Paris. Upon his

encounter of two deaf sisters in an alley, de l'Epee was impressed by the sophistication

of the gestural language they used to communicate, which sparked his interest in

helping the deaf of Paris to become educated. Under his guidance, the first school for

the deaf was soon opened in France, the philosophy of which was that signed language

is the natural way for deaf people to converse, and could most certainly lend itself to

their educational and intellectual development. Although this concept was not embraced

by the Royal Society of France, de l'Epee continued to teach the deaf, as "…he saw

language as more than a verbal system of sounds and orthography…he believed it was

possible to teach deaf students to think logically" (Marschark & Spencer, 2003, p. 13).

Great advances in the acceptance of signed language as a result of his work

gave way to the work of de l'Eppe's successor, Abbe Roch Ambroise Sicard. Sicard

developed a philosophy of compassion, studying the plight of the uneducated deaf and

posing difficult questions regarding the biological, psychological and intellectual

differences between the hearing and the deaf. It is the subsequent re-evaluation of the

ability of the deaf to think rationally that became the foundation of deaf education. Soon,

word of de l'Epee and Sicard's work spread across Europe and the Americas by way of

Laurent Clerc, a pupil of Sicard's successor, Massieu. Together with Thomas Gallaudet,

Clerc opened the first institution to serve the deaf in the United States: the American

Asylum for the Deaf in Hartford, Connecticut in 1817 (Sacks, 1989). Opportunities for

the deaf in terms of education began to grow, but dueling philosophies of "oral" or

speaking, versus "manual" or signed approach at educating the deaf prevailed. Some

argued that to teach a deaf person to speak was ludicrous, as it was a form of

communication that they could never truly grasp. It was even feared, in some American colonies, that attempts to teach deaf children were acts of sorcery or witchcraft (Marschark & Spencer, 2003, p. 13). In the nineteenth century, Alexander Graham Bell crusaded with vehemence against the "…formation of a deaf variety of the human race" (Wrigley, 1996, p.214) and spoke openly about the resulting cataclysm of deaf offspring, which he saw as a threat to the intellectual growth and social status of American citizens.

In sections of the country such as Martha's Vineyard in New England, the deaf population had grown due to the arrival and intermarriage of a vast quantity of deaf settlers from Kent in England. Signed language was used and widely accepted in these areas by both hearing and deaf, and documentation of a high rate of literacy supports the notion that the deaf are not confined to the limitations of being intellectually stunted as previously thought. Because of the work of de l'Epee, Sicard and their successors, momentum for deaf education increased dramatically during the nineteenth century (Marschark & Spencer, 2003). In the twentieth and twenty-first centuries, the oralist versus manual dualism has continued to exist, challenged by technology in the form of cochlear implants as well as societal changes. The norm for educating deaf children is no longer to send them to deaf residential schools, a customary practice in the late 1800s to mid 1900s, but full immersion or inclusion into classrooms with hearing teachers and students. As a result, the push for education and services specifically engineered for deaf people has materialized. Even though enrollment of deaf students in postsecondary educational institutions has grown by over fifty percent since 1965, on average, only a fourth tend to graduate (Marschark & Spencer, 2003).

There are now more than 121 formal and internationally accepted signed languages, including Chilean Sign Language (CSL), Egyptian Sign Language (ESL), Jamaican Country Sign Language (JCSL) and Philippine Sign Language (PSL) (Gordon, 2005). More recently, there has been a call for greater understanding of the true meaning of deafness, Deaf culture and Deaf identity.

CULTURE AND IDENTITY

It is important to begin any discussion of cultural identity by defining what it is to have identity in an ethnic culture. According to Wrigley, "a, if not the, defining feature of self-identity as belonging to an ethnic or linguistic minority is having and using one's own language" (1996, p. 15). It is important to note that ASL is not a visual representation of English, but is a language with its own grammar, syntax and organization. The basic grammatical structure of ASL follows the 'topic-comment' pattern rather than the subject-object form of English; for example, in ASL, "store I go" is translated in English as "I go to the store" (Lane, Hoffmeister & Bahan, 1996).

Before signed languages were organized and exact or recognized as official forms of communication, deaf people were using their own "home sign" which consisted of gestures that originated within the home and became specific to familial and community groups. Because it was frowned upon to use sign in public for many deaf people except in areas such as Martha's Vineyard, the Deaf identity was restricted to growth within the home or by contact with close friends and family. The relative isolation of deaf people has resulted in an ethnic disenfranchisement, and has hindered the development of the Deaf as a culture. However, not every deaf person considers

themselves to be Deaf. To explain, let us discover the difference between deafness and the Deaf.

To say someone is deaf vaguely characterizes a lack of physical hearing ability; the title, Deaf, refers to an identity specific to the cultural group of the Deaf. For the purposes of this study, the word 'deaf' will be used as a general term; the capitalized form 'Deaf' will be used when referring to title or identity marker. According to Lane, et al. (1996), the fundamental tenets of language and its relation to ethnic identity are threefold: as a medium for social interaction, a symbol of social identity, and as a store of cultural knowledge. Deaf folklore has emerged as another facet of Deaf culture, a practice that commonly provides comic relief to the deaf, abating angst and providing an anecdotal outlet for the frustrations incurred by dealing with an oppressive hearing society (Rutherford, 1993).

Varying levels of deafness, from mild hearing loss to profound or prelingual deafness, can contribute to a person's identity or lack thereof with the Deaf community. A person's family environment and amount of exposure to other culturally Deaf people are also crucial factors in a deaf person's sense of identity. The reactions of hearing parents upon learning that their child is deaf are varied, but commonly result in a socially prescribed feeling of pain, guilt or disappointment (Lane, et al., 1996). In the Deaf community, however, the birth of a deaf baby is a joyous event. It might be confusing to the hearing community that a baby with a "disability" might be preferred, but to the Deaf it is an even that confirms family identity, for Deaf identity precludes the notion of disability. Deaf parents begin communicating with their deaf baby immediately in their native language, much as a hearing parent begins speaking to their child at birth

(Lane, et al., 1996). However, depending on the difference between hearing status of the parent and child, a deaf child can face varying levels of acceptance by the Deaf community.

Deaf children of Deaf parents typically enjoy a respected status among the Deaf community, as they are viewed as being "purely Deaf", as opposed to those who become deafened late in life, or "accidentally deaf" (Lane, et al., 1996). The hard-of-hearing can assume a Deaf identity and assimilate with Deaf culture, but those with hearing loss that use speech can be labeled "oral", which implicates a long social and political history of oppression for the deaf (Padden & Humphries, 1988). Hearing parents are often encouraged not to begin using sign language with their deaf children for fear of a delay in language acquisition, but emerging scientific evidence shows that using both methods concurrently results in a higher rate of communication and inclusion within the family (Lane, et al., 1996).

Since it is common for parents to yearn a better life for their children, a perceived disability or limitation would create an environment in which the child grows up with an identity of deficit from inception. Because over ninety percent of deaf children are born to hearing parents, the importance of affirming the deaf child's identity, whichever they might choose, becomes paramount (Wrigley, 1996). Fortunately, claiming a Deaf ethnic identity is a natural process for those born into Deaf families or to hearing families who support their identity-seeking endeavors. Conversely, the acquisition of oral speech for the Deaf, which has been labeled by the Deaf community as a vehicle for the arrest of signed language, is rooted in the notion of curative or therapeutic endeavor. Therefore, resistance to supportive services can become an inherent reaction. As a result,

discovering the accessibility of and ways in which human services can become less threatening and more empowering to the Deaf is the primary function of this study.

<u>CULTURALLY AFFIRMITIVE TREATMENT:</u>

The prevalence of mental illness in the deaf population seems to be greater than that of the rest of the population, alluding to the impact that experiences of cultural insensitivity have on the deaf as a result of oppression and isolation. Because it is impossible for a hearing treatment or helping professional to give him/herself full legitimacy to work with a community to which they do not belong, the task of becoming fully aware of the Deaf experience and developing a full set of appropriate skills is of vital importance (Lane, et al., 1996). Helping professionals must also ask of themselves what biases they possess or transference issues they foresee within the helping context. Glickman and Gulati (1996) state that hearing professionals can "…at times become the object of deaf people's trasferential feelings about hearing people" (p. 25). The task of becoming proficient in matters of Deaf cultural nuance reveals norms regarding eye contact, touching, facial expression, emotional self-expression and self-disclosure, which tend to be vastly different from that of the hearing cultures (Glickman & Gulati, 1996). To illustrate one facet of distinction between hearing and Deaf modes of nonverbal communication, the following chart was constructed by Mairian Corker in her text, *Counselling – the Deaf Challenge* (1994, p.108):

(…)

LINGUISTIC AND CULTURAL CONFUSIONS

Body movement, facial expression or behavior	Hearing interpretation	Additional Deaf use or interpretation e.g. non-manual features of sign language
Nod of head	Affirmation, agreement	Punctuation
Slight Frown	Disagreement, disapproval	Open-ended question (requesting extended answer)
Raising eyebrows (with open mouth)	Surprise	Closed question (requesting yes or no answer)
Hunched shoulders	Withdrawal, depression	Questioning
Eyes down	Avoidance, concealment	Thinking
Persistent lateness	Unhappiness with counsellor or counselling	Culturally based time values, thinking in linear terms
Silence at start of counselling	Uneasiness, uncertainty about where to begin	Need for direct communication with counsellor

Considering the manner in which the deaf have come to view social services, and because the common perception of their lack of hearing is a disability, acknowledging the Deaf culture or identity of a potential client is of the utmost importance. In 1990, the Americans with Disabilities Act (ADA) was drafted into law and prohibits discrimination in the workplace, and provides for accessibility to all services such as schools, welfare agencies and interpreter services (Lane, et al., 1996). The impact of the ADA on the deaf was significant because it raised the issue of access to services via disability accommodation. A dilemma arises for the deaf, as their access to

services is afforded by accepting the label 'disability', whereas a person of another ethnic minority would be accommodated simply by means of acknowledging a pure cultural difference. Therefore, to request the services of an interpreter under the assumption that they are disabled can further normalize the perception of deafness as a problem to be fixed.

A literature review completed by Lane, et al., (1996) reflects language used by professionals to describe traits attributed to the deaf, including inconsistencies such as: explosive and shy, shrewd and naïve, detached and passionate, suspicious and trusting; they assert that these statements are a clear affirmation that "…the psychology of the deaf consists of hearing stereotypes about deaf people" (p. 349). The genuine desire to help and empower the deaf can sometimes become overshadowed by cultural assumptions and institutional biases which effectively impede service delivery; for that reason, understanding the obstacles that helping professionals face will drastically change the outcome of the services they provide.

ROADBLOCKS:

According to Corker's evaluation of linguistic matching in counseling for the deaf, "Research suggests that hearing people tend to develop a particular way of talking to deaf people…which is stilted and unnatural" (1994, p. 97). She also proposes that sixty per cent of speech sounds are unintelligible for lip-readers, which indicates the level of misunderstanding that can occur without an interpreter, or as the result of a deaf person relying solely on their oral upbringing (Corker, 1994). Therapists can also unintentionally solicit responses nonverbally by slight nods "yes" or shakes "no" of the head. Glickman and Gulati (1996) explain that in an effort to achieve culturally affirmative treatment

models, it is common for agencies to elicit training for a staff member to use sign language to ensure a 'quick fix' to the communication barrier; however, such training does not typically acknowledge the necessary cross-cultural context of the service. As a result of such culturally insensitive training, a deaf person might re-encounter situations in which disempowerment and communicative isolation are present, further exacerbating any problems that prompted the person to seek help initially (Glickman & Gulati, 1996).

Harlan Lane describes the hearing-dominated oralist movement as the "…paternalistic, hearing-centered endeavor that professes to serve Deaf people…" (1992, p. 43). The Deaf have christened the philosophy of cultural, linguistic and intellectual repression of the greater hearing culture onto the Deaf as 'audism'; it is "…the hearing way of dominating, restructuring and exercising authority over the deaf community" (Lane, 1992, p. 43). Although hearing people are not generally members of the Deaf culture (except for some familial exceptions), they have classically posed as experts for Deaf issues. The anti-audism movement is concerned with the Deaf community's ability to become an independent entity, free from the perception that deafness is synonymous with disability. The collective Deaf culture generally feels that fundamental tenet of audism is the eradication of deafness, which has surrounded the issue of assisted hearing with controversy and ethical dilemmas (Lane, et al., 1996).

COCHLEAR IMPLANTATION:

Because advances in technology have provided the world with treatment options for hearing loss or deafness, there lies a dichotomy in people's view of inventions such as the cochlear implant. Although experimentation with electrical stimulation of the

auditory system began over 200 years ago, the first cochlear implant system was approved for public use in the 1970s (Marschark & Spencer, 2003). The primary functioning element of a cochlear implant is a multi-channel device that provides electrical stimulation to auditory nerve endings in multiple places within the cochlea. Attached to the implant is a microphone for hearing assistance and a speech processor, worn about the waist of the recipient, which serves to organize information that will be presented to the cochlea for intelligible interpretation by the implant user. The following is a diagram showing how the implant is surgically attached to the head and auditory nerve, accompanied by an image of a new model of cochlear implant:

IMPLANT DIAGRAM
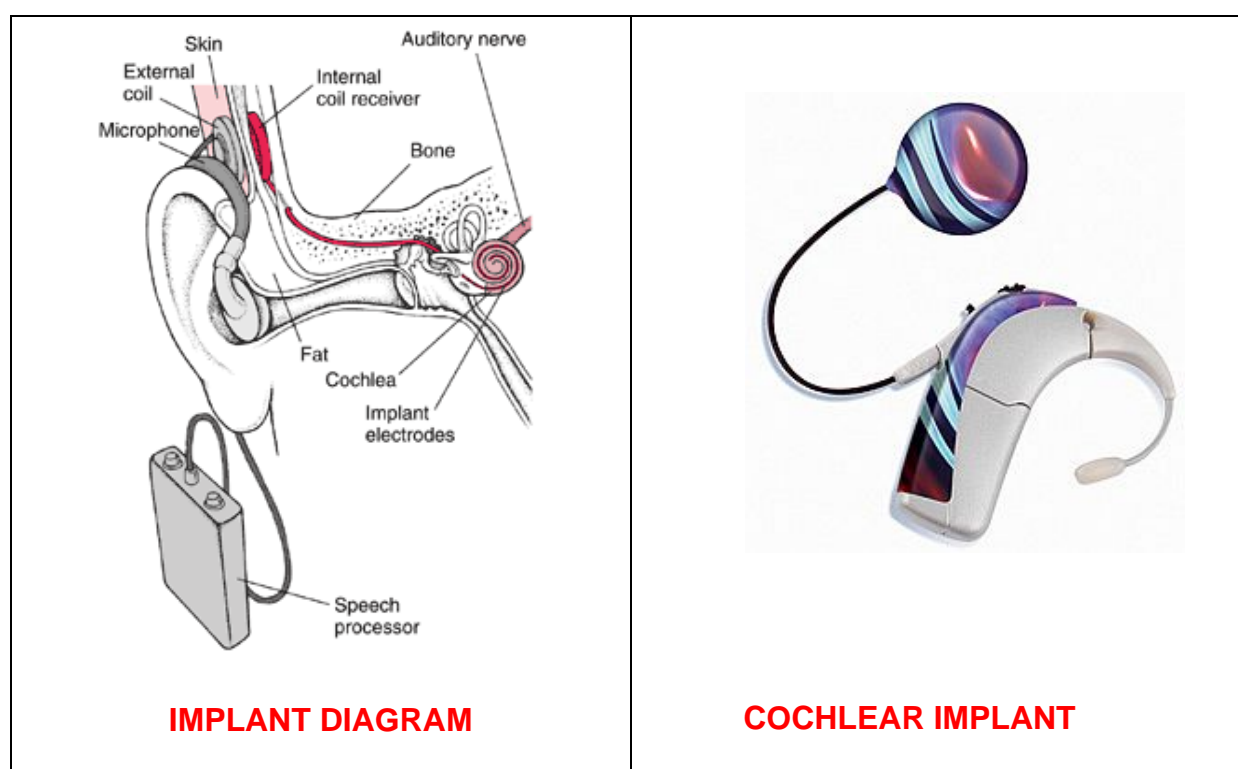
COCHLEAR IMPLANT

Marschark & Spencer (2003) discussed clinical results of cochlear implantation devices and their efficacy, the overwhelming conclusion of which is that the implant doesn't supply the quality of auditory information to a deaf person's auditory nerve to

equal that which a hearing person has naturally. They state explicitly that, "although most users find them useful, cochlear implants do not change deaf people into hearing people" (Marschark & Spencer, 2003, p. 435). In fact, the output of the implant is described as "'coarse' or 'degraded'" (Marschark & Spencer, 2003, p. 435). However, there are several segments of the population that can and do benefit from cochlear implantation and find that it restores their identity, mitigates issues of isolation and rebuilds their self-esteem. Glickman & Gulati (2003) list several groups that show a marked improvement in overall well-being after receiving the implant; for example, those deafened late in life (or post-lingually deaf), the elderly, and people who are hard of hearing. Thus, the true efficacy of the implant can be measured only by the recognition of sound as symbolic, as well as contextual awareness in terms of differentiation, for example, of a human's voice from a bird's call.

The most achievement in regaining hearing ability, although slight, has been seen in post-lingually deaf children and late-deafened adolescents and adults (Glickman & Gulati, 2003). A study conducted in Australia, consisting of telephone surveys conducted between researchers and hearing parents of children who had received the implant revealed that there are benefits including increased access to activities and enhanced interaction between family members, but there were also problems with discomfort and disruptive, bothersome noise (Marschark & Spencer, 2003). The problem with these studies is that none are conducted within the Deaf community; although the majority of deaf children are born to hearing parents, neither members of the hearing majority or Deaf cultural minority were consulted about the effects of the implant on group identity.

The previously mentioned dichotomy of viewpoints occurs surrounding the issue of informed choice among those for whom the implant has the most efficacy (Glickman & Gulati, 2003). Adults and older adolescents have the capacity to understand the surgical procedure, health risks and implications of such an invasive surgery. The Deaf community is primarily concerned for small deaf children who do not have language, cultural identity or the capacity to make an informed choice. It appears that most speech pathology programs that accompany the use of a cochlear implant encourage speaking and discourage signing, although a type of 'total communication' can be formed by using both. The greatest concern for people receiving the implant is focused upon the construct of identity as a deaf *or* Deaf person, due to damaging self-image issues resulting from a lack of peer groups for implanted children (Glickman & Gulati, 2003). The identity crisis can be exacerbated for children as a result of their placement in classrooms with hearing children as the majority; becoming a minority 'other' can further confuse and isolate a child.

Within the text of *A Journey into the DEAF-WORLD* (Lane, et al., 1996), the Deaf cultural perspective on cochlear implants is explained. Aside from the previous discussion regarding informed choice and the risk of negative affects of general anesthesia and other complications of surgery, the issue of predestination in terms of culture is what seems to be most disturbing. If a hearing person becomes deaf, it is quite unlikely that they will decide to exclusively use ASL rather than opt for medical alternatives; but if the person attempts to speak again, there is a great likelihood that the speech used will be rather muted and obvious to those with full hearing ability, stereotypically affirming the identity of 'disability' via inability to speak properly. If the

newly deafened adult chose to use ASL and embrace a Deaf identity, it is likely that they would encounter *either* disdain from the Deaf community as a result of transference, or from the hearing community as a result of perceived rejection. If a deaf child is raised in the 'oral' tradition, they could face contempt from the Deaf community; they might also be pitied and labeled 'disabled' by the hearing community. It is this gamut of cultural discrepancies and incompatibilities that can cause turmoil for the deafened person, either personally, professionally, emotionally or intellectually.

The preceding discussion regarding the history and proliferation of the modern Deaf cultural movement, as well as attempts at its eradication illuminates the fundamental knowledge necessary to build a culturally affirmative treatment model for contemporary helping professionals. Without deep appreciation and comprehension, the prevailing stereotypes and limitations that arise as a result of the collective deaf experience will persist. By consulting the minimal empirical evidence provided by researchers in this field, it is possible that a clearer picture of the deaf experience in social services will emerge.

REVIEW OF RESEARCH AND LITERATURE:

To begin the global examination of barriers to social services for the deaf, this section begins with a study conducted in the United States, focusing on the professional limitations that itinerant and self-contained-classroom teachers face while instructing deaf children in full-inclusion classrooms. Some school districts in the Midwestern United States utilize itinerant teachers for the instruction of deaf children, rather than systematically segregating the children into special education classrooms; therefore, the itinerant teachers have a unique perspective on the teaching and learning process from

the perspective of the deaf child. For example, itinerant teachers in this study cited

concerns regarding the "…non-accepting attitudes of regular education toward deaf and

hard of hearing students…" (Guteng, 2005, p.24). In fact, they pointed out that the

'regular' teachers are so unwilling to revise curriculum to include deaf students that they

would rather send students to a resource teacher for one-to-one sessions. The effects

of social isolation and feelings of 'otherness' can be devastating for any child.

Teachers in this study also noted a "…restriction on payment for special

education services for deaf and hard of hearing students, huge paperwork

requirements…" and a "…lack of clarity in school policy…" for emergency situation

preparedness as it relates to the safety of deaf students (Guteng, 2005, p.26). In

addition, teachers noted concerns about the educational expectation of the deaf

children's parents. One teacher in particular noted the unrealistic expectations of her

deaf student's parents, stating that the parents insisted that their child learn in the same

manner that they did, using speech, while the parents knew no sign language

whatsoever. Another teacher related an anecdote stemming from the psychiatric

hospitalization of one of her deaf students, stating that the lack of parental involvement

in the deaf children's lives is of "…emotional concern…" to the teacher, alluding to the

effect that isolation has on the family dynamic (Guteng, 2005, p.28)

An area that teachers in this study request improvement in is the school's

administrative services. New teachers in the study revealed troublesome relationships

with senior teachers, stating that those who were tenured were allowed to exclude deaf

or disabled students out of preference (Guteng, 2005). This practice forced new

teachers to scramble for administrative support and most certainly affected the quality of

educational experience that the students received. More than anything, teachers in this study noted an overall lack of knowledge of staff about the issues that deaf and hard of hearing students face. One teacher discussed the school principal's lack of expertise in the arena of disability and deafness, so much so that it seemed impossible that the administrators would provide instructional assistance because "…they don't even know about hearing loss" (Guteng, 2005, p.22).

A child's experience in school can either encourage or hinder them, but for deaf children, it can possibly reinforce societal limitations and biases, discouraging the child from developing their intellect and interests as well as hindering the development of social and coping skills. This study of teachers of deaf children found that the lack of support and knowledge are key factors in quality instruction, which has become a common thread in studies of other services for the deaf.

A research article in the *Nursing Standard* (2006) examines acute medical treatment for deaf people in the United Kingdom (UK). The author notes that one of the "…major factors for inequality of care was inadequate training of nurses and medical staff in deaf awareness and associated communication skills" (McAleer, 2006, p. 51). Ironically, in the UK, British Sign Language or BSL was only formally recognized as a language in 2003, which directly affected the availability and reliability of interpreters (McAleer, 2006). Interestingly, the article introduces Deaf culture as a precursor for critiquing the absence of qualified professionals or training in the medical field to deal with culturally appropriate service.

Because confidentiality is of the utmost importance to those in the medical profession, the use of an interpreter can cause concern or discomfort for the medical

professional because doing so is in conflict with the Hippocratic Oath. As a part of culturally sensitive training, or by drawing parallels to other cultural or linguistic minorities, medical professionals should realize that "…without an interpreter patients cannot make informed choices and a full assessment cannot be conducted" (McAleer, 2006, p. 52). Access to services for the deaf in the UK is directly related in this study to the amount of qualified interpreters, which the author claims is alarmingly low.

A paper published in the journal, *Australian Psychology*, emphasizes the importance of acknowledging the relationship of sign language interpreters in the mental health context. The professionalization of interpreting services has led to the creation of international organizations with the purpose of regulating and ensuring the integrity of interpreters. Australian Sign Language (Auslan) was indirectly acknowledged by its federal government around 1989 due to the publishing of the first Auslan dictionary, so the use of Auslan interpreters and services for the deaf in Australia is fairly new.

The holistic nature of interpreting is discussed in the paper, citing the exchange between interpreter, psychiatrist and patient as a "…discourse process, with the interpreter present being a participant within the interaction, rather than a mere conduit who channels information" (Cornes & Napier, 2005, p. 403). This concept of the interpreter as more than just a mere translator is pivotal in the Deaf community, as cultural affirmation requires interpretation of gestures, facial expression and tone.

An article written in the November, 2006 edition of *American Psychologist* chronicles the American Psychological Association's (APA) role in the regulation of research methods for those studying the deaf, the comprehension of which has become necessary to appropriately assess and treat deaf patients. In recent years, the APA has

been working intensively to create opportunities for the deaf to become mental health care professionals, which it claims is the best way to alleviate the disparity in services. In addition, comparative cross-referenced research conducted by the APA summarizes a greater prevalence of mental illness among the deaf than in the general population (Vernon & College, 2006). The most significant considerations for this prevalence are social or linguistic isolation and misdiagnosis; it is problematic that patients, once diagnosed with mental illness, tend to be isolated from hospital staff and psychiatrists "…as a result of their inability to hear or speak" (Vernon & College, 2006, p. 817).The primary contributing factors to mental illness for the deaf, according to the study, are organic in nature and include patients with "…etiologies such as meningitis, prematurity, rubella, and head trauma, which can result in deafness, mental illness, and /or brain damage", which are more common in the congenitally deaf (Vernon & College, 2006, p.817). Because the deaf have a higher recurrence of mental illness, and considering the organic nature of its triggers, the oppressive experiences they have in a predominantly hearing society can impact them much more than commonly thought.

In Lennard J. Davis' article in the journal, *Chronicle of Higher Education*, the issue of identity is addressed in terms of its relation to current concepts of gender, race, religion, ethnicity and sexual orientation (2007). The author supports the previous discussion regarding Deaf identity, that it deafness has come to be seen as more than just an illness or deficiency. However, Davis finds shortcomings in the societal separation that cultural groups create, asserting that "the idea of an ethnic group or minority is tinged with the brutal history of racial politics" (Davis, 2007, p.B6). As such, he draws parallels between the culture of oppression and becoming a colonized people;

further disassociating the Deaf and hearing cultures. Exclusion, Davis claims, might be the downfall of the culture's integrity because the 'pure Deaf' ideal marginalizes those with oral training or the hard-of-hearing who have not yet learned ASL (2006). The article concludes with the suggestion that eliminating rigid ideals of Deaf culture might actually empower the group as a whole, so that it may include those with varying levels of hearing loss as well as those with varying degrees of alignment with Deaf identity.

Similarly, according to Paddy Ladd (2005), although human beings have a tendency toward fixedness, becoming Deaf occurs on a continuum and requires a process of acculturation. Ladd (2005) offers criticism of 'horizontal violence' that is prevalent in Deaf culture wherein members condemn each other for exhibiting certain characteristics This 'horizontal violence' is consistent with the previously discussed literature as well as Lennard Davis' discussion of the Deaf culture's inflexible ideals.

While the quantity of empirical evidence that identifies the state of social services for the deaf is minimal, studies conducted in which members of the deaf minority are consulted about their experience or preferences practically do not exist. However, one such study examined stress levels among the deaf; another consulted deaf people regarding their personal experiences as consumers of human services.

Jones, Ouellette and Kang's article in *American Annals of the Deaf* introduces unique stressors that deaf people experience in everyday life as well as "…circumstances associated with increased stress in the general population" (2006, p.25). The article describes a study chronicling the effectiveness of culturally specific stress-reduction classes for the deaf. Results indicate that the deaf encounter greater external stressors than the hearing and that the classes seemed effective in reducing

the participants' stress, thus decreasing their risk for suffering from related illnesses. Contributing factors include "…underemployment or unemployment, difficulties in daily interactions with hearing people, settings that are not accessible, and the stresses associated with the experience of being members of a cultural and linguistic minority group" (Jones, et al., 2006, p. 26). The article discusses the possibility that deaf adults might have less access to popular media, thus, having less access to information "…concerning the harmful effects of stress and techniques for reducing stress" (Jones, et al., 2006, p. 27). While adaptive technology such as Closed Captioning is used more frequently than in years past, the quality is often poor and requires further interpretation by the deaf viewer (Jones, et al., 2006). The study concluded by asserting that more culturally significant intervention techniques for stress management must be developed and implemented for the deaf, as this study shows that such techniques are successful. Because stress and its related illnesses are problematic for the deaf, it is crucial to the deaf to develop a skill set that allows them to mitigate stressful situations in their lives.

To measure the attitudes of human service professionals toward the deaf, the Attitudes to Deafness Scale was created and has become the most widely used measure in assessing the perceptions that hearing professionals have of the deaf (Cooper, Rose and Mason, 2004). Since its inception, the scale has contributed to the evidence of decreasing negative attitudes of hearing professionals toward the deaf, perhaps because it has added a dimension of awareness within the helping professions to identify biases and negative attitudes toward deafness. Items on the scale differentiate between the positive and negative aspects of deafness as perceived by the deaf. For example, a positive attitude "…would be one in which Deaf culture were

acknowledged and respected" (Cooper, et al., 2004, p.387). The scale is designed to be used by all human service professionals and offers hope for the identification of appropriate professional attitudes toward deaf clients or patients.

The bulk of literature and empirical evidence surveyed in this paper suggests an overwhelming push for acceptance and understanding of Deaf culture within the context of professional settings. Although research may be a bit one-sided, valuable critiques of Deaf culture offer new avenues that the deaf community can explore in aiding the metamorphosis of their collective identity. However, several suggestions for the efficacy and improvement of service delivery for the deaf within the helping professions remain constant throughout, to be discussed in the Results section.

METHOD:

Because the format for this body of work precludes the use of original research, it is of information gleaned through scholarly texts and journals obtained from the library at California State University, Monterey Bay (CSUMB), as well as other texts gathered from course requirements that this study is comprised. Unfortunately, the availability of scientific research relating the deaf and the amount of culturally affirmative human services for them is minimal. The types of literature used in this study fall into three main categories: narrative, scientific and biographical/ autobiographical; the variety of perspectives offered represents the expertise of research analysts, professionals in the field of human services and deaf consumers themselves. Texts used in American Sign Language courses at CSUMB also provide an academic and utilitarian context for examination of the nature of the language and culture of the deaf.

RESULTS AND DISCUSSION:

        After thorough review of the literature amassed for this study, several concepts regarding the availability and condition of human services for the deaf are constant throughout. Because there are few members of the deaf community that have become human service professionals, the lack of cultural representation creates a disparity in the amount of qualified hearing versus deaf experts. Thus, the traditional biases held by the hearing culture have been passed down for generations, permeating every facet of the deaf experience.

        Human service professionals in the UK and Australia also find that biases interfere with the quality of services. More importantly, the two nations are suffering from an overall lack of qualified interpreters to perform their duties within a professional context. The recent adoption of signed languages as official modes of communication, coupled with the strict guidelines and training required by newly created professional interpreter associations makes it difficult to train and employ qualified interpreters.

        Many sources cited a lack of familiarity with and accommodation of Deaf culture as the most significant barrier to service delivery; hearing professionals seem to operate on the premise that the deaf are little different than themselves save for a loss of hearing. Psychiatric and developmental misdiagnoses have also contributed to the barrier in services. The deaf have been subject to psychiatric evaluation plagued with biases, which has resulted in additional skepticism and resentment for the deaf of the true intention of human services. Likewise, the prevailing view of deafness as a disability hinders the client-professional relationship, not only by means of the manner in which the professional's biases affect the patient's autonomy in treatment, but the

tumultuous nature of deaf history in which they have been oppressed and

institutionalized, creates a reluctance of the deaf to be receptive to treatment at all.

At this point I would like to relate two professional anecdotes stemming from

incidents that occurred at my places of employment. I currently work in the mental

health field as a counselor at a residential crisis house for adults with chronic and

persistent mental illness. We treat people belonging to many ethnic and cultural

minorities, including those of Latino, Filipino, African American, Native American and

Korean descent, among many others.

Approximately six months ago, a counselor was sent to the psychiatric unit at

the local referring hospital to conduct an assessment with a Deaf woman who was

considering our program for treatment. The Deaf woman's case file was full of biased

language and derogatory statements, including accusations such as hostility, refusal to

cooperate and disorganized thought. This type of labeled behavior is commonplace

within the context of mental health service, as agitation and non-compliance often

accompany the cyclical nature of severe mental illness. However, it is safe to assume

that the Deaf woman was possibly being misunderstood, or was merely reacting to a

system that is insensitive to her cultural identity.

The Deaf woman's social worker, the person responsible for coordinating

culturally appropriate services, made no attempt to arrange for an interpreter to

accompany the woman in her assessment; in fact, the social worker warned our

counselor that the interview process would most certainly take hours because the

woman 'refused to lip-read' and would only communicate with hearing people by means

of written communication. As a result, the counselor spent several two-hour blocks of

time with the client in an attempt to complete the entire interview process, but the Deaf woman, frustrated with a lack of understanding of the written English language, terminated her interview and decided not to receive treatment. It has been speculated by some of the staff, as an afterthought, that perhaps the woman did not even know that she was legally entitled to interpreter services.

The implications inherent in a lack of cultural acknowledgement can be devastating for any person, but the situation I've just described infers more than insensitivity; the Deaf woman was essentially denied services based on inability to speak English. What was most disturbing to me is that in my experience, accommodations for non-English speaking clients of our program have been made without question. For example, there is a current resident in our facility that neither reads nor speaks a word of English, yet he is accommodated with a counselor and social worker who work diligently to make sure that he receives appropriate treatment for his mental health issues. I believe that because deaf or Deaf people do not have the ability to speak English, that they are somehow perceived as lacking intellectual capacity, which has a direct correlation to the treatment they receive.

Several years ago, I worked as a Life Skills Instructor with an agency that serves adults with developmental disabilities. As a new instructor, I was assigned a caseload of clients to meet with on a weekly basis and develop service plans for, one of which was a Deaf woman with cerebral palsy (CP). First, it is critical to point out that this woman *did not have a developmental disability.* I inquired as to why she was a consumer of services at our agency and was told that it was because of her 'delay in learning' due to the combination of CP and deafness. When discussing her case with my new

supervisor, I was told not to worry, because the woman was able to write in English, which would be our primary mode of communication. Right away, I sensed that something was wrong, but initiated a meeting with the client to commence our professional relationship.

In the first three weeks, the client and I had developed a system of communication involving writing as well as some rudimentary ASL which she had taught me. Apparently, no previous instructors had shown interest in acquiring sign language skills or learning the nuances of Deaf culture, nor had the agency made any effort to provide interpreting services for the client. It became apparent that she had deep intellectual capacity but *lacked a forum for expression*.

I was shocked that for our monthly meetings with the client's social worker, the local Department of Social Services made sure to provide an interpreter; however, no such offer or accommodation was made to ensure clear communication between the client and me. There was no guarantee that the client would receive the quality services which she required, requiring a risky leap of faith. She had agreed to let a complete stranger into her house, knowing that I could not use her native language and she could not use mine. Because I was willing and able to learn ASL, the accessibility afforded to this client by the Americans with Disabilities Act seemed to be nullified. Although I loved working with this client and came to value and respect her, I feel that a qualified, culturally literate, professional interpreter could have provided a necessary link between the client and me. My experience with this client provided the basis for my developing interest in human services and more specifically, examining service delivery for the deaf and restructuring related policy.

I found only one sample within the literature review which posed opposition to the Deaf cultural movement. Lennard J. Davis (2006) offers legitimate criticism of the exclusive nature of 'pure' Deaf culture and its implications for those struggling to find themselves. In order to gain acceptance within the context of cultural identity, the pressure of being 'Deaf enough' holds the same risk within the Deaf community runs parallel to pressures felt by members of any other cultural group, in terms of exhibiting preferred characteristics of that group. Often, remaining in the fringe doesn't lend itself to acceptance within any community.

While I do agree that absolutism or extremism is not conducive to inclusivity, I believe that the evolution of Deaf identity has required the drawing of clear boundaries, as the hearing culture has attempted to control, even eradicate the primary characteristic by which the Deaf identify themselves. The way this concept translates to the greater context of social services is that while the attributes of a culture may serve to disenfranchise some of its members on the fringe, it also provides a forum in which group members can become empowered and remain autonomous, which is also the fundamental purpose of social services.

I am a thirty-year-old woman with only ten years of experience in the field of human services. I am devastated that within that time, I have witnessed exemplification of nearly every disservice committed by the social services system toward the deaf that is described in this study. As a result of my research, I realize that the saturation of bias within the system is far greater than I ever imagined, but with increasing global accessibility of ideas and communities, there is no reason to believe that culturally affirmative social services cannot exist.

PROBLEMS AND LIMITATIONS:

The fundamental problem encountered in the course of this study was the minimal availability of original research examining social service delivery to the deaf. Indeed, only one article was found to consult the deaf regarding their personal experiences with helping professionals, and one article measured the attitudes of helping professionals toward the deaf. In addition, the studies took place in relative isolation; that is, they included statistically small samples of less than ten people. The dearth of information also alludes to a lack of inclusivity in relation to deaf people from undeveloped or third-world countries. There is no way to know how the deaf are viewed or treated in areas of the world which have not yet been studied by the academic community. Because there are millions of deaf and people with varying levels of hearing ability in the world, including larger and cross-cultural samples is critical to the advancement of related services.

The secondary limitation of this study was a lack of literature supporting views in opposition to the Deaf cultural perspective. Although it is difficult to disagree with the affirmation of cultural identity, it is easier to present a one-sided argument when no contradictory viewpoints are available. As mentioned previously, the argument against the philosophy of 'pure' Deafness identified several flaws that had not otherwise been addressed within the texts offering justification of the philosophy. It has become evident that the lack of empirical evidence that describes or critiques social services for the deaf has contributed to the dearth of culturally specific services available to them.

<u>CONCLUSION:</u>

Like many other cultural minorities, the Deaf have survived in spite of attempts to oppress and eliminate them; but research is sorely lacking. However, it is primarily through consulting members of the deaf community that the rest of the world can understand ways in which they can be empowered. Several specific recommendations have been offered to improve services for the deaf, but some will only benefit consumers in individual circumstances and cannot be used across varying contexts. For example, McAleer (2006) suggests that within the medical setting, nurses and doctors should avoid placing any intravenous needles in the hands of deaf patients so that sign language communication will not be hindered. She also recommends that hospitals produce a short video to be shown to deaf patients with an interpreter present, so that any questions the patient has may be answered promptly and by a qualified professional. McAleer (2006) also asserts that the most important thing that doctors and other medical professionals can do is not to converse in the presence of a deaf patient when there is no interpreter available; as described in the "communication confusion" chart on page 11, nonverbal cues can be easily misinterpreted.

Other venue-specific recommendations include administrative support for teachers and increased discretionary funds to purchase adaptive devices for deaf children in mainstreamed classrooms (Guteng, 2005). There is also a call for the return to deaf-centered education and the resurrection of deaf residential schools as a means for strengthening the identity of the deaf starting at a young age (Lane, 1992). There is, however, a deeper commonality within all of the literature.

Creating and adopting culturally sensitive treatment models requires a combination of an understanding of the past offenses committed toward the deaf as well as the acknowledgement of changes that are necessary for advancement. Increasing the availability and quality of human services for the deaf calls for a humanitarian response; because the majority of people in the world are hearing, it is imperative that we become allies of the deaf in order to reverse the cultural bias that exists in the world. This idea also extends to the age-old issue of cultural bias in all its forms and reinforces the need for connectivity and empowerment of all minority cultures. Marion Corker (1994) asserts that meeting the challenge of serving the deaf requires that hearing professionals help the deaf to '"…find their souls" and to allow "…deaf people to be strong and secure in themselves" (p.241). Identity seems to play a major role in the overall well-being of deaf children and adults, as it does with most people. After all, is it not the ethical responsibility of the dominant or majority culture to offer support and allow for autonomy of the minorities? If the dominant groups fall short of this goal, the resulting oppression will reflect upon humanity in a way that will continue to reverberate for generations to come.

Deafness is most certainly not otherness. To think so is foolish, for any person can become deafened at any time in their life.

Now that I understand the magnitude of problems faced by the deaf when searching for appropriate social services, I can truly appreciate the monumental endeavor ahead of me; it is with hope that I roll up my sleeves and immerse myself in the task.

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