

## ABSTRACT

### The Cultural and Medical Conceptions of Deafness: Their Effects on the Self and Culturally Affirmative Mental Health Care

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The cultural model of deafness is one that affirms the legitimacy of the Deaf community as a whole. The medical model of deafness is one that is predicated on disability and focuses on “deaf can’t” rather than “Deaf can”. I take the cultural and medical models of deafness and describe them in detail before relating them to various deaf self-identities. These deaf identities help therapists and researchers create culturally sensitive therapeutic techniques that affirm those identities. The current state of mental health care and accessibility for deaf individuals is discussed and contrasted to what the future of deaf mental health care may look like.

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THE CULTURAL AND MEDICAL CONCEPTIONS OF DEAFNESS: THEIR  
EFFECTS ON THE SELF AND CULTURALLY AFFIRMATIVE MENTAL HEALTH  
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Thank you mum and dad for your unconditional support and unwavering faith in me.

You two give me the strength I need to succeed.

This is for you.

## CHAPTER ONE

### The Cultural Model of Deafness

#### *An Introduction*

In general, there are two different lenses from which one can view the deaf population in America. Looking through these two lenses shows you two different conceptualizations of deaf people. The first model is viewed through the lens of cultural affirmation. There is a consensus among scholars (Abrahams, 2007; Holcomb, 2013; Padden, 1989; Padden & Humphries, 2005) that agree that the Deaf in America are representative of their own cultural linguistic minority group of American Sign Language (ASL) users. This model is referred to as the cultural model of deafness. The second model is viewed through the lens of disability. Deficit defines this model, and deaf are defined by their lack of ability to hear. Every intervention suggested is directed toward the end goal of fixing or healing the deaf person and making them whole and more like the hearing population. This model is referred to as the medical model of deafness.

In my thesis, I will use the widely recognized notation of “Deaf” to describe deaf people who identify with the Deaf cultural linguistic minority group. When using Deaf, I will also be referring to those people who are intimately associated with the Deaf community, such as Children of Deaf Adults (CODAs) and interpreters. The notion of attitudinal deafness refers to “the self-identification of an individual as a member of the Deaf community... [that] supports the values of the community and is accepted as a valid member by others already in the community” (Fischgrund & Akamatsu, 1993, p. 171).

Those associated with the Deaf community will tend to be fluent in American Sign Language and will abide by the customs of Deaf culture; this includes deaf individuals and individuals with attitudinal deafness.

I will use “deaf” to represent individuals who have been identified by the medical community as “partially or wholly lacking or deprived of the sense of hearing” (dictionary.com, n.d.). When using the term deaf, I may be referencing some members of the Deaf community as well. As a general rule of thumb, not all deaf people are Deaf, but deaf people can be Deaf.

The differences between the cultural model and the medical model are striking. These contrasts are vital to recognize because how one person is labeled at birth can drastically affect how a deaf person’s self-concept is created in their formative years. In the next two chapters, I will differentiate between the cultural model and medical model at length, and I will later refer to these models when I describe the effects that each model has on a deaf individual’s self-esteem. The medical model and the cultural model are fundamentally from “two cultures, two points of view, two different “centers”” (Lane, 1992, p. 6).

### *The Cultural Model of Deafness*

#### *Definitions of Culture, Subculture, and Community*

*Culture.* One definition of culture is “that complex whole which includes knowledge, belief, art, morals, custom, and any other capabilities and habits acquired by man as a member of society” (Tylor, 2010, p. 1.). In Sellers’ dissertation, he expands on

this definition and further emphasizes that culture is holistic, learned, shared, meaningful, and symbolic (Sellers, 1993). I will use the five categories listed above in the next section to prove how researchers have analyzed Deaf culture as a whole and have come to the conclusion that Deaf culture is, indeed, a legitimate culture rather than a subculture of the larger American society.

*Subculture.* A subculture can be defined as a “social group exhibiting characteristic patterns of behavior sufficient to distinguish it from others within an embracing culture or society” (merriam-webster.com, n.d.-b). A subculture does not meet the requirements of being holistic, learned, shared, meaningful, and symbolic, as a culture does. Ultimately, subcultures are smaller groups within the larger cultural contexts that they are surrounded by, and they are deviations from the norm rather than their own cultural group.

*Community.* A community is “a general social system in which a group of people live together, share common goals, and carry out certain responsibilities to each other” (Padden, 1989, p. 4). Communities are broadly defined by living in the same area and having the same goals as other members (Holcomb, 2013). There are many Deaf communities within the larger scope of American Deaf culture. Deaf communities may have different foci depending on where they are geographically, however, they share the same defining cultural characteristics with one another. Deaf communities are one of the main ways that cultural transmission of the values of Deaf culture are spread to the younger generations.

The distinctions between culture, subculture, and community are imperative to the Deaf community, especially in the education realm, where advocates are pushing for the acceptance of a bi-cultural bi-lingual (bi-bi) approach to the education of deaf youth. This

approach would utilize both ASL and English as primary modes of communication, and would also actively teach children about American and Deaf culture. Meeting the requirements of being a culture rather than a subculture or community is therefore, vital to the success of the education of deaf children. If Deaf culture were to be recognized as a subculture or a community within American culture, then this approach would not be accepted by educators who determine how deaf children are instructed; Based on these definitions, there would only be one culture, the American culture, that would be legitimate enough to use in classrooms. If Deaf culture is not taught, it could negatively impact the self-concept of deaf children growing up without role models like themselves, which can lead to potential mental abnormalities in their later lives. Representation matters in the development of a healthy self-identity, so the definitions of culture, subculture, and community matter.

#### *The Five Components of the Cultural Model of Deafness - Holistic*

Holism relating to culture encompasses the idea that all of the smaller parts of a culture contribute to make up the entirety of the specific culture. Within a culture, there are different values which relate to different behaviors performed by the majority of the members in that culture. Each simple behavior done by a member of society traces back to a larger belief that is central to the culture as a whole. These beliefs and values are core to the members of the culture, who share common world views. Their world views are reaffirmed every time a behavior specific to the culture is enacted (Sellers, 1993). Three of the major world views of Deaf culture are that of seeing the world through a visual orientation, collectivism, and sharing in an affirmative view of deafness. Below are

descriptions of each world view, and certain behaviors that members involved in Deaf culture engage in. These core world views are the basis of Deaf culture as a whole. They will connect to the four other aspects of culture— learned, shared, meaningful, and symbolic—which are described in later sections.

*Visual Orientation.* The major lens through which members of Deaf culture see the world is through a visual orientation. Having a visual orientation toward the world is one of the most important and defining world views of Deaf culture. According to Stokoe (1989), “the use of vision instead of hearing for getting vital and incidental information is the fundamental difference between mainstream American culture and Deaf American culture” (p. 55). Mainstream American culture does not realize how much they rely on the sense of hearing; this reliance is evident when we consider the many barriers of communication, such as floor plans with many walls and doorbells using sound instead of light, that are constructed by hearing people unknowingly.

The use of vision is heavily utilized by Deaf individuals through the behavior of using ASL, which allows people to freely converse with each other and share information that they may have otherwise not received from non-signing hearing people, due to an English-ASL language barrier. Though many Deaf Americans use English on a daily basis to communicate at either work, home, or school, “ASL is considered to be the most accessible language for deaf people because of its visual properties” (Holcomb, 2013, p. 114). ASL has been described as the most visual hallmark of Deaf culture to outsiders. Relying Shifting one’s focus from an auditory form of information sharing to a visual form can greatly improve a deaf person’s understanding of what is going on around them. It is much easier to receive information in a mode that is natural to you instead of through a

channel that is foreign and largely inaccessible. Deaf people can understand each other one hundred percent of the time when using ASL, which is not the case when communicating with the majority of hearing individuals (Kannapell, 1989). This idea can be summarized by Ben Bahan (1989):

“ASL did not emerge because of what we cannot do, it emerged because of what we can do: see.” (p. 32)

This quote stresses the importance of using ASL the mode of communication of choice for many Deaf people. It also stresses the importance of creating a positive identity by not focusing on the one thing that deaf people cannot do, and instead, focusing on what they can. This affirmation of deafness will also be further described in later sections.

One of the hallmarks of Deaf culture is the fact that everything visible is commented on, including physical appearance (Mindess, 2014). In American culture, this behavior of being very blunt about appearance may seem strange. For example, if a Deaf person were to see that their friend got a new haircut and they did not like it, they generally would not hesitate to tell their friend their honest opinion. Deaf people do not make fun of people by describing them, they take pride in how accurately they can describe the smallest details of an individual (Bienvenu, 1989). In Deaf culture, it is acceptable and encouraged to be blunt and accurate when describing something visual. If it is seen, then there is no way to hide it. If there is no way to hide it, then describing it in detail is the most effective strategy to use during conversation. This behavior stems from the visual world view of ASL, which uses what is seen in order to communicate visually and spatially. When being blunt, “the intent is not to make fun of the person, but rather to identify him as . . . accurately

as possible” (Mindess, 2014, p. 217). This behavior can be defined as straight-talk, which is common and socially acceptable in Deaf circles.

Overall, having a world view geared toward a visual orientation is incredibly important when successful communication with others depends on it. As described above, one major behavior that Deaf individuals engage in is signing ASL. This way of communication is the basis for everything that a Deaf person learns, and later, shares with others. One other behavior that Deaf individuals engage in is using straight talk, which relies on accurately describing individuals based on their outward appearance.

Concerning the world view of visual orientation as a whole, one of the reasons that the medical model does not tend to utilize ASL is because the medical model continually stresses the use of hearing, which does not align with a visual world view. Deaf culture disassociates from sound and does not give much, if any, importance to it. Having a visual orientation toward the world is one way that separates mainstream American culture from Deaf culture.

*Collectivism.* Though the mainstream American culture relies on the independence of each individual, the American Deaf culture is largely a collectivist group. Each person relies on mutual dependence as a way of survival and they generally act in an egalitarian manner (Holcomb, 2013). Deaf people do not generally take all the credit for themselves, like a typical American would when something important happens positively in the community; each person is equally as important as the next and they share in the joy of each other’s accomplishments as a group. Collectivism ensures that each member of the Deaf community has the same access to information and opportunities that every other Deaf person in that same community does. Mindess (2014) sums up the collectivist Deaf

world view in two general statements: “the good of the group is the interest of each individual” (p. 110) and “Deaf people feel it is incumbent upon them, for the survival of the group, to take the “Deaf side”” (p. 108).

As with the world view of visual orientation, the use of ASL is important to the world view of collectivism. The first statement that Mindess made above stressed that the individual is responsible for what happens to the group. Sharing information that is valuable with one another through the use of ASL, is one behavior that falls under the world view of collectivism. Sharing information can be as simple as telling another person which secretary at their child’s school is the easiest to communicate with and which local interpreters are not accurate when it comes to interpreting medical terminology during a physical. Information, such as the examples above, can make everyday tasks simpler for the Deaf individual who has ties to the Deaf community. Deaf culture brings individuals together as a group while creating a wealth of knowledge of solutions to problems that each member will likely encounter at some point in the future. As a general rule of thumb, “one should always act in a way that facilitates communication and access to information” (Hall, 1989, p. 101) if they are fully committed to the collectivist cultural world view. “Culture provides people with access to historically created solutions,” (Mindess, 2014, p. 79) which are shared through the passing on of information.

While the world view of collectivism brings people together, it also creates an insider/outsider distinction between members that are inside of the collectivist group and those that are outside of the group. The behavior of creating, either intentionally or unintentionally, these distinctions echoes what Mindess described in her second quote above, which describes the existence of a “Deaf side”. In the past, this distinction was more

of a hearing/deaf dichotomy, but it has transformed into more of a signer/non-signer distinction in recent years (Mindess, 2014). Those that are inside the group, the signers, are generally more trusted than those outside of the group; The outsiders are those that have fundamentally different world views than the insiders.

One example of trusting the “Deaf side” can be shown through a patient visiting a doctor because their throat is sore. If this patient heard from someone at Deaf club that there was a remedy that made them feel better the last time their throat was sore, the Deaf person may bring up the way that their friend was healed in their own appointment with their doctor. If the doctor does not take the patient’s suggestion seriously, cultural dissonance has happened, and the Deaf patient may be less willing to trust the doctor’s opinion in the future. This interaction has created a stronger bond between the two Deaf individuals and has weakened the bond between the sick Deaf person and their physician; the physician did not take the time to understand where the Deaf person stood culturally, which undermined the importance of the bond between the sick Deaf person and their friend at Deaf club. The point made here shows that if one is not knowledgeable about Deaf culture and the norms associated with it, the signer/non-signer distinction is made excruciatingly apparent.

The behavior of creating insider/outsider distinctions further exemplifies the world view of collectivism in that “the worst punishment that can be meted out is ostracism from the group” (Mindess, 2014, p. 40). If ostracism is objectively the worst punishment, that can mean that when not acting in line with world views of the group, you therefore align yourself with the outsiders and no longer belong to the insiders. The insider/outsider distinction makes it significantly harder to access the solutions created by the previous

generation of Deaf community members once you have been ostracized, which could make communicating more frustrating than if you were still a part of the community.

Overall, the collectivist world view is one of the main tenants of Deaf culture. One behavior that falls under this world view is sharing information and giving advice that has been historically proven to work, specifically when communicating with the non-signing world; Another behavior is the creation of insider/outsider distinctions. The collectivist world view clashes with the mainstream American world view of individualism. This world view and the behaviors that fall under this view confirm one way that Deaf culture is, indeed, separate from mainstream American culture as a whole.

*Affirmative View of deafness.* The last major world view held by members of the Deaf community is having an affirmative view toward deafness as a whole. Earlier, as exemplified by the quote by Bahan, having an affirmative view of deafness creates a positive atmosphere for the members of the community; It is expected of Deaf to reject the mainstream American culture's view of deaf as disabled. Ableism and Audism are two types of discrimination that Deaf culture members face on a day-to-day basis, both of which are antagonistic to the affirmative world view described above. Ableism is defined as "discrimination or prejudice against individuals with disabilities" (merriam-webster.com, n.d.). Audism is a specific type of discrimination pertaining to Deaf people and has been defined as "the belief that people with hearing are superior to those who are Deaf and/or that the English language is superior to ASL" (ahdictionary.com, n.d.). The medical model is partial to having views that are in line with ableist and audist beliefs. This means having an affirmative world view involves actively rejecting the medical model of deafness as a whole.

In Holcomb's (2013) work, the behavior of forming and maintaining a positive self-identity is framed in terms of the larger world view of affirmation:

“It is okay to be Deaf. . . it is possible to have a good life as a Deaf person. . . being deaf is not necessarily an infirmity that one has to suffer (in the perception of the hearing majority) but is rather a source of pride in one's connection to other individuals with a rich history and culture. In essence, Deaf culture provides Deaf people with the basic human right of positive self-identity.” (p. 106)

Creating an identity and forming connections with others that share similar life experiences can greatly benefit one's quality of life. Having a positive self-identity as a Deaf person can enable deaf people to have healthy and realistic expectations of both the hearing and deaf people around them (Holcomb, 1997). Connecting with Deaf culture can help a deaf person learn about cultural deafness. Once this happens, deaf people can learn about Deaf culture, and make their own decisions about whether they want to identify with the medical view versus the affirmative cultural world view of deafness.

As described in both of the earlier world views, ASL is an extremely crucial component to Deaf culture as a whole. The behavior of using ASL in lieu of speaking or signing in an English code contributes to the affirmative world view of deafness. There are many different ways that deaf children are educated in the United States, such as through the methods of oralism, which focus exclusively on speech and aural input, or signed codes for English, such as Signed Exact English (SEE), Linguistics of Visual English (LOVE), Pidgin Signed English (PSE), etc., which focus exclusively on English grammar in a visual format. The active rejection of these approaches to communication is a large step in affirming a positive Deaf identity. In one study by Anglin-Jaffe (2013), in a deaf school

where oralism was the method of instruction, a sign language was created through peer learning despite the teachers' opinions of the superiority of spoken languages. Through using sign rather than other methods, students at the school learned that the "freedom to express oneself" can be interpreted as the "freedom to sign" rather than what the administrators interpreted the students' freedom as, which was "the freedom to speak" (p. 267). Signing is a natural behavior for those who are deaf, and the rejection of other, and generally less effective, modes of communication can affirm deafness.

Deaf clubs were, and in some places still are, a central piece of a Deaf community member's life. The visiting the Deaf club is one last example of a behavior that falls in line with the affirmative view of deafness as a core world view. Traditionally, the Deaf club served as a place where members could go to escape from the hostile hearing world and come home to people they knew would understand them (Hall, 1989). Communicating with hearing people can be tiring, so the Deaf club has served as a place where communication is simple and strong, familial type relationships could be created (Kannapell, 1989). Deaf clubs are still used today, but no longer have the widespread popularity that they once had. Deaf clubs begun to decline in popularity once technology that facilitated communication was more widespread and common in Deaf households (Padden & Humphries, 2005); This decline occurred because Deaf people no longer needed to wait until the next Deaf club meeting to chat with their friends in their own language. The behavior of attending Deaf club, or just gathering with a group of Deaf friends, is an example of affirming a Deaf identity because this behavior involves being around people who are comfortable in their Deaf identity and their ASL usage. According to Bat-Chava (2000), "using . . . ASL and participating in social, civic, and political organizations and networks" (p. 420) can

strengthen a culturally Deaf identity which would lead to an affirmation of deafness; All of the activities listed above can be accomplished when in contact with others who also have strong ties to their Deaf cultural identity.

The world view of affirming deafness is important to comprehend if you are to understand the behaviors that are associated with this view. One example of a behavior that is influenced by the world view of affirmation of deafness is forming and maintaining a positive self-identity. If a positive Deaf identity can be formed, then affirming deafness occurs naturally from that line of thought. Another behavior that fits with this world view is using ASL. Keeping with the theme of establishing a positive self-identity, using ASL instead of other signed codes or speaking can bring you closer to others who are Deaf. Using a shared language can connect you with others that hold an affirmative world view. One last behavior that can help an individual see their world through an affirmative lens is going to Deaf club, or more recently, connecting with Deaf friends using videophones or facetime. As mentioned before, establishing and maintaining friendships with those already involved in Deaf culture can also have a positive impact on the individual that is new to seeing their lives through the cultural model of deafness. Holding this world view and participating in these behaviors easily distinguishes those who identify with Deaf culture from those who see deafness only as a medical condition. Affirming deafness instead of attempting to “fix” it is the paramount difference between the cultural and medical views of deafness.

### *The Five Components of the Cultural Model of Deafness – Learned*

Through conscious teaching and through enculturation, which happens subconsciously, a culture can be transmitted from one person to another (Sellers, 1993). In around 90-95% of homes with a deaf child, you will find that the deaf child has two hearing parents (Holcomb, 2013). Cultural transmission “plays a central role in the formation of cultural traits and norms” and is the “transmission of preferences, beliefs, and norms of behavior which is the result of social interactions across and within generations” (Bisin & Verdier, 2005, p. 2). Since parents of deaf children have most likely never been exposed to the Deaf world before having a deaf child, they are largely unaware of the cultural values included in Deaf culture and the benefits of identifying as Deaf. Parents “tend to prefer children with their own cultural trait and hence attempt at socializing them to this trait” (Bisin & Verdier, 2005, p. 4). If parents are not the agents of teaching children how to conform to certain cultural norms, it falls on the responsibility of deaf peers and other deaf role models to teach newcomers what the expectations of being a member of their society are. This means that Deaf culture has historically been and, still is, transmitted from person to person horizontally rather than vertically. This allows Deaf people to develop strong peer networks (Parasnis, 1998b). Deaf children learn the norms of their culture in different ways than most children because they are not born into their parents’ culture. Typically, deaf children are not exposed at all to their culture in the home. As Padden and Humphries (2005) mention, most deaf people first learn about the Deaf community through contacts at school.

Vertical transmission of culture is how many people tend to learn about their heritage, which is from their parents. Vertical transmission is more of a generational one,

and is much more common concerning the transmission of culture than horizontal transmission. Horizontal transmission is peer learning of culture. This is common in Deaf culture because when deaf children cannot connect with their parents on a deep level due to communication barriers, deaf children look to their peers for comfort and reassurance. Utilizing a horizontal model of transmission is unique, but deaf children are placed in a unique situation where their parents' culture is not the one most natural to them.

Historically, residential schools for the Deaf were the cultural centers of a deaf child's life. This is where deaf children would meet their first deaf contacts, make their first deaf friends, and find their first deaf role models. This is where many deaf children were first exposed to a different outlook on life, which would be a non-hearing one (Holcomb, 2013). At these schools, children would help each other to learn how to sign, which is the first major step many take when learning about Deaf culture. According to Padden and Humphries (2005), some older members of the Deaf community look back on their school years fondly, as they remember feeling accepted by the Deaf community and finding a place where they could be themselves around others similar to them. The tradition of learning about deaf culture in residential school settings has died out in recent years due to the increase of integration of deaf children into mainstream programs. Public Law 94-142, which was intended to integrate deaf children into their local community actually indirectly "[isolated] deaf children from large numbers of their deaf peers and from the milieu in which the culture of the Deaf community [was] traditionally learned" (Emerton, 1998, p. 142). This law has been a main contributor to the decline in popularity of residential schools.

Finding positive Deaf role models for a deaf child can be a daunting task for a hearing parent, especially when there is not assistance given by medical professionals to help the parents locate a local Deaf community for their child to be exposed to. Most parents mean well, but they are ill-informed and do not generally get the resources they need from hearing professionals (Lane, 1992). Since most parents are not able to give their child the exposure they need to develop a positive Deaf identity early in life, enculturation is delayed by many years. The way that many younger people are exposed to the Deaf world today is through exposure to other deaf people during college. There they learn more about Deaf culture, and meet deaf professors who also serve as role models. This exposure to norms and values is essential for a deaf child to learn about their own culture, but in more modern times, this exposure happens very late in a child or young adult's life.

Deaf culture can be learned in different ways and through different mediums. Typically, Deaf culture is transmitted horizontally between peers rather than vertically transmitted by parents. Many deaf children have been traditionally exposed to Deaf culture for the first time through exposure to ASL in residential school settings. Since the passage of Public Law 94-142 (US Department of Education, 2016), deaf children's exposure to ASL and Deaf culture has been delayed, sometimes until the deaf child makes it to college. Deaf children have had the benefit of horizontal transmission of culture for nearly a hundred years. Because Deaf culture has been passed on from generation to generation, we can conclude that Deaf culture is learned, even though it is not vertically transmitted like many other cultures.

*The Five Components of the Cultural Model of Deafness – Shared*

For a culture to be shared, the important parts of the culture need to be taught and learned by other members in the group. Once this learning happens, then the important things, such as the values and humor of the group, can be passed on from generation to generation to promote the longevity of the culture. As a whole, Deaf culture can be defined by its shared history of oppression of ASL and its shared modern oppression by the hearing majority as a cultural and linguistic minority. This shared history is passed down usually in the form of ASL to teach newcomers to the culture about the struggles and triumphs their forefathers experienced.

The traditional shared history of oppression of ASL began in 1880, when those at the International Congress of Educators of the Deaf in Milan decided that oralism was to be used in lieu of sign languages in schools across the world (Padden & Humphries, 2005; Parasnian, 1998a). By around 1920, about 80% of deaf students were taught using oral, or speaking, methods (Padden & Humphries, 2005). The shift from manual education, which would include teaching children through signed language, to oral education meant that the core of education was shifted from a visual orientation to an auditory one. This fundamentally goes against one of the world views that Deaf culture is based upon, which is cherishing vision and disregarding hearing. This shift in education also indicated a change in how deafness and signed languages were viewed by hearing people.

One example of how the views of deafness by hearing people changed is exemplified by the relationship between hearing teachers who only spoke English and deaf children who had a difficult time understanding them through oral methods. Children were effectively rendered “mute” by their teachers in charge; when a misunderstanding happened, the hearing teacher blamed it on a lack of communication from the deaf student

(Padden & Humphries, 2005). This lack of communication happened because the deaf students were not able to effectively communicate with their hearing teachers through speech and no attempts were made by the hearing teachers to understand sign. As well as keeping children silent, these teachers perpetually judged their deaf pupils, which served as a constant reminder that they could not hear and were essentially different (Padden & Humphries, 2005). Taking away a student's voice, which in this case was their freedom to sign, and telling the student that they are less of a person because they do not have a "voice" in the dominant language is oppression.

The shared modern oppression of the Deaf community comes in the form of delegitimizing Deaf culture and not acknowledging that those who are involved in Deaf culture are a part of a cultural linguistic minority. Parasnian (1998a) says that in the 1960's and 1970's, it was discovered that ASL is a language that has its own grammar, which means it exceeds the criteria of being a human language. Stokoe "demonstrated linguistic principles by inventing an entirely new system for representing signs" (Padden & Humphries, 2005, p. 125). Proving that ASL has its own grammar and is considered a legitimate language was in direct opposition to the notion that signed languages were inferior to spoken languages and it gave signers their voice back. The Deaf community adjusted their own viewpoints to be in line with Stokoe's findings and many in the community thought that the "idea of a language and culture promised a great deal; it promised equity and opportunity" (Padden & Humphries, 2005, p. 131).

If we look at how the deaf way of life formally changed into what we know today as Deaf culture, we can trace the shared history of how the cultural view of deafness formed. We can also show that through the legitimization of Deaf culture as a legitimate

culture in the 80's (Holcomb, 2013), a unique cultural linguistic minority in the US was born. In continual opposition to the Deaf as a cultural linguistic minority group, the proponents of the medical model of deafness still define those who are Deaf by what they cannot do rather than what they can. Holcomb (2013) says that "Deaf people often perceive themselves as more similar to members of various linguistic minority groups than to people with disabilities" (p. 55). The current struggle here shows us that even though there has been proof to defend the legitimacy of ASL as a distinct language and to show that Deaf culture is separate from the larger mainstream American culture, there is still opposition to those claims. This opposition is the shared modern struggle of those who identify as a part of Deaf culture.

Lane (1992) summarizes the shared history of oppression in the quote below. He touches on the fact that this oppression is ongoing, though oppression now takes a different form than it did in the past.

"The medicalization of the deaf community is marked by a long history of struggle between deaf people and the hearing people who profess to serve them, for the right to define a problem rather than another—to construe it as a problem of medicine, education, rehabilitation, religion, politics—is won by struggle." (p.25)

This struggle is a shared struggle among all people immersed in Deaf culture. Sharing in both the history and the future of a group's oppression is one way in which a culture can be proven as a true one.

### *The Five Components of the Cultural Model of Deafness – Meaningful*

For a culture to have meaning, you need to look at the abstract underpinnings of actions performed by members of the culture (Sellers, 1993). The actions that Deaf people

have taken in order to be independent from hearing society get their roots from wanting to remedy the unequal power structures that hearing people have imposed on them over the years. Wilcox (1989b) says, “deafness is in essence a cultural problem, one that must be understood in terms of power” (p. 181). Advocating for changing policies regarding education for deaf children and inventing new technologies to improve the standard of living of deaf individuals are two actions that have been directed toward this end goal of equality. Below, I will describe these two actions in detail and will relate them to the larger goal of independence from hearing individuals rather than forced dependence on them.

In the realm of education, more and more deaf students are being placed into mainstreamed classrooms. This means that more and more deaf children are being placed in classrooms full of hearing children, and are expected to perform as well as their peers with the help of an interpreter present in the room. It is not atypical for an interpreter to not interpret in the exact way that an instructor is teaching. Without the necessary resources, “Deaf students are *rendered unable* or disabled by their interactions and struggles with the more powerful Hearing educational establishment” (Wilcox, 1989b, p. 186). If deaf children learn about their history at all in school, some instructors don’t take into account “the nature of the content itself or how deafness and Deaf people are represented within it” (Welch, 2000, p. 8). In the educational setting, D/deaf children are the minority, which can lead to differential treatment from those in charge because they have a certain trait which stigmatizes them (Emerton, 1998). The people in charge of the educational decisions of deaf students are almost exclusively hearing. Most hearing people will naturally harbor phonocentric values if they have not experienced deafness before (Corker, 1998). This means that deaf children are getting instruction from people that do not understand their

needs first hand. Hearing people have a shady history with the Deaf community, as hearing educators at the Milan congress were the ones who decided that they knew what was best for deaf students.

What was described above can be seen as a forced dependence on the Deaf community; hearing educators that think they know best have for centuries told deaf students how they should best be taught. Activists that fight for the right of Deaf educators to determine what is best for their students are contesting the past. There is a deep rooted imbalance in power between deaf and hearing people, especially in the educational arena. The abstract underpinning of battling the current educational system is to bring about equality and to gain independence from hearing society by having people involved in Deaf culture make decisions for the next generation.

Since the invention of the telephone, deaf individuals have had to come up with crafty ways in which to counter inventions that benefit solely hearing individuals. The invention of the phone led to the invention of the teletypewriter. The invention of the talking movie led to closed captioning. The invention of the doorbell led to flashing lights in homes. Phonocentrism shapes a hearing person's structure of thinking (Bauman, 2008). In the inventions above, we can see that there is an underlying assumption that the person relies on hearing. These inventions were not intended to make deaf people feel excluded, however, that was the effect they had on the community. Because there was a need for counter inventions, Deaf creators thought of ideas to make inventions that had the same purpose as the original ones. This creation has the meaning behind it of creating independence from hearing society. Since there is phonocentrism embedded in the minds of hearing people, most tend not to think about different groups that they are excluding. As

long as phonocentrism is a problem, the Deaf community will work toward a more equal standard of living.

Deaf Inventors and educators are on the front lines of the fight toward equality between deaf and hearing people and independence from the larger hearing society. The two examples above prove how actions taken by members of the community can be interpreted in a way that shows that there are larger meanings behind them. Independence and equality can be related back to the world view of having an affirmative view toward deafness. Actions by people in the Deaf community are meaningful, which shows that Deaf culture meets this requirement to be considered a legitimate culture.

#### *The Five Components of the Cultural Model of Deafness – Symbolic*

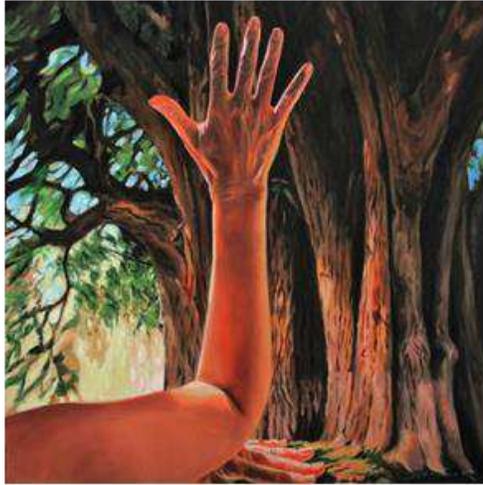
The symbolism found within Deaf culture takes many different forms. The most important symbolic aspect of culture is language, which lets generations connect with each other to transmit cultural meaning (Haviland, 2011). Since ASL has been discussed in length in the above sections, I will discuss different symbolic aspects of Deaf culture other than language. Some of the facets of Deaf culture, such as poetry, literature, and art, portray the experience of being a part of Deaf culture from an insider's perspective. Different symbols are universally understood by members of Deaf culture. These symbols typically fall under two themes: resistance art and affirmative art. Resistance art focuses on oppression and identity formation, while affirmative art celebrates positive aspects and acceptance of Deaf culture (Durr, 2006; Holcomb, 2013). Additionally, in the works of Deaf authors, the "biculturalism, bilingualism, and bicognitivism" (Brueggemann, 1995, p. 415) of Deaf individuals is illustrated. I will describe three major symbols that most people involved in Deaf culture will be able to recognize.

One of the main symbols that can be seen throughout all facets of Deaf art is that of the dinner table. What is referred to as the “dinner table syndrome” is a near universal experience that deaf children face while growing up in households with only hearing family members. The dinner table syndrome “describes how, at the dinner table, hearing family members converse freely through speech about their day at work or school and other issues and, all the while, the Deaf person is missing out on these exchanges” (Whyte, Aubrecht, McCullough, & Lewis, 2013). Mow (1989) describes their experience with the dinner table syndrome: "Everyone and everything are a mirage; you see them but you cannot touch or become a part of them. You thirst for connection. You suffocate inside but you cannot tell anyone of this horrible feeling. You do not know how to" ( p. 38). Being told ““oh, it wasn’t important,” ... painfully reminds some Deaf people from hearing families of the isolation they felt around the dinner table” (Mindess, 2014, p. 119). In Figure 1, we can see Susan Dupor’s interpretation of the dinner table syndrome in her painting, “The Family Dog”. These different descriptions of a regular dinner show how the family table can be seen as a symbol of intense desire to connect with non-signers. This is a symbol that may not be fully understood personally by every person involved in the Deaf community, especially hearing allies that are not deaf as well as Deaf. The dinner table for most, however, represents years of frustration and loneliness, even in one’s own household. This symbol shows the oppression of ASL even when in the comfort of your own home.

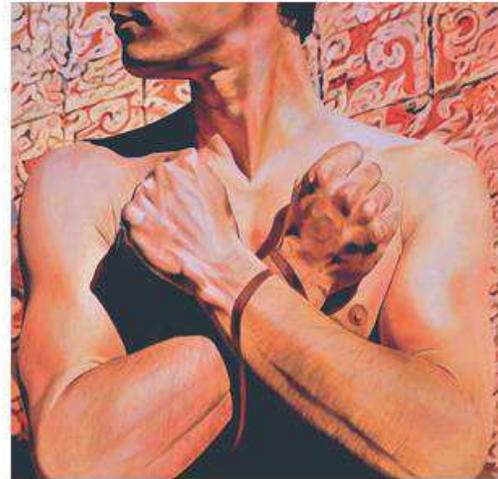


*Figure 1. The Family Dog (Dupor, 1991)*

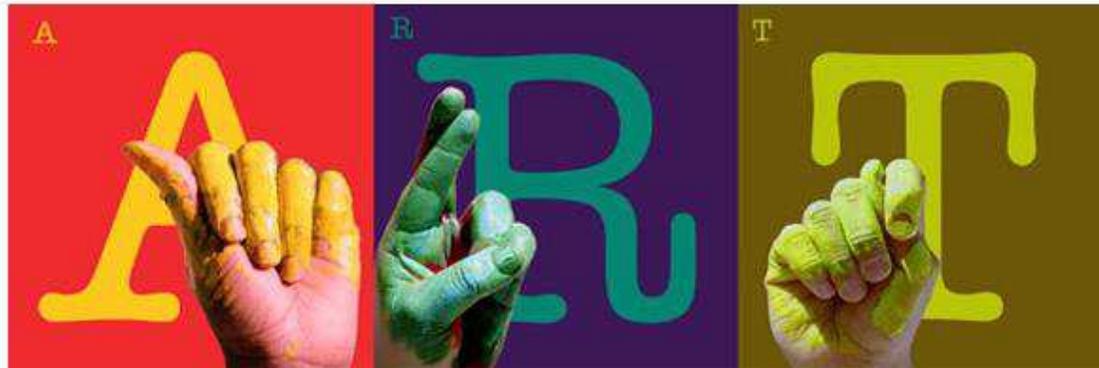
Another important symbol that is used throughout Deaf culture and Deaf art is the hands. In Deaf culture, the hands represent language and communication. Deaf artists embrace the beauty of hands and in many visual art forms, the hands will play a central role in the piece. Some Deaf artists paint snapshot like portraits of hands that seem to be signing; the focus of these pieces is the sign itself, and what that sign represents in the larger context of the work. In Figure 2, Figure 3, and Figure 4, you can see 3 different paintings by Charles Wildbank. In these paintings, a different sign or fingerspelled word is taken and made into an art piece. The hand is the central focus of each piece, and each one celebrates that sign or fingerspelled word for the beauty that it has in itself. As mentioned in the holistic section of this chapter, the hands are seen as sacred while speech is not seen as particularly useful to many individuals immersed in Deaf culture. Showing the symbol of hands in this prominent manner reinforces the world view of the affirmation of deafness.



*Figure 2. Knowledge (Wildbank, 2001)*



*Figure 3. Love (Wildbank, n.d.)*



*Figure 4. Art of the Hand (Wildbank, 2001)*

One last symbol that is incredibly important to Deaf culture is the eye. Without the eye, there would be no way for a person to embrace ASL and therefore, embrace their identity as a Deaf person. In some deaf literature, there is a “theme of a “Deaf Utopia,” often playfully labeled as Eyeth (in contrast to EARth)” (Holcomb, 2013, p. 140). Hearing people are totally reliant on their ears for communication, and signers are totally reliant on their vision. EARth versus EYEth, in this case, would symbolize two different world views. The Deaf culture world view described here is having a visual orientation toward the world, which can be symbolized by the use of eyes in art and literature. One image by Allen Ford,

which can be seen in Figure 5, is one way that the symbol of the eye can be used. Here, he morphs the eye and the ear together, so that it is difficult to distinguish between where one ends and where the other starts. This is to represent that the eye performs the same function as the ear when ASL is used; This ties into the world view of affirming deafness as a positive.



*Figure 5. Ere I Am (Ford, n.d.)*

Overall, there is an incredible amount of symbolism found within Deaf Culture. Looking at the symbols of the family dinner table, the hands, and the eyes can tell us about some important aspects of Deaf Culture that ultimately tie back to the world views of having a visual orientation and an affirmative view of deafness. Deaf culture has its own art forms, and symbols that are universally understood by those involved in it. This proves that Deaf culture meets all of the requirements described in the first section to be recognized as a legitimate culture.

### *Summary of the Cultural Model*

In Ben Bahan's *Notes From A 'Seeing Person'* (1989), he sums up how he views the cultural model of deafness in relation to the medical model. His words are from the perspective of someone who lives life in the thriving Deaf community and proudly lives his life through the lens of the cultural model.

“Now I am not trying to deny my deafness. I am proud to be deaf! So proud that I feel there is a need to erase the pathological (disease) viewpoint of deafness.

Many deaf people do not feel handicapped/disabled. How do we know we are missing something if we never had it in the first place? . . .

The feeling of being handicapped isn't there.

It is the hearing world that tells us we are handicapped and disabled.” (p. 30)

As discussed in the sections above, I have shown that Deaf culture is holistic, learned, shared, meaningful, and symbolic. Deaf culture therefore, meets the requirements to be considered a culture rather than a subculture or a community. The cultural model of deafness arose in opposition to the medical model, which will be discussed in the next chapter. Overall, identifying with Deaf culture can provide young deaf children a legitimate culture with a community attached to it, which can lead to benefits over the lifespan.

## CHAPTER TWO

### The Medical Model of Deafness

#### *An Introduction*

As defined briefly in the first chapter, the medical model of deafness is in contrast to the cultural model of deafness. The medical model can also be referred to as the impairment or deficit model of deafness. “In terms of the impairment paradigm, deaf ... are not seen as normal, and making them normal becomes more important than allowing them to be human” (Corker, 1998, p. 83). This proponents of this model do not care if you are Deaf as well as deaf; it views all deaf people in terms of only the medical model (Corker, 1998). The medical model’s proponents are mostly hearing individuals who have essentially phonocentric world views. These phonocentric beliefs can turn into audist beliefs, which can turn into audist actions that fall in line with the medical model of deafness. Abrahams (2007) says that the medical model includes the ideas that deaf are broken, handicapped, and that they should be made to fit into the larger hearing society.

In the medical field and the educational field, the medical model has been the prevalent view held by many who are in charge of making decisions. The view that deaf people are handicapped has defined what medical and educational advancements are made; the focus of the development of new medical technologies, like improving the cochlear implant, and the focus of what and how a deaf child should be taught are two examples of advancements. There is a “relative absence of people with disabilities in key decision-making roles in government... medicine and psychology” (Olkin, 2007, p. 10). In this

chapter, I will describe both how the medical field and educational field contribute to maintaining the overarching medical model of deafness. I will summarize at the end of the chapter how the medical model compares to the cultural model of deafness while focusing on some of the merits and pitfalls of each.

### *The Medical Model of Deafness*

#### *Definitions of Phonocentrism and Audism*

*Phonocentrism.* According to the Oxford dictionary (oxforddictionaries.com, n.d.), phonocentrism is “the tendency to value speech above writing in linguistic analysis; especially the view... that the spoken language is the immediate realization of meaning.” Phonocentrism can also be described as the tendency to value speech over any other form of communication. If we look at this view, we can see that signed languages would not be valued as much as spoken languages according to someone who is phonocentric. Most hearing people have a phonocentric center without realizing it because they have typically not been exposed to other forms of communication. Without exposure to other modes of communication, their phonocentric world view would not be challenged.

In my experience, it was not until I started to learn ASL that my phonocentric world views were challenged. I learned through signing ASL that there are many different modes of communication and that not all languages are conveyed through the same modality. Just because one language takes utilizes one mode and another utilizes a different one does not mean that they are at their cores any different from each other. It takes time to realize that signed languages are as legitimate as spoken languages; hearing people not exposed to

deafness will not have their unconscious values challenged. Most people who work with deafness in the medical and educational realms are hearing. Because they hold phonocentric values and have not been challenged to question what they believe in, those in charge of the healthcare and education of deaf individuals will be biased, even if they do not realize it. If there are not many people in these roles who are deaf, which happens to be the case, there is no way that these views can be challenged. Phonocentrism can lead to audism if it is not controlled.

*Audism.* Audism was defined in the last chapter as a way that deaf are discriminated against on a daily basis. “In short, audism is the hearing way of dominating, restructuring, and exercising authority over the deaf community” (Lane, 1992, p. 43). In the definition on page 10 of chapter 1, audism consists of two parts. The first part consists of the belief that English is superior to ASL. This refers back to hearing people having phonocentric beliefs. The second part consists of hearing people believing they are superior to deaf people. This part includes anything that would consist of hearing people acting on those phonocentric beliefs. The topic of audism falls under the umbrella of phonocentrism.

Hearing people believing they are superior to deaf people is representative of a struggle that has been persisting for centuries. If we consider our definition of phonocentrism, we can see that the idea that hearing people are superior stems from the fact that spoken and signed languages are not perceived as equal; this perception stems from phonocentric beliefs. If a person is not familiar with another way of communication, they will think that their way of communication is normal. Once someone challenges that belief, they will most likely continue to think that their way of communicating is normal and the way that is different from theirs is deviant. Deviance in certain cases can be

interpreted as a lesser form than what the norm is. In the case of audism, signed languages are deviant from spoken languages; by our line of logic above, this is how the audist idea that spoken languages are superior arises.

We established how languages can be seen as superior from an audist perspective. This explains where the first part of our definition of audism originates. The second part of our definition is a continuation of the first part of our definition. A person's language is an important characteristic of that person. The way that a person thinks is influenced by their language. The way that a person interacts with others is also influenced by their language. If a person does not communicate via the same language, and that person does not know how to converse with them through a different mode, troubles in communication can arise. Ethnocentric individuals that are under the impression that their language is the best can end up becoming prejudiced against others that do not share their language. If prejudice exists, then discrimination can arise as a consequence. This is where phonocentrism turns into audist actions when comparing deaf and hearing individuals. A hearing person can be taught that spoken language is superior; the hearing person can follow that line of thought and make the assumption that people who speak spoken languages are superior to those that do not. There has been evidence documented that shows historically, those without speech have been labeled as mindless and as not as human as people who could speak (Branson & Miller, 2002). This process is how audism changes from focusing signed languages to focusing on the people that communicate via those signed languages. By shifting the focus to individuals themselves, that shows that audism consists of much more than the belief that spoken languages are superior to signed ones.

By this line of logic, we can conclude that individuals with audist tendencies believe that they are overall superior to those that cannot hear.

“Language is... a mechanism through which power is reproduced and resisted (through discourse and ideology) as a means of controlling a particular population” (Mathews, 2011, p. 363). Phonocentric and audist views are prevalent in the medical model of deafness, especially among professionals that work with deaf children and adults. These individuals in charge of their fields may not be controlling a particular population intentionally, however, they do have power behind them in the roles that they play. They use the power they have to propagate their views of deafness and hold English as the standard that other languages are compared to. This is in order to preserve the imbalance of power between those that “help” deaf individuals and those who are deaf.

### *Definitions of Disability and Ableism*

*Disability.* The American Disabilities Association (ADA) (American Disability Association, n.d.) defines someone who has a disability as: “a person who has a physical or mental impairment that substantially limits one or more major life activity.” Thinking that deafness is a disability is the main hallmark of the medical view of deafness. If someone is disabled, according to this definition, this means that they essentially cannot do what those without a disability can do. Disability can also be seen as deficit or something that an individual is lacking. When defining a person based on their disability, you are not focusing on what they can do, but rather what they cannot do. “Physically they are judged defective” (Lane, 1992, p. 7). If you are basing someone off of what they cannot do, that means that deficit is the focus of their entire person. In the case of deaf individuals, they

can be interpreted as disabled by ADA's definition because the physical impairment that limits life activities for them would be their hearing. The ADA's definition focuses a deaf individual's whole life on their hearing. Disability can be interpreted as not being able to do certain things in life the way that a "normal" person would be able to do. In the case of deaf individuals, not living a "normal" life would be evident when looking at the difficulties that many have when communicating with hearing non-signers through spoken English. Since there need to be accommodations for deaf individuals in educational and medical settings to enhance communication between deaf and hearing people, such as providing an in person or remote interpreter, a deaf person would be considered disabled according to the ADA.

*Ableism.* In the chapter 1 on page 10, we defined ableism. This definition essentially means that what we defined as a disability in the last paragraph is what causes people to be prejudiced against certain individuals. Ableism is the oppression of those who are considered able to those who are considered disabled. This oppression is occasionally disguised as a sincere attempt to give "help" to those that are "less fortunate" than themselves. Because "normal" people are able to do all of the things that disabled people are "not able" to do, that means that the "normal" people may feel a responsibility in order to help out disabled people as much as they believe they can. This help is most times unprovoked and not wanted by disabled people. Able bodied people feeling entitled to helping without being asked to do so by the person receiving help is one of the hallmarks of ableism in action.

Ableism in relation to deafness is essentially audism. If you hold audist beliefs and believe that English is superior to sign, that means you think that someone that does not

Speak English would need help in order to communicate because their way of communicating is not the norm. If you are an audist, you would also believe that as a hearing and English speaking person, you are better able to communicate with the hearing and English speaking world than a deaf signer would be able to. In order for audist beliefs to morph into ableist beliefs, the notion that you would want to help a deaf individual would be prevalent. This would be a change from simply thinking that you are better into the belief that because you are better, you have a duty to help. “The sick and the infirm have a claim on our tolerance, and even more, on our “reasonable accommodation,” our compassion, our help” (Lane, 1992, p. 9). Ableism does not take into account whether or not the person wants help, it is simply given without asking. Ableism toward deaf people involves the hearing public grossly and frequently misjudging deaf people’s capabilities (Holcomb, 2013).

Both ableism and audism are pertinent to the medical and educational fields. “Deaf academics and advocates have promoted the use of audism and linguisticism, rather than ableism, as the terms that best characterize the bias and intolerance [deaf individuals] face” (Holcomb, 2013, p. 245). Linguisticism “describes the false belief that ASL contributes to difficulties in learning English among deaf children and therefore should not be used by parents and educators” (Holcomb, 2013, p. 245). Hearing professionals that work with deaf people are confronted with the choice to connect with their patients, students, or colleagues using techniques that would be approved by either the cultural model or the deficit model of deafness. In the rest of this chapter, I will look at the medical field and the educational field in detail and show how the deficit model of deafness affects how hearing people in these fields relate to deaf people in them. Because Deaf people have never truly been in

control of their own bodies (Humphries, 1996), I will focus on showing how the audism, phonocentrism, and linguisticism of hearing people are deeply integrated into the medical and educational fields.

### *Phonocentrism and Audism in the Medical Field*

In the medical field, deaf people have been historically viewed only through the lens of the deficit model. Deafness is seen as a medical condition that needs to be “fixed” and because of that, deaf people are subject to testing, surgeries, and other interventions in order to “normalize” them. In this section, I will discuss how the medical field looks at deaf individuals and tries to figure out how to “fix” them and make them more “normal”, how parents are given few options on what they should do after giving birth to a deaf child, and how cochlear implants are praised and regarded as an answer to curing deafness.

*Terminology of Brokenness.* “The traditional view of deaf people focuses only on what is not there – the missing ability to hear” (Holcomb, 2013, p. 1). Children that are born deaf are typically defined by what they cannot do minutes after they are born. This is because when children are born, they are checked in various ways to see if they are healthy or not. In the case of a deaf child, they cannot do something that a “typical” child would be able to do, so that means that they are defined by their lack of hearing from the start. Pathology is assumed to permeate the deaf person, and because of that, they cannot be considered “normal” (Branson & Miller, 2002). “In the *medical model* disability has been stripped of the moral symbolism and now is seen as representing abnormality within a

person's corporeal self" (Olkin, 2007, p. 5). This frame of brokenness is generally the start of where deaf children begin their lives; parents are told of the many ways to "fix" this brokenness.

The medical model is also known for "its paternalistic stance and its view of disability as inherently pathological" (Olkin, 2007, p. 5). This frame that views brokenness as something that needs fixing fits well with audist beliefs. An audist individual can have paternalistic beliefs toward deaf individuals because from their frame of reference, they would know what is best. Since they think that they know what is best, they will make decisions on the deaf person's behalf. In the medical field, hearing people make up the vast majority of health care professionals. Because of the disproportionate ratio of hearing to deaf healthcare professionals, hearing people are viewed as more knowledgeable because more of them have degrees in the medical field. If hearing professionals have the prestige of degrees behind them, they are likely to be trusted by other hearing people. By gaining the power of trust, they have the opportunity to make decisions for people, such as decisions regarding what is best for a deaf child. "Hearing experts generally do not concede to deaf people a major opinion in the conduct of deaf affairs" (Lane, 1992, p. 44). Doctors' frame of reference tends to be one from a deficit standpoint, which means that if they are acting paternalistically, they will want to change, or rather fix, whatever it is that is deviant from the norm. Audism comes into play because what doctors want to change is a deaf child's hearing capabilities.

"Deaf people are fantastically flawed in nearly all respects; so it is clear the purpose of the devaluation of the deaf person is to enhance the apparent value of the audist professional" (Lane, 1992, p. 72). Because deaf people are "broken" there need to be

people in order to “fix” them. This is why there are dozens of different kinds of professionals that all exist to assist with hearing related medical matters. “There is a tendency to oversimplify... deafness and the people who are living with... deafness” (Ferndale, Watson, & Munro, 2013, p. 594). Reducing a person to their hearing ability is the reality that many deaf people face on a day to day basis when encountering those involved with audiology. This reduction allows audism to flourish.

*Few Options Available.* “Health professionals are the ones who families most often turn to first, given that they are the ones who usually deliver the diagnosis of hearing loss” (Humphries et al., 2012, p. 201). Parents with children that are born with disabilities need information told to them about what to expect from their future (Olkin, 2007). When parents have a deaf child, one of the first things that is typically brought up to them is the option of giving their child a cochlear implant and the necessity of implanting a child as soon as possible in order to receive the best results from the surgery. “The social authority of medicine and the subsequent respect and trust that parents place in doctors is the starting point for examining how a hegemonic medical model of deafness is established and reproduced” (Mathews, 2011, p. 365). Parents are told from the time that their child is born that they should trust the opinion of the professionals in the auditory field because they know what is best for their deaf child. The application of procedures that these professionals suggest is thought of by them as the “right thing” to do (Leigh & Marschark, 2005). Professionals that diagnose deaf children are experts in auditory matters, but they often have little to no knowledge of how deaf individuals live outside of the clinic (Vernon & Andrews, 1990). Parents’ choice of preferring a cochlear implant over teaching their child to sign is usually guided by not having a lot of information on the benefits of ASL or

the different services that can be provided to the child should they choose to communicate through sign (Mathews, 2011).

Most parents are told about their available options from the vantage point of an audist. In this case, some professionals use “a negative discourse of Sign Language whereby parents run the risk of ‘damaging’ their child by introducing them to Sign Language” (Mathews, 2011, p. 369). Linguisticism is so deeply entrenched in the debate between ASL versus oral methods of communication, that linguisticism first appears days after a child is born. From an audist medical professional’s perspective, a child will be better off with a cochlear implant rather than using ASL to communicate. Someone who believes in linguisticism would take the quote from Mathews above and take it a step further; they would say that if a child learns how to sign, they will be damaged. If signing is damaging to a child, that would imply that the damage to the child comes from the child not learning English first. Linguisticism is based on the idea that any type of signing will be detrimental to a child learning English; this fear is apparent when looking at how doctors portray the options of signing and learning English as mutually exclusive rather than complementary. What some medical professionals do not realize is that “if your child’s speech is delayed, it is not the signing that delays speech... it is something else entirely, because communication doesn’t delay communication” (Coleman, 2011).

The options that parents are given regarding their child’s education and of involving themselves with Deaf culture are also limited in medical settings. Typically, parents of deaf children are not fully made aware of the options that are available to their child education wise. The school almost acts as a secondary clinic for some deaf students, especially ones with a cochlear implant, as the “central focus of the school [is] its ability through science

and technology to produce hearing, speaking students. Academic matters [are] secondary” (Branson & Miller, 2002, p. 205). No matter what choice in school that parents make for their children, these children will typically be subjected to scrutiny when it comes to speaking properly.

If parents only went with the options that were presented to them by clinicians, deaf culture would not be as prevalent today as it actually is. Deaf culture succeeds despite the fact that medical professionals tend to talk only about options that are directly related to the sciences and to “fixing” their child’s problem. Parents are not taught about Deaf culture or ASL and are only taught about how to change their child as much as possible into a hearing person, even if the parents want to know more about Deaf culture (Jackson, Wegner, & Turnbull, 2010). This limits parents in what they can do unless they know that there are options other than the ones presented to them.

*Cochlear Implants.* Deaf children and adults can choose to have cochlear implant surgery in order to “regain” their sense of hearing. Cochlear implants are typically recommended to parents for their children before they even leave the hospital. “If a person does not acquire language before the age of five, that person is greatly at risk of not becoming fluent in any human language” (Humphries et al., 2012, p. 195). If a child is to learn to speak English properly, proponents of the cochlear implant say that their goal is to get the deaf child to start speaking by the time their hearing counterparts start speaking. If they start hearing as soon as possible, that will help them develop their spoken language skills. In order to do that, implants are given to children as early as six months old.

Getting a cochlear implant is not an inexpensive or easy process. Children need to visit an otolaryngologist, which is an ear, nose, and throat doctor, multiple times before

they are deemed candidates for cochlear implantation (Health, n.d.). During surgery, the portion around the ear is cut and folded back in order to get to the cochlea, where the wires and internal processor are placed in the ear. There is a long healing process, and three to six weeks after implantation, the external processor can be programmed (Health, n.d.). The external processor is what takes noises and converts them into electrical pulses that trick the cochlea into thinking that it is hearing real sound. Some children have reported feeling a sense of detachment from their implants; the implants are described as being “robotic machines” inserted in their heads rather than considered a part of their selves (Ford & Kent, 2013).

“Regardless of whether or not a deaf or hard of hearing child receives an implant, the child will function within both the hearing and the deaf communities” (National Association of the Deaf, 2000). The intention of the cochlear implant is to essentially help a deaf child assume the role of a hearing child in the hearing world. Medical professionals tend to focus on what the implant can do for a person positively without looking at the drawbacks. The purpose of the implant is essentially making a deaf person less deaf. In this case, audism is blatantly found in the motives behind wanting to give a child cochlear implants. If an audist thinks that deafness is less than the state of hearing, the best way to remedy that inequality is to make the deaf person as hearing as possible. Implanting levels inequality, which is basically fulfills the goals an audist has. There is a consensus that after a deaf person receives an implant, the deaf adult or child that received one is still deaf (National Association of the Deaf, 2000; Tucker, 1998). Audists believe that getting an implant is a cure for deafness; this line of thought complements the idea of brokenness, which I discussed earlier in this chapter.

Phonocentrism is prevalent in cochlear implantation, as English is the main, and sometimes only, language used when teaching a child with an implant to communicate. “Many health care professionals advise against offering an implanted child a sign language and instead urge therapies using aural input only, such as verbal-auditory therapy” (Humphries et al., 2012, p. 198). Without supplementing spoken language with a sign language, you become totally dependent on whether a child will be able to learn to speak English and hear through the use of their implant. A “lack of early, full, and effective exposure to language may put many deaf students in... a “double burden” situation” (Marschark et al., 2009, p. 366). This double burden situation is placing children in a situation where they cannot learn because they do not have the necessary language skills in order to do so. The phonocentric idea that English is superior to sign is what drives the choice to teach implanted children only through aural input. Signing does not inhibit learning English, which is in opposition to what linguisticism represents. Parents are told by health care providers that the implant is the best thing for their child and that learning English through the implant is the best course of action in order to ensure they are a healthy and fully functioning adult. Medical professionals do not take into account the fact that sign can help enhance English development and that the implant may not be the best option for every deaf child.

*Conclusion.* When looking at the medical field, you can see that audist ideas are prevalent when it comes to making important decisions for the future of deaf children. The medical model essentially views “deaf people [as] either hearing people with hearing difficulties but with good lipreading and speaking skill or [as people who] lack hearing and do not connect with society” (Rosen, 2007, p. 11). Those that choose to sign rather than

Speak are seen as deviant, and are viewed as secluding themselves from the hearing world because they did not do what they “needed” to in order to become like a hearing person.

Audism prevails in all aspects of the medical field. Typically, doctors are the first people that parents encounter when making decisions on what to do about their deaf child. This leads parents to develop the mindset that their children need to be fixed. Parents are also given few options; one popular option offered is implanting their child with either one or two cochlear implants. Thinking that implants are the only option for their child is a dangerous mindset to have. Parents need to “learn about deafness, about ASL, and about Deaf culture so that they can make informed choices about what they want rather than having particular perspectives imposed upon them” (Brown & Gustafson, 1995). With few options, parents are thrown into an audist environment that approves of linguisticism. Having a deaf child grow up with a deficit mindset already instilled in them could be harmful. “One of the greatest dangers to the emotional development of a young deaf child occurs when the parents do not understand the child’s situation properly or project fear, concern, or other kinds of emotional distress into their relationship with the child or even into the larger environment of their child” (Humphries et al., 2012, p. 202). Children are susceptible to what their parents feel, and if the parents believe that their children’s difference is a negative thing, that can be detrimental to their self-perception.

### *Phonocentrism and Audism in the Educational Field*

Phonocentrism and audism play a huge role in the history and the current education of deaf students. The Second International Congress on the Education of the Deaf in Milan and the history of asylum-like institutions for deaf students ignited the start of audism in

deaf education settings. Residential schools and the Milan congress also led to the beginning of the prevalence of linguisticism. In more modern settings, we can see that audism is still present in deaf education; proof for this is found in the use of signed English systems rather than the use of legitimate ASL in the classroom, the mainstreaming of deaf students into all-hearing classrooms, and the continued rejection of a bi-cultural and bi-lingual approach to education. Below, I will show how audism and phonocentrism have become central to the education of deaf children. In later chapters, I will use this discussion as a starting point to examine the effects of audism being a normal part of the school day on the self-esteem and psyche of deaf children.

*The Second International Congress on the Education of the Deaf and Oral-Only Institutions.* The First International Congress on the Education of the Deaf did not have the impact on deaf education that the second congress did. The first one, in 1878, focused on collaboration between French educators using the oral method and seeing what techniques were working the best at the time. They wanted a way to standardize their teaching methods. (Oehrlein, 2005) The Second International Congress on the Education of the Deaf in 1880 in Milan, Italy drastically changed the face of deaf education. Those in the field of deaf education are still affected today because of the consequences of the decisions made during this conference. This congress, made up of 164 members in 8 different countries, decided that deaf children around the world should be taught via oral/aural methods in their home nation's language. (Oehrlein, 2005) Signed languages were deemed inferior at the congress, and when the deaf educator representatives from each country went home, they were expected to go tell the rest of the educators in their country about the agreed upon way of teaching deaf children. This continued the phonocentric thought that speech was

better than sign, and this idea was now being implemented in educational settings. This shift in how to teach deaf children was agreed upon by most of the people that went to the convention. This shift from manual to oral education promoted audism and made it so that the children in the educational system would be indoctrinated with audist beliefs.

The decision at the Milan conference was a decision that was made with the spirit of linguisticism in mind, even though that term would not be applied until decades later. Educators at the Milan conference believed that whatever sign language that was used in their country was less of a language than the spoken language in their country. Because of those phonocentric beliefs, the educators decided to ban sign languages in schools and only focus on teaching spoken languages. Since signed languages were not allowed in schools, that means if a student signed, they would be detracting from learning the spoken language they should be practicing. The educators did not think about the fact that deaf students may be more inclined to learn through manual methods rather than oral ones. The teachers and administrators decided that the students that did not learn how to speak “properly” were doing so because they knew how to sign. Signing was regulated “to the level of prosthesis” and was used “because [deaf students] could not speak or hear” (Humphries, 1993, p. 7); students would be taking the easy way out if they did not learn to speak properly. If students knew how to communicate one way, which would be through sign, they would not be motivated to learn how to communicate the way that their teachers would have preferred them to, through speech. Wanting to motivate students to learn how to speak was one of the main reasons sign was completely banned in deaf schools.

After the Milan congress, in order to implement the oral methods that were decided to be the best for deaf students, deaf teachers had essentially lost their place in the

educational system. More hearing teachers were needed to teach students to pronounce words properly; deaf teachers were not able to help their students with that skill. There was nearly a complete upheaval when shifting the educational system from manual to oral methods. Because deaf teachers did not have the hearing necessary to teach children proper pronunciation, they were either given other jobs on campuses that did not involve instruction or they lost their jobs entirely. This meant that deaf students were taught by mostly hearing people, which created a lack of deaf role models in schools. This showed deaf students, even if it was unintentionally, that hearing people had something that they did not. Because the teachers could hear, they were able to get a good job as a teacher; deaf teachers after the Milan congress were deemed unfit to teach. “Audist education of deaf children has... equipped them primarily to enter the manual trades and not the professions serving deaf children and adults, to which are naturally inclined” (Lane, 1992, p. 48). Deaf people were defined by their working class standard until the 1960’s (Padden, 1998b). This working class standard was initiated by laying off teachers after the Milan congress.

With the advent of oral only education in the US, audism became more widespread. Because administrators encouraged the phonocentric belief that English is better than ASL, it would not be surprising if the teachers underneath them began thinking in audist ways or believing that their quality of life was better than that of a deaf person’s. Some of the educators may have “[distanced] themselves from whoever [was] perceived to be inferior” (Holcomb, 2013, p. 247). This distance influenced by the decisions of the administrators may have caused the teachers to feel like they were superior to their students; the educators spoke the language that the students were having trouble with and they were completely in control of what and how the students actually learned. Since their students were dependent

on them for everything that they learned implies that the power imbalance held between the deaf students and hearing educators was a greater imbalance than if the students and educators were both hearing.

Most deaf education in general after the conference was conducted through asylum type institutions. The deaf student would leave their family and live on a residential campus. They typically would not leave unless there was a school holiday. One reason the residential school became a staple of deaf education was by living with other students, the students were able to learn social behaviors and would be able to get the most benefit from their education through practice communicating using the oral methods they learned in class (Padden & Humphries, 2005). The children were generally forced to use the methods they learned in class to communicate with their peers. There was no debate on whether or not to let the children sign after class; the way they were taught to communicate in class was expected to continue when they left school for the day.

The institutions were defined by their silencing of students and their judgment of students. The judgment acted as a constant reminder to students; it reminded them they could not hear (Padden & Humphries, 2005). As mentioned above, the students were not allowed to communicate via a mode that was natural to them; they were forced to use oral methods. Deaf students “[learned] not how to communicate, only how to parrot words, never to speak [their] own” (Mow, 1989, p. 38). The majority of hearing teachers judged their students’ intelligence on their ability to speak, not their ability to communicate their thoughts. This implies that the “handicap” of deafness is the defining factor of each deaf student’s life (Abrahams, 2007). Since students may have felt uncomfortable using oral methods most of the time, the fact that silence prevailed is not a surprising one. The

judgment by the teachers of the students based on their ability to speak again perpetuated audism and the notion of linguisticism. Since schools were places where students were secluded when they were taught, it may have been harder for teachers to be exposed to outside beliefs that may have countered the culture of audism within the institutions. The schools cultivated and nurtured the audist belief of hearing superiority inherent in teaching oral methods to natural signers. As shown above, audism and linguisticism have been engrained in the fabric of deaf education since the Milan congress.

*Signed English.* Signed English comes in many different forms. One popular form is Signed Exact English (SEE). All of the different forms are basically a different variation of a code for English; instead of speaking the words, you would be manually creating them through signs. Signed English is not the same as ASL. The definition of SEE, as described by Miller (2010) is:

“Signed Exact English is a system to communicate in English through signs and fingerspelling. Signed Exact English, in most cases, uses English grammar (that is, you are signing English). The vocabulary is a combination of ASL signs, modified ASL signs, or unique English signs.”

SEE or any other form of signed English would be considered a code for English, like Morse code or braille, rather than a language, such as ASL is. SEE uses the same grammar and structure that English does. The reason that Signed English was invented was because teachers needed an easier way to teach English to their deaf students in addition to or in place of using the oral methods that were decided upon during the Milan congress.

Signed English systems have had mixed reviews from the Deaf community, because some claim that by signing English instead of a natural signed language, like ASL,

you are promoting linguisticism and audism. Branson and Miller (2002) describe the assumptions made when choosing to sign English over ASL:

“The development of signed forms of English reinforced the control of deaf people by means of linguistic and cultural deprivation. The “symbolic violence” of signed English... [is] based on two familiar assumptions: first, the assumed superiority of English as a language for the transmission of knowledge and second, the assumption that deaf people need to be assimilated as much as possibly into the hearing world by the use of the majority hearing world by the use of the majority language.” (p. 214)

If we look at the quote above, we can see that through the medical model’s propagation of wanting to use English as the primary language of communication, linguisticism continues to have influence in classroom settings. Linguisticism in this case applied, because when given the choice between two languages where you can use the modality of sign, you would still choose to sign English. English would still be perceived as the superior language and ASL would still be seen as a nuisance. Students would not learn about ASL because though it utilizes signs, the structure and grammar of the language would interfere with that of English’s structure.

In addition to linguisticism, audism is also inherent in the decision to use SEE or another signed code for English rather than ASL. Audism has a parental quality to it, where the hearing person acts as a parent that “knows what’s best” for the deaf person. The hearing people that developed SEE and other Signed English systems thought they were doing so in order to help out the deaf children that did not do well with oral-only education. These systems were intended to help deaf children with their English reading skills. They

did not think that teaching children through ASL would be the next best thing for the deaf children's education. Creating an entire code for a language instead of using a language that was readily available is audism in action. Hearing educators thought that even though deaf children were struggling with learning English, it would still be best to teach them English so that they could eventually function better in the mainstream hearing world. Signed English is, therefore, a product of audism and linguisticism.

*Mainstreaming.* Mainstreaming deaf children into hearing classrooms focused on the "basic ideologies of equality and the rights of the individual" (Branson & Miller, 2002, p. 218). Mainstreaming is all about the principle of inclusion and bringing together the deaf and hearing worlds. Mainstreaming involves "placing deaf students, or others with special needs, in regular public school classrooms" (Marschark, Young, & Lukomski, 2002, p. 187). Mainstreaming was created in response to the fact that residential schools for the deaf kept deaf children away from hearing children unless they were visiting their parents back home. There were some concerns after Public Law 94-142 was put into legislation, which caused educators to question whether deaf children were indeed in the least restrictive environment or not.

The least restrictive environment standard is one that is used for placing children with various disabilities into classrooms. The definition of least restrictive environment according to the US Department of Education (1990) is:

"To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only

when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.”

This definition of least restrictive environment spurred the normalizing of mainstreaming deaf children into hearing classrooms. This law was passed with the intentions of bringing deaf children more in contact with the hearing world. The notion of least restrictive environment automatically includes the assumption that the most restrictive environment for a deaf child is a deaf residential school.

Walker (2014) reflects on his experiences of being in a mainstreamed school environment:

“I then realize that inclusive education is not about ME being included in the hearing school – it is more about hearing people wanting to see deaf people in their classrooms, because it is a “good idea”.”

This echoes the experience of many deaf individuals that have been in mainstreamed classrooms. We can see from the quote above that some hearing people believe that mainstreaming deaf children into hearing classrooms is a good idea. If hearing people think that something is a good idea and then they use their power to put that idea into action, that is considered audism. Hearing people took on the parental role here and decided that instead of intermingling with other deaf students, deaf students should mingle with hearing students. This is another example of hearing educators with power taking control by deciding what is best for deaf students. This is another example of a power imbalance between hearing and deaf; the legislators that drafted the laws concerning least restrictive environment were a part of a group that the laws would not actually effect. The power

imbalance in the late 1880's during the Milan congress set a precedent that would carry on throughout the history of deaf education. This precedent of audism can be seen in the enforcement of mainstreaming. In the eyes of an audist, hearing schools are perceived to be superior to deaf schools, so deaf students should therefore go to hearing schools.

*The Rejection of the Bicultural Bilingual Approach to Teaching.* Bilingualism and biculturalism are two important ideas that need to be considered when thinking about deaf education. Using the bi-bi approach, which stands for bilingualism and biculturalism, deaf students are exposed to English, ASL, Deaf culture, and mainstream American culture in the classroom. Bilingualism is defined as “the regular use of two or more languages” (Parasnis, 1998b). Biculturalism is defined as “the coexistence and/or combination of two distinct cultures” (Parasnis, 1998b). Through this culture-affirmative approach to education, deaf students would not need to choose between the Deaf way and the American way of doing things. The students would learn what they needed to from both worlds. This approach allows deaf graduates to go into the world having experience with the two worlds in which they will need to function.

Linguistic interdependence is the idea that academic skills learned using one language can be transmitted to a different language (Hakuta & Mostafapour, 1998). If a child is learning in a bi-bi program, the child should be able to develop linguistic interdependence. This idea is in direct opposition to linguisticism, which says that learning one language can completely block out the learning of a different language. Learning English and ASL alongside each other shows students that the languages are simply different ways to express oneself, and that one way is not inherently better than the other (Humphries, Martin, & Coye, 1989). Since the bi-bi approach is predicated on the fact that

linguistic interdependence is a skill learned by those who know more than one language, the idea of linguisticism is incompatible. ASL and English in this case would be used together in order to help the deaf child fully understand what they were being taught in a non-judgmental space in terms of language preferences.

Deaf students are not, if at all, given the option to pursue a bi-bi approach to their education. The Bi-bi approach is typically used only in residential school settings, so students in mainstreamed classrooms would not be able to access this kind of education (Padden, 1998a). Bilinguals have, in some instances, been judged by their poor performances, have had their talents ignored, and have been scrutinized through a deficit philosophy (Hakuta & Mostafapour, 1998). Residential schools are a safe place in which Deaf culture has been accepted as a part of the core curriculum. Unfortunately, most mainstreamed classrooms do not share the same philosophy that bi-bi programs do. Mainstreamed classrooms are characterized by putting deaf students into hearing classrooms with only the help of an interpreter. When viewing students through the deficit lens, the students are seen as not able to learn through the use of two different languages, which follows the rules of linguisticism. The students are, through the deficit lens, taught through methods such as straight oral education or education through Signed English.

The rejection, or rather omission, of the bi-bi approach in mainstreamed schools is another product of audism in action. Hearing people know best, so instead of admitting that ASL and Deaf culture have a place in the education of a deaf child, hearing administrators can continue to push mainstreaming in order to meet their goal of making the deaf child as “normal” as possible. Not including mentions of deaf culture in the classroom can serve to isolate the deaf child from their history. Because hearing educators generally decide what

deaf children will learn in school, audism acts as a filter through which hearing teachers operate. Linguisticism is shown by not utilizing the bi-bi approach. The bi-bi approach accepts that the child should learn through the use two languages; the continued dismissal of learning through two languages by hearing educators is an effect of linguisticism.

*Conclusion.* Overall, “the primary purpose of education within a deficit (or medical) model is to shape deaf children into the standards prescribed by the wider “hearing society”” (Anglin-Jaffe, 2013, p. 264). Teaching deaf children in an attempt to make them as much like hearing children as possible has been going on for over a century. Starting with the Second International Congress on the Education of the Deaf in Milan, audism and linguisticism have been integrated into the teaching of deaf children. Audism, linguisticism, and phonocentrism have persisted through the decades and have shown themselves through various other forms. These forms include the use of Signed English in the classroom, mainstreaming, and the rejection of the bi-bi approach. Through the descriptions in the previous section, can see exactly where audist undertones exist in these facets of education. “The pedagogy of education is the act of depositing. The students are at best empty containers, at worst broken copies of normal people, and they need to be fixed and filled” (Wilcox, 1989c, p. 157). Because many deaf children have experiences in school that focus on what they cannot do rather than what they can do, children’s psyches may be impacted later in their lives when they are creating their own self-identities.

### *The Cultural Model and The Medical Model of Deafness*

Carol Padden (1998a) described the difference between the cultural and medical definitions of deafness from her view rooted in the cultural model of deafness:

“The medical definition is predicated on repair and replacement; it sees the past as littered with failure and ignorance. The cultural subscribes to an ideal of equality, that all languages and cultures are equal because they are adaptations to the conditions of life.” (p. 85)

From Carol Padden’s view, the cultural model of deafness focuses on what is there rather than what is not there. The cultural view sees life through a lens that deafness is something that does not need fixing, but it is simply something that needs to be adapted to. The deficit model is predicated on fixing deafness, whereas the cultural model affirms that deafness is a state of living. The cultural model says that there is a community with a vibrant culture that already has solutions to problems deaf individuals may encounter in daily life.

Overall, the struggle between the cultural and medical models can be exemplified by this quote by Woodward (1989):

“The Deaf community’s preservation of linguistic and cultural traditions in the face of strong opposition exemplifies the ability of people to adapt for survival in addition to pressures faced by other minority groups. The Deaf person has been viewed as a medical pathology, has undergone oppression of linguistic channel and code, and has not often had refuge in the home from sociolinguistic discrimination.”  
(p. 172)

This quote does a great job of showing that not only the medical and educational fields can discriminate against the cultural model, but that a deaf person can be viewed in a derogatory way by their own family. The Deaf community, in the quote above, acts as a way to connect those who struggle with being ostracized by individuals who view deafness through the medical lens. Though there is oppression of aspects of Deaf culture through medical

technology advancements and the stifling of learning ASL in schools, the cultural model finds a way to make life for the minority group of deaf individuals better.

“The deafness of which I speak is not a disability but rather a different way of being” (Lane, 1992, p. 21). Lane, in this quote, claims that deafness is not a disability, which is how the medical model generally views deafness. Lane is coming from the point of view of a deaf culturalist. If we were to view deafness through Lane’s point of view, we would see that he believes that instead of claiming that deafness is a disability, deafness allows people to see the world in a different way than they would than if they were hearing. According to Lane, deafness is all about a person’s point of view.

In my opinion, the most important quote that sums up the relationship between the cultural and medical model of deafness is from *The Proceedings of the Convention*:

“We have interests that are peculiar to ourselves which can be taken care of by ourselves.” (Deaf, 1880, p. 39)

This quote shows that the cultural model fully rejects audist philosophy. “The Deaf fantasy is not that they could hear, but that the world would be Deaf” (Smith, 1996, p. 80). Audists have been known to act as unwanted parents to deaf individuals, and have helped them even when they have not asked for it. This quote rejects unwanted help by hearing people, whether they were well meaning or not, and states that deaf people are fully capable of managing their own lives. This shows that deafness does require different solutions to everyday problems; hearing people do not have to deal with these problems because they are unique to deaf individuals. This shows that through Deaf culture, there are solutions already in place in order to make life easier. The cultural model claims that just because someone is deaf does not mean that they need help. The medical model would disagree

with the statement above made by the cultural model; they would say that technologies to eradicate deafness rather than solutions made by the Deaf community are the best way to enhance the quality of life of deaf individuals.

In sum, the cultural model of deafness and the medical model of deafness differ in a few important ways. The most important way is that the cultural model affirms deafness, while the medical model tries to find solutions in order to make the deaf person in question as hearing as possible. Both models have merits and pitfalls, and we will see in the next chapter how the two models interact in regards to conceptualizing a positive self-identity as a deaf person. In the next two chapters, I will focus on the cultural model of deafness and examine how having a positive self-identity within the cultural model can be beneficial for individuals' psychological health.

## CHAPTER THREE

### The Self and the Development of the Self

#### *An Introduction*

The medical model and the cultural models of deafness are both deeply engrained in the fabric of every deaf individual's life. Both of the models compete against each other while a deaf person develops their identity; they can have a serious impact on what a deaf individual's self-concept eventually develops into. As a deaf child grows up, they will be forced to question their identity and where they stand on the spectrum between the cultural and medical models of deafness.

In this chapter, I will first dispel the myth that there is a psychology of the deaf. Next, I will discuss what self-concept and identity are. I will also discuss how identity is formed in relation to deafness. The Deaf Identity Development Scale is a great tool in order to measure how acculturated an individual is into the Deaf community. That scale will be discussed in detail. I will then take the different identities defined using the scale and discuss what elements within the identities positively or negatively impact deaf individuals' self-esteem or positive identity development.

## *Self-Concept and Identity*

### *The Myth of a Psychology of the Deaf*

Before describing aspects of individuals' psyches, it is important to show that there is no psychology that is specific to deaf individuals. There are some authors that believe that there is a "psychology of the deaf" and that deaf individuals face increased levels of pathology because of the fact that they are deaf (Vernon & Andrews, 1990). The "coexistence of deafness and psychiatric problems may have led caregivers and teachers to the unwarranted assumption that deafness explains all, the phenomenon of diagnostic shadowing" (Van Gent, Goedhart, Hindley, & Treffers, 2007, p. 956). This approach to thinking about mental health concerns in deaf individuals has become grossly outdated. There are concerns that are specific to the deaf community that hearing individuals do not need to worry about because they have not had those certain experiences. This, however, does not imply that there is a separate psychology for deaf individuals solely because they are deaf. Lane (1992) definitively answers the question of if there is a psychology of the deaf:

"What we have... are stereotypes recast as science, stereotypes that blame the victims in order to obscure the failings and self-interest of the audist establishment... there is no psychology of the deaf." (p. 64-65)

According to Lane, there is no psychology of the deaf. The only reason that some may think that there is one is because stereotypes have become twisted in actual sciences. Stereotypes are what are portrayed as differences in psyches; this can lead one to think there is a psychology of the deaf. Once we take away the stereotypes, we can clearly see

that the unique psychology of the deaf is a myth. Hoffmeister and Harvey (1996) make an excellent point with their statement: “Is there a psychology of the Hearing? Of course not, just as there is no psychology per se of the Deaf” (p. 96).

There are, however, differences in research methods used when learning more about mental health concerns that relate to the Deaf community. There are linguistic, communication, and cultural traits that are important to take into account when discussing this population. I will discuss these topics more in depth in chapter 4 of my thesis.

### *Definitions of Self-Concept and Identity*

*Self-Concept.* “Self-concept refers to an individual’s concept of him- or herself and that individual’s own identity, abilities, and worth” (Holcomb, 1997, p. 90). Self-concept can also be described as ‘not the “real self” but, the *picture* of the self’ (Rosenberg, 1979, p. 7). One’s self-concept is not developed in a vacuum. The way that one sees themselves depends heavily on the way that they think the others in their lives see them. Self-concept is how one views themselves; this view is changed when the other people in that person’s life begin to question the view that person has of themselves. Once that happens, one’s self-concept can be reevaluated and further developed. One’s self-concept can be divided into three separate parts; the parts of self-concept are direct reflections of the self, the perceived self, and the generalized other (Rosenberg, 1979). Overall, people will see themselves through the eyes of others through the three categories above and will create their own self-concept based on how other people view them.

Direct reflections of the self are reflections of us based in part on certain other’s opinions. The opinions of these people matter much more individually to the person whose

self-concept is on the line. These could be opinions of people like close friends or family members. Because their opinion matters more to you than a stranger's opinion would, they have more of an influence on your self-concept and how you will view yourself in the future. Direct reflections are exactly how the other people view you, it is not about how you think they view you. This is how the individual sees himself as he is actually seen by others (Rosenberg, 1979).

The perceived self differs from direct reflection in that the perceived self is how the individual thinks that the others in their life view them. The reality of how the others perceive the person does not matter. What is actually important is how the individual infers how other people view them. In an example given by Rosenberg (1979), "If... he *infers* that [the others] feel contempt for him when in fact they have no knowledge of his peccadilloes, his resulting low self-esteem would be the produce of his the perceived self" (p. 67). The perceived self is entirely dependent on how the individual believes that they are seen.

The last component of developing a self-concept is through examining the generalized other in the individual's life. "The attitude of the generalized other is the attitude of the whole community" (Mead, 1934, p. 60). The generalized other shows you what your community thinks as a whole and then imposes those agreed upon values onto you.

"The individual possesses a self only in relation to the selves of the other members of his social group; and the structure of his self expresses or reflects the general behavior pattern of this social group to which he belongs, just as does the structure

of the self of every other individual belonging to this social group.” (Mead, 1934, p. 66)

The generalized other is created by the people in your social group and it pressures you into behaving in certain ways that the group approves of. The generalized other is also influenced by your own participation in the group, because the group as a whole decides the attitudes they have toward certain behaviors. As a member of the group, your voice is also considered when deciding what those attitudes should be. The generalized other affects the development of the self-concept by making the individual think about how they relate to other people in their group and what the group as a whole thinks of them and their actions. The generalized other “[applies] to the self the attitudes of [their] society as a whole” (Rosenberg, 1979, p. 67).

Overall, the conception of the self is a product of multiple different sources. One of the sources is direct reflections of what others in an individual’s life actually think of them. Another one of the sources is the perceived self of what an individual thinks how other people view them. The last source is the generalized other, which is how an individual believes that their groups as a whole view their actions. The self-concept of an individual affects the levels of self-esteem and self-confidence in a particular person. A person’s self-concept also affects what stage they are in when looking at the Deaf Identity Development Scale, which will be described in detail later in this chapter.

*Identity.* There are also many different aspects that make up an individual’s identity. Two important aspects of identity are group membership of an individual and important events that happen over the lifetime of an individual. Group membership can determine how an individual acts and how they perceive themselves in relation to those that are close

to them. The narrative of an individual person over the lifespan shows how identity can change over time. By examining what happens over a long period of time, you can see what aspects of identity are the most salient to a person during a certain period of time, and what aspects are most salient to the person over the lifespan as a whole.

One important aspect of identity is that your identity is highly dependent on what groups you join. “Membership groups are socially recognized bases of classification and constitute important elements of social identity” (Rosenberg, 1979, p. 10). Group membership is especially important when forming one’s identity as a Deaf individual; becoming a part of a community that positively affirms deafness is a prerequisite in order to develop a Deaf identity. Groups can either have a positive or negative effect on identity development. “If group membership does not make... a positive contribution—as in the case of groups whose members are stigmatized by the majority—the individual will attempt to leave the group physically or psychologically” (Bat-Chava, 2000, p. 420). Group membership can be a source of bonding within a group, which influences an individual’s identity development in a positive way, but it can also lead to stigmatization by the larger population in certain cases.

The other important aspect of identity that I will discuss is the biographical component of identity. There is a “biographical component in which respondents chronicle a series of events, experiences, and moves that lead to modifications in identity across time” (Foster & Kinuthia, 2003, p. 282). By looking at changes in group membership, identity salience, and responses to larger societal conditions, we can view how an individual’s identity changes over time. “Identity salience provides a way of understanding the perspectives of respondents... who described a particular individual characteristic as

more central to their identity than others or more persistent over time” (Foster & Kinuthia, 2003, p. 286). Identity is not static, and as we will discuss below, there are different deaf identities that can be viewed as common to the Deaf experience. When looking at the development of deaf identities, identity salience is incredibly vital to understanding the difference between them. If a hearing identity has more salience than a deaf identity, that deaf person is going to view themselves in a fundamentally different way than someone who gives more importance to their deaf identity. By tracing the evolution of an individual’s identity over time, we can see how they view themselves now, and how their current view has been shaped by their own past experiences.

Overall, identity can be thought of as the interaction between the self and the social structures surrounding the self (Foster & Kinuthia, 2003). This is a description of identity by Mitchell (2006):

“It is a conceptual representation of my continuous processes of (re)negotiation, (re)mediation, and (re)identification. My Self is always (re)active, (re)moving, never still.” (p. 138)

This conception of identity takes into account the fact that she is a product of her environment and that her identity has inevitably changed over time. As we will later see, one common narrative of forming a Deaf identity is first viewing yourself through the medical model of deafness. After that, you can then become enculturated into the Deaf community and embrace a positive Deaf identity. Possibly integrating your Deaf and hearing identities together is also possible.

*Summary.* There is no psychology of the deaf, but there are deaf specific difficulties that people face on a day to day basis. These problems arise because the world is catered

to those that have an aural/oral center rather than a visual center. Just because there are different concerns more pertinent to the Deaf community when it comes to health care does not mean that deaf psyches are fundamentally different than hearing ones. The self-concept and identity of an individual are intertwined. While one's self-concept and identity may seem similar, there are important distinctions between the two. One's self-concept deals with how an individual perceives themselves and how they believe that individual others and other groups perceive them; identity deals with your membership certain groups and how you change over time. Both identity and self-concept are important when thinking about the formation of Deaf identities. Deaf identities are formed over the lifespan and are heavily impacted by the different groups that you identify with at certain points in your life.

### *The Deaf Identity Development Scale*

#### *The Identities Defined in the Deaf Identity Development Scale*

The Deaf Identity Development Scale describes four different identities, or stages, of Deaf identity development. These “identity constructs are rooted within a societal framework, meaning that they evolve out of various social experiences” (Leigh, Marcus, Dobosh, & Allen, 1998, p. 329). The main goal of defining these different identities is “to provide an operational measure of Deaf people's orientation to and affiliation with the Deaf community and Deaf culture” (Glickman & Carey, 1993, p. 280). The identities describe different phases that deaf people may go through while finding the identity that they are most comfortable with. Individuals do not have to go through the identities in a certain

order, nor do they have to go through all of the identities to find one that defines them best. These identities are not mutually exclusive either, so one person can fit into one or more identities at any given time. Culture and identity theories in general “describe the changes in consciousness and self-definition that members of oppressed groups experience as they move from oppression to liberation” (Glickman & Carey, 1993, p. 275). The identities defined below will all be in different stages of liberation in terms of looking at hearing identity and Deaf identity affiliation.

*Culturally Hearing Identity.* “This refers to the dominant “hearing” understanding of deafness as a medical pathology or disability” (Glickman & Carey, 1993, p. 276). In this identity, deafness is not seen as a defining factor of the deaf person’s life. Deafness is considered something that a person has to deal with, not something that they embrace and that they are proud of. “Hearing norms are the reference point for normality, health, and spoken communication” (Leigh et al., 1998, p. 331). Deaf individuals that view themselves in this stage of cultural identity may be proponents for oral-only education and may be strong advocates for cochlear implants for children. This identity is typically the identity that deaf children are born into because this mindset is typically the one that parents are familiar with; parents become familiar with this mindset through their contact with medical professionals that function within a disability mindset. Those who identify as culturally hearing will not identify with the deaf world, but will tend to fit in well with the hearing world.

*Culturally Marginal Identity.* “This orientation is typical of people who experience themselves as fitting between the Deaf and hearing worlds, comfortable in neither”

(Glickman & Carey, 1993, p. 276). In this identity, deaf children do not fit into the hearing world, because English may be difficult to learn for the child. Deaf children also do not fit into the Deaf world, because their parents have had no exposure to it; because of their parents' lack of exposure, they are unable to acculturate their child into it. The importance of this identity to the Deaf experience is highlighted below:

“This child must fashion an identity without an explicit, well-formed notion of cultural contrasts (i.e., deafness versus “hearingness”) and often without the language needed to conceptualize this process. This burden may be unique to the Deaf experience.” (Glickman & Carey, 1993, p. 277)

This identity is almost like a purgatory for cultural development. In this stage, deaf individuals are in a state of limbo between the Deaf and hearing worlds. Often times, deaf individuals with a culturally marginal identity are unable to communicate through ASL or English well, so it becomes increasingly more difficult to cater to their unique needs. This stage is where a lot of problems arise for deaf individuals that want to solidify their cultural identity in either the hearing or the Deaf world.

*Immersion Identity.* “Aspects of this identity include a positive and uncritical identification with Deaf people, the belief that only Deaf people should serve or guide other Deaf people, and anger and resentment toward hearing people” (Glickman & Carey, 1993, p. 277). In this identity, there is a hatred for things that are related to audism in any way. Anti-audist tones are found in the quote above by the belief that Deaf people should be the only ones helping out other Deaf people. This is in direct opposition to the paternalistic attitudes that many audists hold. The immersion identity takes everything about deafness and makes it all about acceptance. ASL is praised and any oral methods of education have

no place in the life of someone with an immersion mindset. Immersion is about accepting everything that the Deaf world has to offer.

*Bicultural Identity.* “Deaf people who have achieved some feeling of comfort in both Deaf and hearing settings and some skill in negotiating these cultural differences are conceptualized as bicultural” (Glickman & Carey, 1993, p. 277). This identity is one in which a deaf person has achieved comfort in both the hearing and deaf worlds. Someone who is bicultural would accept that they are Deaf and affirm that identity, while embracing hearing people that support them. They do not automatically think that all hearing people are audist and are intending to oppress their rights, like someone with an immersion identity may think. These Deaf individuals would most likely learn through a bi-bi program; they would also read and write English and sign ASL to communicate. They embrace Deaf culture and the larger American culture that their families live in.

*Conclusion.* The identities described above are from the original study (Glickman & Carey, 1993) that formally defined the different deaf identities and created the distinctions between them, though the distinctions are not rigid. Culturally hearing, culturally marginal, immersion, and bicultural are the four identities that are discussed in this study. These identities are referenced in countless other studies regarding the development of identities in deaf individuals and improving self-esteem.

### *The Deaf Identity Development Scale Identities and Their Effects on Self-Esteem*

The identities defined by the Deaf Identity Development Scale are all related in some way to how an individual’s self-esteem morphs over time. Self-esteem:

“entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is *competent* to live and *worthy* of living.” (Branden, 2001, p. 110)

A high self-esteem, according to this definition, would belong to a person that feels like they are worthy of praise and that they serve a purpose in life. Self-esteem can be further broken down into two parts: outer self-esteem and inner self-esteem. Outer self-esteem “refers to how people evaluate themselves in varying situations in accordance with specific feedback they receive” and inner self-esteem “refers to how people globally evaluate themselves, unrelated to a specific dynamic situation” (Levinger & Ronen, 2010, p. 31). Self-esteem conceptualized by those definitions portrays that self-esteem is not a product of one event, but that it is an average of how self-esteem changes throughout various situations. The inner and outer self-esteem combine together to make up the essence of an individual.

The Deaf Identity Development scale “examines the psychological processes by which audiotically deaf people acquire culturally deaf identities, particularly in an environment that has been traditionally oppressive of deaf cultures and signed languages” (Maxwell-McCaw & Zea, 2011, p. 327). Below, I will describe how an individual’s self-esteem can change over time as the individual travels through each stage of the Deaf Identity Development Scale. I will go into detail and describe some of the different factors that could help a person’s self-esteem improve or decline in each of the different stages as well.

*Culturally Hearing Identity.* For a person with a culturally hearing identity, they are going to act more like a hearing person than anything. Three things that are prevalent

in the life of someone that is culturally hearing are parents and doctors acting as a source of encouragement, oral education being the main way of learning, and a discourse of disability surrounding the individual. These things all have effects on the self-esteem of a deaf individual that identifies as culturally hearing.

For a culturally hearing child or adult, sources of encouragement will likely come from people that can hear in their lives. Whether these figures are teachers, parents, friends, or doctors, as long as they are progressing, they will have a positive support system behind them. One way that parents can support their child with a culturally hearing identity is through treating them as if they were hearing. Brooks (1998) describes her experience as a culturally hearing deaf individual:

“Rather than face the inevitable and unknown consequences of my hearing impairment, family members chose to ignore it. This became a positive rather than a negative influence on me. It allowed me to maintain a semblance of normalcy and minimized the trauma of additional changes in my life.” (p. 253)

By not focusing on her hearing as a large part of her identity, she found that she could fit in more with her family. In a family where every person is hearing, hearing status is typically not brought up as an everyday discussion topic. By acting like the deafness did not exist by not speaking about it, Brooks was able to improve her self-esteem through encouragement from her parents that her disability did not define her.

Having your deaf child learn via an oral/aural method can be seen as either a positive or negative influence on their self-esteem. As described in the last chapter, an oral education is an education where signing is not allowed, and the teachers give students extensive training and therapy in pronouncing English words properly. If a child performs

well in an oral school setting, that child will naturally be praised for their talents and successes. When a child succeeds in school and is recognized for that success, that can enhance a child's positive self-esteem. If, however, the child does not succeed in an oral education classroom, that can be detrimental to the child's self in multiple ways. As well as not getting praise from parents and educators, that child may be missing out on learning the information presented to them entirely. Children in oral environments are in settings that do not cater to the needs to visuospatial learners, but rather cater to hearing children; because they are not focused on visuospatial learners, that places unintentional barriers in front of deaf children (Marschark, 2006). If children are not learning the information they need to and are not earning reinforcement from their parents and peers, a diminished self-esteem can result. Depending on how the child succeeds in the oral classroom environment determines whether the classroom is a positive or negative effect on self-esteem.

A child that is culturally hearing will also be no stranger to discourse surrounding their disability. Since their parents and peers most likely follow the medical model of deafness rather than the cultural model, they are likely to think of themselves in terms of brokenness rather than wholeness. Many families may feel like it is their 'duty' to produce 'healthy' children (Mathews, 2011). This idea can lead to stigmatizing attitudes about the deaf individual to surface. "If deafness is perceived as a source of shame, then building self-esteem in the deaf child will be a challenge" (Akamatsu & Cole, 2000a, p. 97). Public stigma is "what a naïve public does to the stigmatized group when they endorse the prejudice about that group" (Corrigan, 2004, p. 616). If the general public around the deaf child, such as their family, thinks that the child is disabled and that they need special help, the child may start to believe that discourse. Public stigma can morph into private stigma,

which is "what members of a stigmatized group may do to themselves if they internalize the public stigma" (Corrigan, 2004, p. 616). Internalizing stigma is one possible harmful effect on self-esteem for a person who is culturally hearing. Since culturally hearing identities are surrounded by people that are considered 'normal' while they are considered 'disabled', not being able to do anything about 'fixing' their hearing status could damage self-esteem.

A culturally hearing identity is one in which deaf children and adults are treated as if there is nothing wrong with them. In this identity, self-esteem can be improved by parents and doctors acting as sources of encouragement by ignoring deafness altogether and succeeding in an oral education classroom. Two ways that could negatively impact a deaf child's self-esteem with a culturally hearing identity are failures in an oral classroom and thinking of themselves in terms of disability discourse. A culturally hearing identity can potentially be a positive identity for a deaf child to have as long as they have clear speech. With speech, the deaf child has the support system they need in order to succeed socially and in the classroom.

*Culturally Marginal Identity.* In a culturally marginal identity, there is no secure world in which the deaf individual fits into. This person is constantly bouncing between two separate worlds, the Deaf world and the hearing world, but not feeling accepted in either of them. The 95% rule, mainstreamed classrooms, and a lack of meaningful friendships can all effect self-esteem for a deaf individual with a culturally marginal identity.

The 95% rule is a phenomenon exclusive to the Deaf experience. This rule basically states that 95% of deaf babies are born to hearing parents. This rule also says that about

95% of parents have no prior encounters with deaf people before having a deaf baby, 95% of deaf adults have hearing children, and 95% of deaf children are in mainstreamed schools (Holcomb, 2013). What the 95% rule tells us is that the vast majority of deaf babies are being born into a world where their parents will not intimately understand their experiences in life. Though parents can emphasize and advocate for their children, there is no possible way that they will be able to experience what their children experience. In part because of the struggle between parents and children not being able to understand each other, children in one study reported that their parents take less time to listen to their concerns and do not value them (Kouwenberg, Rieffe, Theunissen, & de Rooij, 2012). This perceived lack of support due to differences can cause lowered self-esteem to form in deaf children.

There are cases of deaf children's hearing status going unnoticed for a long time; this, almost exclusively unintentional, neglect can cause self-esteem to lower drastically in the long run. "Stress experienced exclusively by people born deaf may in part be associated with the parents not understanding the toddler's reactions and communication before the child was diagnosed as deaf" (Kvam, Loeb, & Tambs, 2007, p. 5). If the deaf child experiences stress because their parents cannot understand them, the parents are likely to feel stress as well. Parental stress can come from the parent-child relationship directly, or it can come from the lack of support they may get because of their deficit in ties to the Deaf community or lack of resources to help the child (Schenkel et al., 2014; Sebald, 2008). In one study, it was found that parents feel less stress when they perceive that they have increased support from outside sources (Pipp-Siegel, Sedey, & Yoshinaga-Itano, 2002). If parents are stressed because they do not have the resources necessary in order to help their

children, and if children become stressed because their parents do not know how to help them or do not realize that they need help, self-esteem can be lowered.

One more important effect of the 95% rule on self-esteem deals with the rule of thumb that says about 95% of parents to deaf babies will have had no contact with the Deaf community before their child was born. This can have some detrimental effects to a child's self-esteem. This essentially means that for at least a period of time, a deaf child will live in a vacuum and will not have contact with other people that have had the same experiences as them. Medical professionals, as discussed in chapter 2, typically do not help parents get in contact with leaders in their local Deaf communities. Deaf adolescents will generally have fewer friends and the friendships they do have will be of a lesser quality because of a lack of connection with other Deaf individuals (Blom, Marschark, Vervloed, & Knoors, 2014). "Inadequate communication with significant others during one's developmental years severely impedes all facets of psychosocial development" (Harvey, 1996, p. 158). For example, deaf adults may feel a sense of loneliness with their own children because they did not learn the skills they should have learned during adolescence to communicate with the hearing population (Jones, Strom, & Daniels, 1989; Levinger & Orlev, 2008). Without contacts to other people that have experienced the same things, deaf individuals can become isolated and not have ties to groups that would be able to support them. Suicide levels can be linked to hopelessness and decreased levels in perceived social support (Turner, Windfuhr, & Kapur, 2007). This is not a common occurrence, however, without ties to a group that would be able to support them, deaf children may have low enough levels of self-esteem to see suicide as an answer to their isolation from the Deaf community.

Mainstreamed classrooms are a hallmark of a deaf child that has a culturally marginal identity. As described in chapter 2, mainstreamed classrooms are integrated classrooms with hearing and deaf children that have the goal of bringing hearing and Deaf cultures together. What most educators do not realize is that “inclusion does not guarantee acceptance” (Mowl, 1998, p. 239). Mainstreamed classrooms are often described in terms of social isolation and academic isolation by those who have learned in them (Foster, 1998).

In terms of socialization, communication barriers can leave the deaf child feeling isolated from the hearing world; often times, communication barriers also leave the deaf child isolated from the Deaf community as well. Young deaf children with a culturally marginal identity tend to not have a solid foundation in any language, which contributes to isolation (Delgado, 2000). Even though there may be attempts to join clubs at mainstreamed schools, deaf students can have negative experiences with unsuccessful attempts at trying to become involved with school activities (Holcomb, 1998). Since communication barriers can leave children on the margins of social groups, social isolation from both the hearing and Deaf communities can occur. Social isolation can lead to increased levels of low self-esteem. Communication barriers can also lead to miscommunication between different children in the school setting, which could possibly lead to bullying in the classroom.

In some mainstreamed schools, there are self-contained classrooms. These classrooms place all of the deaf children in a school together into one room, despite differences in their grade levels or their ages. The existence of a self-contained classroom can contribute to bullying because “of the wide range of intellectual, physical, and

socioemotional development” between the children in these classrooms (Miller & Weiner, 2006, p. 65). In classrooms where bullying takes place, deaf children can be interpreted as overreacting by their teachers (Dixon, 2007; Dixon, Smith, & Jenks, 2004). If the teachers believe the students are overreacting when bullying occurs and proceed to let the bullying happen instead of taking care of it, a student’s self-esteem can be at risk. Side effects of bullying include reduced academic achievement, anxiety disorders, low self-esteem, increased risk of depression, suicide, self-concept problems, and feelings of alienation (McCrone, 2004; Weiner, Day, & Galvan, 2013). Other effects of being bullied are social exclusion and marginalization (Bauman & Pero, 2011). Though bullying is not accompanied by all of those side effects every time a deaf child is bullied, they are possibilities of long term effects of what could happen. Though the bullying most likely will not lead to those extreme effects, having a lowered self-esteem because of being bullied is a likely outcome.

Mainstreamed classrooms also leave the deaf child in the classroom to communicate with one person in the room naturally; this person is usually the interpreter for the child. Sometimes, the interpreter in a mainstreamed classroom is under qualified or even completely unqualified to do the job they are assigned to do (Marschark, Sapere, Convertino, & Seewagen, 2005). If an interpreter is not qualified to do the job they are assigned to do, that will not only affect a student’s ability to learn in the classroom, but it will also hurt the student in terms of being able to communicate with their peers. If an interpreter cannot sign properly in the classroom, that is a good indicator that the interpreter will not be able to sign in settings where the child is interacting informally with other children. Interpreters are also advised to stay away from dual relationships (“NAD RID

Code of Professional Conduct,” n.d.). Interpreters are not ethically allowed to carry on dual relationships with clients; this means that if an interpreter and a deaf child became friends, that would not be an appropriate relationship for them to have since that would be considered a dual relationship. If children have a hard time communicating with hearing children and they cannot make friends with the one person that knows their natural language, social isolation can occur. When social isolation happens, lowered self-esteem is a common side effect.

Overall, the culturally marginal identity is one that clearly portrays that deafness can be interpreted in most, if not all, aspects of life as a negative trait. We examined the 95% rule and mainstreamed classrooms in detail with regards how these two ideas could negatively impact a deaf child’s self-esteem. A perceived lack of parental support, stress in the relationship between parent and child, and a non-exposure to Deaf role models in the community all can have the negative effects of a lowered self-esteem of a deaf child. In mainstreamed settings, social isolation and bullying are two broad categories in which lowered self-esteem is a common narrative. The individual with a culturally marginal identity is stuck in between the hearing and Deaf world. There is no comfort from others in having a culturally marginal identity; a group of deaf individuals and a group of hearing individuals would both most likely not fully accept you with this identity. This identity is unique to deafness; a person can easily get lost directly in the middle of two completely different cultures. A culturally marginal identity is typically not the best identity for a deaf individual to have, as many individuals with this identity suffer from the various negative effects on their self-esteem described above.

*Immersion Identity.* Deaf children and adults with an immersion identity tend to be very proud of their involvement with Deaf culture. They tend to have attitudinal deafness, which implies they identify themselves as a members of the Deaf community and are accepted by other members (Rutherford, 1989). These individuals are very passionate about the issues that are pertinent to Deaf culture and work together with other Deaf culture activists in order to maintain their status in the community. One of the hallmarks of the immersion identity is only maintaining relationships with those involved with Deaf culture; these relationships are very strong bonds that are not easily broken. Three things that can influence self-esteem of deaf individuals with an immersion identity are identification with a group, discourse of an affirmation of deafness, and the idea of Deaf gain.

Identification with a group is incredibly important in order to maintain a healthy level of self-esteem. When you become involved with Deaf culture, you are involved with communities that know about the same struggles that you are going through; they are typically willing to help you learn how they got through those same situations in their own lives. In the first chapter, I extensively described Deaf culture and the benefits of living life through the viewpoint of the cultural model. Being a part of Deaf culture allows you to sign to people in your native language that have had the same sorts of experiences that you have; it allows you to collaborate and learn about the solutions that others who have been in your situation have already come up with. “The need or self-expression through language is so great that all of the accouterments of self-expression have become emotionally charged, particularly the peer group, which symbolizes this self-expression” (Becker, 1980, p. 106). Having social support is beneficial for self-esteem, especially when those supporting you take joys in your successes, such as those in collectivist cultures do.

Through a common language, Deaf individuals are able to bond and enhance each other's self-esteem.

Affirmation of deafness is, also as described in chapter 1, central to Deaf culture. "In order to be a member of the Deaf community, a person needs to meet the requirements of political, audiological, linguistic, and social expectations of members" (Holcomb, 2013, p. 42). Needing to fulfill requirements in the different aspects of the Deaf community ensure that members are actively working toward solidifying their membership status and that they are also actively trying to help other members. This tight-knit community is formed in part because of these requirements. The political, linguistic, and social expectations of members all include the idea of affirming deafness as more than an audiological concept. Working toward goals that will better the community, spreading the use of and normalization of ASL, and building relationships with other members are all requirements for being involved in Deaf culture. Because there is a lot of work that goes into becoming an actual member of the Deaf community, self-esteem can be raised once one is accepted as a member. This acceptance by the group acts as a reward for all of the hard work that the individual has done for their community. Affirmation instead of disability discourse can also raise self-esteem, because focusing on what one is rather than what one is not can be an empowering line of thought.

Deaf-gain is about "reframing the meanings of "deaf" from loss to gain" (Bauman & Murray, 2015, p. 2). The idea of Deaf gain is slightly different from the affirmation of deafness through socialization and acceptance in the Deaf community, as described above. Deaf gain can be described in this manner:

“All individuals would be enriched by becoming a bit more Deaf. By that we mean society would do well to become more acutely aware of the nuances of communication, more engaged with eye contact and tactile relations, more fluent in a language rich in embodied metaphor, more aware of the role of being a member of close-knit communities, and if nothing else, more appreciative of human diversity, so that we are constantly reminded that the bedrock of reality may be just as diaphanous as any other social construction.” (Bauman & Murray, 2015, p. 22)

Deaf gain is not only about the individual feeling more accepted in the Deaf community, but it is about advocating for the community as a whole to the larger hearing population. This could be classified as something political that a Deaf individual would need to advocate for in order for acceptance into the community. Deaf gain can be seen as making the rest of the world Deaf accessible, rather than Deaf individuals needing to adjust the hearing world. Fighting for a cause that would better the entirety of your community is a noble cause. Self-esteem can be heightened when working together with others in your life toward bettering your community as a whole.

Overall, an immersion identity can be very beneficial for a Deaf individual’s self-esteem. In this identity, your self-esteem can be improved through interactions with others like you in your group, through affirming your Deaf identity through political, linguistic, and social matters, and through advocating for Deaf gain. This identity is usually one that Deaf individuals will experience after finally connecting with other Deaf individuals for the first time. This identity is all about building up a Deaf person’s self-esteem after possible years or decades stuck in a culturally marginal identity, which tends to break down self-esteem.

*Bicultural Identity.* Deaf individuals with a bicultural identity have achieved a status of identity within both the Deaf and hearing worlds. A person with this identity would be able to manage the two worlds with ease, and would be almost the opposite of an individual with a culturally marginal identity. Individuals with this identity “acquire and maintain characteristics of Deaf culture while simultaneously acquiring and maintaining characteristics of the hearing, predominant culture” (Maxwell-McCaw & Zea, 2011, p. 338). Some factors that effect a bicultural individual’s self-esteem are fitting into a world where they can communicate with parents and peers, and learning about their world in a bi-bi school environment.

Deaf children with a bicultural identity are acculturated into the Deaf and the hearing worlds. “Acculturation is a normal, universal human process that occurs regardless of minority or majority status” (Rudmin, 2003, p. 30). This is essentially taking both worlds and making them into a unique blend of the two for each bicultural individual. Each bicultural person will identify with different parts of each culture and to different extents. What is unique about a bicultural identity is that the individual does not need to choose to use mostly English or ASL; a bicultural person can use whichever language is most appropriate depending on the situation. Switching is used between languages depending on the situation an individual is in because bilinguals tend to use their different languages in different facets of their lives (Grosjean, 1998).

For Deaf individuals, the two cultures that they switch back and forth between tend to be the culture of their parents, American culture, and the culture of their peers, Deaf culture. I mentioned in chapter 1 that Deaf culture is passed from person to person horizontally, which means that it is a peer learned culture. Deaf bicultural individuals are

able to identify both with their families at home and with their peers, which means that they have two support systems. We can consider a deaf bicultural identity one that complements additive bilinguality; additive bilinguality is where two cultures and languages come together in order to bring positive elements to a bicultural person's life (Hamers, 1998). With two cultures and languages working together to bring an individual closer to two important sets of people in their life, the self-esteem of a person with a bicultural identity is likely to be positive. The two cultures add together in order to supplement the bicultural person's life in various ways. Having two support systems that you can connect to is one way that self-esteem can be enhanced.

A bi-bi education, as described in chapter 2, is one in which considers ASL and English as equally important. It also teaches the value of being able to switch between hearing and Deaf cultures. "Once deaf children are considered in the same light as other non-English-speaking minority children, with their own language, culture, and social conventions, their educational lot and their relations with the hearing world are bound to improve" (Charrow & Wilbur, 1989, p. 115). Learning about both ASL and English improves understanding in the classroom, which improves a child's knowledge base, which likely improves the quality and number of job choices that an individual is likely to encounter after graduation (Peal & Lambert, 1962). If a child is bilingual, they are able to use resources and knowledge gained in one language and use it in their other language and vice versa (Padden, 1998a). Theorists have questioned "how very young deaf children come to a point of knowledge and develop increasingly complex cognitive schema as they attempt to make sense out of a world that for them is dominated by visual stimuli" (Christensen, 1993a, p. 20). Children are able to learn through the bi-bi approach because

it caters to the need of a visual environment. Being able to communicate first in ASL and then learning English based off of that foundation is a hallmark of the bi-bi approach to education. With the foundational language skills learned through ASL, it is easier for a Deaf child to learn English (Grosjean, 2010). Once you have a foundation of a language, that improves a child's understanding of how other languages relate to their foundation. If a child is fluent in both languages, that can help with the development of higher order cognitive functioning as well (Kushalnagar, Hannay, & Hernandez, 2010). With a positive educational experience tailored to gaining understanding and knowledge rather than only practicing speech skills, children are able to enhance their self-esteem.

“When mutual respect is achieved, both learners and teacher can progress toward academic and psychosocial milestones of development” (Christensen, 1993b, p. 180). Children in bi-bi classrooms are likely to encounter hearing teachers that understand what Deaf culture is about; their teachers may even be Deaf themselves. This turns the classroom into a positive environment where there are role models in Deaf children's lives that are living the same lives that they are. “A multicultural curriculum invites students to investigate and identify their own cultural selves and opportunities, to learn about those selves from multiple perspectives” (Welch, 2000, p. 16). As well as having Deaf educators, children are also taught about their heritage and learn to embrace it. Asking children about their experiences as Deaf individuals is important in understanding them and empowering them through their education (Cheng, 2000). The affirmative attitude toward Deaf culture and legitimizing children's experiences in the Deaf world enhances self-esteem for Deaf students in bi-bi classrooms.

For the bicultural identity, there are many ways that self-esteem can be improved for a Deaf child. Because bicultural individuals can switch between ASL and English, which means that they can switch between the hearing world of their parents and the Deaf world of their peers, they have two sources of encouragement and support. A bi-bi education, which many individuals with a bicultural identity have, is supplemental to self-esteem in many ways. Two of these ways are through giving a positive educational experience to children that focuses on imparting information rather than teaching speech and through providing positive Deaf role models to students that affirm deafness through teaching about Deaf culture and history. This identity is about inclusion of all parts of a Deaf person's life, which ends up improving self-esteem in most cases.

*Conclusion.* Overall, the separate identities of the Deaf Identity Development Scale have different effects on an individual's self-esteem. These identities are not concrete or mutually exclusive, so it is possible for one individual to be a mix of one or more identities or not fit into any identity described at all. The different identities can help to improve an individual's self-esteem or to diminish it depending on how the individual interprets the particular situation that they are in.

### *Conclusion*

Examining the Deaf Identity Development Scale identities in depth and looking at how they can either boost or diminish self-esteem is important to do before looking at how the mental health care of D/deaf individuals has been treated historically. Especially for individuals with a culturally marginal identity, deaf individuals have had limited access to resources that may have been able to help them. Individuals with identities characterized

by lower levels of self-esteem, as is with any person with a low level of self-esteem, are especially vulnerable to various mental health concerns. With little outside access to the hearing world to gain valuable information, getting treatment in the proper way for various different mental health issues has historically been a problem for the Deaf community. I will examine in the next chapter some of the various barriers the Deaf community faces regarding mental health care and counseling services. I will use the culturally marginal identity as a starting point, and from there, I will integrate my discussion of the cultural model of deafness, the medical model of deafness, and various levels of self-esteem into difficulties encountered by individuals trying to receive much needed mental health care.

## CHAPTER FOUR

### The Current State of Mental Health Care for Deaf Individuals

#### *An Introduction*

Looking at the current state of mental health care for D/deaf individuals is a task that should not be taken lightly. For decades, the D/deaf population has faced many different struggles while trying to gain quality mental health care. Accessibility and availability are poor. For culturally Deaf individuals especially, finding culturally sensitive care or medical professionals that sign, are familiar with the Deaf community, or are Deaf themselves is quite difficult.

One of the foundational problems of D/deaf mental health care is the fact that the research methods used in order to gain knowledge about the problems that D/deaf individuals face are not always conducive to finding results that are accurate. Inaccurate results can come from creating studies from the viewpoint of deafness as a disability when the population in question is a culturally Deaf one. Knowing who your population is before starting research is important to develop methods that will actually help your target population. By not having research methods that are accurate, the results of these studies can be skewed from their original intention, which can then lead to the methods developed from these studies to ultimately be ineffective. Researchers in the Deaf community have not had the best reputation in the community, as many Deaf individuals have a history of mistrusting researchers; The researchers either have language barriers with the Deaf community or they have not earned cross cultural legitimacy (Graybill et al., 2010). I will

discuss the various problems that are found within mental health research with a specific emphasis on how D/deaf individuals are affected.

Secondly, I will look at problems that are found within mental health care treatments themselves. I will focus specifically on counseling contexts, and explain in detail how therapist qualification, various interpreting methods, and cultural sensitivity all contribute to the effectiveness of therapy sessions. Looking at counseling contexts specifically will give us insight in how a lowered self-esteem through the development of a culturally marginal identity can result in non-treatment due to aspects of the therapy session that are out of the deaf individual's control. Problems with research methods contribute to having a lack of qualified therapists to deal with culturally sensitive material. The lack of cultural understanding leads therapists to use interpreters in ineffective ways during therapy sessions, which can contribute to ineffective or non-treatment.

#### *Ethical Concerns with Research Methods*

When looking at differences in research methods, we can examine what it means to be an ethical researcher when doing research with deaf individuals. When looking at these methods, we must examine the linguistic, communication, and cultural traits within the methods themselves (Levinger & Ronen, 2008). The three things listed above are concerns that need to be thought about when doing research with deaf populations, especially with culturally Deaf populations. The lack of using ASL when presenting research materials and not taking into account whether individuals are Deaf or deaf are concerns that the deaf population faces. Not using ASL and not considering culture when conducting research can lead to ethical concerns. Researchers that work with Deaf

participants are expected to conduct investigations ethically and protect the individual rights of their participants regardless of their linguistic preferences or cultural identity (Singleton, Jones, & Hanumantha, 2014). Careless research done with deaf individuals can lead to results that are unrepresentative of what is being researched.

### *Linguistic, Communication, and Cultural Traits within Research*

*Linguistic Traits.* “Research with the Deaf community requires decentering “hearingness,” so that American Sign Language and Deaf culture are given back to Deaf people” (Harris, Holmes, & Mertens, 2009, p. 116). The linguistic trait that is relevant to conducting ethical research is choosing a language that participants will feel comfortable using in the study; this tends to be the dominant language of the participant (Gerner de Garcia, 1993). For someone with a culturally hearing identity or bicultural identity, they may be more comfortable using either spoken or written English during the study. For someone with a bicultural or immersion identity, they may be more comfortable using ASL. An individual with a culturally marginal identity may not be able to communicate effectively through English or ASL, which means that additional linguistic measures may need to be taken in order to enhance comprehension for the participant. The choice of what language or languages to use in a study depends on the kinds of deaf participants that you will have in your study. Research done about your target population is essential in order to determine the way that each material in the study needs to be adapted to.

*Communication Traits.* There are various ways that a deaf individual can communicate with a researcher in the experimental setting. Researchers can take advantage of different methods of communication in order to effectively communicate with their

participants. When researching deaf populations, three common ways to communicate with the participants during research are through signing ASL in real time, through written English, and through having ASL prerecorded for the participant to watch. These different methods are used for various reasons during the research process. To be ethical while using these communication methods depends on the population that you are researching and how you utilize the methods to fit their needs.

Signing ASL in real time is not used very often when conducting research. This is because there is great variability between different individual's signing styles, which could mean that every participant would not be receiving the same material that every other participant does. Translation working groups (TWGs) are groups in which signers come together and determine the best possible script in order to convey the exact message that they want to give to their participants (Graybill et al., 2010). These groups are intended to decide what the best way would be to sign a certain idea to participants in order to receive the most comprehension from the most people for that idea. Studies that do not engage in TWGs run the risk of not communicating in the same way to every participant, which can confound results. It can be difficult for signers to stick exactly to a script, so having a video recording of the signers giving the information is a better way to standardize the research process.

One other problem with live ASL is that researchers may not be as fluent in sign as they believe they are. If they deviate from the script and sign something different in order to explain the concept in a different way, that can interfere with the true intention of what is being conveyed. Unskilled signers should generally not be researching deaf populations, but if they are, they should let skilled signers or members of the Deaf community do the

translations of English materials into ASL, sign the research materials to the participants, and sign the answers to any questions that the participants may have. Signing in real time has many variations; because of high variability, the better option for presenting ASL in a research format to participants is through recording the material first. Real time ASL should only be used in situations in which the participant has a specific question; if this occurs, a skilled signer should be assigned to answer that question.

Using a videotape of someone signing ASL is a great way in order to standardize what you are giving to participants while making participants comfortable by using their native language. In one study, the use of a videotaped consent video increased understanding of what rights each individual had as a participant in the study (Singleton et al., 2014). There are some drawbacks to using this method of research, as some participants think that viewing a video of someone signing personal questions to them is too public and an invasion of their privacy (Levinger & Ronen, 2008). This study was conducted in a semi-public setting; it found that people who thought that their friends or family in the next room would view the personal video over their shoulder chose the written version of the material, even if they would have been more comfortable watching the video version. Confidentiality is crucial to any study, so making sure that participants are either alone or only with the experimenter can enhance participant comfort and ensure that their answers will be kept secret.

Recording ASL is preferred to live signing because it ensures that each person will view the same exact thing. One study had four different signers sign the exact same script, which was beneficial to the participants; if the participant did not like one signer's signing style, they were given the freedom to watch someone else, but get the same material while

doing so (Graybill et al., 2010). If participants want to view the research material presented to them in a visual format, using videos is the best way to make sure that information is presented to the participant as clearly as possible.

Written English is the last way that you can present research materials to deaf participants. In one study, participants were given the choice to pick between watching a video of the text, the original version of the text, or a re-written version of the text into an easier to understand English form. 57.4% of participants preferred the original version of the text, 42.6% preferred the easy written version of the text, and 2 people out of the 101 participants chose the video version of the text (Levinger & Ronen, 2008). This surprised the researchers because the deaf community in this particular study did not want to use the video version of the materials.

There are many reasons that the deaf participants in the study may have wanted to use written over signed materials. One reason has been described above, which is that the participants may be concerned about their confidentiality. Another observation of the researchers in the study was that good portion of participants wanted to use an easy written version of the materials. This has practical use because for those with lower levels of exposure to scientific terms used during research, there is a way to provide the same information through the same medium. One last reason one may choose written materials over signed is when an individual has a background in oral education, it would be more natural to them to read and write in English rather than communicate in ASL. This is another reason that the researchers need to learn about the background of the participants before the study to develop methods that are useful to them or need to develop multiple formats of the same material for the various participants to choose from.

*Cultural Traits.* “*Cultural Competence* in research can be broadly defined as a systematic, responsive mode of inquiry that is actively cognizant, understanding, and appreciative of the cultural context in which the research takes place; it frames and articulates the epistemology of the research endeavor, employs culturally and contextually appropriate methodology, and uses community-generated, interpretive means to arrive at the results and further the use of the findings” (Harris et al., 2009, p. 113). Cultural competence is vital to conducting research with multicultural people groups, such as those who have been socialized into the Deaf and American cultures. To develop methods that will help the culturally diverse populations at hand, culturally competent interventions are necessary. If the methods used to gain information are not culturally competent, the methods developed from the research will certainly not be effective.

When considering differences between research methods needed for use with Deaf acculturated individuals and American acculturated individuals, we need to specifically think about the adaptation rather than translation of test materials. Translation “refers to a one-to-one transfer without any consideration of linguistic differences” (Haug & Mann, 2008, p. 139). Adaptation “takes into account both linguistic and cultural differences and involves more flexibility in test construction” (Haug & Mann, 2008, p. 139). By taking the adaptation of test materials rather than having a direct translation means that you are considering the differences that exist between the cultures and you are actively doing something so the differences between the cultures do not confound the results. Considering the cultural differences and changing the study in order to reflect those differences is one way to conduct ethical research.

In order for a study to be culturally competent, the researchers first need to recognize that the population they are working with has a background in a culture different from the mainstream American culture. That culture needs to be taken into consideration when designing the study. Adaptation rather than translation of research methods, as described above, is also needed in order to ensure cultural competence. Cultural traits are necessary to take into consideration not only because it validates the participants' culture, but because to record data that will be helpful, you need to think about culture. Individuals with different levels of acculturation into Deaf and American cultures will interpret the various aspects of the study differently. Researchers need to be aware of that fact and adjust their study accordingly for each person.

Researchers also need to take into consideration that clients may have other cultural identities that are not related to American culture or Deaf culture. Sometimes, when working with deaf clients, the "Deaf" identity is considered more salient than other ethnic identities, even if that is not the case (Gerner de Garcia, 2000; Grace, 1993; Ramsey, 2000; Struxness, 2000). The dominant identity of an individual can be determined by the groups in which they self-identify (Fletcher-Carter & Paez, 2000). Deafness can be considered a source of shame in some cultures (Akamatsu & Cole, 2000b), so having a Deaf culturally affirmative approach to research with a participant that holds this belief would not be beneficial to them. It is important to do a full examination of where one's cultural identity lies in order to ensure that they are treated in culturally affirmative ways. "Deafness makes one no less a member of a racial, linguistic, or ethnic group" (Cohen, 1993, p. 54). As a researcher, the only right way to ensure that you are honoring a participant's culture is

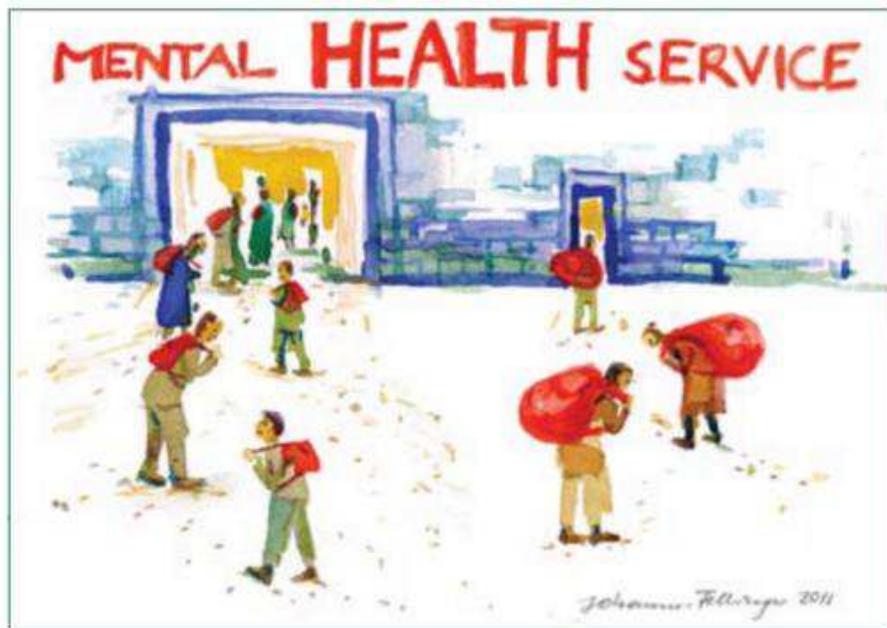
through a thorough cultural examination. After that, you can determine if the participant falls in the target population of your study and proceed from there.

*Conclusion.* All of the participants in a certain study cited “hearing researchers’ lack of sign language proficiency and cultural knowledge as the principal concern or source of their discomfort” during the study (Singleton et al., 2014, p. 62). Researchers that work with D/deaf communities must realize that their research is important, but that means that they have certain obligations to those communities when they conduct their research. Researchers must conduct themselves in an ethical manner; “ethical considerations include respect for cultural norms of interaction, beneficence involves the promotion of human rights and increased social justice.” In order to ensure that D/deaf communities are being represented properly, linguistic, communication, and cultural traits of the materials the researchers use need to be analyzed.

Researchers need to first determine the kind of deaf population or deaf populations that will be involved in the study, and choose a language or languages that will be the most appropriate. Once a language is established, different forms of materials in the decided language need to be developed for the study. These forms can be written English, easy written English, videotaped ASL, or live ASL. Each of these have pros and cons to them, and can be effectively used with different deaf populations. Lastly, cultural considerations need to be taken into account. Cultural competence is needed by researchers in order to design studies that affirm the target population’s culture rather than marginalize it. Cultural adaptation is one way that researchers can achieve that goal. They can do this through looking at the cultures and then examining how they can change their study; they do this through looking at the meanings of materials as a whole rather than utilizing an one-to-one

translation from one language to another. This shows that certain precautions were taken when transferring information from culture to culture. Ethical considerations are necessary to take into account because without doing so, the studies created would not be contributing to research that would help the target population. Ethical research done with culturally marginal identities is especially important, because they are not typically accepted into any culture at all. Research for culturally marginal individuals is necessary in order to develop counseling techniques that can help them develop a healthier sense of self and possibly help them begin to develop a different deaf identity.

*Mental Health Care Concerns*



*Figure 6. The Burden of Mental Health Problems on Deaf People (Fellinger, Holzinger, & Pollard, 2012, p. 1042)*

Mental health in D/deaf populations has historically been a burden for those individuals. The figure above portrays this burden in a visual manner. The red sacks represent the burden that individuals carry with them while they look for mental health

services that will fit all of their cultural, linguistic, and communication needs. The large door on the left represents how the hearing population has easy access to the mental health care services that they need. Their small red sacks easily fit through the wide entrance. The small door on the right represents the accessibility of needed services for D/deaf individuals. The red sacks of D/deaf individuals are entirely too large to fit through the door, which means that the burdens that D/deaf individuals carry with them are often too numerous for mental health care providers to accommodate. The problems in mental health care accessibility for D/deaf populations that I will discuss are all problems that metaphorically make the door on the right smaller.

I will discuss the lack of cultural sensitivity that many therapists have when working with the culturally diverse individuals of D/deaf communities. I will then discuss the lack of qualified therapists that work with these communities. Their lack of qualification is not because they are not certified as a therapist in general, but because they may not have the cultural knowledge to work effectively with individuals that identify themselves with Deaf culture. Lastly, I will discuss the various problems in therapy sessions that are caused due to needing interpreters. Some of these problems include interpreters not being qualified to work in medical settings, the cons that come along with Video Remote Interpreting, and the awkwardness and confidentiality concerns that come with having a third person in an intimate therapy setting.

### *Cultural Sensitivity*

Cultural sensitivity within the Deaf community encompasses all of the ethical concerns that I discussed in the above section. Without knowledge of the communication,

linguistic, or cultural concerns of the Deaf community, there is no possible way to ethically treat D/deaf individuals in mental health care settings. By discussing the role of written English in a medical setting, culturally insensitive acts, and the Deaf Identity Development Scale, we can see how therapists can interact with their clients in either culturally sensitive or culturally insensitive ways.

*Written English in Therapy Settings.* Written English should not be used as the main source of communication between therapist and patient during a therapy session. If this is the only way that a client can interact with the therapist, it may need to be utilized. Otherwise, other ways of face-to-face communication are preferred, such as through spoken English or ASL. Depending on what the cultural identity of the deaf individual is in therapy, English may not be a language that they are comfortable using in any format, whether it be spoken or written. There are cases where “providing [Deaf clients] with documents in written English does not necessarily mean that they will understand their meaning. This is especially problematic when [health care providers] ask Deaf people to read and sign legal consent forms and other written documents” (Fileccia, 2011, p. 176). In certain cases, cultural sensitivity means that the therapist knows when to bring an interpreter into a situation when a client may be dealing with legal material that may be misunderstood if only presented in written English.

*Culturally Insensitive Acts.* For many Deaf individuals, there are different acts that hearing people do that are considered demeaning by most of the Deaf population. One example of a culturally insensitive act is thinking that a deaf individual is not able to hear you because you are speaking in your normal tone of voice. Health care providers must “recognize that shouting, gesturing, and mouthing English will not increase the Deaf

person's comprehension or ability to hear" (Fileccia, 2011, p. 178). If therapists are not aware of how their hearingness affects their actions, they can be grossly offensive to their clients without realizing it. Being in contact with the Deaf community is one way to learn how to interact properly with individuals involved with Deaf culture and obtain cultural competence.

One other culturally insensitive act that therapists can engage in is not examining their own cultural views and how those views interact with the values held by Deaf culturists. The hearing world's ignorance of ASL is what creates the disability of deafness (Olkin, 1999). Therapists need to examine their own cultural assumptions created by the phonocentric society they live in before working with Deaf clients with wholly different world views (Williams & Abeles, 2004). Once therapists realize that they may have a different center than their clients, they can actively work to make sure that their worldviews are not imposed on their client. "Counselor awareness of personal biases and assumptions related to the individuals who are deaf will likely assist this relationship" (Peters, 2007, p. 188). Therapists must understand their client's worldviews before starting any type of treatment. There is a potential threat that audist ideals may come into the therapy session because some therapists "see a need and view their ethical mandate as requiring them to help" (Hoffmeister & Harvey, 1996, p. 78). In order to counter any audist intentions, therapists must engage in self-reflection and understand their motives for wanting to work with deaf clients; they must challenge their values in order to best serve their clients. "The treatment process should move clients from being done *for*, to doing *with*, to doing *independently*" (Zitter, 1996, p. 236). This model ensures that clients are being treated in

an empowering way. Not evaluating your worldviews, especially when they may stem from a phonocentric or audist center, may result in culturally incompetent care.

One last culturally insensitive thing that therapists can do during the therapy session itself is ask deaf clients to engage in tasks that obstruct communication. One example of an act that can blatantly obstruct communication is asking a client to close their eyes and imagine a situation that they have experienced; obviously this would be culturally insensitive because in order to receive instruction, the client needs to have their eyes open to watch the signer (Leigh, Corbett, Gutman, & Morere, 1996). Though this may be a common strategy to use in a session with a hearing client, if a therapist is not consciously thinking of how they need to adjust their methods to fit the needs of their deaf client, time will be spent during the therapy session educating the therapist on why what they are doing is ineffective. Before therapy starts, therapists must examine the materials and methods they intend to use with their clients in order to ensure that they are culturally competent.

*The Deaf Identity Development Scale.* “Using the [Deaf Identity Development Scale], therapists can assess the degree of cultural identity of their clients who are deaf, or they can at least ask relevant questions as guided by the [Deaf Identity Development Scale]. Once the cultural identity of the client is determined, the therapist can provide more culturally affirmative counseling for clients with deaf identity concerns such as self-awareness and degree of comfort with deaf and hearing worlds” (Fischer & McWhirter, 2001, p. 358). This scale is incredibly useful for therapists and researchers alike in determining what exactly participants or clients need in order to have their cultural identity affirmed. The scale shows therapists that all deaf identities are not the same, and that there are “many within-group differences among the deaf population” (Peters, 2007, p. 183). A

culturally sensitive therapist knows the differences between the Deaf Identity Development Scale Identities and understands that they are malleable and not static.

*Conclusion.* Overall, cultural sensitivity is achieved in therapy settings when therapists understand all facets of the culture that the individuals they are treating identify with. In terms of Deaf culture, therapists need to be aware that writing English is not an effective way to communicate thoughts to their clients, and that legal documents written in English may need to be interpreted by an interpreter to be understood fully by the client. Culturally insensitive acts include therapists raising their voices, not examining their existing cultural views, and asking their clients to engage in acts that will obstruct communication. Lastly, the Deaf Identity Development Scale shows therapists that there are multiple deaf identities, and that treatment that may be an appropriate for one client may not be appropriate for another. Culturally sensitive therapists take all of the factors above into consideration when determining the best course of treatment for their client; this ensures that the client will be treated with culturally sensitive techniques.

#### *Lack of Qualified Therapists*

Therapists that work with Deaf communities need to have cultural competence in order to be considered qualified to work with Deaf populations. Without cultural competence, qualified therapists will be unable to provide effective treatment to their clients, which would render them unqualified for that certain job. Therapists that are qualified to work with deaf populations must demonstrate sufficient cultural and linguistic knowledge in order to work effectively with their clients.

The example by Pollard (1996) below gives us insight into what a qualified therapist would do in the treatment of a patient with psychosis:

“Darryl’s illness was not definitively diagnosed until a psychologist specializing in services to deaf people was able to identify how Darryl’s sign language was distorted in ways that parallel how spoken language gets distorted by psychosis. Such knowledge requires both mental health training and sign fluency, a rare commodity among hearing psychologists.” (p. 389)

This example shows that a therapist that works with Deaf individuals needs to have the correct cultural and linguistic knowledge to treat their patients in the most culturally sensitive way possible. Without linguistic knowledge of ASL, diagnosis would have not been possible for this client. Qualified therapists must be fluent in ASL or at least be familiar with the language before being considered as qualified enough to work with deaf populations.

When therapists categorize their clients into either the medical model or cultural model of deafness without taking into consideration the identity of the client, they are not exhibiting cultural competence; being categorized into a model different from what the client identifies with can change the way that individual fundamentally views themselves. Deaf individuals may internalize messages of disability and apply the messages in ways that can lower their self-esteem if the messages are not congruent with their world view. “Some deaf persons internalize [the] negative messages. They develop beliefs that deaf people are “less than” hearing people or that “deaf can’t”. Such a belief system makes it easier to rely upon chemicals, unhealthy behaviors, or unhealthy relationships in an attempt to cope” (Anderson, Glickman, Mistler, & Gonzalez, 2016, p. 29). Categorizing all deaf

individuals and saying that they all identify with the medical model of deafness without consideration as to if they actually do so is harmful; this viewpoint can undermine the positive self-esteem that an individual may receive from their immersion or bicultural identities. A qualified therapist would take the time to ensure that their client's correct cultural identity is affirmed before starting any treatment.

Without considering the model which a deaf individual most identifies with, a therapist could easily categorize a deaf individual into an identity that they do not fit into. Some individuals identify with the linguistic minority construction of deafness and want to learn how to use their cultural voice through the therapeutic alliance (Lane, 1996), while others prefer to view themselves from a culturally hearing standpoint and identify first with the larger American culture. A good portion of deaf individuals enter therapy wanting to work through issues of identity (Lytle & Lewis, 1996). To work with various deaf identities, therapists need to recognize that there is more than one way to relate to one's deafness; one way to relate to deafness is through embracing a disability model, another way to relate to deafness is through the cultural model. For therapists that work with Deaf clients, having an intimate understanding of oppression is necessary to understand why the cultural model is preferred for clients with immersion or bicultural identities (Glickman, 1996b). The model of deafness a client identifies with tells therapists how the client relates to his or her deafness. The different identity models can be used as guidelines for therapists to choose culturally affirming techniques in their sessions.

Overall, the lack of qualified therapists that work with Deaf populations is caused by a lack of understanding of ASL, Deaf culture, or both. Without understanding the implications of how language or culture effects how an individual will view themselves, a

therapist will not be able to assist their client in the way that would best benefit them. Therapists that are both linguistically and culturally qualified are far and few between. Therapists must be linguistically competent in English and ASL to be qualified to work with Deaf populations. Therapists must also not assume that their clients identify with the medical or cultural model of deafness before discussing it with them. Lastly, therapists must recognize that there is more than one way to relate to deafness; If a client relates to their deafness through a culturally affirmative approach rather than a medical one, a therapist must know how to do affirm their client's culture while giving appropriate treatment.

### *Interpreting Problems*

“Interpreting... is not merely transposing from one language to another. It is, rather, throwing a semantic bridge between two different cultures, two different “thought-worlds”” (Gerver, 2013, p. 25). Therapists need to ensure that there is clear communication access, so interpreters are a vital part of the counseling process and are necessary in order to make therapy successful (Lomas & Johnson, 2012). “Certified interpreters are... skilled in assessing the client's communication needs, adjusting communication to suit client preferences, providing translations back and forth between ASL and English, and maintaining confidentiality and professional boundaries” (Leigh, Corbett, Gutman & Morere, 1996, p. 367). Without accurate interpretations, the majority of deaf clients would not be able to benefit from any sort of counseling or therapy.

There are some specific problems that can arise once an interpreter is brought into the therapy setting. Some interpreters may not be qualified to interpret in medical settings,

different types of interpreters may need to be used at different times, and there may be awkwardness in the therapy setting or concerns with confidentiality caused by adding a third person into the intimate setting between client and therapist. These three potential problems are examined in detail below.

*Medical Interpreting Problems.* If there were more D/deaf counselors or therapists, there would be no need for interpreters in counseling settings to work with D/deaf clients. Since most therapists that deaf clients visit are hearing, interpreters are a necessity. When an interpreter is chosen to participate in therapy sessions with the same client and therapist over a prolonged period of care, certain expectations must be met by both the interpreter and the therapist. These expectations need to be discussed in advance, and must be communicated to the client so that if they are not being met, the client can take the appropriate action to resolve the problem.

Interpreters are not trained in mental health care, so they will most likely not know about the different ways that transference and countertransference may happen during therapy; the mental health professional needs to teach the interpreter about what these phenomena are and how to avoid transference and countertransference with the client (Hanks & Hill, 2015). These are phenomena that happen only during a therapy session, so teaching an interpreter what to expect before actually going into the session is beneficial for everyone involved. Teaching the interpreter about necessary techniques before the session starts reserves the time within the session wholly for the client. There is no time taken from the therapy session in order to teach someone involved about how to conduct themselves in this new environment. If improvements can be made, the therapist and interpreter can discuss what changes are necessary for the next session; this can be done

either with the client present or with the therapist and interpreter alone after consent is granted by the client for them to have a private conversation.

When interpreting in medical settings, there is also specialized jargon that the interpreter must be familiar with in order to explain to their client what is happening in the most accurate way. Since a client may not be familiar with the terms used in the therapy setting, it is the interpreter's job to control the pace of the conversation and make sure that the client fully understands what is going on before moving on to the next topic. The interpreter is responsible for making sure that communication breakdowns do not happen, and in order to do this, the interpreter needs to educate themselves on the various medical topics that may be discussed beforehand.

*Different Kinds of Interpreters.* Two different kinds of interpreters that can be used in therapy settings that differ from the traditional interpreter are Video Remote Interpreters (VRI) or Certified Deaf Interpreters (CDI). Their uses and pros and cons are discussed below.

VRIs are interpreters that are not physically present in the setting but are interpreting for two people that are in the same room. The deaf person and the hearing person that need an interpreter will use a laptop or tablet of some sort to call a VRI service. From there, a VRI will appear on the screen and will interpret the conversation that happens between the two individuals. VRIs are used when an actual interpreter cannot be present in the room at the time the interpretation needs to happen. This is not an ideal solution for a therapy setting; when subscribing to a VRI service, you will likely get a different interpreter every time. To ensure confidentiality in a therapy setting, it is ideal to use the same interpreter every time. Using the same interpreter every time also builds trust between the

client, therapist, and interpreter. For those reasons, VRIs are not the ideal choice for therapeutic settings, but they can be used if necessary.

CDIs are deaf individuals that take what a hearing interpreter signs to them and interprets it into either ASL or an emergent language for their deaf client to better understand. In a setting where a CDI is used, a hearing person would start the chain of interpreting by saying their message in English. A hearing interpreter would take the spoken English and interpret it into Signed English for the CDI. The CDI would then take the Signed English and sign the message in the preferred sign language of the deaf client. In one study (Anderson et al., 2016), the use of a CDI greatly enhanced one patient's experience in therapy during her recovery. A CDI is typically not used in interpreting settings because of budgetary constraints, but if a client requests a CDI to be present, that may enhance communication during the therapy process. A CDI may be used in an interpreting process if a client has a culturally marginal identity and has little language skill; in this case the CDI would be interpreting from Signed English to whatever home sign system that the deaf client uses. If a client has an immersion identity and only signs in ASL heavy with classifiers, a CDI may also be necessary to give the client the visual image that they need.

*Confidentiality Concerning A Third Person In The Therapy Session.* Overall, when a third person is used in a therapy setting, confidentiality is something that is considered a major challenge (Hanks & Hill, 2015). When bringing an interpreter into the therapy session, all codes of conduct need to be met by the interpreter and the therapist by their respective governing bodies. Both the RID code of conduct (“NAD RID Code of Professional Conduct,” n.d.) and the APA Code of Conduct (“Ethical Principles of

Psychologists and Code of Conduct,” n.d.) have sections that are dedicated exclusively to rules that ensure client confidentiality. The interpreter and therapist need to be very open with the client about how they intend to proceed with therapy and how they will enhance confidentiality.

With interpreters, dual relationships in the Deaf community may arise. It is the interpreter’s legal job to not discuss information that happens in an interpreting session with anyone. The first tenant of the RID Code of Professional Conduct (“NAD RID Code of Professional Conduct,” n.d.) is to maintain confidentiality. The interpreter must be able to separate their personal from their professional lives to protect the client. Without this, however, the client is in danger of not getting the protection that they are legally entitled to. Building trust in the therapy setting without building what could be considered a friendship is difficult, yet necessary.

*Summary.* Overall, the interpreting relationship is one of the most important aspects of deaf mental health. There is a lack of qualified interpreters that can work in settings such as this because when interpreting in a therapy setting, the interpreter is committing to a long term relationship that is much more demanding and fragile than the normal relationship between interpreter and client. There are nuances of the therapy session itself that the interpreter needs to be trained to handle. The interpreter also needs to go out of their way to learn how to express different medical terms that they may not be familiar with to their client. Using a VRI can change the therapeutic triad by making the relationship less personable; not having person to person contact or repeated contact is not ideal in interpreting relationships. Using a CDI can change the therapeutic triad by adding a fourth person into the room; this may be necessary if a deaf client has emerging language skills

or strong ASL skills that a hearing interpreter would not be able to cater to. Lastly, codes of ethics by both RID and the APA guide interpreters and therapists to act in ethical and confidential ways. Trust needs to be built between client, therapist and interpreter. By being open about concerns, worries about confidentiality can be managed effectively.

### *Conclusion*

There are many different reasons that deaf mental health care has not been as effective or as widespread as it should be. One reason that deaf mental health care resources have not been utilized in the past stem from the stigma that some deaf individuals hold toward receiving medical help. In reference to responses to why there is a low level of utilization of mental health services for Deaf individuals, responses ranged from “perceived or actual lack of accessibility or availability of mental health specialists in deafness, embarrassment or discomfort about acknowledging the need for professional services, and a desire to avoid exposure of mental health problems within the Deaf community.” Even if there is a serious problem that needs to be looked at by a mental health professional, “Deaf clients do not always disclose their problems to deaf friends” (Isenberg, 1996, p. 173). By not talking about their problems to their friends and family, some deaf individuals are living with untreated problems.

There is almost a self-fulfilling prophecy occurring concerning specialized deaf mental health care and not receiving help. Because deaf individuals may not want to notify their friends and family that they need help, mental health services can interpret that as not needing to put resources into specialized services for the deaf community. Because there are no specialized services, deaf people may not let their friends and family know that they

need help because they would not get the caliber of care that they would need. In order to stop this cycle, we need to recognize that Deaf therapists are a necessity, and that we cannot exclude an entire culturally diverse group from mental health care.

“Therapists who can [comfortably] show expertise and sensitivity on... cultural identity concerns, including self-awareness and comfort with their own cultural identity, are well on their way to becoming effective therapists with culturally different people” (Glickman, 1996a, p. 150). As we learn through research on existing treatments, therapists in the future will be more prepared to be culturally sensitive to the needs of various deaf clientele. We examined the lack of qualified therapists, cultural sensitivity, and interpreting problems above; this is to show that though there are current problems in the system, they are not wholly unfixable.

In the last chapter, I will look at what the future of mental health care for D/deaf individuals could look like. Improving culturally sensitive care and broadening service accessibility are two goals that I will examine in detail. I will also look at how resilience training can be used to improve the self-esteem of a deaf person no matter what their deaf cultural identity is.

## CHAPTER FIVE

### The Future of Mental Health Care

#### *An Introduction*

Resilience can be used in therapy settings as an idea to counter some of the culturally insensitive people that Deaf culturists will encounter in their daily lives. Resilience can improve the self-esteem of a person with any kind of Deaf Identity Development Scale identity. I will briefly discuss resilience and how that can affect the self-concept of D/deaf individuals positively. I will also speculate on what the future of mental health care could look like. I will discuss increasing accessibility to care and how to improve cultural sensitivity in therapeutic settings. At the end of the chapter, I will summarize how the medical and cultural models of deafness as well as the various Deaf Identity Development Scale identities could fit into that care to improve the self-esteem of deaf individuals

#### *Resilience*

Resilience “is used to refer to the factors, processes, and mechanisms which, in the face of significant risk/trauma/adversity/stress/disadvantage, nonetheless work to enable an individual... to thrive and be successful” (Young, Green, & Rogers, 2008, p. 42). One main idea in resilience training is the navigation of experience. Engaging in navigation of experience refers to finding “the factors that may enable us to steer successfully through the life course in such a way that experience has a positive effect” (Young et al., 2008,

p. 49) Keeping a focus on the things that you can change in life is a hallmark of resiliency. If someone has a deaf identity where there is a lot of adversity in their life because the hearing population imposes attitudes of disability on to them, resiliency teaches clients to problem solve and reach their goals one step at a time; this can improve self-esteem (Bat-Chava, 1993). Resiliency empowers the patient (Rogers, Muir, & Evenson, 2003) by teaching them that they already have the strengths that will allow them to counter life stressors.

Resiliency can also be thought of as a group phenomenon. According to the social identity theory, “an individual will remain a member of a group if the group has some contribution to make to the positive aspects of his or her social identity (i.e., a positive contribution to self-esteem)” (Bat-Chava, 1994, p. 494). Groups can be resilient by coming together and opposing any group that may oppress them. By doing so, group members can impart knowledge of resiliency to other members of the group in the form of information sharing; this information can make the lives of the other group members easier.

Overall, resilience offers “a positive response to what, for many [deaf individuals], may be experiences of acute and/or sustained adversity, disadvantage, harm and pain” (Young et al., 2008, p. 51). Resilience can offer a sense of hope to Deaf individuals in the face of the difficulties that they may experience living in a world designed for hearing people. Resilience can be thought of as a positive trait that deaf individuals have (Rogers et al., 2003), which can improve the way that one’s self-concept as a deaf individual develops. The following quote, made by a research participant named Brent (Rogers et al., 2003) shows how resilience instilled in an individual can bring an overall a positive outlook to one’s life:

“I want to show the world things, things about Deaf culture, what it looks like. I feel like there is so much inside that I want to express, so much inside of me. I want to make an impression, I want to be successful in that endeavor and to touch different groups of people with it.” (p. 230)

### *The Future of Mental Health Care*

“Mentoring opportunities for students in the fields of medicine, social work, interpreting and rehabilitation counseling are... being developed so that students can be comfortable working with deaf, deafblind, and hard of hearing persons with mental illness and intellectual disabilities early in their training” (Mathos & Pollard, 2016, p. 192). Counseling training programs work on early exposure to cultural sensitivity with their students. An increase in cultural sensitivity during a therapist’s education can improve the quality of therapy they will give their future clients. In the future, we may expect that cultural sensitivity training will become even more specialized.

Increasing awareness in therapists and bringing attention to whether a client identifies with the cultural or medical model of deafness is another way that mental health care can improve in the future to be more culturally sensitive. “Deaf consumers who obtain services from nonspecialized programs (e.g., programs without ASL-fluent staff and familiarity with Deaf culture) face misdiagnosis and inaccessible or limited treatment services” (O’Hearn & Pollard, 2008, p. 401). Having therapists that specialize in deafness in general is a step in the right direction. The next step in creating a more culturally affirmative therapy setting would involve therapists specializing in intentionally treating clients through the medical or cultural models of deafness. Therapists that are Deaf

themselves or have interpreters on standby, that are aware of the cultural differences between Deaf culture and American culture, and know techniques that are effective for visually oriented deaf clients are not found often in today's therapeutic context. In the future, teaching therapists about the cultural model of deafness and contrasting that with the medical model will increase Deaf culture awareness. By increasing the number of qualified therapists, culturally sensitive care for deaf individuals will become the norm; this will have an overall positive effect on the services themselves.

In the far future, mental health care services can strive to cater to the different Deaf Identity Development Scale identities. In practice, this would entail different therapists caring for people of specific deaf identities instead of every person in the general deaf population. For example, a therapist could specialize in treating clients with immersion identities; they may treat a client with a focus on more involvement in their local Deaf community or through encouraging political activism that could benefit all members of Deaf culture. By training therapists to work with specific deaf identities, care can be tailored to the individual, which will ultimately lead to an increased in cultural sensitivity.

Increasing accessibility to services is necessary for the future propagation of deaf mental health care. Currently, accessibility to these services is poor. "Although deaf individuals, whether or not they identify with Deaf culture, have the same needs for social services as the general population, there are relatively few social workers, mental health clinicians, therapists, or social service providers who have been trained to work with clients who are deaf or hard of hearing" (Holte & Dinis, 2001, p. 348). By increasing access to service, you also increase awareness of mental health problems that affect the Deaf community. In the Deaf community currently, mental health care is typically not discussed

between members; this creates a silent stigma against any member that may seek help. With increased accessibility, a sense of normalcy of treatment will follow; this will allow the stigma from discussing mental health problems to decrease. By decreasing stigma, deaf individuals will be more likely to seek out help. With more of the deaf population getting the care that they need, there will need to be an increase in deaf mental health services. This increased demand will force accessibility to improve to satisfy the influx of deaf clientele.

The future of deaf mental health care is predicated on educating therapists early in their training about cultural sensitivity, making sure that therapists treat clients in the client's preferred view of deafness, increasing the specialization of therapists that work with deaf populations, and increasing accessibility to care. The future of deaf mental health care is focused on increased cultural sensitivity, which will affirm the identity of the client and increase their self-esteem and resilience over the course of the therapeutic relationship.

### *Conclusion*

Throughout this paper, I have discussed how the cultural and medical models interact with each other in a variety of contexts. Both of the models have their benefits and drawbacks; however, they are both capable of giving deaf clients what they need in order to develop a positive self-concept. The cultural model of deafness works from an affirmative viewpoint of deafness, which actively disagrees with the fact that deafness is a disability in itself; deafness is seen as disabling only because society makes it that way. The medical model of deafness says that deafness is a disability; the ultimate goal of health professionals with this mindset is "fixing" the problem of deafness.

Developing a healthy self-esteem can be done through the development of a healthy D/deaf identity. I listed the deaf identities and explained how a healthy or unhealthy self-concept can stem from each identity. Individuals with the culturally marginal identity are the most vulnerable to mental health problems because they tend to not have any strong group affiliations. Without ties to any group, self-esteem cannot be built up; a lack of self-esteem can lead to a multitude of health concerns which may require treatment.

The current state of mental health care accessibility for deaf individuals is bleak; the state of health care is improving with updated research methods that work toward a common goal of creating more culturally affirmative techniques to use in therapeutic settings. By using affirmative techniques, the deaf identities discussed before are empowered rather than disenfranchised; empowerment increases self-esteem and can contribute to developing resilience in individuals. The future of mental health care for deaf individuals should focus more on catering to the different deaf identities and making care easier to access overall. The goal of this thesis is to bridge Deaf studies, sociology, and psychology, and to bring much needed awareness to a group of people that has historically been ignored by the larger hearing American culture surrounding it.

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