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## The Lack of Mental Health Professionals and Services for Children Who Are Deaf or Hard of Hearing

Kiley Morgart

Providence College, kmorga08@providence.edu

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THE LACK OF MENTAL HEALTH PROFESSIONALS AND SERVICES FOR  
CHILDREN WHO ARE DEAF OR HARD OF HEARING

A project based upon an independent investigation, submitted  
in partial fulfillment of the requirements for the degree of  
Bachelor of Arts in Social Work.

Kiley Morgart

Providence College  
Providence, Rhode Island

2008

Kiley Morgart  
The Lack of Mental  
Health Professionals  
and Services for  
Children who are  
Deaf or Hard of  
Hearing

### ABSTRACT

Children who are deaf or hard of hearing are vulnerable to abuse and are not receiving proper care at an early age due to their parents' negative reactions towards having a child who has a hearing impairment. The lack of proper care and their vulnerability to abuse puts these children at a high risk of not developing properly. A qualitative study was undertaken using interviews to find services/agencies that provide help to parents of children who are deaf or hard of hearing in Rhode Island. Findings indicate that there is a sufficient amount of service for parents but these parents are not utilizing the services. Implications for social work practice and policy are to broaden social workers' knowledge about the Deaf community and have an understanding, if not fluency, in American Sign Language (ALS), as well as mandating parents to attend ASL courses.

## *Outline*

### I. Introduction

- A. Problems with the mental health services for children who are deaf or hard of hearing.
  - 1. In general, many children between the ages of birth and eighteen need mental health services.
  - 2. Many children are deaf or hard of hearing.
    - a. explanation of deafness
  - 3. Children who are disabled (including hearing impairment) are more vulnerable to be victims of abuse.
  - 4. Lack of professionals who are able to properly communicate with children who are deaf or hard of hearing.
  
- B. A huge deficit in mental health services specifically for children who are deaf or hard of hearing. There is also a lack of information about mental health services for these children.
  - 1. General mental health statistics (children)
  - 2. Deaf statistics
  - 3. Deaf children and abuse statistics
  - 4. Mental health treatments, early intervention and prevention statistics (how lacking)
    - (both national statistics and statistics from Rhode Island)

### II. Main Points

- A. Children who are deaf or hard of hearing are very vulnerable to abuse
  - 1. These children have more difficulty standing up for themselves in an abusive situation
    - a. they might not be able to verbally respond (both to the abuser and for help)
    - b. they are not aware of who to contact for help
    - c. they are not able to communicate with anyone who can help
  - 2. They might not be properly informed about abuse
    - a. they are unaware of the types of abuse
  - 3. They are dependent on others
    - a. the abuser might be the child's primary caregiver
    - b. the abuser might be someone that helps the child with his/her everyday life activities
    - c. only source of attention
  
- B. Negative reactions from parents whose child is deaf or hard of hearing
  - 1. Initially shocked about their child's impairment
    - a. parents are in denial, so therefore the child does not receive early interventions
    - b. parents do not believe their child needs services
  - 2. Continuous lack of proper care

- a. parents might not accommodate to a child's special needs
  - b. parents and children do not communicate properly
    - i. do not know sign language
  - c. parents do not place their children in proper services
- C. The importance of early intervention when it is first discovered that a child is deaf or hard of hearing
- a. types of early interventions
  - b. downfalls of not utilizing the services
  - c. positive outcomes of early interventions
- D. The problem with not having enough professionals who can properly communicate with these children (along with not enough mental health services)
- a. lack of services to train professionals to work with deaf or hard of hearing children
  - b. the overuse of interpreters
  - c. an impersonal relationship between professionals and clients because of the constant use of an interpreter
  - d. these children are not receiving adequate care because of the language barriers
    - i. problems are not being talked about
    - ii. trauma treatment can not be fulfilled
    - iii. corrective measures are not being taken (removal)

### III. Opposing Points

- A. There are several factors that make children vulnerable to abuse
- a. age
  - b. sex
  - c. personality structure
    - i. whether or not parents were abused as children
    - ii. their ability to cope with those issues
  - d. external factors
    - i. family size
    - ii. employment, income and poverty
- B. There are many deaf parents who properly care for their deaf children
- a. proper early communication
  - b. children gain a better understanding of the deaf culture at an early age
  - c. parents are 'identity-models'
  - d. children have a higher self-image
- C. Early intervention programs
- a. lack of programs

- D. There are some mental health services, meanwhile there are many mental health services for children in general and many services for children who are mentally retarded
  - a. inpatient treatment programs
  - b. Rhode Island Commission on the Deaf and Hard of Hearing
  - c. services for children who are mentally retarded
  - d. positive benefits of sign language interpreters

#### IV. Hypothesis

If more services were mandated to parents with deaf children, there would be an increase in proper communication among the family members and therefore a decrease in abuse and mental health problems in deaf children.

#### V. Methodology

- A. Sample: type/how selected/number
- B. Data Gathering: method/tools/variables
- C. Data Analysis: application of statistical procedures to derive meaning from the data gathering tool
- D. Findings: results of statistical procedures

#### VI. Conclusion

- A. A restatement of what the problem is, what you hypothesized, what you found, and a concluding statement.
- B. Implications for social work practice, research and policy.

## *Preface*

Children who are deaf or hard of hearing are vulnerable to abuse and there are times when they do not receive the proper care due to their parents' negative, negligent or even non-existent responses to their diagnosis. Early Intervention Programs are crucial to these children and when parents are in denial about their child's hearing impairment, these services are sometimes never utilized. Considering parents are the primary support system for children, the researcher studied what services are provided in Rhode Island for parents of children who are deaf or hard of hearing, such as learning American Sign Language and to become better equipped to properly care for their child. If there is a sufficient amount of services and ultimately if parents utilize these services, there will be an increase in communication within the family and proper care. There is a sufficient amount of services in Rhode Island for these parents, but they are not always taking full advantage of the resources. There needs to be a better understanding about the deaf population and what services these children and their parents should be utilizing.

## *Introduction*

There are many children in the United States who are being diagnosed with emotional, behavioral or mental health disorders (Armstrong, 1998, p. 120). They are in need of specialized services that can appropriately treat these issues. Some of these disorders include attachment issues, disrupted behavior or Attention Deficit Hyperactivity Disorder and can result from poverty, neglect and abuse or traumatic events ("RI Kids," 2004, p. 52). Many times people are unaware that all of these same issues and more can also occur in the deaf or hard of hearing populations.

People who are deaf could have been born without the ability to hear, could have lost their hearing at a very early age, or even lost it later in life (“NCTSN,” 2006). There are different degrees of deafness. The mild to severe range classifies people as hard of hearing allowing them to use several forms of communication. There are several attributes that can distinguish a child who is hard of hearing; lip reading, residual hearing or hearing aids (Bamford, 2001, p. 971). The profound degree of hearing loss classifies people as deaf, leaving them more likely to communicate through a form of sign language (“NCTSN,” 2006). Prelingual deafness is a profound hearing impairment that occurs before the child has the ability to use verbal language (Campbell, 1997, p. 438). The degree of hearing loss can determine the level of communication used; whether is it just speech and listening or incorporating visual cues (“NCTSN,” 2006). The onset of a person’s hearing loss and whether or not there were early interventions available and effectively used also have an impact on the method of communication that person uses (“NCTSN,” 2006). There are different degrees of hearing loss and results that follow. It is important to have a clear understanding about this hearing impairment and all that it involves.

In general, children who lack communication skills whether it is from deafness, a learning disorder or a language disorder are vulnerable to abuse (Temkin, 1994, p. 402-4). Children who are deaf or hard of hearing have higher abuse rates than children who can hear (Sullivan, Vernon, & Scanlan, 1987, as cited in “NCTSN,” 2006). These children tend have more difficulty standing up to an abuser or getting help. There is also some understanding that children deaf or hard of hearing might not be properly informed about abuse (Temkin, 1994, p. 403). Many deaf or hard of hearing children rely and



depend on other people therefore do not have a sense of self and independent strength to stick up for themselves (Temkin, 1994, p. 403). Lacking a strong sense of self may increase a child's vulnerability to abuse.

Many children are underserved because of the severity of their disorder and because there are no specialized services for their particular needs (Armstrong, 1998, p. 122). Specifically, there is a lack in mental health services specifically for children who are deaf or hard of hearing ("NCTSN," 2006). Nationally, there is a deficit of mental health professionals who know sign language or can properly work with an interpreter and the client (Critchfield, 2002, as cited in "NCTSN," 2006). In hopes of addressing all issues with people with disabilities, included hearing impairment, the Americans with Disabilities Act, ADA, was passed. Title II of this act specifically states that there needs to be proper and effective communication with people who are deaf ("A Guide," 2005). There needs to be more adequate services that are complying with the ADA Title II act in order for this vulnerable population to receive effective treatment when dealing with abuse and neglect.

In 1998 in the United States, approximately twenty percent of children and adolescents combined were diagnosed with an emotional or behavioral disorder (Armstrong, 1998, p. 120). More recently, in 2004, one in every five children between the ages of nine and seventeen were diagnosed with a mental or addictive disorder ("RI Kids," 2004, p. 52). Children with these types of disorders need mental health services, but that does not always occur. In the United States in the early 1980's, there were approximately 3 million children who were diagnosed with an emotional disorder, but only one third of those children were actually receiving services (Armstrong, 1998,

p.120). More specifically in 2003, there were 7,593 children who were treated at the Community Mental Health Centers in Rhode Island (“RI Kids,” 2004, p. 52).

There are about two million Americans who are deaf (National Institute on Deafness and Other Communication Disorders, 2005, as cited in “NCTSN,” 2006). Within the United States, close to 140 of every 1,000 people have some level of hearing impairment (Gallaudet Research Institute, 2005, as cited in “NCTSN,” 2006). Alone there are approximately 90,000 people in the state of Rhode Island who are deaf, deafblind, hard of hearing or late deafened as of 2006 (“Rhode Island,” 2006). Out of this many people, there are many children who are deaf or hard of hearing that are victims of abuse.

There was several research studies conducted in the past twenty years that formulated some statistics about this issue. The National Child Traumatic Stress Network indicated that there were a couple of studies completed in 1987 focusing on children who were deaf. Out of 150 residential school students, half reported being abused (“NCTSN,” 2006). A different study included 100 children who were sexually abused and about half reported that the abuse occurred at school and the remainder reported that it happened either just at home or at both establishments (“NCTSN,” 2006). A more recent study which focused on the prevalence of maltreatment during the childhood of 770 deaf adults found that half of the sample studied reported some sort of abuse; abused by caregiver, by residential staff, sexual abuse, and neglect (“NCTSN,” 2006). These are just a few examples of research indicating the high level of maltreatment towards children who are deaf or hard of hearing.

Considering the risk of maltreatment towards children who are deaf or hard of hearing, mental health services are in high demand. These mental health services will only be effective for children who are deaf or hard of hearing if they provide the appropriate auxiliary aids, including sign-fluent clinicians and trained interpreters (“NCTSN,” p. 7). Roughly only two to fifteen percent of the deaf children in the need of mental health services actually receive them (“NCTSN,” 2006). Since there is an obvious lack of available services, prevention and early interventions can be an important area of focus to help compensate for this lack.

The importance of early intervention for children who are deaf or hard of hearing is when these children are properly cared for immediately; it helps with their linguistic development (Luckner, 2007, p. 54). Being able to properly communicate as these children get older, this could decrease the level of maltreatment because they would be more likely to trust and report the abuse. Increasing family involvement and their understanding of the deaf culture is another type of early intervention. Prevention programs are designed to educate children on the types of abuse but these programs have yet to be used with the deaf population (“NCTSN,” 2006).

The lack of mental health services for children who are deaf or hard of hearing is an issue that needs to be fixed within the social work practice. There are not enough mental health professionals that are able to communicate with children who are deaf or hard of hearing and there are not enough trauma-specific services for them, so therefore these children are not getting any services that are needed.

*Vulnerability to Abuse*

Both physical disabilities and outside forces have a prominent and long lasting affect on the lives of children. Children with disabilities are very vulnerable to abuse. Specifically, children who are deaf or hard of hearing are at a deficit because of their lack of verbal communication (Temkin, 1994, p. 402). Just in the recent years, discussions occurred about children with disabilities and their vulnerability to abuse and the possible idea that these children might be at a higher risk of physical or sexual abuse than children without any physical disability (Temkin, 1994, p. 402). There are several aspects that reflect why a child who is deaf or hard of hearing is more vulnerable to abuse than children without the disability.

Many children who are deaf or hard of hearing have a difficult time standing up for themselves; both to the abuser and in the process of seeking help. Consider that sign language might not be the perpetrator's use of language, so therefore the victim will have a hard time protesting against the abuser (Temkin, 1994, p.402). These children might not know who to turn to or even what to say. It can be hard for these children to explain what happened to them to someone who does not sign (Temkin, 1994, p. 403). These are all aspects that perpetrators look at as beneficial for their victimization.

Many abusive situations might result because of the child's lack of knowledge about what is appropriate and inappropriate. These children might not have had a conversation with an adult about the different types of abuse (Critchfield, 1983, as cited in "NCTSN," 2006). The ability to accidentally overhear a conversation or even to pick up on a protective message, one such as awareness about abuse, throughout a child's school aged years are difficult and close to impossible for a child who is deaf or hard of hearing. It is often overlooked, but many children learn about issues in society through

peers, siblings, friends and even television (“NCTSN,” 2006). It is rather difficult for a child to randomly stumble upon information that will help build their social awareness due to their hearing impairment and possible lack of social skills. Since these children can not benefit from incidental learning, there needs to be a more direct approach to informing the children about abuse and safety precautions that can be taken (“NCTSN,” 2006). This indicates that deaf children need to be informed about certain topics, such as abusive behavior, at an appropriate age before any harmful behavior begins. They need to be educated about issues that would normally be discussed among peers on a daily basis in a school setting. Having an understanding about inappropriate touching and abuse before it occurs might help to lower incidents of abuse.

Being deaf can lead to a life of dependency on others; both on a day-to-day basis and continuing later in life. There are many instances where children who are deaf or hard of hearing are strongly dependent on a parent or another adult figure in his/her daily life. This dependency can be a negative factor when the primary caregiver is abusive. Many of these children’s needs are met by the caregivers; so if there is no one else to turn to for support many times these children are forced to stay in an abusive situation (Temkin, 1994, p. 403). There are situations where these children are abused by people other than primary caregivers. Dependency on adults for everyday life activities subjects these children to a higher vulnerability to abuse than a child who is more independent (Jones, 1999, p. 497). In 2000, 770 deaf adults were surveyed about childhood maltreatment and just about half of the recipients reported some type of abuse. There was a response of 19% who were abused by a caregiver, 30% who were abused by residential staff and 18% who were sexually abused (“NCTSN,” 2006). Another problem behind this

issue of dependency is the lack of self-confidence and self-esteem. Since, children who are deaf or hard of hearing are dependent on others; their self-confidence level might be low. A lack of self-confidence and being dependent on others can affect a child's sense of self worth. Many of these children do not stand up for themselves in abusive situations because of their lack of inner personal strength and their tendency to be dependent (Temkin, 1994, p. 403). Also considering that many of these children might not receive affection on a normal basis from loved ones due to their hearing impairment and surrounding environment, they might accept the abuse as at least some sort of attention (Temkin, 1994, 9. 403). It is important for people to help these children build up their self-esteem; it may help to reduce their vulnerability to abuse.

#### *Negative Reactions from Parents*

Initial reactions from parents of children who are deaf or hard of hearing have an enormous affect on these children. There are several downfalls for deaf children with hearing parents; one of them being the parent's lack of knowledge about the deaf community and sign language. The National Census of the Deaf Population stated that 91.7% of the deaf children in the United States were born to hearing parents (Delk, 1974, p.35). Recently, it was also mentioned that over 90% of deaf children are born to parents that never expected to be parenting a deaf child and have very little understanding about deafness ("NCTSN," 2006). Many parents have a difficult time accepting that their child has a disability and fall into a state of denial; sometimes for years. Denial might not be the only reaction; others include anger, depression and guilt. These feelings also might arise within the parent as the child nears life transitions, such as adolescents or school ("NCTSN," 2006). With the onset of denial from the parents, these children are probably

not receiving proper early interventions and services that are needed for their hearing impairment. Denial from parents whose child is hard of hearing can result differently than denial from parents whose child is deaf. When parents find out that their child is not profoundly deaf and will be able to use residual hearing with the help of services, it sometimes gives the parents the okay to push aside their child's problem of hard of hearing (Harvey, 2003, as cited in "NCTSN," 2006). Interaction might be decent at home, but once a child enters into school he/she is going to become aware of the communication barrier. There are many instances where children hide this issue from peers, teachers and parents because of receiving reinforcements for their ability to function regularly in a classroom. Not being able to properly understand what people are saying and hiding this issue, can be very exhaustive for the child; both physically and mentally ("NCTSN," 2006). This can mentally drain a child and make it hard to formulate or keep relationships with people both at home and in the school setting. Not only would relationships be at risk, but most importantly, the proper development of the child would be at risk as well. Parental denial is a huge problem because it results in children not receiving proper services to help with their development.

The long term care provided from parents is another determining factor for the well-being of the child. One of the most negatively impacting problems is when the family members do not learn sign language; a deaf child's first language (Gannon, 1998, p.290). This is sometimes a message of rejection to the child; parents and other families members will not take time to learn sign language, which would allow full communication to occur. Similar to what was mentioned above, everyday conversations, stories and even important information will not get across to these children. This child

has no common connection with the other members of the family and there will always be a struggle for mutual understanding (Gannon, 1998, p.290). This communication isolation within the family can cause traumatic experiences for these children; feelings of isolation, negative child-parent attachment, and poor psycho-social development. In 1996, adult deaf clients were asked if communication isolation can be traumatic for a deaf child. The overlying response included that since language-based communication within a family is a normal human need; the lack of it is very detrimental and falls outside the range of ordinary human experiences. Also, the lack of communication with family members during developmental years has a severe negative impact on psycho-social development (Harvey, 1996, as cited in "NCTSN," 2006).

This communication barrier between a deaf child and his/her non-signing family can lead the child to formulate a family of choice. This happens often and a substitute family could include residential school peers, friends, other children and adults who are deaf or teachers (Gannon, 1998, p. 290). These people usually fill the role of primary educators and show these children their acceptance of deafness. They give the children the opportunity to be with people who use the same language and help them to feel a sense of connection.

When a child does not have anyone else to associate with, the lack of communication can also add to a child's vulnerability to abuse. Many children and parents become frustrated on a daily basis from the lack of proper interaction. A build up of anger towards a child who is deaf or hard of hearing can place that child at a higher risk of maltreatment; physical or sexual abuse (Sobsey & Doe, 1991, as cited in "NCTSN," 2006). If the child is the only one who knows how to sign; there is no one to



turn to for help. As it was mentioned above, abuse towards children with disabilities can also come from staff members at a residential school. In the same survey mentioned above, 770 deaf adults were asked about maltreatment in relation to family communication and residential schools. It was found that a lower quality of family communication and a normal attendance at a residential school for deaf children does increase the risk of physical and sexual abuse (Embry, 2000, as cited in "NCTSN," 2006). Both a lack in proper communication within the family and an increase in relationships with other possible caretakers can result in abuse for children who are deaf. There are parents who are not sign-fluent and therefore can not communication with their deaf child. Since, this can be very detrimental to a child it indicates the importance of providing services for parents to learn sign language. This could possibly become mandated for all parents who have a deaf or hard of hearing child.

### *Early Intervention*

Once it is established that a child is deaf or hard of hearing, initial approaches need to be taken. Early intervention programs are important to the development of the child and the forming of relationships with other people. Early diagnosis and early intervention programs help to formulate and support positive attachment bonds between the child and the parents (Marshark, 1993, as cited in "NCTSN," 2006). There are several aspects that go into an effective early intervention program; one of the key factors is family involvement. There was a study completed in 2000 that looked at the relationship between age of enrollment in intervention and language outcomes of five year old children who were deaf or hard of hearing (Moeller, 2000, p. 1). The overlying outcome

proved that the best combination for deaf or hard of hearing child is high levels of family involvement and early enrollment into the intervention services.

There are several aspects within effective early intervention services. Once there is any sign of hearing impairment, the child should be referred to an audiologist (Steinberg, 1991, p. 386). Audiological evaluations are taken to signify the actual level hearing impairment and psychological evaluations are completed to measure nonverbal intelligence and development (Moeller, 2000, p. 3). There are auditory/oral programs and a total communication program, both which were developed for the improvement of language for deaf and hard of hearing children. Total communication is a teaching method where the parents incorporate both speaking and signing (Candlish, 1996, p. 136). Children can also have the chance to work with speech pathologists and their vocabulary skills are tested by the Peabody Picture Vocabulary Test, which is also commonly used in measuring vocabulary in English (Moeller, 2000, p.3). Considering family involvement is very important to early interventions, there are also family-centered programs for parents whose children are deaf or hard of hearing. These programs were established to help parents identify their child's needs and make the appropriate decision about interventions. They are pre-early intervention programs and help point parents in the right direction and towards which services would be the best for their child's needs (Moeller, 2000, p.3). There are several early intervention programs in the United States. Early Intervention Program for Infants and Toddlers with Disabilities was established in 1986 with a purpose to provide multidisciplinary and coordinated services. Another is Head Start which was established in 1965 to provide services to children with developmental delays from low-income families ("Future," 1996). These

are two programs that run throughout the states. Specifically, there are five regional Early Intervention programs in Rhode Island serving children from birth to three (“RI Kids,” 1998, p. 68).

There are many positive outcomes to receiving these services. Early intervention programs, including those in Rhode Island, are designed to provide an assessment and an evaluation of the child’s development and possible problems. These programs also include medical and social work services as well as psychological and speech/language therapy (“RI Kids,” 1998, p. 68). Receiving the proper services can increase the level of language, psychological and social development that will be attainable. Enrollment into early intervention programs does not always occur. Even though early interventions start when the child is very young, without these services the child might not develop the ability to sign at the appropriate age, develop attainable vocabulary skills and social skills; all of which are important to a developing child. The early years of a child’s life are very important and impressionable, even for a child who is deaf or hard of hearing. These early intervention programs are beneficial and help these children get off to the right start.

#### *Lack of Mental Health Services*

Even though there are services for children who are deaf or hard of hearing, there is lack of a sufficient amount in today’s society. Specifically, there is a nationwide shortage of mental health services and professionals who can work with children who are deaf or hard of hearing. Considering the high risk of maltreatment and abuse towards these children, mental health services are in high demand. It would be ideal to provide these children with specialized interventions programs with sign-fluent clinicians

("NCTSN," p. 7). Within this shortage, there is also a deficit of trauma-specific mental health services and fluent sign language interpreters. Roughly only two to fifteen percent of deaf children in need of mental health services actually receive them ("NCTSN," 2006). There is not a lot of professional material circulating throughout the social work field about the lack of mental health services for children who are deaf or hard of hearing and suffering from maltreatment. That is one of the biggest problems; this issue needs to be addressed because it is a growing problem.

Working with deaf clients could be very challenging for mental health professionals. It could be difficult forming that client-clinician connection when each person has a different first language (Steinberg, 1991, p. 380) Relying on lipreading as their form of communication, will probably not be very effective. In a conversation through lipreading, only about 40% of spoken language is comprehensible (Steinberg, 1991, p. 381). This is a strong example of why there needs to be specific mental health professionals that have been trained to work with children who are deaf or hard of hearing.

There have been some alternative models developed that clinicians can follow. Consultation-liaison model allows nonspecific clinicians to provide trauma-specific therapy to children who are deaf or hard of hearing. One of the main focuses of this consultation model is for the clinicians to be culturally competent of the deaf culture while providing treatment services ("NCTSN," 2006). Cultural consultation includes an assessment of the social and culture factors that could have an influencing affect on the type of treatment chosen. Taking a client's cultural background and social history into consideration is important for a clinician to do before starting to work with the client, and

there should be nothing different about this approach when it involves a child who is part of the deaf community. Another important initial approach is establishing a communication strategy that will provide the best therapeutic relationship possible (Steinberg, 1991, p. 382). There have been small strides towards adjusting mental health professionals to be able to work with children who are deaf or hard of hearing, but nothing that stands out and has really escalated.

Sign language interpreters are used in mental health services regularly and give the client-clinician relationships a chance to uphold. There are both good and bad aspects about interpreters. First of all, considering the lack of mental health professionals who are sign-fluent, interpretation is the only effective way to connect the clinician and the client (“NCTSN,” 2006). Initially, there should be time where the client and interpreter can interact and get to know each other. There is a very high chance that the child is already nervous about attending therapy. This gives the client time to develop trust in the interpreter and the interpreter can pick up on the client’s needs (“NCTSN,” 2006). The use of interpretation is also highly recommended in family therapy sessions. In order for the interpretation portion of the therapy sessions not to interfere with the work being done, the same interpreter should be present at every session.

There are also some downfalls to relying on interpretation for mental health services. There is a chance that the presence of an interpreter will affect the dyadic client-clinician relationship and could therefore alter the results of therapy (Steinberg, 1991, p. 383). A clinician’s goal is to build rapport with his/her client, but considering the client’s direct communication is with the interpreter, there is a high chance that the client will build rapport with the interpreter and not the clinician (“NCTSN,” 2006). Without the

proper relationship established, it is likely that the treatment might not be as affective. Confidentiality is also an issue to consider when an interpreter is present. The client might be reluctant to reveal certain information in fear that the interpreter will talk about it elsewhere and there is also the possibility that the clinician does not feel safe that the interpreter will keep the information confidential (Steinberg, 1991, p. 382). Also, having a family member or friend as the interpreter is neither effective nor appropriate. There are the possibilities that the person would become emotionally involved, not be able to keep information confidential, not know mental health interpretation skills and could very likely be a reason why this child has to see a therapist. With the abuse rates high for children who are deaf or hard of hearing and the majority of the perpetrators being primary caregivers, having a family member be the only interpreter would not be in the best interest for the child (“NCTSN,” 2006). There are instances where clients only feel comfortable one on one with just a clinician, but with the language barrier it forces an interpreter to be present. It may very likely negatively affect the treatment the client receives.

Even though there are interpreters to help make a connection between mental health professionals and clients, there needs to be a more direct approach. There are problems that are not being talked about, trauma-specific treatment that is not being fulfilled and corrective measures, such as removal from an abusive home, which are not being taken because of the lack of services and professionals. Children who have been sexually or physically abused need trauma-specific treatment and not having the professionals to work with their mental health issues strictly because of a language

barrier is unacceptable. It is very important for the client-clinician relationship to develop in order to help the child at the highest level possible.

### *Vulnerability to Abuse*

There are several factors besides physical disabilities, including hearing impairments that leave children vulnerable to abuse. Outside forces become stressors for families, which can lead to an abusive atmosphere. In the United States, the National Committee for the Prevention of Child Abuse (NCPCA) produces an Annual Fifty-State Survey and in 1993 there were approximately 2,984,000 reports of child maltreatment (Lewit, 1994, p. 236). Child maltreatment includes physical, sexual and emotional abuse. There are characteristics for both the abuser and the abused that seem to be primary indicators that lead to this inappropriate treatment.

Incidents of child abuse can be instigated by age and sex. Even though children of all ages are vulnerable to abuse, most of the time the youngest child in a family is the primary target (Hankerson, 1979, p. 401). This is highly due to their inability to protect themselves and report the maltreatment. Younger children also suffer from more severe injuries (Wall, 1975, p. 222). In the late 1970's, a study was conducted about the sex distribution of those abused. At an earlier age, boys were more likely to be abused than girls and they also suffered more fatal injuries (Gill, 1968, as cited in Hankerson, 1979). Once children neared the time of puberty, girls were more likely to be abused. These statistics and facts about children's vulnerability to abuse confirm that there are several indicators besides a hearing disability that may be the cause of child abuse.

Considering the personality structure of the abuser can also explain about other instigators of abuse. Whether or not parents were abused when they were children and if

they had meaningful and healthy relationships can affect if they will abuse their children. Parents who are unable to properly cope with past experiences from their childhood will have difficulty formulating a healthy relationship with their children (Hankerson, 1979, p. 402). This difficulty will ultimately put children in unsafe circumstances and lead to maltreatment.

Beyond internal factors, there are several external factors that leave children vulnerable to abuse. Having a large family can add stress to the overall atmosphere and induce the likelihood of abuse. Children in families who have five or more people residing are more likely to be abused (Hankerson, 1979, p. 402). Parents with an insufficient support system, such as relatives to help care for the children or even other forms of child care, become overwhelmed and this can lead to abuse as well as keep it consistent (Hankerson, 1979, p. 399). Employment and income are two important external factors in relation to vulnerability to abuse. Unemployment and dissatisfying job are two factors that occur outside the home, but they could hinder the family atmosphere at home (Hankerson, 1979, p. 399). Unemployment as well as a low income can result in financial stressors for a family. In 1974, 2,000 families were surveyed about child abuse and the majority of them reported to having a family income of less than 6,000 dollars per year (Hankerson, 1979, p. 401). When there is stress between parents and the surrounding environment, it is more likely for children to be vulnerable to abuse. As seen from this information, outside forces such as family size and financial income play a big role in a child's vulnerability to abuse in addition to a child's physical disability.

Poverty does not necessarily determine whether or not children are abused, considering abusive parents are from all socioeconomic levels (Hankerson, 1979, p. 400).



Although, there can be an understanding between child abuse and severity of economic deprivation. In 1981, welfare recipients were surveyed and more than one-third of the families who were in the most deprived material circumstances were severely abusing their children, while only one-tenth of those in less deprived material circumstances were severely abusing their children (Horowitz and Wolock, 1981, as cited in Dornfeld, 1994).

These are all factors that hinder a family on a daily basis; which make children more vulnerable to abuse than those in families with less stress inducing circumstances. There are many other children in today's society besides those who are deaf or hard of hearing that are being abused. Children with physical disabilities are just a small portion of all the children in abusive situations. It is important to know that abuse is occurring throughout all types of children. There are many factors in today's society that may leave children very vulnerable to abuse. It needs to be known that abuse is occurring everywhere and there needs to be more awareness about the issue and preventions.

### *Parenting*

Many deaf or hard of hearing children are parented by deaf adults. While many hearing parents who have a deaf child have negative reactions towards the situation and do not properly care for the child, there are also many deaf parents who welcome their child into a loving and nurturing environment. In the 1960s and 1970, there was a mass research study conducted which found that deaf children with deaf parents are at an advantage to deaf children with hearing parents on a few several occasions; social-emotional adjustment and academic achievement ("NCTSN," 2006). Many deaf children

of deaf parents do not suffer from early communication isolation and have a richer environment to start the learning process of effective communication (“NCTSN,” 2006).

Considering deaf parents have a solid understanding of the potential problems that are associated with being deaf, their children will be properly informed at the appropriate times. Deaf parents help these children accept and fully understand their own membership in this specific subgroup of the human population (Meadow, 1969, p. 432). Deaf parents become ‘identity-models’ for their children; they resemble the child’s own identity in the deaf community (Meadow, 1969, p. 430). It gives them a sense of security that somebody else understands what they are going through on a daily basis. There are not as many feelings of isolation and there is a higher possibility of a positive child-parent attachment.

The availability of other people in the deaf community is a beneficial factor for children who are deaf or hard of hearing. It raises their self-esteem and self-confidence throughout early adolescence. Deaf children and their demonstration of self-image were evaluated in relation to whether or not their parents were hearing or deaf. It was found that children with deaf parents have a higher positive self-image than children with hearing parents (Meadow, 1969, p. 434). Along with bettering a child’s self-image and understanding of the deaf community, deaf parents also help their children begin to sign and become socially adjusted.

There is a factor that may indicate that deaf parents might not properly care for their children. Considering that children who are deaf or hard of hearing are more vulnerable to abuse than their hearing peers, is it more likely that deaf parents were abused when they were children than their hearing peers. It depends on the extent to

which they dealt with those issues as a child and growing up, whether or not they will be more likely to become abuser as well (“NCTSN,” 2006). Even though this is a strong possibility, considering deaf children’s vulnerability to abuse, having a deaf parent is beneficial and an important factor throughout the child’s growth. Many deaf parents are strong support systems for their deaf children, but many hearing parents are not properly educated to care for their deaf children at the appropriate level. This indicates that there needs to be services to better educate hearing parents about the proper ways to care for their deaf children and truly connect with them.

### *Early Intervention*

There are early intervention programs for children who are deaf or hard of hearing, there is just not a sufficient amount. The basic purpose of early intervention programs are to provide children from birth to four years old with educational preparation; language, parent-child communication and social skills (“NCTSN,” 2006). In order for these children to properly develop, early interventions need to be provided immediately. Considering the lack of services for children who are deaf or hard of hearing, early intervention programs would be a positive attribute, but there are still not enough children receiving those services. Even though there are some services and early intervention programs to help deaf children, there are still many children that are not receiving these services because their parents have not entered them into the programs. This indicates that hearing parents are not well educated about the services that their deaf children are in need of, as well as, just an overall shortage of services for these children.

### *Mental Health Services and the Use of Interpreters*

There are some mental health services in today's society that provide children who are deaf or hard of hearing with care. The main focus of these services needs to be client-centered and strength-based in order to produce the most effective results ("NCTSN," 2006). There are several mental health providers for the hearing impairment in inpatient treatment programs. Many times parents have to send their children to these treatment programs because there is a shortage of these services (Steinberg, 1991, p. 384). At inpatient treatment programs there are professionals who are sign-fluent and can properly care for these children. Specifically in Rhode Island, The Rhode Island Commission on the Deaf and Hard of Hearing (RI CDHH) advocates and provides services for these children. They provide affordable and equal opportunities, lobby for favorable legislation and educate consumers and agencies about the Americans with Disabilities Act ("Rhode Island," 2006). Specifically, the RI CDHH has a mental health committee, comprised of professional clinicians, consumers, service providers and advocates, who collaborate in search of how to improve the mental health services ("Rhode Island," 2006). There is awareness throughout Rhode Island and strong devotion towards bettering the mental health system for children who are deaf or hard of hearing.

In comparison to the lack of overall mental health services for deaf or hard of hearing children, in the past twenty years there has been progress towards catering to the financial needs of mental health services for children in general (Armstrong, 1998, p. 121). While the betterment of mental health services in general is being taken into consideration, services for deaf children are barely being lifted off the ground ("NCTSN," 2006). In relation to services for children who are deaf, services for children who are mentally retarded seem to be prospering. Medical help, nursing care, help with

daily activities and help with development and education are all services that children who are mentally retarded receive on a daily basis (Haveman, 1997, p. 419). These children also receive dieticians, speech therapists and in-home respite care (Haveman, 1997, p. 422). Even though these services are not specifically mental health related, just the vast amount of resources for children who are mentally retarded are overwhelming compared to the mental health services for children who are deaf or hard of hearing.

In comparison to the downfalls of always using a sign language interpreter, there are beneficial factors of their use in the mental health system. Considering there is a lack of sign-fluent mental health professionals, interpreters are the only solution for proper communication (“NCTSN,” 2006). In 1988, approximately 100 deaf students were studied to find a relationship between disability status of a counselor, whether hearing or deaf, and communication method, sign language, interpreter or written, with a counselor (Dowd, 1988, p. 258). There was no significant difference in the results in relation to if the students were willing to see the counselor who used an interpreter versus the counselor who used sign language (Dowd, 1988, p. 261). When a counselor or a mental health professional is not sign-fluent, interpreters must always be present in order for the service to reach its highest potential. It is important to understand the role of interpreters and their effectiveness due to the lack of sign-fluent mental health professionals.

### *Hypothesis*

Many deaf children are not receiving adequate mental health services when they are in need of them. In some cases, parents are in denial about their children’s hearing disability and refrain from entering them into early intervention programs and other services. There are also many parents who have not learned to sign and therefore can not

properly communicate with their deaf child. Due to this lack of communication, many deaf children are being abused and there is nowhere for them to receive adequate mental health services since there are not enough sign-fluent mental health clinicians in this field. Many deaf parents can properly care for their deaf children, but for those deaf children with hearing parents there needs to be a better support system and an abundance of services to help both the children and their parents.

If more services were provided and mandated to parents with deaf children, there would be an increase in proper communication among the family members and therefore a decrease in abuse and mental health problems in deaf children. Parental services, such as sign-language education and a thorough overview of the special needs of deaf children, could ultimately result in fewer cases of abuse due to proper communication in the home.

### *Methodology*

#### *Sample*

A convenience sample was used in this study; which indicates that the chosen sample selected by the researcher, were the most feasible and available participants. This sample was found through numerous internet and telephone book searches. There were a total of fifteen participants in this sample, but not all provided helpful information. Some of the participants included female secretaries from Rhode Island College, Providence College, Salve-Regina University, and Rhode Island School for the Deaf. Other participants included a female audiologist from the Women and Infants Hospital of Rhode Island, a female program manager from the Commission on the Deaf and Hard of Hearing, a female program coordinator for the Family Guidance Program & Early Childhood Program and a male American Sign Language Program Director. Two more

participants were a clinical director for Perspectives Corporation (deaf and hard of hearing services) and a female general staff worker from the Early Intervention Program at Meeting Street.

Out of the fifteen participants within the sample, five were not providing of helpful information. The secretaries at the executive office of Health and Human Services, the Department of Human Services, the Department of Children Youth and Families, which is the backbone of children protective services in Rhode Island, and Hasbro Hospital, were not able to provide information regarding services for parents of children who are deaf or hard of hearing. Hasbro did refer the researcher to Women & Infants Hospital of Rhode Island, which was ultimately informative.

### *Data Gathering*

In order to gather the information, the researcher first identified and found services and agencies in Rhode Island that work with children who are deaf or hard of hearing and/or their parents. This occurred through several internet and telephone book searches and once services and agencies were identified, the researcher contacted a total of fifteen that seemed highly possible to be informative. The sampling tool that was used was open ended questions, asked either through a telephone interview or in person. There were a couple instruments used; depending on what service or agency was being called, different questions were asked. The instrument consisted of the following questions: what services are being provided for parents with children who are deaf or hard of hearing? Are these services being utilized by parents? What is the cost and accessibility of these services? How are these services advertised to parents?

There were a total of ten participants with valuable information; nine interviews were conducted over the telephone and one was in person. The purpose of these interviews was to gather information about what services in Rhode Island are available to those parents who have children who are deaf or hard of hearing, this was the independent variable in the study. With more services and accessibility to parents, the researcher was predicting that ultimately, there would be an increase in communication between children who are deaf or hard of hearing and their parents, which could then lead to a decrease in abuse; the dependent variable. Following the interviews, data was compiled for analysis. Below is a chart listing all the services or agencies contacted and whether or not there was information provided pertinent to this study.

<b>CONTACTED</b>	<b>WHETHER OR NOT PROVIDED INFORMATION</b>
Executive Office of Health & Human Services	<b>No</b> , referred researcher to Dept of Human Services
Department of Human Services	<b>No</b>
Department of Children Youth and Families	<b>No</b>
Hasbro Hospital	<b>No</b> , referred researcher to RI Women & Infants Hospital
Women & Infants Hospital of Rhode Island	<b>Yes</b>
Rhode Island College (RIC)	<b>Yes</b>
Salve-Regina University	<b>Yes</b>
Providence College	<b>Yes</b>
Rhode Island School for the Deaf and Hard of Hearing	Initial contact – <b>No</b> Following contact – <b>Yes</b>
American Sign Language Program Director (through RI School for the Deaf)	<b>Yes</b>
Family Guidance Program & Early Childhood Program (through RI School for the Deaf)	<b>Yes</b>
Commission on the Deaf and Hard of Hearing	<b>Yes</b>
Perspectives Corporation	<b>Yes</b>
Goodwill Industries of Rhode Island	<b>No</b> , only works with deaf adults



Meeting Street (Early Intervention)	Yes
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### *Data Analysis*

Once the data was gathered, the researcher processed the qualitative data and organized the findings into a chart below. The researcher was able to contact fifteen services/agencies in Rhode Island regarding this study. Out of the ten services/agencies that were responsive (an interview was held), only 8 informed the researcher that their services do support parents who have children who are deaf or hard of hearing. The data was organized according to what service/agency was contacted: hospitals, colleges or universities, and all other general service providers/agencies available for parents of deaf or hard of hearing children. Considering the researcher obviously asked the appropriate questions depending on which service/agency during the data gathering, the findings were also grouped accordingly. Once the findings were organized, the researcher extracted meaning from this qualitative data and analyzed if there seems to be a sufficient amount of services to help education parents on how to better care for their deaf or hard of hearing child. Also, from the data that was gathering, the researcher was able to analyze if parents are utilizing these services to appropriate measures.

Before the successful data findings, the researcher had a difficult time finding departments or services who knew the answers to the questions above. The Department of Children, Youth and Family, the Department of Human Services, and the Rhode Island School for the Deaf and Hard of Hearing did not give the researcher any concrete information; only referrals to other services. Considering some of these basic human service providers in Rhode Island were not able to provide helpful information, the

researcher took these findings and analyzed that it might be difficult for parents in this state to find the help that they need.

<b>CONTACTED</b>	<b>SERVICES THAT ARE PROVIDED</b>
<b>Hospitals</b>	
Women & Infants Hospital of Rhode Island	<ul style="list-style-type: none"> <li>- newborn hearing testing</li> <li>- on-going check ups</li> <li>- refer parents to Early Intervention and/or Family Guidance Program</li> </ul>
<b>Colleges or Universities</b>	
Salve-Regina University	<ul style="list-style-type: none"> <li>- full semester of an American Sign Language course</li> <li>- open to the public</li> <li>- does cost money</li> </ul>
<b>Other service providers/agencies</b>	
Rhode Island School for the Deaf and Hard of Hearing	<ul style="list-style-type: none"> <li>- schooling for children who are deaf or hard of hearing (general information about the school)</li> </ul>
American Sign Language Program Director (through RI School for the Deaf)	<ul style="list-style-type: none"> <li>- ASL courses free for parents of deaf and hard of hearing children</li> <li>- reaches out for encourage parents to come</li> <li>- provides parents with transportation and day care</li> <li>- very accessible</li> </ul>
Family Guidance Program & Early Childhood Program (through RI School for the Deaf)	<ul style="list-style-type: none"> <li>- hearing center/testing</li> <li>- providing children with hearing aids</li> <li>- collaborate with Early Intervention</li> <li>- home visits</li> <li>- provides guidance for children and parents</li> <li>- very accessible</li> </ul>
Commission on the Deaf and Hard of Hearing	<ul style="list-style-type: none"> <li>- guidance for parents and children to other services</li> <li>- pamphlets for services in RI</li> <li>- library of books and videos about deafness</li> <li>- Rhode Island Resource Guide for Families of Children who are Deaf of Hard of Hearing</li> <li>- very accessible</li> </ul>
Perspectives Corporation	<ul style="list-style-type: none"> <li>- ASL courses free for parents of deaf and hard of hearing children</li> <li>- work with children from 3-21 and their parents</li> <li>- home based therapeutic services</li> <li>- works with clients and family members to develop personalized plans</li> <li>- reassess status of child every six months</li> </ul>
Meeting Street (Early Intervention)	<ul style="list-style-type: none"> <li>- parent education (ASL)</li> <li>- children 0-3</li> <li>- home visits</li> <li>- very accessible</li> </ul>

*Findings*

Throughout the process of gathering information from the participants, the researcher had a difficult time with a few of the initial contacts. Some of the main human service departments of the state were not able to give information stating that they help children who are deaf or hard of hearing and their parents or even who else the researcher could contact to gather appropriate information. From these occurrences, the researcher was able to pinpoint that there is not an abundance of services in Rhode Island for these children and their parents. Considering the secretary of the Department of Human Services was unable to give specifics about services for these parents, it is highly likely that it is very difficult for parents of deaf children to find help in Rhode Island.

Despite the difficulty and the lack of information from certain departments, the researcher was able to contact a doctor, secretaries, program managers, program directors, and a clinical director all of whom had beneficial information about the services for parents and deaf or hard of hearing children. The researcher interviewed Dr. Chung, an audiologist from Women & Infants Hospital of Rhode Island, over the telephone. She first discussed the initial hearing test that is conducted with newborns and that if there are signs of hard of hearing or deafness, there are on-going check-ups. She refers parents an Early Intervention Program, such as Meeting Street, and/or Family Guidance Program, a non profit agency. When asked if her patients' parents are following her recommendations, she responded, "Many parents do not follow our suggestions and recommendations. These parents should embrace their child's diagnosis, but many do not." Dr. Chung also explained that how the parents find out about the hearing impairment, might determine how parents/families handle the child's diagnosis.

This was something that caught the researcher's attention. It was not an initially researched reason why parents were not involved in helping their children who is deaf or hard of hearing, but it could be a determining factor whether or not children receive proper services when they are diagnosed.

Out of the two colleges and the one university that were contacted, only one provides an American Sign Language workshop open to the public. The researcher interviewed the registrar office's secretary at Salve-Regina University and she provided general information regarding the workshop and its costs. The university does offer a full time course, but only to its students. These workshops are their only link to the public and American Sign Language. As for its accessibility to parents who are deaf or hard of hearing, it is not free and they do not specifically advertise to these parents. The only way that parents would be able to find out about these workshops, would be to call. Providence College and Rhode Island College both do not provide American Sign Language courses or workshops. Both secretaries that were interview by the researcher explained that there have been courses in past years, but recently there has not been enough people signed up for them to move forward with the course or workshop.

The actual interview with the secretary from the Rhode Island School for the Deaf and Hard of Hearing was not too informative. She just referred the researcher to the school's website and encouraged to send emails. When the researcher asked about any services provided for the parents, she explained that it is mostly just schooling and some sport activities for the children. She was unable to provide what the school has to offer parents of the children who attend. In response to this interview, the researcher went to the school's website and found two programs that do provide services for the parents.

The researcher conducted a telephone interview with Manny Martin, the American Sign Language (ASL) Program Director. This ASL course/program is what he called “a friend of Rhode Island School for the Deaf and Hard of Hearing,” not actually part of the school. This program offers free general ASL courses for parents of children who attend RI School for the Deaf and Hard of Hearing as well as all parents in RI who have a child who is deaf or hard of hearing. Manny was able to provide specifically how many people attended his courses the first three years they were offered. The first year, fourteen people signed up for the course and only 6 finished. Many of those people abused the course; did not attend all the classes and repeatedly showed up late. The second year, 4 people signed up and only 2 finished. The third year, no one signed up for the course. Manny stated, “Parents will not come to these general courses. They do not want to. They feel uncomfortable that their child uses another language.” In the past he has offered parents transportation and day care in order to help relieve them of stressors of why they could not attend the courses; parents still did not come. Within the past two years, he has sent out 240 letters to parents, grandparents, and relatives of deaf children to advertise the ASL course and try to encourage them to attend. The current course is open to everyone and there is only one parent and two grandparents who are attending. This program is in the RI community; it is very accessible to these parents and it is free. This finding strongly puts emphasis not the fact that there are some services for these parents; they are just not utilizing them to their fullest capacity, if not at all.

The program coordinator from the Family Guidance Program was able to contribute helpful information. This program has a hearing center to test all children and is collaborated with Early Intervention programs, which means that they work with

children ages 0-3. Members of the Family Guidance Program go on home visits to help the children with language development as well as work with the parents. The main focus of this program is to get children hearing aids and to help the parents get acquainted. There are currently twenty families in this program. The program coordinator explained that when it comes to hearing aids, parents are very willing to learn and help their child, but they have seen parents who are not as interested in learning American Sign Language. This finding concluded that there is another program that has experienced parents who are not very willing to learn ASL in order to properly communicate with their child. This program is accessible to parents through the Rhode Island School for the Deaf and Hard of Hearing website. Dr. Chung (from Women & Infants Hospital) also refers all of her patient's parents to this program.

The only in-person interview that the researcher conducted was with Pamela Zellner, the program manager and the active referral specialist of the Rhode Island Commission on the Deaf and Hard of Hearing. Pamela is deaf, so the researcher's interview with her also occurred with Melissa, a free lance interpreter. This department and its three employees is the main center of all the services and agencies that work with the Deaf population. The RI Commission on the Deaf and Hard of Hearing provides many pamphlets, such as Hearing Loss Association of RI, Rhode Island Registry of Interpreters for the Deaf, Early Intervention, Audiology Department at Women & Infants, etc. There is a library of books and videos about hearing impairment and many other topics associated with it for people to borrow. Two examples of the types of books that are offered include, *Language Learning Practices with Deaf Children* and *Kid-Friendly Parenting with Deaf and Hard of Hearing Children*. The Commission is ideal for parents

of children who are deaf or hard of hearing to contact; they point the parents in the right direction. Pamela provided the researcher with the Rhode Island Resource Guide for Families of Children who are Deaf or Hard of Hearing. This guide was published in 2006 and includes topics such as: learning that your child is deaf or hard of hearing, methods of communication, getting an early start with learning, risk factors for hearing loss, deaf culture, etc. This guide is accessible to parents throughout the state; they are available at the RI Women and Infants Hospital, RI School for the Deaf and Hard of Hearing, RI Hearing Center, and the RI Association of the Deaf. Interviewing Pamela and having access to all the resources at the RI Commission office was very important in regards to this study.

Jim Simon, the clinical director of Perspectives Corporation was another informative participant. The Perspectives Corporation offers a free American Sign Language course for parents and it is also open to the public. Besides the ASL course, this corporation also provides home based therapeutic services for both the child and the parents. They work with children ages 3-21 and the parents to develop a personalized plan for the child and the family. The plan is renewed every 6 months and the majority of the clients are receiving their services up to a year and a half. For example, a plan for the next 6 months could consist of the parents and the child to learn sign language and to help the child to learn how to act in a social setting. Parents need to follow through with the plans or their case could be terminated. Jim explained, "There are some parents who are not active and do not care. These parents have a hard time following out with their set goals. If parents can not follow the treatment plan, their case can be terminated." There are currently twelve families at Perspectives Corporation and one third of them have not

taken an ASL course. When asked, Jim explained a few reasons why parents might not be involved; family stressors or being a single parent with other children. Something else that he mentioned that was very shocking was that he has worked with parent who were very wealthy that were not involved with their child's care but there has been poor people who were very involved. Perspectives Corporation is a home based service where the workers go to the home to help these families develop goals and reach them. Pamphlets for this service are at the RI Commission on the Deaf and Hard of Hearing and considering that it is a home based service, besides the ASL course, it is very accessible to the parents in RI.

The researcher was able to get just a brief overview about the Early Intervention Program at Meeting Street. The Early Intervention Program is similar to Perspectives Corporation, but they only work with children ages 0-3 and their parents. Once these children have aged out of the Early Intervention Program they are eligible to attend Perspectives Corporation. The Early Intervention Program also focuses on parent education (about hearing loss) and teaches them ASL. Once there is an initial call to the program, the workers make a home visit to assess the family and their specific needs. The telephone interview was short and that was all the information that was provided to the researcher.

As for the general findings, the researcher gathered information regarding that there are services for parents of deaf or hard of hearing children in Rhode Island. Interviews were conducted with program managers, clinical directors, doctors, etc. The researcher was able to see written excerpts about these services as well as hear about them straight from people specialized at those services; which led the researcher to



believe in the face value of the findings. There is always a possibility that any of the participants who the researcher interviewed were new or in-experienced employees or provided inadequate information, so there is a chance that the findings may not be truly valid.

Even though there are services, there is not an abundance of these services and they are not advertised very well throughout the state, considering it took the researcher some time to find appropriate participants. Initially there were services and departments that would not be able to provide information. This made the researcher strongly believe that it might be difficult for parents to find the correct service that is needed, which ultimately could result in children not receiving proper care at crucial times in their lives. The overall shocking finding was that the majority of the services in Rhode Island are not being utilized by the parents in need. Even though there are services being provided to help the deaf population, hearing parents are not always taking full advantage.

### *Conclusion*

There is a lack of services for children who are deaf or hard of hearing as well as services for their parents. Specifically, there are services in Rhode Island but only a limited amount. Also, of those services that are provided for parents in Rhode Island, they are not being fully utilized. Opportunities for parents to take American Sign Language courses and to be fully educated about what it takes to raise a child with a hearing impairment are available in Rhode Island; they are just highly under enrolled. The researcher hypothesized that if more services were provided and mandated to parents with deaf children, there would be an efficient initial planning of the child's future care and

there would be an increase in proper communication among the family members. With this increase in proper communication, there would ultimately be a decrease in abuse and mental health problems in deaf children.

The researcher found that even though there is not an extensive amount of services for parents of children who are deaf or hard of hearing in Rhode Island, there is a sufficient amount of services that are providing beneficial and crucial help to those parents and children. The other finding that was mentioned by many participants was that parents are not utilizing these services. Many parents are not learning American Sign Language and many are not being active in their child's development. Whether parents are not taking the offered free ASL courses because they are single parents with other children at home or they feel uncomfortable that their child uses another language, parents are still not enrolling in these courses. This lack of proper communication is ultimately leading to the children's vulnerability to abuse. These children learn sign language as their first language and when parents are not willing to accommodate to their child's hearing impairment and learn his/her language, this causes problems for the child. These services are here to help parents become better equipped to care for their child; they need to be used.

In regards to the deaf population, social work practice could become better prepared if master social workers had a strong understand, if not fluency in, sign language. Sign language courses could possibly become mandated in the master's program. Another implication for social work practice is having social workers specialize in working with parents who are having a difficult time accepting their child's hearing

impairment. Workshops and trainings could prepare these social workers with specific ideas to help those parents.

An area that would be important to social work research would be why parents decide not to accept their child's hearing impairment, why they choose not to learn sign language, and why they choose not to be active in their child's development. Another beneficial area to social work research would be studying whether or not other family stressors, that are occurring while a child is diagnosed with a hearing impairment, affect how the family handles the situation. During the interview with Dr. Chung, from Women & Infants, she mentioned that other current family stressors affect how the parents handle accepting that their child has a hearing loss. Further research about the impact family stressors have on how parents react to their child's diagnosis could help social workers gain a better understanding about why parents react the way that they do and how to help them accept their child as deaf or hard of hearing.

An implication for social work policy would be the write up of a bill mandating parents to take sign language courses and to learn their child's language. Right now there are courses that are being provided, but parents are not following through. These children are living in homes where they are unable to communicate with their families. If parents and other family members are not stepping up to make a difference, the state must formulate a bill to be passed. Many children who are deaf or hard of hearing are not receiving the proper care from their parents. Social workers can make a difference. Pushing new policy issues, finding new areas of research, and ultimately acting on these problems through social work practice will help children who are deaf or hard of hearing receive the needed services, both from their parents and from service providers.

## Appendix A:

### Open Ended Interview Questions

- 1.) What does your program/agency provide for parents of children of deaf or hard of hearing?
- 2.) How many families are you currently working with?
- 3.) Where do you refer parents to for additional services?
- 4.) Is your program over or under enrolled?
- 5.) How accessible is your program to these parents?
- 6.) Are the parents active in your program?
- 7.) What is the reasoning that parents give about being disengaged in your program?

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