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Deaf Children, Self-Esteem, and Parents' Communication Patterns

Lynn Marie Bloom
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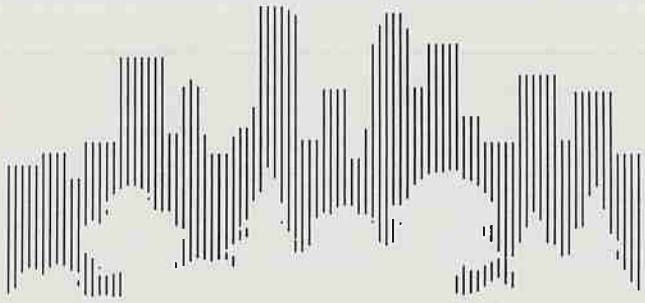

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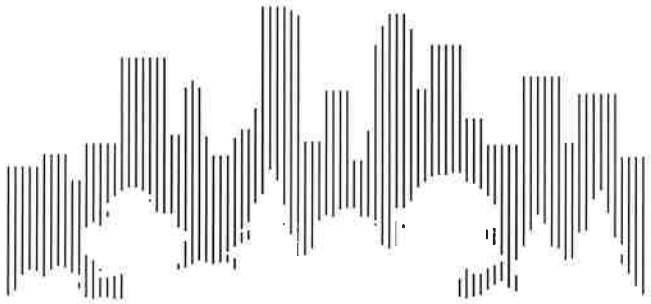

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Submitted in partial fulfillment of
the requirement for the degree of
Master of Social Work

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

1999

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of: Lynn M. Bloom

Deaf Children, Self-Esteem, and Parents' Communication Patterns

has been approved by the Examining Committee for the thesis requirement for the Master of Social Work Degree.

Date of Oral Presentation: Thursday, July 29, 1999

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Thesis Reader Marian Hausladen

Words from a mother to her deaf child

The river of time has reached the sea
the sun has turned crimson in its setting
the leaves have bronzed that once were green.

As I look back into my yesterdays
when all your life was spring
and mine had summered into fall

When I return to your dormant years
to the struggling hours of your silence
within your world that was all glass

Oh, to forget those memories of rejection
of your deafness, of your difference
a need for a mirror of my hearing world

You who desperately yearned for my love
for me to accept and to come into your world
for my hands to talk to you, for my sign

Across the years I've learned the beauty
of your difference, the joy and wonder
of your being your own unique self

I beg of each deaf child of this world
and of all worlds translucent in their silence
Dear child I love, please forgive my guilt.

-- Merv Garretson

DEDICATION

To my family

and

Deaf children

I use speech in situations where it is helpful, but this is entirely a matter of free choice. My entire education was taken in a residential environment, from elementary school through college, where sign language was the dominant language used in and out of the classroom. In fact, I learned American Sign Language before I learned English...What is important to success is not how people communicate but the extent to which they are willing to apply themselves in pursuit of their life's goal.

Robert R. Davila,
Former Deputy Secretary, U.S. Department of Education,
Deaf Life (July 1995)

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To my parents, Milton and Jeanne Bloom, I give my heartfelt gratitude for their courage and effort in raising a Deaf daughter, myself. Thank you for doing your best for me, and for giving me the opportunity to discover my own potential.

To my friends, Liz, Sara, and Jenko, your cheer and wonderful support kept me going on my "BIG" paper through this very long, trying process. Just by being there, you helped me attain this goal. Thank you! I look forward to all our tomorrows!

Abstract

Deaf Children, Self-Esteem and Parents' Communication Patterns

Methodology: Quantitative

Lynn Marie Bloom

August 1999

The purpose of this study was to analyze the responses from high school students who are Deaf or Hard-of-Hearing regarding self-esteem, and communication methods used in the family. The quantitative design examines how the parents' communication methods affect the Deaf child's level of self-esteem. Several studies have reported there is a relationship between the family's communication method and the deaf child's level of self-esteem. Parents whose sign language skills were more proficient had children whose self-esteem scores were higher than those of parents who were less skilled in sign language. Also, parents have an important part to play in preparing their children not only to adapt to the mainstream culture but also to fit into the Deaf culture and to move back and forth between the two cultures. Due to the small number of participants, the findings of this study indicating a deaf adolescent's self-esteem may be influenced by the parents' communication method were not significant. The implications for social work practice are parents' communication methods have some level of impact on the deaf child's self-esteem and parents are influential in shaping their deaf child's self-esteem.

Table of Contents

Chapter I

INTRODUCTION

The *Dictionary of American Sign Language,* published in 1965 by Bill Stokoe, Carl Croneberg, and Dorothy Casterline, was unique for at least two reasons. First, it offered a new description of Sign Language based on linguistic principles. Second, it devoted a section to the description of the "social" and "cultural" characteristics of Deaf[1] people who use American Sign Language (ASL).

It is unique to describe Deaf people as constituting a "cultural group" because professionals in sciences and education of deaf people typically describe deaf people in terms of their pathological condition: hearing loss. "...The fact remains that Deaf people form groups in which the members do not experience 'deficiencies' and in which the basic needs of the individual members are met, as in any other culture of human beings" (Padden, 1980, p. 90).

Deaf people, far from groaning under a heavy yoke, are not handicapped at all. Deafness is not a disability. Instead, many deaf people now proclaim, they are a subculture like any other. They are simply a linguistic minority and are no more in need of a cure for their condition than are Haitians or Hispanics (Dolnick, 1993, p. 37). Roslyn Rosen, the president of National Association of the Deaf (NAD) in 1991, is Deaf, the daughter of Deaf parents, and the mother of Deaf children. "I am happy with who I am," she says through an interpreter, "and I do not want to be

[1] The term D/deaf will be used to denote individuals who are members of one or the other of two groups. Use of the upper case "Deaf" indicates a member of the Deaf Community, individuals who share a culture and a language: American Sign Language (ASL). The lower case "deaf" indicates a person who has an audiological condition: a hearing loss of any degree (Padden & Humpries, 1988).

'fixed.'" Pride, heritage, identity, and similar words are thick in the air (Dolnick, 1993, p. 38).

National Center for Health Statistics (NCHS) of the U.S. Department of Heath and Human Services (1990-1991) reported that the Deaf and Hard-of-Hearing population is approximately 20 million persons, or 8.6 percent of the total U.S. population 3 years and older have hearing problems. Gallaudet University (Center for Assessment and Demographic Studies) reported in 1992-93 that the cause of deafness by heredity is 13% and the other known causes followed by pregnancy/birth complications (including Rh incompatibility, prematurity, and birth trauma at 8.7%. Meningitis, at 8.1%, is the leading known cause of hearing impairment occurring after birth.

"Ninety percent of all deaf children are born to hearing parents. Many people never meet a deaf person unless one is born to them. Then parents and child belong to different cultures, as they would in an adoption across racial lines" (Dolnick, 1993, p. 38). Deaf children acquire a sense of cultural identity from their peers rather than their parents. But the crucial issue is that hearing parent and deaf child do not share a means of communication. Deaf children cannot grasp their parents' spoken language, and hearing parents are unlikely to know sign language. Communication is not a gift automatically bestowed in infancy but an acquisition gained only by laborious effort (Dolnick, 1993).

Deaf children of Deaf parents learn ASL as easily as hearing children learn a spoken language. "...Deaf children 'babble' (manually) before producing their first words in signed language. Some studies indicate that the acquisition of ASL may be

faster than that of spoken language. Several studies find that the first sign tends to appear in a Deaf child's language two to three months earlier than a hearing child's first spoken word, (other studies do not confirm this, however)" (Lane, Hoffmeister, & Bahan, 1996, p. 45). "In the case, babies' vocal and manual babbling appear to have important social roles for hearing and Deaf parents, respectively, and lead to conversations that contribute to social and cognitive development as well as language learning" (Marschark, 1997, p. 105). Marschark (1997) said that in any case, babies' vocal and manual babbling appear to have important social roles for hearing and Deaf parents, respectively, and lead to conversations that contribute to social and cognitive development as well as language learning.

At the heart of the idea that deafness is cultural, in fact, is the Deaf community's proprietary pride in ASL. Children are born into families. Families are members of communities. Communities make up societies. A society's way of life is a culture. The culture is large and is communicated through language - ASL (Baker & Battison, 1980).

Statement of the problem

It has been known for more than 100 years that a child's emotional life strongly influences his/her interpersonal relations, behavior, and learning. Recent research underscores the importance of the early childhood years as a critically important period for the development of future mental health and self-esteem. Children with a healthy sense of self-esteem feel that the important adults in their lives love them, accept them, and would go out of their way to ensure their safety and well-being. Low self-esteem (feeling unwanted, unloved, and unaccepted) can

often lead to learning disabilities, disciplinary problems, and depression later in life (National Association for the Education of Young Children, 1998).

As our nation becomes more linguistically and culturally diverse and as the issue of bilingual education becomes more politically charged, early childhood educators have a responsibility to understand how best to meet children's needs and how to provide effective early childhood education for *all* children. Communication is the vehicle for intellectual development, exchanging information, sharing feelings, and developing strong emotional bonds. A parent or family member who chats encouragingly with a child about many of the things he or she is doing, thinking and feeling enhances the child's language development, and helps him build confidence in his or her independence (National Association for the Education of Young Children, 1996).

Research described in a recent article examined the effect that family communication patterns have on the self-esteem of a deaf child (Desselle, 1992, p. 322). Having experience in such a setting, the researcher dealt with deaf students in a public school. In most cases, the parents of the subjects did not know sign language, and very little communication between hearing parents and their deaf children took place (Desselle, 1992, p. 322). If a deaf child is labeled uncooperative, a cycle of failure is initiated, with negative consequences for the child's self-esteem. It is important to have an early bond with a child, whether deaf or hearing and the bond is necessary for positive feelings of self. When the parents are frustrated because they cannot communicate with the child, the child internalizes the frustration. The deafness itself does not directly cause poor self-esteem; rather, the degree to which

one is able to communicate may be a contributing factor in the development of self-esteem (Schlesinger & Meadow, 1972).

The problem that arises for D/deaf children born into hearing families is that deafness is looked upon as a defect or pathological. The way parents react toward their D/deaf child affects their self-esteem. If parents make every effort to communicate through all available means, such as sign language, fingerspelling, and getting amplification equipment for the child, then his or her self-esteem could be positively influenced.

Significance and Purpose of the Study

Children's sense of self-esteem is developed by many factors, one of the most important being acceptance of those around them. The purpose of this study was to examine the effects that family communication patterns have on the self-esteem of a deaf child. Deaf students in a suburban high school were given a questionnaire to complete. This researcher examined the communication method(s) used at home, in school, and with friends.

Research Questions

This study was designed to address the following questions regarding the ways in which a deaf child's self-esteem is affected by the parents' communication patterns:

1) In what ways do parents and other adults communicate with D/deaf adolescents?
2) Is there a relationship between the family's communication method and the D/deaf child's level of self-esteem?

Summary

The ability to communicate within an environment is an advantage only if the environment contains information worth absorbing. In the case of the D/deaf child of hearing parents, the young person emerges into adolescence with his or her adolescent crisis relatively unresolved (Schlesinger & Meadow, 1972). The unresolved identity crises of adolescence do not just go away during young adulthood. One important aspect of communication competence involves learning to use language for a variety of functions, describing events, promising, and making jokes.

The research questions explore the concept of self-esteem itself, and examined how D/deaf children are affected by the parents' communication patterns. The social work research should suggest strategies to help hearing parents of deaf children focus on issues such as educating about various aspects of their child's deafness, and how their acceptance of their child affects his or her self-esteem.

Chapter II

LITERATURE REVIEW

Overview

There are five modes of communication most widely used by deaf people in this country. In alphabetical order they are: American Sign Language, Auditory-Verbal, Cued Speech, Manually Coded English, and Oral. Each mode is defined in terms most commonly used by those who advocate for it (Oticon, Inc., 1998).

American Sign Language. ASL is a visual/gestural language used by many members of the Deaf community in the United States and Canada. It is estimated to be the third or fourth most commonly used language in the U.S. Although it is a language that utilizes the visual/gestural medium, it is not merely gesture or mime: one cannot understand it until one learns it. For those who wish to learn it as a second language, it takes many years of study and interaction with people who use it (Humphries, Padden, & O'Rourke, 1994).

ASL is a language in its own right. It is not derived from English. ASL has it own grammar and syntax (patterns of arrangement or words and phrases to make sentences) which are distinct from those of English. Other important aspects of ASL are the use of appropriate facial expressions and body movement. ASL is most often used in families where the parents are deaf and their native language is ASL. When the young deaf child is fluent in ASL, he or she may then be taught English as a second language so as to facilitate literacy. English may be taught via fingerspelling and/or written format or, by a native speaker of English, via Cued Speech.

If hearing parents wish to learn ASL for use with their deaf child as a primary or secondary language, classes may be available through their public school special education association, a local college, or a community service organization. It is significant that frequent and prolonged exposure is required in order for language fluency to develop.

Auditory-Verbal. The auditory-verbal philosophy is that it is the right of children with all degrees of hearing loss to have the option of developing their abilities to listen and communicate using spoken language while growing up in the regular living and learning environments of their communities. Following auditory-verbal principles helps children who are deaf or hard-of-hearing learn to use their amplified residual hearing and/or a cochlear implant to listen, to process verbal language, and to speak. The child is promptly fitted with appropriate amplification, making use of the most advanced technology.

The auditory-verbal approach utilizes diagnostic therapy to continually assess the child's progress over time in each of the above developmental areas. Support services are also provided to facilitate his or her educational and social inclusion in regular education classes. It is similar to the oral approach. Key differences are that with the auditory-verbal method, speechreading is not emphasized. The goal of the auditory (oral) methods is to teach children how to use their residual hearing – often enhanced with hearing aids or cochlear implants – so they can develop spoken language. There is also great emphasis on speech and speechreading. The ultimate educational goal is to place the child in a mainstream school environment. Auditory/oral training not only stresses auditory training but also trains a child to use

lipreading and contextual clues to receive information. Children who have this training tend to pick up sign as a second language. Auditory/verbal (AV) training only trains children to use their residual hearing.

Cued Speech. It is a visual communication system which, in American English, uses eight handshapes – representing consonant sounds – in four different locations near the mouth – representing vowel sounds. Consonants are "cued" in the appropriate vowel locations allowing the cues to be synchronized with what is actually being spoken – syllable by syllable. Literacy is the original and primary goal of Cued Speech. It allows the child who is deaf to "see-hear" the English language as it is spoken and to pick it up naturally, in essentially the same way as a child who is hearing. Most hearing parents can learn the system in a week or two and can become quite proficient in a few months of use.

It is a visual picture of the speech sounds and sound patterns that are used in the English language or any of the other fifty languages and dialects for which cuing has been adapted. Dr. Orin Cornett invented cued speech in 1966 at Gallaudet University. This system uses eight hand shapes in four locations near the mouth to eliminate the ambiguity of lipreading. The system is used in combination with traditional auditory methods.

Manually Coded English. It is a group of systems, developed for educational purposes that use signs, fingerspelling, or gestures separately or in combinations to represent English manually.

Oral. It combines the use of speech, residual hearing, and speechreading as the primary means of communication for persons who are deaf. The oral

communication approach is based on the premise that most children actually have functional residual hearing, and that the speech signal is redundant, so that not every sound must be heard in order to understand a message. For oral language learning to be successful with children who are deaf or hard-of-hearing, the hearing loss must be identified at an early age, preferably through infant hearing screening procedures before the infant is discharged from the hospital. Almost all auditory oral approaches today rely heavily on the training of residual hearing.

When parents first find out their child is deaf, they receive much conflicting advice from doctors, teachers, and other professionals about which communication method to use. Parents must ultimately be the ones to choose and choose quickly how to communicate and how the child will communicate with the rest of the world. ASL, Auditory-Verbal, Cued Speech, Manually Coded English and Oral are options. When hearing parents discover that a child is deaf, they face an abrupt change in their lives. It is a challenge that requires understandings of themselves as parents and of what it is to be human (Higgins & Nash, 1987).

In history, several philosophies emerged that emphasized the return of sign language. The new philosophies and approaches were not grounded so much in empirical foundations, but rather were based on assumptions regarding language development and the accessibility of language input (Coryell & Holcomb, 1997). The several hundred-year history of education of deaf students is marked by controversy concerning the appropriate means for educating deaf children. Should deaf children be educated through oral means that include speech, speechreading, and auditory training – or should sign language be the primary method? (Higgins &

Nash, 1987). Within the United States in the past 100 years, sign language has not been universally used in educational programs for deaf students. Sign language was primarily used in state residential schools for deaf students, particularly with older students, many of whom had not been successful with the oral method when they were younger. Only since approximately 1970 has there been a growing emphasis on the use of sign language within a classroom and that emphasis on what is often called total communication (Higgins & Nash, 1987).

Few communities have and long as tragic a history of language oppression, however, as deaf communities. Let us trace the history briefly and see where it has led us today. Many centuries went by before the world even recognized manual languages. At the dawn of deaf education in the seventeenth century, its founder in the speaking world, Jan Conrad Amman, writes, "The breath of life resides in the voice. The voice is the interpreter of our hearts and expresses its affections and desires...The voice is a living animation of that spirit that god breathed into man when he created him a living soul." (Lane, 1984). Because signers did not use their voice, "What stupidity we find in most of these unfortunate deaf," Amman wrote; "how little they differ from animals" (Lane, 1984). Civilization waited until the middle of the French Enlightenment before education of deaf children was undertaken using the language of the deaf. The founder of this education, the Abbe de l'Epee, and his successor, the Abbe Sicard, thought their pupils' manual language to be without grammar or method. Said Abbe Sicard: "we all know the kinds of sentences in use among the Negro tribes; well those used by the deaf and dumb are even closer to nature, even more primitive" (Lane, 1984). All but the Americans

voted for a resolution exalting the dominant oral language and disbarring the sign language. Teachers who used sign language were forced into retirement so that sign language could be totally banished from the schools. The signing community protested. At the Convention of American Instructors of the Deaf (CAID) in 1890, a decade after the Congress of Milan J. Schuyler Long, author of the first pronouncing dictionary of American Sign Language, published in 1908 said "the people who prevent sign language being used in education of the deaf... are denying the deaf their free mental growth through natural expression of their ideas, and are in the same class of criminals" (Lane, 1984).

Parents' Communication Methods

Exposure to a rich signing environment during the early years of life may alleviate the language delays previously expected for deaf children with hearing parents. A number of reports have indicated that deaf children acquire signs relatively rapidly when their parents learn signs and use them frequently (Champie, 1981; Howell, 1984; Schlesinger & Meadow, 1972). But, Hearing parents' expressive use of signs is often limited. Lederberg, Binz, McIntyre, and McNorton (1989) reported that the majority of hearing mothers in their studies whose deaf children were participating in programs incorporating manual communication signed infrequently to the children. Bornstein (1990) reported that hearing fathers of deaf children in manual communication programs tended to learn signs to the beginner level only. Given the relationship suggested between hearing infants' acquisition of language and the quantity of language produced by their parents (Huttenlocher, Haight, Bryk, Seltzer, & Lyons, 1991; Tomasello, Mannle, & Kruger, 1986), D/deaf

children whose parents use a limited amount of signing can be expected to face severe barriers in acquiring language. Parents must decide about modes of communication, that is, which version of signing, speech and lipreading, or a combination of manual and verbal skills they will learn and use with their child (Nash & Nash, 1981). It is not an easy decision and must weigh the options that fit the Deaf child in the best way.

What happens to this dynamic if the child is D/deaf? If a deaf child has deaf parents, signed language develops similar to the way spoken language does in hearing families. For a D/deaf child with hearing parents, however, communication may be severely limited or nonexistent. Lack of linguistic stimulations leads to language deficits, seriously stunting the child's language development (Germain, 1991; Schlesinger & Meadow, 1972).

Without the ability to communicate, bonds between parents and child are weakened, adding to the strain created by the stigma of having a handicapped child in the family. The child has no linguistic outlet for the expression of needs, thoughts and feelings, and so begins to act out behaviorally in order to communicate (Portner, 1981; Schlesinger & Meadow). The capacity to communicate with family members gives a child a sense of competence in his environment; the feeling that he is able to influence the social systems in which he participates, which fosters a sense of self-esteem (Germain, 1991).

Family Atmosphere

The family atmosphere into which a deaf child is born has a lot to do with the child's self-esteem. Deaf children are vulnerable to the reactions of significant others

concerning their deafness. If the whole family participates in communicating with the child, then the child will feel like an accepted member of the family. A Deaf child born to Deaf parents may feel much more accepted because the deafness is not foreign to the parents. Deaf parents, on the other hand, are less likely to see their child's hearing impairment as a personal tragedy, and thus the family integration is less likely to be threatened as a result of the hearing loss (Schlesinger & Meadow, 1972).

Hearing parents can influence the deaf child's self-esteem by communicating acceptance to the child, done by treating the deafness as a family issue rather than as a deficiency in the child (Schlesinger & Meadow, 1972). On the other hand, the goals the hearing parents initially set for their perfect infant must now be compared with the emerging reality of their imperfect child's limitations. The inability to communicate easily can lead to family tension and, at times, dysfunction. The child with a disability may potentially be drawn into marital discord or playing the role of scapegoat.

"Therefore, in addition, deaf children are often at a disadvantage in being able to communicate with parents about more complicated feelings. Increased knowledge about factors that are important for the development of simple and complex emotion concepts would be valuable to parents, teachers, and professionals who are interested in the mental health of these children" (Cantor, 1996, p. 3-4).

Deaf parents are likely to have close rapport with their Deaf child, fluent communication, high expectations, and a well-founded positive outlook because they share the same language and culture. On the other hand, fearful and frustrated

hearing parents may not be able to communicate substantively with their deaf child, who, in turn, is frustrated and tantrum prone (Lane, Hoffmeister, & Bahan, 1996). So, the roots of the problem cannot be the deaf child. Rather it must lie with the parents. It lies indeed with the hearing parents' inability to expose their deaf child to a natural language without taking special measures.

Family climate has also been linked with deaf children's self-image (Meadow, 1969); self-image and family climate scores were higher among deaf children of deaf parents than were those of hearing parents. Self-image and family climate scores were also significantly related, although deaf children of hearing parents rated high in family climate were more likely to demonstrate a better self-image if they were also doing well in school (Cantor, 1996). Since many Deaf child are born to hearing parents, the Deaf child will experience social isolation and as well as language delays. If the parents show acceptance towards the Deaf child, then the Deaf child will have a better self-image. Also, if the influence of parental sign language is stronger at younger ages, and that Deaf children's sign language skills eventually surpass that of their parents.

Cantor (1996) reported that deaf children often experience language delays as well as communication difficulties with family members who do not adequately sign. The degree to which the family consistently and competently uses sign language was expected to be predicted by the level of parental acceptance of the child's deafness. Parents who are still grieving the handicap or hoping that the child will eventually hear would be less likely to learn sign language, since learning requires a lot of time,

patience, and persistence. In contrast, it was expected that parents who demonstrated greater acceptance would have better sign language skills.

Deaf Culture

What is a Deaf community? More precisely, who are the members of a Deaf community and what are the identifying characteristics of such a community? There are ninety-four different definitions of "community" proposed by various researchers who have studied communities of people. One definition of community on the other hand, is a general social system in which groups of people live together, share common goals, and carry out certain responsibilities to each other. A person's beliefs and actions are mainly influenced by his/her *culture*, but his/her work and many social activities are carried out within his/her *community*.

Each deaf community in the United States is uniquely affected by its location. For example, the identity of the Washington, D.C. community is undeniably influenced by the political and educational institutions in Washington, D.C. The Los Angeles deaf community is shaped by the fact that it is located in one of the largest urban areas in the United States. A great number of deaf people are employed in this area which make up a very large and powerful community.

There are many different deaf communities across the United States, but there is a single American Deaf culture. A primary goal of the national Deaf community is to achieve public acceptance of deaf people as equals. An equally important goal is the acceptance and recognition of their history and their use of signing as a means of communication. Deaf people do not live in isolation within the larger world peopled by those who hear.

Therefore, a hearing loss is not a sufficient condition for membership in Deaf communities (Higgins, 1980; Padden, 1980). However, neither is an extremely profound impairment a necessary condition for membership (Furfey & Harte, 1964, Higgins, 1980; 1968; Schein, 1968). Membership is achieved through identification with the Deaf world. Members of the Deaf community associate with one another through friendships, formal organizations such as churches, clubs, social activities, publications, and other means.

Members of the Deaf community share cultural beliefs and values. Within the Deaf community, there is equality of empowerment not always realized when deaf and hearing interact (Kanapell, 1989; Lane, 1992). "Many deaf people believe that having to learn to lipread and wear hearing aids forces them to participate in life as defective hearing people" (Desselle & Pearlmutter, 1997, p. 24). ASL (American Sign Language) is a symbol for many Deaf people of their identification with their Deaf community and culture (Dolnick, 1993, p. 40).

Self-Esteem

Most parents want their children to have a healthy sense of self-esteem. Schools around the country include self-esteem among their goals. Many observers believe that low self-esteem lies at the bottom of many problems in our society.

Parents and other adults who are important to children play a major role in laying a solid foundation for a child's development. When parents and teachers of young children talk about the need for good self-esteem, they usually mean that children should have "good feelings" about themselves. Children with a healthy sense of self-esteem feel that the important adults in their lives accept them, care

about them, and would go out of their way to ensure that they are safe and well. During their early years, children's self-esteem is based largely on their perceptions of how important adults in their lives judge them (National Association for the Education of Young Children, 1998).

Self-esteem is also related to children's feelings of belonging to a group and being able to adequately function in their group. There seems to be an innate drive that pulls deaf adolescents toward each other. They need to be with each other in order to mature as teenagers. As a result of increased social opportunities, some deaf students describe forming a stronger identity and learning independence and assertiveness. In the comfort with other bright deaf teenagers, their confidence grows. On a lesser scale, low self-esteem adversely affects an individual's perception of self as being competent and negatively impacts one's ability to enjoy a happy, creative, satisfying life, which includes the capacity to cope with life's difficulties and disappointments (Branden, 1994; London, 1997). When a Deaf child can do more then he/she can accomplish more and be satisfied with his/her life as a Deaf person regardless of obstacles.

"When children share common characteristics and attitudes with others, when they are part of a group, their self-esteem grows. A variety of studies have examined the self-esteem of Deaf children and identified factors that promote or hinder its development. Most generally, it is now well documented that Deaf and hearing children do not differ, overall, in their self-esteem, a finding that holds from age three all the way through college" (Marschark, 1997, p.172).

Deaf children, youths, and adults tend to use ASL for socialization outside the classroom while refraining from using ASL as students attempt to use English inside the classroom (Mason & Ewoldt, 1994). Outside the classroom, students discuss a limitless range of topics and issues. Students should also have opportunities to explore, investigate and/or deliberate on them as part of their in-school curriculum, in their own language. Deaf children are often in the unusual situation of having teachers and/or peers who communicate with them more easily than their own family (Cantor, 1996, p. 3). Research has connected communication ease and classroom experiences (Long, Stinson & Braeges, 1991), employment (Johnson, 1993), parental factors (Desselle & Pearlmutter, 1997), and language (Luey, Glass & Elliot, 1995) as either directly or peripherally related to low self-esteem in this population. Long term adverse consequences of low self-esteem in D/deaf individuals mimic the results of the studies with groups of women; social and emotional difficulties, depression, and a history of being under or unemployed (Cates, 1991; Schroeder, 1983; Watt & David, 1991; Williams, 1990).

The communication barriers experienced by a deaf child will surface first in the family. The communication barriers experienced by deaf and hard-of-hearing children surface next in their classrooms. Perceived effectiveness of communication and its relation to academic success was studied by Long, Stinson and Braeges (1991) who found that students who felt they were effective communicators felt more positive about the communication event and were more likely to learn. Those students who thought they understood the communication interactions between themselves and their peers and teachers, felt a greater sense of control over the

outcome of their learning process and showed a high level of engagement in the classroom (Long, Stinson & Braeges, 1991). The study determined these perceptions were a good predictor of academic success for deaf students and also concludes with a suggestion that the ease with which a deaf student communicates and its relation to self-esteem and motivation needs to be researched more fully, perhaps by comparing students in both mainstream and residential settings (Long, Stinson & Braeges, 1991).

The link between communication frustration and a negative self-concept experienced by deaf adolescents has been borne out in research on language acquisition and self-esteem done by Long, Stinson and Braeges (1990). Negative self-concept, prevalent among deaf individuals (Cates, 1986), may be a factor in the tendency of deaf adolescents to display a higher incidence of academic, behavioral, and emotional problems, including problems with depression and boredom (Greenberg, 1980; Watts & David, 1991).

Research on self-esteem in deaf and hard-of-hearing (hearing impaired) adolescents is not conclusive. Although Yachnick's (1986) study showed a higher self-esteem rating in deaf adolescents with deaf parents than deaf adolescents with hearing parents, the conclusion warned against interpreting the results to mean that deaf adolescents of hearing parents have low self-esteem.

"Despite the existing research, there is a scarcity of information on how to work effectively with deaf and hard-of-hearing people" (Holte, 1998, p. 3). Although these people have the same needs for social services as the general population, there are 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 (Portner, 1981; Luey, Glass & Elliot, 1995). The capacity of school counselors and teachers to adequately develop educational programs and community supports for deaf and hard-of-hearing youths was impaired by their inability to fully understand life as a deaf person (Freeburg, Sendelbaugh & Bullis, 1991).

According to Schlesinger (1978), hearing parents can influence the deaf child's self-esteem by communicating acceptance to the child. This can be done by treating the deafness as a family issue, rather than as a deficiency in the child. If the whole family participates in communication with the child, by whatever means – whether sign language, fingerspelling, lipreading, or any combination – the child will feel like an accepted member of the family (Schlesinger & Meadow, 1972). Familial influences on self-esteem as it relates to communication was studied by Knight and Bon (1984). The results showed that poorer communication with parents was related to a lower sense of self-esteem in adolescents. The parent-child relationship is a key factor in a child's adjustment and personality development (Schofield, 1979).

The studies done by Debra Desselle (1992, 1997) are significant because it suggests the need for increased use of total communication. Also, it suggests that hearing parents of deaf children have an impact on their child's self-esteem. Parents who are highly skilled in sign language can positively influence their deaf child's self-esteem. In Deselle's study (1992), the deaf students who had parents who knew only a few signs or who communicated by letting their child lipread had lower self-esteem. The findings of her study should be cautiously considered in light of the fact that for most of the responses in the study, the mother answered the questionnaire.

This would be considered a common occurrence because in most cases the mother is the primary caretaker.

Desselle's (1992) hypothesis was: A positive relationship exists between the family's communication method and the deaf child's self-esteem such that parents who use total communication will have children whose self-esteem scores are higher than those of children whose parents who use an oral-only method of communication. "A positive relationship was found between the family's communication method and the deaf child's self-esteem, such that parents who used total communication (speech, fingerspelling, and sign) had children whose self-esteem scores were higher than those of children whose parents used an oral-only method of communication (speech)" (Desselle, 1992, p. 322). Desselle's findings support the position that a deaf child's self-esteem is influenced by his or her parents' communication method. Her study suggests that hearing parents of Deaf children have an impact on their child's self-esteem. Parents who are highly skilled in sign language can positively influence their Deaf child's self-esteem. Desselle's study is similar to this study to examine how parents' communication patterns affect Deaf children's self-esteem.

"Early language experience for deaf children has been shown to have a significant impact on their personalities and emotional development, just as it does with hearing children. Most research in this area has focused on the benefits of early exposure to sign language, but the important thing is to have consistent two-way communication, regardless of whether it is spoken or signed" (Marschark, 1997,

p.172). Families play a larger role in Deaf children's socialization than in hearing children's socialization.

Sign language is a great importance of the Deaf culture. Parents have a responsibility not only to help their Deaf child use ASL but also to model the ability to travel between two cultures by learning and using ASL with the Deaf child. "For the deaf child to feel accepted in the deaf culture, he or she must be able to use ASL. It is documented that sign language helps create bonds among members of the deaf community" (Dolnick, 1993).

Summary

"Parents who learned ASL and used total communication may have made the deaf adolescent feel more accepted in the family and experience less sense of exclusion" (Desselle & Pearlmutter, 1997). This influence of parents on a deaf child starts early. If the deaf child feels accepted by the family, especially the parents, this feeling will positively affect self-esteem. Families that are more cohesive (degree of emotional bonding among family members) and better able to communicate with the deaf child and more adaptable will have adolescents who are able to cope (Kurdek & Sinclair, 1988).

The deaf child's grasp of language and communication may significantly increase if early efforts are made to introduce the child to ASL at an early age. Social workers and other professionals can help parents decide how to communicate with their deaf child and can educate parents about the various aspects of deafness and how acceptance of their child affects his or her self-esteem.

The following chapter contains a conceptual framework, self-esteem, self-confidence, and cognitive approaches. Chapter four explains the methodology used for current study and chapter five provides the results with a summary of the findings. The final chapter is the discussion including relevance to the literature, implications for social work practice, generalizability, future research, and conclusions.

Chapter III

CONCEPTUAL FRAMEWORK

Overview

Self-confidence and self-esteem are essential for empowerment. Self-esteem refers to a person's judgment of his or her value. Children with high self-esteem might be described as successful, active, self-confident, and optimistic. Those with low self-esteem, on the other hand, might best be described by terms such as depressed, isolated, discouraged, and fearful. In other words, children with higher levels of self-esteem exhibit traits that are valued by others, and in essence, are more competent (Zastrow & Kirst-Ashman, 1994). The cognitive component of self-esteem is an integral piece of the framework.

London (1997) unearthed over 200 definitions of self-esteem and claimed to have found more than 30 self-esteem inventories used to measure this construct. Semantic idiosyncrasy and scientific inconsistency prompted London (1997) to describe self-esteem as a "conditional, illogical, global rating of one's worth of intrinsic value toward an internal or external standard" (p.21). The laundry list of interchangeable terms to use in scientific study – self-concept, self-worth, self-regard – adds an additional layer of ambiguity to the definition (Bitioni, 1992; London, 1997).

Someone with low self-esteem is more likely to give up in the face of disappointment and difficulty, or become mechanistic in attitude as a way of coping (Branden, 1994). Satisfaction, in this context, translates to an underlying sense of well-being about one's self and one's life.

Children's sense of self-esteem is developed by many factors, one of the most important being the acceptance of those around them (Mindel & McKay, 1971). As one of the case with other people, self-esteem plays a major role in shaping the deaf person's capacity to contribute to society. If a deaf child has grown up in a family that considers the child's deafness a stigma, the child is likely to have low self-esteem (Goffman, 1974).

Cognitive Approaches

The cognitive approaches such as appeals to logic and clarifying the person's thinking may be acceptable alternatives to discussing feelings. Cognitions are awarenesses which are based on personal assumptions or attitudes that have been developed from previous experiences (Beck, 1990). People who are trying to live between two cultures, often with conflicting values, may experience social or emotional problems (Kirst-Ashman & Hull, 1993). The ability to function cognitively, i.e., make choices, delineate between thoughts and feelings, analyze and judge issues, provides a sense of control over one's life (Branden, 1969).

To understand a child's intellectual growth and his/her eventual successes and failures in school, we have to consider both cognitive development and intelligence (Marschark, 1997, p. 151). Cognitive development refers to the increasing knowledge and mental abilities that are seen in children as they get older. Over time, the mind grows both in its contents (that is, knowledge) and in the ability to understand, remember, and use those contents. Such growth results from interactions among maturation, learning, and an increasingly analytic or problem-solving approach to the world (Marschark, 1997, p. 151). All of the aspects of

cognitive development include thinking, memory, problem solving, quantitative skills, and communication/language. Language creates the most complexity for understanding a deaf child's intellectual functioning.

Epstein and Schlesinger (1991, 1996) cite four means by which family members' cognitions, behavior and emotions may interact and build to a volatile climax:

- The individual's own cognitions, behavior, and emotion regarding family interaction (e.g., the person who notices himself or herself withdrawing from the rest of the family)
- The actions of individual family members toward him or her
- The combined (and not always consistent) reactions several family members have toward him or her
- The characteristics of the relationship among other family members (e.g. noticing the other two family members usually are supportive of each other's opinions).

A person who is aware of her or his cognitive schema begins to understand how people, relationships, and events can influence how she or he views herself or himself.

Branden (1969) describes the interlocking elements of self-esteem as a "sense of personal efficacy and a sense of personal worth" (p.110). Personal efficacy is the belief that one is "competent to live" (p.110) and ties into an individual's understanding of her own knowledge, awareness, and recognition of reality.

This cognitive-type approach is increasing one's enjoyment of her life is supported by other research as an appropriate therapy to improve many areas of life; increased self-esteem has been regarded to be a by-product of cognitive changes

(Bitioni, 1992). Cognitive therapy holds the premise "that it is usually more productive to identify and modify 'core' problems..." (Beck, Freeman, & Associates, 1990), an experiential perspective that applies the processes of cognition to examine everyday events as they relate to the core problem of low self-esteem.

Harter & Buddin (1987) adopted a cognitive-developmental explanation, using the skill theory developed by Fischer (1980), to illustrate why children's understanding of simultaneous emotion progresses along this path. "As already mentioned, deaf children are often frustrated and upset with family members because of communication barriers, and this is an issue that is frequently raised in clinical situations. Increasing our knowledge about the development of multiple emotion understanding in deaf children as it applies to people vs. events would be helpful to clinicians who work with this population" (Cantor, 1996, p.14).

Summary

Cognitive approaches are an ideal framework for this study. The research questions ask how children define their relationship with their parents based on the communication method(s) used.

If a person's self-esteem is intact, then the individual feels worthy of contributing to the community. If one has poor self-esteem and feels unable to perform any worthy task, the actions of such a person reflect these feelings of uselessness (Desselle, 1992).

It is important for the parents to show their deaf child that their deafness is accepted and able to talk about issues related to Deaf culture. One way this can

happen is through communication so the child feels accepted regardless of hearing loss.

Chapter IV

METHODOLOGY

Overview

This section restates the research questions, followed by the research design, operational definitions, and subjects. It also includes the procedures used in the current study, data collection, protective measures, and measurement issues.

Research Questions

This study is designed to examine the adolescents' level of self-esteem and which communication methods the parents used. The communication variables consisted of each parent's communication methods (speech, sign language and speech, sign language, cued speech, etc.). There were no control groups. Comparisons were not being made with hearing adolescents. No adolescents with Deaf parents were included. This study focused on the majority, which are deaf adolescents with hearing parents.

This study probes the following questions regarding the level of self-esteem of deaf children and parents' communication methods:

1) In what ways do parents and other adults communicate with D/deaf adolescents?
2) Is there a relationship between the family's communication method and the D/deaf child's level of self-esteem?

Research Design

The current study employs a quantitative design using a questionnaire to examine if family communication patterns have an effect on the self-esteem of Deaf

adolescents. This study was primarily quantitative. "At the opposite end of the continuum from exploratory research is the use of qualitative methods to add depth and detail to quantitative studies where the statistical results indicate global patterns generalizable across settings or populations. For example, when a large-scale survey has revealed certain marked and significant response patterns, it is often helpful to fill out the meaning of those patterns through in-depth study using qualitative methods. The quantitative data identify areas of focus; the qualitative data give substance to those areas of focus" (Patton, 1987, p. 38). "Quantitative methods, on the other hand, use standardized measures that fit diverse various opinions and experiences into predetermined response categories" (Patton, 1987, p.9). The advantage of this approach is that it measures the reactions of a great many people to a limited set of questions. It gives a broad, generalizable set of findings. On the other hand, qualitative methods typically produce a wealth of detailed data about a much smaller number of people and cases. The number of responses that participated in this study was not many and could not be generalized.

Operational Definitions

Self-esteem. The operational definition of self-esteem used for this study is Webster's (1989) Ninth New Collegiate Dictionary: "a confidence and satisfaction in one's self" (p.1066). "Having higher self-esteem and a sense of control better enables children to think for themselves and make good decisions about how to act and who to emulate" (Lane, Hoffmeister & Bahan, 1997, p. 29).

Communication. The operational definition of communication: is to make opinions, feelings, information, etc. known or understood by others, e.g. by speech,

writing, or bodily movements." An example of communication given in the questionnaire included: "How does your mom communicate with you? How does your dad communicate with you? How does your teacher communicate with you? Students were asked to pick one of the following responses: speech only, sign and speech, sign only, cued speech and other.

Subjects

The subjects in this study were deaf adolescents ranging in age from 15 to 18 years. They were recruited from a public high school with a Deaf/Hard-of-Hearing program in the Midwest. No adolescents with Deaf parents were included. This study focused on Deaf adolescents with hearing parents. Parental consent forms were obtained along with an ID number (Appendix B). The initial contact with the students was made in their homeroom session. The study was explained to the students. Each student was given a consent form (Appendix C) and a questionnaire. They had all day to fill out the questionnaire then return it to the researcher in an office by end of the day. The students were unknown to this researcher.

All of the adolescents in this study met the following criteria: a) ages 15 to 19 years, b) have some kind of hearing loss, and c) an educational placement consisting of special education classes with other deaf and hard-of-hearing adolescents, with sign language and speech used in the school setting.

Protective Measures

Providing sign language support to aid the students' comprehension of the study and their rights was a safeguard to insure informed consent. Obtaining parental consent for all the deaf adolescents, including those 18 or over, was an additional

precaution, since it was assumed that the primary interest of the parents would be their child's welfare.

Given the design of this research, which examined preexisting conditions and attitudes, psychological risks were minimal. However, if any participant had experienced significant anxiety or distress due to involvement in this study, appropriate referrals, such as for school counseling, would have been given. The opportunity was also given to the parents (via parents' consent form, Appendix B) to contact this researcher to discuss questions or concerns related this study. Those expressing an interest in the results of the study would be sent a summary of the research findings.

In the field of deafness research, there have been some attempts to relate family language or emotion variables to various child outcomes. An area that has received much attention is the role of the hearing status of the parents (Cantor, 1996). Studies have consistently found that Deaf children who have Deaf parents perform better than deaf children of hearing parents in a variety of domains including academic achievement and language skills (Harris, 1978), self-esteem (Yachnik, 1976), and social adjustment (Harris, 1978; Schlesinger & Meadow, 1972). Meadow (1980) concludes that, in general, Deaf children of Deaf parents are socially more mature, and their self-concepts are more positive than deaf children of hearing parents. Researchers speculate that it is the combination of early and consistent language exposure together with immediate and continued parental acceptance of the deaf child which is responsible for these deaf children's relative successes (Altshuler,

1974; Harris, 1978; Moores, 1978; Rodda & Grove, 1987; Schlesinger & Meadow, 1972).

Procedures

Questionnaires conducted with each student provided information relevant to the research questions. The questions were designed to focus the students and also, limit the number and types of questions on the questionnaire to provide consistency. The information from the questionnaire was then examined for possible patterns in the ways in which the students might have certain level of self-esteem. The questions asked were about hearing loss, parents' communication method, the students' own communication methods, and rating of self-esteem.

Students' participation was voluntary. These individuals, the adolescents and their parents, could withdraw from the study at any time without prejudice. Assurance was given regarding the confidentiality of obtained information, as indicated in the parent's consent forms and student's consent forms (Appendix B & C).

Parental consent forms were obtained for all adolescents who participated in this study. Participating adolescents were also asked to sign a consent form (Appendix C), which was explained to them in American Sign Language. They were encouraged to read the form, as well, before deciding whether or not to sign it. Adolescents were reassured of their rights to participate in the study or not and to withdraw from the study at any time. Students were encouraged to ask for assistance if they did not understand any word or item in their questionnaires. This researcher explained that the data were to be analyzed for the group, not for individuals, given

the nature of the research. The students were made aware of the counseling services available at that school.

The questionnaire used unbiased wording (to minimize systematic error) and terms that respondents would understand (to minimize random error). The procedures used with the students and parents were carefully evaluated approved by the Institutional Review Board (IRB). The IRB made sure the consent forms and questionnaires were not biased. IRB is responsible for reviewing the ethics of proposed studies involving human subjects and also, may require that certain modifications be made in order to make the research acceptable. During the initial contact with the students, parents' consent forms were given out before participating in the study. After receiving the parents' consent forms back from the students, the researcher met with the students again in a homeroom session, then students' consent forms and questionnaires were distributed.

The participants were asked to fill out the questionnaires, which consisted of twenty questions. They were asked which communication method they used with their parents, friends and teachers at school, whether or not, they are proud being Deaf or wished to become hearing, and give a rating of their level of self-esteem at the end of the questionnaire. When they were done, they returned it to the researcher in an office at any time during that day.

Measurement Issues

"With *close-ended* questions, the respondent is asked to select an answer from among a list provided by the researcher. Close-ended questions can be used in self-administered questionnaires as well as interview schedules..." (Rubin & Babbie,

1997, p.192). Also, questions asked in a questionnaire should be relevant to most respondents. The questionnaires were designed to solicit information appropriate to analysis. Questionnaires in general are used primarily in survey research and also in experiments, field research, and mother modes of observation. The questionnaire was made sure to contain clear instructions and introductory comments where appropriate.

"If you want to measure self-esteem, for example, each of your items should appear *on its face* to indicate some aspect of self-esteem. You might conceive of concepts related to self-esteem, such as depression, but your self-esteem scale should include items reflecting depression. If you are measuring self-esteem, you would not ask people if they feel lonely or blue just because you think that depression is related to self-esteem. Instead, you would reserve that question for a scale that measures depression and restrict the self-esteem scale to items pertaining to the favorableness of one's self-image" (Rubin & Babbie, 1997, p.210).

Some of the questions on the questionnaire had nominal variables, such as "How does your mom communicate with you?" The students had to check one of the following: speech only, sign and speech, sign only, cued speech or other. The analysis was restricted to calculating which method was in the various categories, with percentage. The students were asked about their sign language and speech skills. Also, they were to rate their self-esteem, high 1, somewhat high 2, okay 3, somewhat low 4, and low 5. That is an example of ordinal measure for self-esteem rating.

The questionnaire was obtained from Gallaudet University by Faye E. Miller (1995) and this researcher could not get the instrument with the scores of the other items to produce an overall score. There is no information on Faye E. Miller's general description. The questionnaire by Faye E. Miller was obtained by a school social worker, which the researcher has borrowed from. Therefore, the reliability and validity cannot be determined for this study.

"Random error have no consistent pattern of effects. The effect of random errors is not to bias our measures, but to make them inconsistent from one measurement to the next. This does not mean that whenever data change over time we have random error. Random errors can take various forms. Perhaps our measurement procedures are so cumbersome, complex, boring, or fatiguing that our subjects say or do things at random just to get the measurement over with as quickly as possible" (Rubin & Babbie, 1997, p. 168). The students seemed anxious to complete it quickly as possible. It was near to the end of school year. It is possible that the students could quickly circle their answer for each question without thinking thoroughly.

Summary

Components of the methods used for this study have been presented in this chapter, including protective measures, research questions, research design, operational definitions, the sample, procedures, and measurement issues. The next chapter will explain the results of this study.

CHAPTER V

RESULTS

Overview

This study used quantitative methods to examine how parents' communication patterns affect deaf children's self-esteem. This chapter will explain the demographics, research questions, and summary of findings.

Demographics

This group attended a public high school with a Deaf and Hard-of-Hearing program in the Midwest. Six students (n=6), two females and four males, participated in this research study. They ranged in age from 15 to 18. Five were Caucasian and one was Hmong. Three students were in ninth grade, one was in tenth grade and two were in eleventh grade. One student has a severe hearing loss (71-90 db), two had profound hearing loss (90+ db) and three were not sure of their level of hearing loss.

Five students live with both of their parents at home. One student lives with the mother at home. All students reported that there is no other Deaf member in their family.

How do you prefer to communicate? The students were asked to check one of the following: speech only, sign and speech, sign only, cued speech and other. They had to pick one communication mode that they were using primarily. Three students chose sign and speech and the other three picked sign only.

How are your sign language skills? The students were asked to rate their sign language skills from excellent to none. Three students reported that their sign

language skills were excellent. One student reported that his/her sign language skills are good. Two students reported that their sign language skills are average.

How are your speech skills? One student reported that his/her speech skills were good. Two students reported that their speech skills were fair. Three students reported that they have no speech skills.

Which word do you use most often to describe yourself? Three students reported that they are Deaf. One student reported that he/she is hard-of-hearing. Two students reported that they are hearing-impaired.

Research Questions

The first research question was "in what ways do parents and other adults communicate with the D/deaf adolescents?" To answer this question, several items were included on the self-administered questionnaire.

How does your teachers communicate with you? Four students reported that their teachers use sign and speech. The other two students reported that their teachers used sign only.

How many deaf or hard-of-hearing adults work at your school? The students have reported that there is an estimate of four Deaf teachers in their Deaf and Hard-of-Hearing program.

How does your mother communicate with you? Two students reported that their mothers use speech only. Two students reported that their mothers use sign and speech. Only one student reported sign only. One student reported that the father interpreted for the mother.

How does your father communicate with you? Two students reported that their fathers used speech only. One student reported the father used sign and speech. Three students reported that their fathers used sign only.

If you need to discuss a problem with an adult, who do you usually talk to? The options included: mother, father, aunt, uncle, grandmother, grandfather, teacher, school counselor and other. Four students chose their mother to discuss a problem. Two students picked their father. One student picked the uncle.

To address the second research question: Is there a relationship between the family's communication method and the deaf child's level of self-esteem? The students were asked to report their level of self-esteem.

If you could change yourself, what would you change? One student chose to become hearing. Another student chose to become more deaf. Three students chose not to change anything. Some people are in denial of their deafness and are ashamed to admit they are deaf. Also, some function well in the hearing world with excellent lipreading and speech skills. Being deaf and being Deaf are not the same thing. Capital-d Deaf is applied to people who are part of the historical and cultural community of deaf people and who use ASL as their primary means of communication. The causes and extent of hearing losses vary for each individual and as well as deaf people's use of spoken or signed communication and their involvement in the Deaf community.

Rate your self-esteem. Each student was asked to give a rating on a semantic differential format on their self-esteem. There was a range of five levels of self-esteem: high, somewhat high, okay, somewhat low and low. Two students reported

having a high self-esteem, two students reported somewhat high of self-esteem and two reported okay self-esteem. The student who reported having high self-esteem had both parents using sign and speech. The other student who also reported of having high self-esteem had both parents who use sign only.

I like the way I am. Five students reported that they like the way they are. One student reported that he/she does not like the way he/she is.

There were three students who preferred to sign only and the other three students chose to use sign and speech. Also, the teachers at the Deaf and Hard-of-Hearing program used sign and speech and sign only. The students used sign and speech and sign only with their hearing friends to communicate. They also reported having both hearing and deaf friends. Only two students reported having high self-esteem. Of these two students, one student had both parents using sign and speech. The other student had both parents using sign only. By using sign language more, the higher the level self-esteem.

Two students reported having somewhat high self-esteem with both parents using speech only. The question is, if both of their parents used sign and speech, would their level of self-esteem be higher?

CHAPTER VI

DISCUSSION

The findings of the study support the concept that a Deaf adolescent's self-esteem may be influenced by the parents' communication method. However, the sample was very small and underrepresented. Based on this very small sample, the more the parents were able to converse in the deaf students' language-sign language- the higher the self-esteem scores of the students.

The first research question was in what ways do parents and other adults communicate with the D/deaf adolescents? Students were asked to pick which communication modes they used to communicate with their parents, teachers, and friends. The findings of this study support the concept that a deaf adolescent's self-esteem may be influenced by the parents' communication methods. Hearing parents who used sign language may have an important role in influencing their deaf child's level of self-esteem.

To answer the second research question: Is there a relationship between the family's communication method and the deaf child's level of self-esteem? Only one student reported having high self-esteem when their parents use sign language only and another student also reported having high self-esteem when the parents used speech and sign. Both parents did used sign language. That could influence the deaf child's level of self-esteem. Having any kind of communication with a child is important and understanding each other well. This study suggests that hearing parents of deaf children have some kind of an impact on their child's level of self-esteem by using sign and speech, almost like total communication, a method which

uses all potentially available sources of linguistic communication, including sign, speech, and amplification through the use of hearing aids. Using such methods are designed to give deaf children access to as much information as possible. Total communication is not the same as ASL.

Parents have a responsibility to model the ability to travel between two cultures by learning and using sign language or other means of communication with the deaf child. Parents can learn different aspects of deafness and show their acceptance of their child's deafness. The parents choose the best method of communicating their acceptance to the child.

The main purpose of this study was to investigate the relationship between family's communication patterns and the level of the deaf child's self-esteem. "Deaf children born to hearing parents are often in the unusual situation of not immediately sharing a primary communication mode with the rest of their family, and families vary widely in their willingness and commitment to learn sign language" (Cantor, 1996, p. 73). Cantor (1996) said there is research comparing deaf children born to Deaf parents verses hearing parents has consistently found that deaf children of deaf parents perform better on a variety of academic and social measures. Parents have the responsibility to become educated themselves about deafness, communication choices, and psychosocial ramifications. "To many parents, learning sign language itself is clearly a critical responsibility and one that could not be ignored regardless of the obstacles; for other parents, however, it is more difficult to achieve. Clearly, the degree to which sign language classes, books, etc. are made accessible and affordable is relevant" (Cantor, 1996, p. 76).

"It is true that Deaf children of Deaf parents also have other advantages, such as access to a substantial amount of background or incidental information, acquired especially from peers and from observing their parents when they are conversing with each other or with other Deaf people. It is also true, for hearing parents, that learning ASL means learning a second language, and one that is difficult for many English speakers because it is so different from English, not only in mode of expression, but in form and structure. Hearing parents (and siblings) of Deaf children who undertake to learn it may never become thoroughly fluent (though the siblings may well do so if they start when they are young). But a parent's lack of fluency does not mean that the effort does not make a difference. Deaf children of hearing parents do better in academic programs using Total Communication than in 'programs oriented towards speech, socialization and parent adjustment,' and the former programs present at least some signed language, albeit in a much impoverished form" (Lane, Hoffmeister & Bahan, 1996, p. 310-311). Lane, Hoffmeister and Bahan (1996) reported that there were studies of parents who communicated orally with their Deaf children and who rejected any form of signed language. Researchers found them often so focused on the quest to normalize their Deaf child that they are unaware of the accomplishments their child was demonstrating. "One other advantage accrues to the Deaf child of hearing parents if ASL is introduced into the home and used in preschool programs. The child and family come into close contact early on with members of the DEAF-WORLD[2]. We

[2] When we refer to the DEAF-WORLD in the U.S., we are concerned with a group) an estimated million people) possessing a unique language and culture. This language and culture have only become recognized and accepted of late. " Deaf: The New Ethnicity," was the cover line for a 1993 lead story in the *Atlantic Monthly*.

noted above that culture is carried by language, and Deaf culture is no different. Introducing Deaf culture to Deaf children can be an enormous benefit, furthering their understanding of the world and assisting them in developing a fund of information from which they can approach the learning of literate strategies and academic information" (Lane, Hoffmeister & Bahan, 1996, p. 312).

"Childhood and adolescence are a time of growth, as personality and social skills emerge from interactions of children with others in their environments. Regardless of whether children are hearing or deaf, they seek the same kinds of emotional and practical support, learn the same kinds of behaviors, and are influenced by the same kinds of factors. Communication plays an important role during these years, as children learn their roles as members of a family, a gender, a community, and a culture. Deaf children who have access to other people's interactions and explanations for behaviors better understand social dynamics" (Marschark, 1997, p.182).

Deaf is used as an adjective, referring to deaf people who see themselves as part of a community bound together by a common culture and a common language-ASL. "Hard-of-hearing is a term frequently encountered in reference to hearing loss. To most people, hard-of-hearing people represent a larger group than deaf people. Some educators and public officials describe hard-of-hearing people not as those with a broader range of hearing losses, but as those who have been able to acquire a spoken language, regardless of the extent of their hearing losses" (Marschark, 1997, p. 24). "The term *hearing impaired* is one that is used frequently. According to the World Health organization, an impairment is any loss of physiological or

psychological structure or function considered normal for human beings, a disability is any restriction or lack of ability to perform "normally" due to an impairment, and a handicap is a disadvantage for particular individual, resulting from an impairment or disability, that limits or prevents that person's full functioning in appropriate social career roles (Marschark, 1997, p. 7).

ASL is considered a language of the Deaf community. It is a visual/gestural language, composed of manual gestures in combination with various types of nonmanual grammar (mouth morphemes, appropriate facial expression, body movement, etc.). ASL has its own grammar that is distinct from English. Sign and speech is like total communication, which is a technique that uses a variety of methods. People can use sign, writing, mime, speech, pictures or any other method that works, depending on the needs of a person. Oralism is to teach people how to use their residual hearing – often enhanced with hearing aids or cochlear implants so they can develop spoken language. Cued speech is a visual picture of the speech sounds and sound patterns that are used in the English language. This system uses eight hand shapes in four locations near the mouth to eliminate the ambiguity of lipreading. ASL, oralism, cued speech, total communication, etc. are choices. Parents of Deaf children have options when considering the best way to teach their child to communicate. Sometimes, when the Deaf child grows up, the communication method can change. Some deaf people did not learn sign language until they were older. It depends on each individual's preference of communication method.

Relevance to the Literature

This study's findings are similar to Deselle and Pearlmutter's (1997) studies about determining the effect that parents' communication methods had on the self-esteem of their deaf children. However, Deselle and Pearlmutter's studies had larger sample (n=53). They used a different test, Modified Self-Esteem Inventory (MESI) to measure the deaf child's level of self-esteem. This study has similar ideas with Deselle and Pearlmutter's about having parents communicate with the deaf child with sign language to enhance their self-esteem. The only difference with Deselle and Pearlmutter's study was the parents were surveyed. They answered ten questions about their communication patterns with their deaf children (Deselle & Pearlmutter, 1997, p. 23).

If the parents make every effort to communicate with their child through all available means, such as sign language, fingerspelling, and getting amplification equipment for the child, then his or her self-esteem could be positively influenced (Moores, 1987). "Results indicated that parental sign language competence appears to play a central role in the emotional life of the family" (Cantor, 1996, p. 99). Self-esteem plays an important part in the development in children. Families play an important factor in establishing self-esteem. Parents can influence their children not only by what they are but also by what they do.

Implications for Social Work Practice

Social workers can help hearing parents navigate through their feelings and reactions by acknowledging the parents' feelings of disbelief, grief, guilt, and anger. Also, social workers can help parents with options that are in the best interest of the

D/deaf child. "Even if the hearing loss was diagnosed years ago, it may not be until the child enters school that the parents confront the previously denied feelings of loss and their fears about their child's education and psychosocial development. The social worker needs to gently explain the importance of recognizing the significance of the child's hearing loss and the importance of early and ongoing intervention" (Desselle, 1992, p. 323).

The professionals, educators, and parents of older D/deaf children can help educate the parents about the various aspects of their child's deafness and how their acceptance of their child affects his or her self-esteem. Also, they can assist them in choosing the best method of communicating their acceptance of the child's deafness. Social workers can discuss recent studies that show the benefits of early intervention with children whose deafness is acknowledged and accepted. Children receiving early intervention grasp learning skills more easily, and a developmental learning gap is prevented.

Social work involves practice with people from diverse cultures, backgrounds, experiences, and languages. Therapy, whether in a group or 1:1, case management, or other work with a deaf client, needs to take into account the client's language preference, cultural affiliation, if that is a factor, and life experience so that appropriate services can be provided.

Limitations of the Study

This study had several limitations. The recruitment of subjects was difficult, resulting in modifications in the original criteria for this study. Due to the small number of participants, the results of this study cannot be generalized to a wider

population. Despite the risks, some studies rely on available subjects still have great value. Rubin and Babbie (1997) suggest that reliance on available subjects should always be considered with great caution.

The impersonal nature of contacting individual through the questionnaire also impacted subject recruitment. Parents were asked to sign the consent form, but no personal contact or questions were asked regarding their deaf child. This lack of personal contact may have limited their willingness to participate.

The strengths of this study were that the need to address this issue since this is an underdeveloped area of research. There are very few studies related to self-esteem, family climate, and parents' communication patterns in relation to deafness. Another strength of this study is this researcher's deafness and bilingual skills in spoken English and ASL.

Generalizability

The small sample size limits generalizability to the larger population of deaf adolescents and their families. Only six students participated in the current study. The subjects were volunteers who responded to the questionnaires to this researcher's invitation to participate. This was not a randomly selected sample, nor was it a large sample. This limits generalizability of the results to the larger population of deaf adolescents.

Suggestions for Future Research

Since the generalizability of these findings was limited by a very small sample size and certain characteristics of the subjects (e.g. students in public high school with Deaf/Hard-of-Hearing program only), it is recommended that future studies

include significantly larger samples, including equal numbers of males and females. Future research with larger samples may also allow for meaningful comparisons of early, middle, and late adolescents in terms of communication patterns in families and peers. Differences in patterns between residential students versus day students might also be explored. Comparisons of deaf parents and hearing parents, in terms of communication patterns in families, may also be studied with larger samples.

Future research on the variables included in this study should incorporate different methods for assessing some of the variables, particularly the communication and self-esteem variables. Direct assessment of the parents' signing skills, using observations of interactions between the parents and their deaf child, would be preferable to self-report. Observational and interview formats are options. More cross-cultural research is needed in the field of deafness in general, and in the area of attachment research in particular (Samuel, 1996).

Conclusions

Deafness is a unique and invisible disability. "Deaf leaders do their best to defuse such fears that parents have. 'We don't say that hearing parents aren't qualified to make decisions about their deaf children,' says Roslyn Rosen, of the National Association of the Deaf. 'We say that they need to have contact with the deaf people if they're going to make educated decisions. The way the system works now is that the first people the parents see are doctors and audiologists, who see deafness as a pathology. What we need are partnerships between hearing parents and the deaf community, so that parents can meet deaf people who are doing well'" (Dolnick, 1993, p. 51). ASL is certainly easier for the deaf child to learn, but what

about the rest of the family? How can parents express their feelings and thoughts in a foreign language? It is critical for parents to communicate with the child regardless of barriers and whether it is spoken or signed. ASL is the everyday language of perhaps half a million Americans and a shared language makes for a shared identity and a strong Deaf community.

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Appendices

Appendix A

MEMO

May 11, 1999

TO: Ms. Lynn Bloom

FROM: Dr. Lucie Ferrell, IRB Chair

RE: Your IRB Application

Thank you for your response to the IRB concerns about your research. Your solutions are both effective and creative! Your study, "Deaf Children, Self-Esteem, and Parents' Communication Patterns," is approved, IRB approval # 99-37-3. Please use this number on all official correspondence and written materials relative to your study.

Your research should provide valuable information for social work practice. We wish you every success.

LF:lmn

c: Dr. Lois Bosch

Appendix B
Consent Form – IRB #99-37-3
(To be given to parents)

Your child is invited to be in a research study of self-esteem and communication patterns between Deaf children and parents. Your child was selected as a possible participant because he/she is enrolled in a program that provides services for the Deaf and Hard-of-Hearing students.

My name is Lynn Bloom. I am conducting this study as part of my master's thesis at Augsburg College. I am obtaining a degree in Master of Social Work (MSW).

Background Information:
The purpose of this study is to see if there is a relationship between the family's communication method and the deaf child's level of self-esteem. Information on enhancing students' level of self-esteem will help social workers, educators, and others to help students succeed in and create barrier-free communication with the family.

If you agree to let your child be in this study, this researcher would ask the child to do the following things.

First, your child will be given a consent form to read before filling out the questionnaire. Before your child begins, he/she will be asked if you have any questions about the consent form or about the research. After reading the consent form, if he/she still wishes to participate then he/she will sign the consent form. The questionnaire consists of 20 questions. Filling out the questionnaire will only take 30 minutes or less to complete.

All of the questions asked in the questionnaire will be about your child's hearing loss, communication methods used at home, your communication methods, and your child's self-esteem.

Risks and Benefits of Being in the Study:

This study has one risk. The questions may be sensitive when asking about your child's feelings about himself/herself. It may bring back negative feelings and they are free to refuse to answer any of the questions asked.

Confidentiality:

The records of the study will be kept confidential. Your child will be told not to give his/her name. Only this researcher and Dr. Lois Bosch, my thesis advisor, will have access to the questionnaires.

A) All questionnaires and other data will be destroyed by August 31, 1999. All data will be reported as a group only.

B) General information will be destroyed with all identifying information removed by August 31, 1999.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with the high school or Augsburg College. If you decide to let your child participate in the study, your child is free to withdraw at any time without affecting any relationships.

Contacts and Questions:

The researcher conducting this study is Lynn Bloom. If you have any questions or comments, you may contact her at: (612) 827-4671 (V/TTY) or e-mail: ExplorRed@aol.com. If you are not using TTY, you can contact me through Minnesota Relay Number, 1-800-627-3529. This researcher's advisor, Dr. Lois Bosch can be reached through Augsburg College, Department of Social Work, (612) 330-1633 (V). The Program Facilitator of D/HH students, Ms. Mary Sheie, can be contacted at (612) 928-6049.

You should keep page 1 and 2 of this form for your records. Any student can feel free to see the counselor(s) at no cost if they have concern or questions after filling out the questionnaire. Their general phone number to reach the counselors is (612) 928-6120.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent to let my child participate in this study.

Signature of parent or guardian _____ Date _____

Signature of investigator _____ Date _____

- Please keep these first 2 pages and the questionnaire.
- Please return the last page to Lynn Bloom by May 24, 1999. Thank you.

Please return this page only to Lynn M. Bloom

I have given consent to my child to participate in the study and will return this to Lynn M. Bloom. Thank you.

Signature of parent or guardian _____ Date _____

Signature of investigator _____ Date _____

Appendix C
Consent Form
(To be given to students)

You are invited to be in a research study of self-esteem and communication patterns between Deaf children and parents. Your child was selected as a possible participant because you are enrolled in a program that provides services for the Deaf and Hard-of-Hearing students.

My name is Lynn M. Bloom. I am conducting this study as part of my master's thesis at Augsburg College. I am obtaining a degree in Master of Social Work (MSW).

Background Information:

If you agree to let your child be in this study, we would ask you to do the following things.

First, you need to read the consent form. Before you begin, you will be asked if you have any questions about the consent form or about the research. The questionnaire consists of 20 questions. Filling out the questionnaire will only take 30 minutes or less to complete. After reading the consent form, if you still wish to participate then you will need to sign the consent form. If you do not wish to participate in the study, that is fine. You do not have to volunteer to participate in the study.

Risks and Benefits of Being in the Study:

This study has one risk. The questions may be sensitive when asking about your feelings about yourself and about your relationship with your family. It may bring back negative feelings. You have the right to refuse to answer any questions asked.

Confidentiality:

The records of the study will be kept confidential. You will be told not to give your name. Only this researcher and Dr. Lois Bosch, my thesis advisor, will have access to the questionnaires.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with the high school or Augsburg College. You are free to withdraw at any time without affecting any relationships. There are counselors at your school if you want to contact them to share concerns or ask any questions at no cost.

There is my phone number and e-mail address on the first page of the questionnaire that you can tear off for you to keep if you want to contact me later.

ID Number

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent to participate in this study.

Signature of student _____ Date_____

Signature of investigator _____ Date _____

Appendix D

ID Number

My Feelings About Myself

Faye E. Miller, Gallaudet University, 1995

Age:

Sex (Circle one): Female Male

Grade:

Directions: Here is sets of statements that tell how some people feel about themselves. Read each statement and pick the answer the best way you can. Try your best to answer each question. Put an X or a check on the line for the answer. Remember that there are no right or wrong answers. Only you can tell us how you feel about yourself.

Please tear off bottom page for yourself.

This researcher conducting this study is Lynn Bloom. Here is the phone number if you wish to contact me to ask any questions or share concerns, (612) 827-4671 (V/TTY). If you are not using TTY, you can contact me through Minnesota Relay Number, 1-800-627-3529. You can e-mail me at ExplorRed@aol.com.

1) What is your hearing loss? (Check one)

_____Mild (25-40 dB) _____Moderate (41-55 dB) _____Mod-Severe (56-70 dB)

_____Severe (71-90 dB) _____Profound (90+ dB) _____I don't know

2) What is your race or ethnic background (Check one)

___White ___African-American ___Native American ___Asian

___Hispanic ____Hmong ____Other (What? _____)

3) How do you prefer to communicate (Check one)

___Speech only ____Sign and speech ____Sign only ____Cued speech

____Other (What? _____)

4) How does your teachers communicate with you? (Check one)

___Speech only ____Sign and speech _____Sign only ____Cued speech

___Other (What? _____)

5) How do most of your friends communicate with you? (Check one)

____Speech only _____Sign and speech _____Sign only _____Cued speech

____Other (What? _____)

6) How does your mother communicate with you? (Check one)

_____ Speech only _____ Sign and speech _____ Sign only _____ Cued speech

_____ Other (What? _____)

7) How does your father communicate with you? (Check one)

_____ Speech only _____ Sign and speech _____ Sign only _____ Cued speech

_____ Other (What? _____)

8) How are your sign language skills? (Check one)

____Excellent ____Good ____Average _____Fair _____Weak ____None

9) How are your speech skills?

___Excellent ___Good ___Average _____Fair _____Weak _____None

10) Who lives with you at home? (Check all that apply)

____Both natural parents ___Mother only ____Mother & Step-Father

____Father only ____Father & Step-Mother ____Adoptive parent(s)

____Other (who? _____)

11) Who is deaf in your family? (Check all that apply)

___No one ____Mother ____Father ____Sister(s) _____Brother(s)

___Aunt(s)/Uncle(s) ____Cousin(s) _____Grandparent(s)

12) How many deaf or hard of hearing students are in your school? _____

13) How many deaf or hard of hearing adults work at your school? _____

14) If you need to discuss a problem with an adult, who do you usually talk to? (Check one)

____Mother ____Father ____Aunt ___Uncle ____Grandmother

____Grandfather ____A teacher ____School counselor

____Other (Who? _____)

15) Which support services have you used? (Check all that apply)

____Resource teacher ____Guidance counselor _____Psychologist

____Social Worker ____Other (Who? _____)

16) How many friends do you have? (Write number)

Deaf or Hard of Hearing _____ Hearing _____

17) Which word do you use most often to describe yourself? (Check one)

___Deaf ____Hard of Hearing ____Hearing Impaired

18) If you could change yourself, what would you change? (check one)

____I would become hearing ____I would become more deaf

____I would not change a thing

19) Rate your self-esteem (Circle a number)

1	2	3	4	5
High	Somewhat high	Okay	Somewhat low	Low

20) I like the way I am Yes_____ No_____