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Abstract

In today's society, it is important for researchers and practitioners to note that the generation known as the Baby Boomers is more than a socio-demographic clump; it represents a significant part of the population. This paper will be reviewing the issues facing the deaf baby boomers population and how they are contrasted to their hearing counterparts. The areas examined include social/political, technological, physical healthcare, and mental healthcare. In each area, this paper aims to illustrate that it can sometimes be difficult for deaf individuals in the baby boomer generation to find and utilize any number of societal resources.

Keywords: deaf, aging, Baby Boomers, deaf healthcare, deaf politics, deaf technology, deaf mental health

The purpose of this paper is to primarily examine some of the problems that exist in today's society for individuals assigned to the social group known as the baby boomers. It will first be established that it is important for researchers and practitioners to note that this group is more than a socio-demographic clump known only by age, and is actually comprised of a large part of the population, whose characteristics may spread across a number of delineating categories. Moreover, the purpose of this paper is to bring to light some of the specific issues facing the deaf baby boom population and how they compare and contrast to their hearing counterparts. As always within the deaf population, there is a paucity of research in existence. Because of this, there are fewer primary sources available upon which to draw empirical hypotheses, and less up-to-date research available for practitioners. The differences and similarities between the deaf and hearing populations will be examined in the social/political, technology, physical healthcare, and mental healthcare areas. The latter two are examined separately because of the great differences that can emerge, especially with the baby boom generation, in availability, accessibility, usage, and perceptions of necessity between the two.

The generation now commonly known as "The Baby Boomers", is comprised of individuals born between 1946 and 1964 and is made up of roughly 72 million Americans, or approximately one-third of the population of the United States. The deaf individuals encompassed in the baby boom generation are in a unique position because they are truly the largest generation of deaf individuals to be widely accepted into general society and not turned away and institutionalized. The deaf baby boomers are those who became the adult beneficiaries of such social transformations as the Americans with Disabilities Act (ADA; 1990) and the *Deaf President Now!* (DPN) movement. This is a generation with unique concerns. They not only face the same issues as the hearing baby boom population, but also face the additional lingering concerns and problems for the deaf in today's society as well (e.g., workplace discrimination, lack of accommodations, linguistically inaccessible environments).

Often times, the society in which we live is characterized as being ageist (in that stereotypes, a devaluation of social status, and prejudices are based on age) in addition to one that stigmatizes individuals that are hard of hearing or deaf (Pray, 2002). It is important to note, however, that this group of aging citizens, hearing or deaf, is not a curse on the resources of America. The baby boom generation was a generation on the cutting edge of many social issues. The generation contributed to record-low birth-rates because of an increase of contraceptive consciousness, changed the expectations for compensation of women in the work force, and even set record numbers for mothers working outside of the home (Wattenberg, 1986).

In research examining the baby boom generation, it is indicated that it is a generation with a high level of social conscience, with reported concerns including world over-population, rational economics, and the decline of the environment (Riggs & Turner, 2000). Research has also indicated a concern on the baby boom generation over the imbalance of resource distribution. Research within and specific to the deaf population, however, is still scarce and often seemingly outdated; this is reflective of not only the lack of attention paid to this specific group in the research community as well as what current researchers examining the deaf population have with which to work. Nevertheless, studies also indicate that this is a generation in general that in today's world feels increasingly powerless in their ability to address or help manage these issues (Riggs & Turner, 2000).

The nation's allocation of resources and its institutions will be fundamentally altered as this baby boom generation moves through their life cycle (Wattenberg, 1986). In our nation's current system, working-age Americans will have to increase the amount of money they pay into a support system for the dependent population. They will also face the possibility that Social Security will not be available for them when they are of age to take advantage of the system (Hamil-Luker, 2001). In the year 1950, for every Social Security beneficiary there were 16.5 working Americans; that ratio is projected to drop to 2 workers for every beneficiary over the coming years (Lee, 1996).

Social and Political

Researchers examining the baby boom generation have found that it is significantly better prepared than its preceding cohort in many ways, including outlook, attitude, values, and self-perceptions (Ahmad, 2002; Alalaakkola, 1996; Gunter, 1998;Moschis, 1996; Vuori & Holmlund-Rytkonen, 2005). Perhaps then, it would be more beneficial to not examine the baby boom group in the context of an age war over the distribution of public resources, and instead reexamine the demographics of this generation based on defining characteristics such as class, race, and gender (Hamil-Luker, 2001).

Research has shown that this age group does not consistently exhibit synchronous tendencies in a number of areas, including politics; in fact, respondents of studies examining the political tendencies of this population have established a number of in-group preference differences, including sex, education, income level, and race (Binstock & Day, 1996; Day, 1990; Street, 1999; Hamil-Luker, 2001; Naegele & Walker, 1999). Perhaps then it could be beneficial when examining the baby boom generation, to avoid characterizing this group solely by perceived inequalities that separate this group due to age, but rather reframe and examine the population in terms of differences and a multitude of subsequent needs. It is also important to remember that some people that may belong to one group of demographic classifiers, such as socio-economic status, may belong to another, such as level of education (Blau, 1994).

Public resources available to this generation may sometimes not be accessible to the deaf baby boom population because of many issues that still exist between deaf culture and hearing culture, including a lack of

information transmission, poor communication, and feelings of mistrust (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006). The size of the deaf community in America has not even been accurately estimated. For instance, the U.S. Census Bureau does not currently ask about American Sign Language (ASL) use; they also focus on audiological hearing loss and do not take into account cultural and linguistic affiliation. Due to this, estimates of the deaf population have ranged from 100,000 to 1 million Americans (Barnett, 1999). This is an important distinction because not all deaf people belong to the cultural group that employs the usage of ASL (Padden, 1989).

The role of language is to allow an individual to openly express their thoughts, feelings, and beliefs to those around them. In a hearing world, it can sometimes be difficult for a deaf individual, especially a deaf baby boomer, to find and utilize the appropriate resources (e.g., interpreters) and technologies (e.g., videophones, relay services) to openly express themselves. The experience of isolation of communication could represent a pervasive and devastating trauma (Glickman, 2009; Harvey, 1996; Mindel & Vernon, 1971; Moores, 1982; Schlesinger & Meadow, 1972). It has been suggested that the first step necessary in successfully supporting deaf people is to meet their communicative needs (Hansen, 1999). In today's world of ever-advancing communicative technology, both the deaf and hearing baby boomers may both find themselves equally struggling to adapt and communicate effectively.

Technological

As technology continues to develop, so too does the breadth of research examining and incorporating it. Few research projects have been completed recently addressing the use of technology and the older generation, and even fewer still concerning the generation of older deaf individuals.

Obviously, one of the greatest stigmas and sources of conflict surrounding perceptions between the deaf and hearing communities has been on communication. Hearing people often express frustration when attempting to communicate with deaf people, and of course the opposite is also true. Common misunderstandings can occur from something as minor as incongruent facial expressions or poor eye-contact (Corns & Napier, 2005; Horvath & Symonds, 1991; Lambert, 1992). Good communication as well as the difficulties associated with it when interacting with the hearing

population are very important issues in the deaf community. Therefore, it is expected that new tools that will facilitate better communication as well as a more widespread database of available services to the deaf population will be utilized in the near future.

Stereotypes surrounding the older population often include a level of discomfort with change and modernization, specifically regarding technological developments. Older people are often portrayed as uncomfortable with modernization, and reluctant to experiment with and subsequently adopt new technology. It has been suggested that the population at large perceives that the 50-plus generation is set in its ways, hesitant to experiment, and generally uninterested in new technological services or products (Szmigin & Carrigan, 2000).

What may be truer, however, is that as technology is marketed to the younger generation, both the availability and applicability of new technology is perceived as of little to no use to the older population (Vuori & Holmlund-Rytkonen, 2005). The number of older people that are implementing technology, such as browsing online, is actually growing. A study conducted in 2000 by Wired/Merrill Lynch (McLuhan, 2000; Vuori & Holmlund-Rytkonen, 2005), found that out of all internet users in one year, the percentage of those over the age of 50 has increased from five percent to 15 percent. Therefore, our stereotypes may be misguided. It has been proposed that the acceptance of new technology in the baby boomer population is very closely related to the overall perception of the receipt of benefits of said technology use, as well as to the assigned significant meaning to those benefits (Menchin, 1989).

Despite the fact that there may naturally be products that older consumers are not interested in, evidence is beginning to emerge that suggests older consumers are not necessarily as averse to technology in general as was once believed (Szmigin & Carrigan, 2000). It may be fair to assume that when people are presented with a new innovation that they perceive as difficult to understand, coupled with the perception that their familiarized technological comforts are rapidly becoming extinct, they may experience anxiety (e.g., the gradual cultural transition from home phones to cell phones). While it is merely a speculation to assume that this anxiety could lead to aversion and refusal, it is certainly not out of the realm of possibility, and is based on the hypotheses of this literature review.

According to Cognitive Behavioral Therapy (CBT), in order to experience the positive effects of desensitization, one must first be systematically exposed to the original source of anxiety. It has repeatedly been shown that in the technological realm, as well as any other realm, adaption occurs by increasing the exposure to the new stimulus until comfort and familiarity are developed and the perceptions of novelty subside (Austen & McGrath, 2006). In order to begin exposure to the novel stimulus, however, the individuals should find some quality in which to place value, otherwise their interest and intensity will be limited by the amount of cognition they elect to employ in attending to the tasks of appraisal and acquisition.

Although it is often stereotyped that technology is for those adapting quickly and by proxy (as well as through microagression) the younger generations, it is not untrue to say that of late, little technology has been developed that is geared toward for the baby boom generation. One of the great differences that exists between the hearing and deaf baby boom population however is that the deaf population possesses additional barriers between adapting to modern technology when compared to the hearing baby boom population. If technology is viewed as designed for the hearing population through either the integration of auditory prompts and stimuli or simply auditory advertising that is not accessible to a population reliant on visual communication, there is little motivation to assign value to an object that is not viewed as supportive of, or easily integrated into, a deaf lifestyle.

In no way does this mean that the deaf baby boomer population is unable to adapt to or integrate technology; individuals simply need to be able to find value and accessibility in an innovation. Certain technology that some hearing baby boomers might find new and difficult to adapt to has already been used and distributed throughout the deaf community for years. The best example is the videophone. Studies have shown that compared to a similar age group, deaf individuals are significantly more confident in the use of the videophone than their hearing counterparts. This might be because rather than being viewed as one of many communication options, the videophone has found its place in the deaf society as a near necessity for effective communication (Austen & McGrath, 2006). It has been hypothesized, that if all "hearing-only" phones were replaced with videophones, hearing individuals could soon develop the proficiency of deaf individuals.

Although videoconferencing has been found to be significantly linked to previous use(Austen & McGrath, 2006), does this suggest that necessity breeds acceptance? Although some technological innovations such as videoconferencing have contributed to improved communication between deaf individuals and the community, neither deaf nor hearing individuals are immune to the difficulties that research has repeatedly demonstrated such as anxiety surrounding novel technology and gaps in experience between the baby boom and the younger generation (Austen & McGrath, 2006).

Physical Healthcare

One of the greatest roles that technology can play for the baby boom generation is with increasing the accessibility and availability of healthcare services for both the deaf and hearing population. Studies have shown once familiarized with the potential healthcare service provided therein, the internet can provide up to 80 percent of individuals support with over-the-Internet education or counseling (Austen & McGrath, 2006). Why, then, are the baby boomer populations (both hearing and deaf), still underrepresented in care received and technology utilized across the population?

Previously, the baby boomers have been on the forefront of medical advances and trends. It was they who led the world in what has been previously referred to as the "Contraceptive Revolution", altering and establishing new norms in the patterns of reproduction. In 1978 the United States documented its lowest birth rate on record, and the number of births annually has not risen significantly since that mark was set (Wattenberg, 1986). Somewhere since then however, the pace of society has begun to pass and neglect this generation.

Deaf people use health care services in different ways than the general population. However, very little research has been done to attempt to understand the reasons behind this phenomenon (Prior & Conway, 2008). The phrase most widely used in the deaf literature to express the population's healthcare concerns is "traditionally underserved" (Dew, 1999). Reports from deaf healthcare consumers have often indicated that their healthcare experiences are associated with strong negative emotions, which may help explain why adults who were deafened before acquiring English as a language (including those born deaf) are less likely than individuals in the general population to visit a physician (Barnett & Franks, 2002). It is therefore understandable that language deprivation and subsequent limited

language access, primarily access to the language used by the healthcare provider, has been shown to be a major etiological factor for problems with healthcare access in individuals either born deaf or becoming deaf early in life (Glickman, 2009).

Deaf individuals have also used adjectives such as frustration, distrust, and fear to describe their encounters with healthcare professionals (Steinberg et al., 2006). The deaf share many similarities with other cultural minorities, since the potential for limited access to the English language can cause great concern, especially when English is the primary or only language of the healthcare provider. Language gaps can pose many problems in the healthcare arena for the deaf, including poor and infrequent communication with clinicians, an inability to accurately express cultural implications, and being forced to convey personal information through a third party, such as an interpreter (Steinberg et al., 2006).

The role of any interpreter, spoken or sign, is to facilitate the communication between any number of parties that do not share a similar language and to ensure that all parties involved in an exchange have an equal access to the interaction content. However, problems in the healthcare setting can arise with an interpreter, including an interpreter who is too leading (thus influencing the responses if the client), or the possibility of a too literal interpretation of the client's responses. An ethical concern for interpreters in the healthcare field is to ensure that they do not advise, counsel, or interject personal opinions (Taylor, 2002). Cornes and Napier (2005) also noted that the clinical intuition of the provider may be diluted or lost when questions and responses are filtered through a third party.

Many deaf healthcare consumers also report that they possess only a limited knowledge or understanding of their legal rights as a consumer. Others report that they have been in situations where they did not advocate for themselves (Steinberg et al., 2006). Although studies have consistently shown that deaf people use health care services in a different way than their hearing counterparts, the deaf have continued to report difficulties with accessing services, even after the passage of the Americans with Disabilities Act (1990, ADA; Steinberg, Sullivan, & Loew, 1998; Witte & Kuzel, 2000).

Although the use of the English language is probably not the biggest concern for much of the hearing baby boom generation, many of the aforementioned communication difficulties, including problems

understanding legal rights, loss of advocacy, and problems expressing cultural differences, are present. It is only for a short while longer that the population regarded as baby-boomers will remain a small cultural minority. This population is projected to grow significantly over the coming years. Estimates of people born between 1946 and 1964 (currently between 46 and 64 years old) put the number of this group somewhere around 72 million, or roughly one-third of the American population. According to data previously gathered by the United States Census Bureau (1997), whereas only 11% of the population was aged 65 years or older in 1980, that number will rise to 20% of the population by the year 2050 (Hamil-Luker, 2001; U.S. Bureau of the Census, 1997), and has already seen a 16% increase over the last 10 years (U.S. Bureau of the Census, 2010). Therefore, the issues facing healthcare providers and consumers now will only be compounded as the population of this group continues to rise.

Mental Healthcare

Traditional stigmas that surround mental healthcare include the fear of diagnostic labeling, potential discrimination due to a misunderstanding of the implications of mental health problems and the benefits of treatment, and social ostracizing based on the misperception that someone is "insane" because they are receiving mental health services. Despite these stigmas though, recent research has suggested that many older individuals are willing to try mental health services (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002; Feldman & Gum, 2007).

Some research has indicated that, contrary to their hearing counterparts, deaf people are more likely to experience mental health difficulties (National Institute for Mental Health, 1999; Prior & Conway, 2008). These difficulties include mood and anxiety disorders, attention-deficit problems, and learning disabilities. Another issue facing the deaf population with regard to mental healthcare is the fact that population data and normative samples on psychometric tests are generally gathered from a hearing sample population (Marschark & Spencer, 2003), and normative data on the deaf population is limited a few, albeit growing, number of assessments; however, the use of these norms for clinical reasons are still statistically questionable (Braden, 2010). Even in situations where working with the deaf population is examined, older clients are still not typically the focus of clinicians when discussing providing therapy to this population (Pray, 2002).

However, part of the problem facing the mental healthcare field is the familiarity of older individuals with their pre-existing general healthcare routines and physicians, and a general obstinacy to change once an ingrained routine is established. Partly, this is understandable; primary care providers already have an extensive history on the patient and a complex understanding of their physical problems, and therefore consumers would feel less anxiety when adding mental health to the services they are receiving because they have established familiarity and rapport with their clinician. Subsequently, many surveys consistently show that older adults would prefer to seek mental health services from their primary care physicians (Areán, Hegel, & Reynolds, 2001; Feldman & Gum, 2007). However, this could potentially lead to the consumer receiving sub-standard mental healthcare, as their practitioner is not as experienced in the field as properly trained and educated mental health professionals. This problem is compounded considering the potential for this to occur across a generation of individuals. The issue may prove particularly plausible, and worrisome, in the deaf population.

As it has already been discussed, communication difficulties between the deaf consumer and healthcare practitioner are prevalent and widespread, and can cause reluctance to seek services, or even a lack of awareness of service availability. Research has indicated that deaf adults are generally less aware of existing mental health services in the community than their hearing counterparts. They are also less trusting of mental health professionals, not as likely to act appropriately in the event of a mental health emergency, and not as likely to know from whom they should seek services (Feldman & Gum, 2007). However, the onus for knowing the availability of mental health services is not entirely on the deaf population. Deaf adults are rarely the target of advertising for mental heath services, which may contribute to older deaf adults turning away from services when needed (Feldman & Gum, 2007). The deaf population in a community can also be relatively geographically widespread (that is, lacking the centrality of a traditionally ethnic neighborhood), making it more difficult to target specific areas of the community for centralized care or even advertising (Cornes & Napier, 2005; Cornes & Wiltshire, 1999).

As previously discussed, comfort and familiarity with medical professionals contribute significantly to older deaf adults seeking and receiving services, and these issues are also affected greatly by the communication between doctor/therapist and patient. However, problems

arising from communication are not restricted to the consumer. Clinicians cannot perform their jobs to the best of their abilities if they are not receiving accurate information from the client. Currently, some interpreters are available in large communities or in hospital settings, but it has also been acknowledged that the interaction dynamics between provider and consumer, already sensitive, can be strained or worsened by an interpreter's presence (Bot, 2003; Wadensjö, 2001). These problems can be either due to the interpreter's unfamiliarity with psychological terminology when the interpreter is brought by the client, or due to the lack of trust between the consumer and the provider's interpreter (such as in a hospital setting).

The role of the therapist may be easily confused and increasingly complicated when working with a deaf client. Cornes and Napier (2005) examined some of the problems associated with using an interpreter in the therapeutic setting, and the factors therein that can contribute to a poor transmission of information between the therapist and client. They found that miscues in communicative factors such as not maintaining eye contact, something that can be seen as relatively trifling by a hearing clinician, can lead to misunderstandings and the transmission unintentionally disrespectful meta-messages when working with a deaf client. They also noted that it is important that the clinicians are wary of appropriate conduct and potential problems that may arise from the presence of the interpreter in the therapeutic setting, as well as being aware of shifts in the therapist-client dynamic in the presence of an interpreter. For instance, some important aspects of the clinical relationship (such as transference) or clinical tools (such as free association) may no longer be helpful to the clinician.

Despite all of the potential pitfalls of hearing clinicians working with deaf clients, the therapeutic relationship can prove productive. For instance, according to Duffy and Veltri (1998; Cornes & Napier, 2005, Twersky-Glasner & Sheridan, 2005) some studies have demonstrated the therapeutic benefit and effectiveness of a sign language interpreter. The caveats, however, are that the patient must desire to work on their issues and change, the interpreter must study and recognize the complexity of the mental health milieu, and the therapist must respect the sign language and the deaf culture.

What could better benefit the deaf client is the presence of clinicians involved in deaf culture. Research examining the preferences of deaf mental health consumers illustrated that the biggest preventative barrier for seeking mental healthcare has been the lack of signing professionals, and

that signing, deaf mental health practitioners are most preferred in the deaf community (Feldman & Gum, 2007). While it may not always be possible for a consumer to locate a deaf clinician, it could be possible for mental health practitioners to increase their understanding of the deaf population. It stands to reason that an increased understanding of any population or demographic and their culture will build familiarity and comfort, as well as increase the ease with which a trusting therapeutic alliance is established and care is more fluidly provided.

An improvement in the delivery of service models to older deaf adults may result from a better understanding of both the preferences of the older population and the deaf community (Feldman & Gum, 2007). Research has noted that there are significant benefits to designing a treatment model that aligns with the thoughts, beliefs, and perceptions of the client (Glickman, 2009; Meichenbaum & Turk, 1987).

Conclusion

Although much social and economic research is being conducted on the baby boomers, there is a need for more to be conducted in the fields of physical and mental health, technological accessibility, and social and political issues regarding this population. Furthermore, there is a dearth of research examining the deaf baby boomer population in particular.

Some studies that have been done examining the older population and various technological innovations are speculative, and merely presuppose differences or significant effects. Further research regarding the benefits of developing technology in the older population need to be conducted, not only for the purpose of determining the impact of implementing technology, but also because of the rapid rate of new technological development. New and enhanced technology is constantly being examined and developed, seemingly as rapidly as researchers design and publish their studies.

Beyond technology, the breadth of research on baby boomers, specifically deaf baby boomers, needs to be expanded. As has been illustrated in this paper, although the deaf often are regarded as a minority population, there appears to be a paucity of research in the mental health field when compared to sexual and ethnic minorities. For instance, some studies examining communicative factors between the deaf mental health consumer and hearing clinician suggest that an increased education on deaf culture

and even ASL by the service provider may enhance the client-practitioner relationship. However, there is a scarcity of research studying the efficacy of any deaf-education or ASL training programs for clinicians and the effects they have on the therapeutic alliance and treatment effectiveness.

Finally, as has been illustrated, there are important differences between the population of deaf baby boomers and hearing baby boomers which can have significant implications concerning services that need to be provided. Some of the differences examined in this paper even have an influence on the willingness of clients to seek services and technology that they may need. Future research examining the similarities and differences between the deaf and hearing baby boomer population is needed in order to help our generation better understand the needs of the this specific generation of deaf elderly and thus be effectively prepared to serve them.

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References

Ahmad, R. (2002). The older or ageing consumers in the UK: Are they really that different? *International Journal of Market Research, 44*, 337-360.

Alalaakkola, L. (1996). Aged consumers as a research subject. In P. Tuominen (Ed.), *Emerging Perspectives in Marketing, series A-10*, Publications of the Turku School of Economics and Business Administration, Turku.

Americans With Disabilities Act of 1990, 42, U.S.C.A. § 12101 *et seq.* (West 1993). Areán, P. A., Alvidrez, J., Barrera, A., Robinson, G. S., & Hicks, S. (2002). Would older medical patients use psychological services? *Gerontologist, 42*, 392-398.

Areán, P. A., Hegel, M. T., & Reynolds, C. F. III. (2001). Treating depression in older medical patients with psychotherapy. *Journal of Clinical Geropsychology, 7*, 93-104.

Austen, S., & McGrath, M. (2006). Telemental health technology in deaf and general mental health services: Access and use. *American Annals of the Deaf, 151*, 311-317.

Barnett, S. (1999). Clinical and cultural issues in caring for deaf people. *Family Medicine, 31*, 17-22.

Barnett, S., & Franks, P. (2002). Deaf adults and healthcare utilization: relationship with age at onset of deafness. *Heath Services Resources, 37*, 105-120.

Binstock, R. H., & Day, C. L. (1996). Aging and politics. In R. H. Binstock, & L. K. George (Eds.), *Handbook of Aging and the Social Sciences, 4th ed.* (pp. 56–74). Academic Press: San Diego, CA.

Blau, P. M. (1994). *Structural contexts of opportunities.* Chicago, IL: University of Chicago Press.

Bot, H. (2003). The myth of the uninvolved interpreter interpreting in mental health and the development of a three-person psychology. In L. Brunette, G. Bastin, I. Hemlin, & H. Clarke (Eds.) *The Critical Link 3: Interpreters in the Community.* (pp. 27-36). Amsterdam: John Benjamins.

Braden, J. P. (2010). *Deafness, deprivation, and IQ.* New York: Plenum Press.

Cornes, A., & Napier, J. (2005). Challenges of mental health interpreting when working with deaf patients. *Australian, Psychiatry, 13*, 403-407.

Cornes, A. J., & Wiltshire, C. J. (1999). Still waiting to be heard: Deaf children in Australia. *Australasian Psychiatry, 7*, 313-318.

Day, C. L. (1990). *What older Americans think: Interest groups and aging policy.* Princeton, NJ: Princeton University Press.

Dew, D. W. (Ed.). (1999). *Serving individuals who are low-functioning deaf.* Washington, DC: George Washington University Regional Rehabilitation Continuing Education Program.

Duffy, K., & Veltri, D. (1998, October). *Working with interpreters in the mental health setting.* Paper presented at the First World Conference on Mental Health and Deafness, Gallaudet University, Washington D.C.

Feldman, D. M., & Gum, A. (2007). Multigenerational perceptions of mental health services among deaf adults in Florida. *American Annals of the Deaf, 152*, 391-397.

Glickman, N. (2009). Adapting best practices in CBT for deaf and hearing persons with language and learning challenges. *Journal of Psychotherapy Integration, 19*, 354-384.

Glickman, N., & Gulati, S. (2003). *Mental health care of deaf people: A culturally affirmative approach.* Mahwah, NJ: Erlbaum.

Gunter, B. (1998). *Understanding the older consumer: The grey market.* London, England: Routledge.

Hamil-Luker, J. (2001). The prospects of age war: Inequality between (and within) age groups. *Social Science Research, 30*, 386-400.

Hansen, E. M. (1999). Supported employment for people who are deaf: An overview of the unique needs and challenges. *Journal of Vocational Rehabilitation, 13*, 143-152.

Harvey, M. (1996). Utilization of traumatic transference by a hearing therapist. In N. Glickman & M. Harvey (Eds.), *Culturally affirmative psychotherapy with deaf persons* (pp. 155–167). Mahwah, NJ: Erlbaum.

Horvath, A. D., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Lambert, M. J. (1992). Psychotherapy outcomes research. In J.C. Norcross, & M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (pp. 94-129). New York, NY: Basic Books.

Lee, D. E. (1996). *Generations and the Challenge of Justice.* New York, NY: University Press of America.

Marschark, M., & Spencer, P. E. (2003). *Oxford handbook of deaf studies, language, and education.* New York, NY: Oxford University Press.

McLuhan, R. (2000, May 11). Silver surfers join the internet party, *Marketing* (p. 37). Retrieved from http://connection.ebscohost.com/c/articles/3329132/silver-surfers-join-internet-party

Meichenbaum, D., & Turk, D. (1987). *Facilitating treatment adherence: A practitioners handbook.* New York, NY: Plenum Press.

Menchin, R. (1989). *The mature market: A strategic marketing guide to America's fastest growing population segment.* Chicago, IL: Probus Publishing Company.

Mindel, E. D., & Vernon, M. (1971). *They grow in silence.* Silver Spring, MD: National Association for the Deaf.

Moores, D. (1982). *Educating the deaf: Psychology, principles and practices, 2nd ed.* Boston, MA: Houghton Mifflin.

Moschis, G.P. (1996). *Gerontographics: Cluster segmentation for marketing strategy development.* New York, NY: Quorum Books.

Naegele, G., & Walker, A. (1999). Conclusion. In A. Walker, & G. Naegle (Eds.), *The Politics of Old Age in Europe* (pp. 197–209). Buckingham, PA: Open University Press.

National Institute for Mental Health. (1999). Mental health and deafness: towards equity and access. Best practice guidance. *An implementation guide for Sign of the Times.* London, England: Department of Health.

Padden, C. (1989). The deaf community and the culture of deaf people. In S. Wilcox (Ed.), *American deaf culture: An anthology* (pp. 1-16). Burtonsville, MD: Linstock Press.

Pray, J. L. (2002). Ethical considerations for counseling deaf and hard of hearing adults. In V. Gutman (Ed.), *Ethics in mental health and deafness* (pp. 68-83). Washington, DC: Gallaudet University Press.

Prior, S., & Conway, M. (2008). 'All the doors are closing': National deaf service users' thoughts and views on deafness, mental health and employment. *British Journal of Occupational Therapy, 71*, 95-102.

Riggs, A., & Turner, B. (2000). Pie-eyed optimists: baby-boomers the optimistic generation? *Social Indicators, 52*, 73-93.

Schlesinger, H. S., & Meadow, K. P. (1972). *Sound and sign: Childhood deafness and mental health.* Berkeley, CA: California University Press.

Steinberg, A. G., Barnett, S., Meador, H. E., Wiggins, E. A., & Zazove, P. (2006). Health care system accessibility: Experiences and perceptions of deaf people. *Journal of General Internal Medicine, 21*, 260-266.

Steinberg, A., Sullivan, V., & Loew, R. (1998). Cultural and linguistic barriers to mental health service access: The deaf consumer's perspective. *American Journal of Psychiatry, 155*, 982-984.

Street, D. (1999). Special interests or citizens' rights? 'Senior power,' social security, and medicare. In M. Minkler, & C. L. Estes (Eds.), *Critical Gerontology: Perspectives from Political and Moral Economy* (pp. 109–130). Amityville, NY: Baywood.

Szmigin, I., & Carrigan, M. (2000). The older consumer as innovator: Does cognitive age hold the key? *Journal of Marketing Management, 16*, 505-27.

Taylor, L. (2002). Defining the shadow: Recognizing the imprint of the interpreter in the mental health setting. In V. Gutman (Ed.), *Ethics in mental health and deafness* (123-148). Washington, DC: Gallaudet University Press.

Twersky-Glasner, A., & Sheridan, M. J. (2005). Vocational, educational and psychological assessments of deaf inmates. *Justice Policy Journal, 2*, 1-26.

U. S. Bureau of the Census (1997). Statistical Abstract of the United States: 1997. Washington, DC: U. S. Government Printing Office.

U. S. Bureau of the Census (2011). Statistical Abstract of the United States: 1997. Washington, DC: U. S. Govt. Printing Office.

Vuori, S., & Holmlund-Rytkonen, M. (2005). 55+ people as internet users. *Marketing Intelligence & Planning, 23*, 58-76.

Wadensjö, C. (2001). Interpreting in crisis: The interpreter's position in therapeutic encounters. In I. Mason (Ed.), *Triadic Exchanges: Studies in Dialogue Interpreting* (pp. 71-86). Manchester: St. Jerone.

Wattenberg, E. (1986). The fate of baby boomers and their children. *Social Work, 31*, 20-28.

Witte, T. N., & Kuzel, A. J. (2000). Elderly deaf patients' health care experiences. *Journal of the American Board of Family Practice, 13*, 17-22.