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Challenges Impacting Professional Capacity to Assess the Social-Emotional Functioning of Deaf and Hard of Hearing Youth: A Qualitative Study

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Report

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Arts

The University of Texas at Austin

December, 2014

Acknowledgement

I would like to thank Dr. Stephanie Cawthon for her unconditional support and encouragement throughout the qualifying process. I would also like to thank the additional members of my qualifying process committee: Dr. Diane Schallert and Dr. Deborah Tharinger for their insightful and invaluable feedback.

Abstract

Challenges Impacting Professional Capacity to Assess the Social-Emotional Functioning of Deaf and Hard of Hearing Youth: A Qualitative Study

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The University of Texas at Austin, 2013

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The role of the practitioner assessing social-emotional functioning of deaf and hard of hearing (DHH) youth is complex and requires extensive cultural, linguistic, and educational training. The range of required competencies, the insufficient number of professionals currently in practice, the dire need for service provision, and the ultimate influence of service provision on youth functioning merit deeper exploration of the challenges faced while assessing social-emotional functioning. This study employs a grounded theory approach to analyze semi-structured interview data from 13 school- and community-based professionals to explore challenges related to the assessment and conceptualization of social-emotional functioning of DHH youth. Seven key categories emerged from the data: challenges in early training and supervision, challenges in gathering sufficient background information, dual challenges in employing specialized assessment and therapy techniques, challenges in writing descriptions of youth functioning, challenges in working with interpreters, and the need for professional support. Future directions and implications for future generations of practitioners are discussed

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Chapter 1 Introduction

When considering contexts for social and emotional development of deaf and hard of hearing (DHH) youth, it is important to first recognize that these individuals comprise only 0.1% of the general school age population in the United States (Data Accountability Center, U.S. Department of Education, Office of Special Education Programs, 2008). In addition to the low-incidence nature of this population, individuals who are DHH comprise a highly heterogeneous group with great variation in communication modalities and preferences, educational experiences, and identification with capital 'D' Deaf cultural groups (Fellinger, Holzinger, & Pollard, 2012). Being D/deaf can defined in an infinite number of ways and can include a range of experiences related to hearing levels, age of onset, age of identification of hearing loss, cause of hearing loss, primary and preferred language, access to early intervention, and cultural identification with Deaf groups (P. Albee, personal communication, Sept. 20, 2013). In broader terms, variability in the Deaf cultural beliefs and affiliation, educational opportunities, and early language access all contribute to differing experiences, and definitions, of D/deafness (Easterbrooks, 2008).

Current Understandings of Social-Emotional Functioning of DHH Youth

As a cultural-linguistic minority population, DHH individuals are often underserved, particularly when it comes to appropriate and effective mental health care. A comprehensive understanding of the scope of mental health needs of DHH populations is still being formed, including the epidemiology of various mental health disorders. Two of the leading experts in the field of Deaf Mental Health (DMH), Neil Glickman and Robert Pollard, report that research on DMH is at least forty years behind that of hearing

mental health research. The majority of research before the 1970's falsely portrayed DHH individuals as lacking in intelligence and suffering from greater rates of extreme psychopathology, such as schizophrenia, than hearing populations (Glickman, 2013). A previously mentioned, DHH populations, including DHH youth, are a widely heterogeneous group, with great variation in cognitive, emotional, and social early experiences and developmental trajectories (Fellinger, Holzinger, & Pollard, 2012). Previous misconceptions of the abilities and functioning of DHH groups combined with wide cultural, linguistic, and educational variability make it difficult to determine exact statistics on the epidemiology (including incidence, distribution, and possible control of factors relating to mental health) of various disorders in DHH populations. Additionally, it is difficult to know what tests are most useful and appropriate to diagnose various mental health conditions, given that tests normed on d/Deaf populations are rare (Glickman, 2003). Thus, a comprehensive understanding of exactly *how* cultural, linguistic, and educational differences impact social and emotional functioning of DHH youth is not fully established in the literature (Hintermair, 2010; Moeller, 2007).

However, what research does suggest is that DHH individuals are subjected to a significantly greater number of mental health risks than hearing counterparts due to factors including but not limited to: an early and/or pervasive lack of communication access in society as well as with family members, a lack of appropriate educational services, and a lack of access to necessary physical and mental health treatment services (National Association of the Deaf, 2003). While it may be difficult to determine the exact impact of these early risk factors on social and emotional functioning, it is thought that certain cognitive and emotion-regulation skills are impoverished by a lack of access to

early communication (Glickman, 2013). Most DHH children are born into hearing families, with some reports as high as 90% of DHH children born into hearing worlds (Calderon & Greenberg, 2011; Leigh & Pollard, 2011). These statistics suggest a challenging terrain for DHH children as they navigate important attachment and relationship-building tasks with their families and in society.

Research has suggested that for DHH individuals, important social and emotional outcomes are related to effective linguistic access and interactions between caretakers and the child (Calderon & Greenberg, 2011; Rosenbaum, 2000). Glickman (2013) asserts that for DHH children growing up environments without early or consistent access to a communication modality that suits their needs, there is a greater likelihood for the "development of behavioral, social, and emotional disturbances including aggression, self-harm, a gross deficiency in interpersonal skills and perceptions, poor school and vocational attainment, and significant deficits in fundamental independent living skills such as money management and healthy living practices" (p. 580)

School-based research indicates that deaf and hard of hearing (DHH) school-aged youth do demonstrate social-skill deficits when compared to hearing counterparts (Calderon & Greenberg, 2011). Studies have shown differences in the rates of social-emotional problems experienced by DHH students compared to hearing peers, with rates as high as two to three times (Dammeyer, 2010; Fellinger, Holzinger, & Pollard, 2012; Hintermair, 2007; van Eldik, 2005). Studies comparing DHH youth to same-age hearing peers have found that DHH students interact less frequently and are less successful at maintaining peer interactions over time (Antia & Dittillo, 1998; Antia, Kreimeyer, Metz, & Spolsky, 2011; Keating & Mirus, 2003). In addition to social skill deficits, the

literature has suggested that DHH students exhibit emotional difficulties such as impulsivity, poor emotion regulation, low frustration tolerance, egocentricity, and lack of introspection (Calderon & Greenberg, 2011; Meadow, 1980). Studies on the school experiences of mainstreamed DHH students have reported that feelings loneliness and few close friendships are prevalent (Foster, 1988; Leigh & Stinson, 1991; Stinson & Lang, 1994; Stinson & Whitmire, 1997; Stinson, Whitmire, & Kluwin, 1996). Social and emotional interactions during formative years have lasting effects on subsequent relationships and quality of life for DHH youth, thus it is necessary to consider additional factors, such as the professional capacity of practitioners to effectively assess, conceptualize, and intervene in the social-emotional difficulties of DHH youth.

Specialized Competencies Required of Practitioners Serving DHH Youth

Today, more than 80% of children who are DHH are educated in mainstreamed public settings (Gallaudet Research Institute, 2006). It is predicted that the number of DHH students who are educated in public school settings will continue to increase due to precedents set by the Individuals with Disabilities Education Act (IDEA), continued closure of many state schools for the deaf, and the increase in the use of technology that provides access to auditory language modalities (Antia, Kreimeyer, Metz, & Spolsky, 2011; Hintermair, 2010; Calderon & Greenberg, 2011). As shifts in the socio-cultural and educational landscape for DHH youth occur, professionals working specifically with DHH youth are in a unique position to assess and conceptualize the functioning of this cultural-linguistic minority population. In order to work affirmatively and effectively with DHH populations, training and experience beyond the foundations of mental health disciplines are necessary. In 2012, The National Association of School Psychologists

encouraged all psychologists to increase their "skills, awareness, and sensitivity to serve this distinct population" (NASP, 2012, p. 1). Practitioners must have familiarity with cultural, linguistic, and educational influences on functioning. As the national school for the Deaf, Gallaudet University's school psychology training program stands as the premier model for work with DHH youth: it requires five global competencies including American Sign Language (ASL) proficiency, knowledge of deaf-related issues, psycho-educational considerations for DHH students, psychological assessment, and specific evidence-based interventions for DHH students (Gibbons, 2009). As Peoples (2002) asserts, in the realm of mental health services, it is possible to choose Deafness as a "legitimate clinical domain" (p. 99). NASP also endorses that professionals working with DHH students become intimately aware of any limitations in their training or background. In order to provide quality services, practitioners must know when to seek necessary outside consultation or to refer patients to other providers (Gutman, 2002). For hearing professionals, the appropriate and effective use of an interpreter is also an important specialized competency. A 2008 national survey found that only 10.7% of practicing school psychologists were fluent in a language other than English and less than 1% of practicing school psychologists reported ASL fluency (Charvat, 2008). Due to the scarcity of school and community psychologists who are proficient in ASL, interpreters are relied upon to assist in assessment and therapy settings.

The Low-Incidence Nature of Highly Specialized and Competent Practitioners

Given the low-incidence nature of DHH populations, it is not surprising that numbers of practitioners specializing in DMH are also low. Mainstream educational settings vary widely in their provision of mental health services for DHH due to

inconsistent levels of expertise in DHH-related issues (Vernon & Leigh, 2007). The majority of secondary school professionals, including most mainstream school psychologists, have little exposure to deaf culture, no background in sign language, and are unfamiliar with the evaluation process for students with hearing loss. It is also the case in other mental health settings that a shortage of psychologists who have the training and experience to assess DHH youth. The number of psychologists adequately prepared to work with DHH individuals is significantly lower that the current need for psychological services (Leigh & Pollard, 2011; Luckner & Bowen, 2006). Ultimately, this means that psychologists currently working with DHH youth are overburdened and likely take on cases that may need to referred to practitioners with expertise in areas that meet the needs of the individual client (Peoples, 2002).

Chapter 2 The Current Study

The wide range of required professional competencies, including knowledge about Deaf culture, combined with the insufficient number of current practitioners and the dire need for social and emotional service provision necessitate further exploration of the professional experiences and challenges faced by practitioners. The current study explores, from the perspective of professionals serving this cultural-linguistic minority, various challenges related to the assessment, conceptualization, and treatment of compromised social-emotional functioning in DHH youth. This study also explores the impact of these challenges on the professionals' capacity to serve DHH youth facing social-emotional difficulties in school and community settings.

Of primary importance is the acknowledgement of this author's status as a hearing person conducting research on DHH individuals. My own views, including the interview questions I posed to my research subjects, have been influenced by my experiences as a hearing person. McCullough (2007) encourages all hearing researchers to explore their own personal motivations for studying Deaf people, including motivations of self-interest, rather than a concern for the wellbeing of Deaf communities. An additional acknowledgement is my status as psychologist-in-training. My position as a psychology student interested in serving DHH youth allowed for enhanced access to interviewees; given my expressed background and interest, the participants were most eager to speak to their experiences in terms of their training and challenges. Some aspects of conversation, such as references to various assessment tools, were expedited because of my background knowledge.

Method

This study utilized a grounded theory approach based off of Corbin & Strauss's 2008 guidelines (*Basics of Qualitative Research, Third Edition)*. All interviews were transcribed and analyzed as they were collected, which is known as the constant comparison method, because it allows for a continuous understanding of the data (Strauss & Corbin, 1990). Credibility of the data came in the form of member checking by subsequent interviewee, in which expressed challenges, factors contributing to the challenges, and subsequent impact of challenges on professional capacity were either validated or countered with opposing experiences.

Participants

Thirteen professionals participated in this study. Seven of the professionals were licensed school psychologists (four DHH, three hearing) and six were psychologists or licensed professional counselors in community mental health settings (one DHH, five hearing). All interviewees had at least 8 years of professional experience post-training, and represented nine different states within the contiguous United States, thus supporting effective data saturation. All school psychologists who attended the 2013 National Association of School Psychologist (NASP) conference and who were involved with the DHH special-interest meeting were invited to participate. Psychologists and licensed professional counselors in community mental health settings were recruited using a snowball sampling technique through the Post-Secondary Education Planning Network 2.0 (PEPNet 2.0).

Interview Procedure

Thirteen semi-structured interviews each lasting 1-hour were conducted using *Omnijoin,* a web-based conference technology. Interpreters were requested as needed

through PEPNet 2.0, thus, we were ensured certified interpreting. Interviews were audio and video recorded to capture signing and all recorded material was transcribed for analysis. A pilot interview conducted at the 2013 NASP National Convention revealed the need to inquire specifically about the use of interpreters during assessments, thus questions on this topic were added to the interview protocol. All semi-structured interviews were guided by questions that allowed the professionals to explore topics as they felt so moved. The first author made every attempt to listen actively for additional avenues to explore during the interview process. Using this approach, it was not uncommon that questions were asked of some participants and not of others, resulting in a rich collection of data. All interviewees were asked to share their professional backgrounds, training programs, ASL fluency, experiences with DHH individuals, experiences in social-emotional assessment, and their use of interpreters.

Data Analysis

Open coding. Initially, transcripts were read and re-read and concepts were extracted from the raw data. This process, known as open coding, was performed on an ongoing basis during the data collection phase. All of our interview transcripts were analyzed line by line, to break the data apart. Concepts that stood as blocks of raw data, also known as meaning units, were labeled with 'codes' (Strauss, 1987). Open-coding labels were often at a fairly low level of abstraction and were derived from the language of the interviewees; in many cases, codes were labeled using the specific language of participants, which is also known as an 'in vivo' code (Strauss & Corbin, 1990).

Memo writing. Memos were written at every juncture that represented new meaning in the data as a means of code exploration, and to begin establish higher-order

categories. Memo writing included elements of comparison-making, question posing, elaboration on the nature of relationships between codes, interactions between the participants and their environments, and subsequent consequences.

Axial coding: Forming initial categories of information. In this stage of analysis, codes extracted from the data were examined for repetition, similar phrases, patterns, relationships, commonalities, or disparities. Codes which repeated or shared commonalities were condensed according to their similar properties, known as categories. In qualitative research, categories are sometimes referred to as themes (Strauss, 1987). Such categories represent relevant phenomena in the data as a level of higher-order meaning making. This process was known as axial coding: the contextualizing, putting-back-together of specific codes into broader categories or themes and to one another (Strauss & Corbin, 1990, pp.96-97)

Hypotheses specifying conditions and consequences among categories. As our categories emerged and our data was sorted, a technique known as validation was employed (Strauss & Corbin, 1990). It was at this point that member-checking strategies were employed. When our data supported the hypotheses, we allowed this to verify our grounded theory. When data did not support the hypotheses, we considered this still significant because it demonstrated exceptionality within our grounded theory framework (Lasser & Tharinger, 2003).

Diagramming of a Conditional Matrix. To visually represent our qualitative data, a conditional matrix was diagrammed (See Figure 1). Our conditional matrix depicts the thematic categories of findings which pertained to our topic of interest: challenges

impacting the professional capacity to assess social and emotional functioning of students who are DHH (Strauss & Corbin, 1990, p.161).

Chapter 3 Results

As is common in grounded theory approaches to data analysis, the first round of analysis involved open-coding, in which well over 50 codes were identified. These codes were then organized into seven axial, superordinate categories of professional challenge to subsume initial codes. The next step was to synthesize the conditions and consequences observed within those seven axial, superordinate categories as a means of ascribing to the 'grounded theory' approach. The final step was to create a visual model, or a conditional matrix, of the conditions surrounding the central phenomena. In Figure 1, we present our conditional matrix to visually depict our data. The center of the matrix represents the professionals' capacity to assess, conceptualize, and treat the compromised social and emotional functioning of DHH youth. The seven spheres surrounding our central phenomena represent the thematic challenges impacting the professional's capacity to serve DHH youth. Our diagram also depicts surrounding conditions that directly impacted the professionals' capacity to serve: ASL proficiency emerged as the most essential professional competency; thus, it most proximally surrounds the center of our matrix to indicate its pervasive influence on professional capacity. ASL competency seemed to have the most direct impact on the professionals' capacity to effectively assess, conceptualize, and treat the issues faced by DHH youth; greater the proficiency with ASL resulted in an increase in ability to gather necessary background data from deaf families, interact comfortably with DHH clients, and discern subtle diagnostic differences in youth functioning.

The influence of Deaf culture, language access, and quality of training and education also influenced all interviewees, thus we visually represented this in the

backdrop of our entire matrix. Examples of *Impact of Culture* included both student and practitioner identification with, beliefs about, and orientation towards capital 'D' Deaf culture. In all cases, practitioners expressed a cultural, as opposed to medicalized view of deafness. Examples of *Impact of Language* included whether the practitioner had effective communication access with the youth and his or her family; this was particularly salient influence when families were comprised of non-English speakers. Examples of *Impact of Education* included the influence of training backgrounds from a variety of professional fields, experiences in various d/Deaf settings and overall quality of professional training.

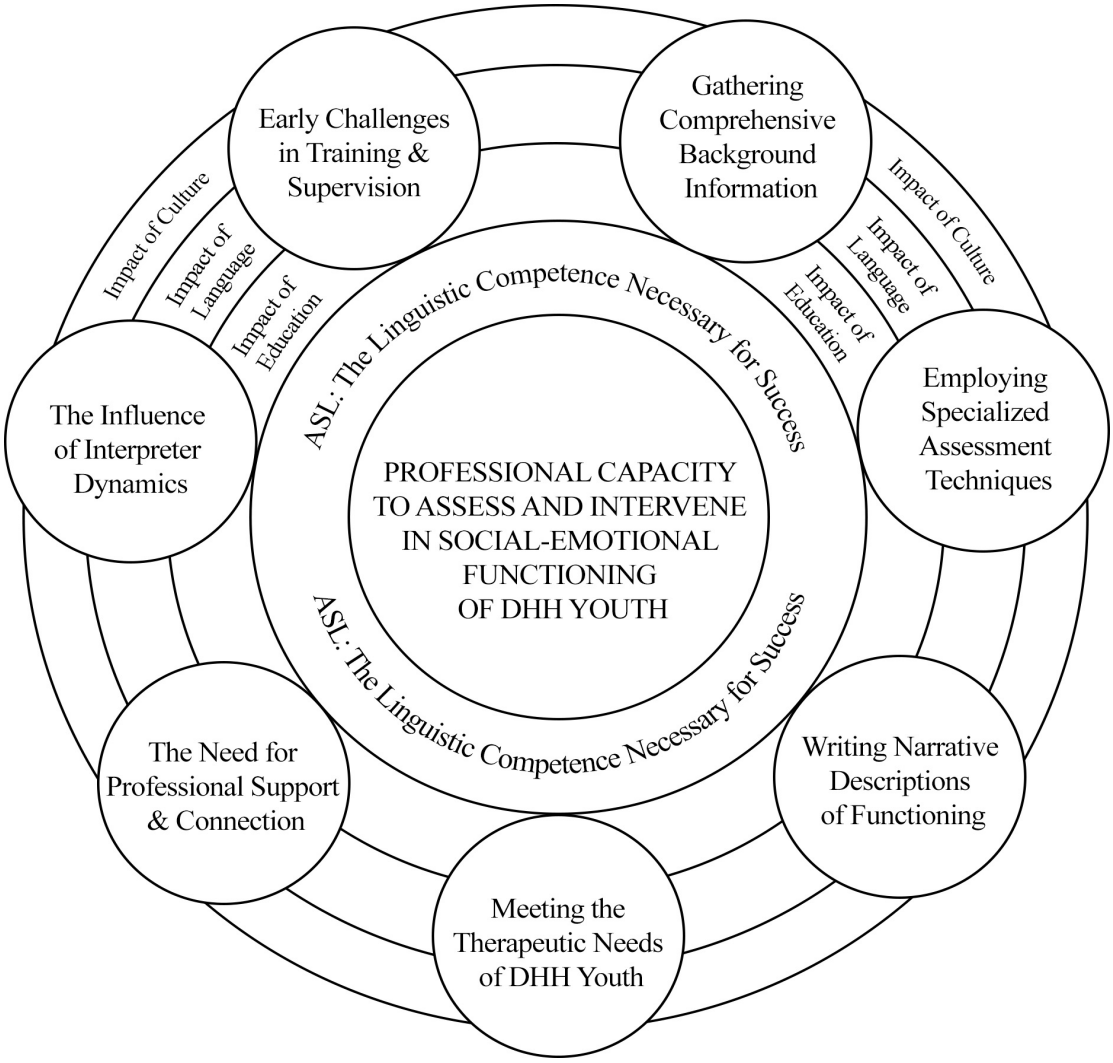

Figure 1. Conditional Matrix: Challenges that Impact Professional Capacity to Serve DHH Youth

American Sign Language (ASL): Necessary for Professional Legitimacy and Success

Despite working in various regions across the country, the interviewees shared a unique commonality. Before beginning their careers as psychologists and counselors, one third of professionals spent earlier years earning degrees in Deaf Education and were employed as educators of the deaf in both mainstream and/or residential settings. Another third of the professionals spent time as vocational rehabilitative specialists where they worked with individuals with wide ranges of cognitive and physical disabilities on

vocational training. The professionals all took complex and challenging paths to become competent mental health service providers who specialize in serving DHH youth. Their professional journeys were long, lasting on average well over 8 years of education within multiple programs so they could specialize and then re-specialize. Most of the professionals relocated several times during their careers, migrating from various regions to areas where jobs in schools or clinics were available, or to areas with large Deaf populations in need of mental health services.

For all interviewees, competency in American Sign Language (ASL) was the most integral part of their professional development. Most of the professionals had personal backgrounds in ASL, had received additional credentials as interpreters, or had majored/minored in ASL during college. "It's the only reason I'm doing this job. I'm fluent in ASL, and I understand ASL culture, and I understand how growing up as a person with hearing loss in a predominantly hearing world impacts development. Socio-emotional, intellectual, all those things. And it's my expertise in that that has given me the niche I need to be successful in my career…" expressed one hearing interviewee as an example of how ASL proficiency allows her to be successful with DHH children. "If you're not familiar with sesame street characters…and you don't know how they sign it, you're going to have a missed opportunity because you don't have that language and you can't get at that level," shared another professional. In the most fortunate of cases, language gaps between the practitioner and a DHH child were transformed into opportunities to build rapport. In the case of one school psychologist, her linguistic error was a source of comedic relief for adolescent she was assessing. She said, "One time I was working with a kid and I tried to sign, 'You are really smart,' but I really ended up

signing 'You are really stupid.' He just about rolled off of his chair!" Despite her error in signing, she took the opportunity to reduce her position of power, particularly as a hearing professional, to a level closer to the adolescent she was working with.

Early Professional Challenges: The Struggle for Adequate Training and Supervision

The professionals who studied at institutions other than Gallaudet University, the national school for the Deaf, noted the limited existence of specialized training and supervision opportunities. One psychologist noted that her clinical psychology training program had nothing to do with deafness and that she, "ended up needing to make it that way for myself and make it on my own." Hearing professionals ran into financial barriers: if interpreting services were needed during training, funds were rarely available. Many professionals struggled to find appropriate supervision during on internships. One Deaf school psychologist commented that, "At my first job after graduate school, I [basically] had no supervising. It was just not very good. The supervisor I did have, it was just not very good." Another community mental health professional noted that she paid for her own outside supervision to specialize in play therapy for deaf children. Despite these barriers, the interviewees expressed a passion for their work. One school-based professional commented how thankful she was for "amazing situations to open not only my eyes, but to make me more aware of the differences in the types of disabilities I would encounter. Especially when you have a kid who has 4 or 5 eligibilities [for school-based services] and you have to take each one apart…there is nothing more beautiful to me than someone signing. I get chills every time I think about it, there is nothing more beautiful."

Current Challenges: Gathering Comprehensive Background Information

The professionals emphasized the heterogeneous nature of the youth they worked with. As discussed earlier, DHH youth arrive at school settings with a wide range of linguistic abilities and preferences, educational backgrounds, and cultural influences. Because of this heterogeneity, the professionals expressed challenge in gathering sufficient background information about the youth they serve. One hearing school psychologist described this process, "First you need to start with a very good background history, a social history. What kind of background someone came from, what of the country, what kind of educational system they were involved in, how they were being instructed, how they were taking in information, whether they were signing or whether they were in an oral program, what kind of exposure they had to education, that kind of background from the parents." However, many of the professionals commented on the challenge associated with a lack of quality or insightful background information about the youth they worked with, particularly because DHH youth may travel far distances to attend state schools for the Deaf. Many DHH youth transfer schools due to negative experiences in mainstream settings; during this process information and records may become lost.

When Background Information is Unavailable. "Some parents simply do not have knowledge about factors relating to their [deaf] child's history and functioning. A few times I've had [hearing] parents tell me they can't answer questions because they don't know the child well enough," remarked one psychologist. While this may be difficult to imagine, communication gaps between parents and their children create these types of scenarios far too often. The professionals took great measures to obtain whatever information they could about the youth they served. "There are times when I asked for a

phone number and called a grandparent from another country, El Salvador, to get that information in order to be able to figure out what a score [on an assessment] really means," recalled one hearing school psychologist.

The Need for Bilingual Service Provision. Additional challenges arose during the information gathering process. A growing need for competent bilingual service provision exists; in particular, Spanish-speaking service providers are in high demand, especially at state schools for the deaf. Simply providing parents with questionnaires or surveys in Spanish is not enough. "[The parents] can't read or write in Spanish but we really need to get that information. The next thing we would do is get our sole Hispanic interpreter to work with that family," described a Deaf psychologist. She continued, "I use ASL and then it will be translated from ASL to the [Spanish] interpreter and then the interpreter interpreters it into Spanish and so there are actually two interpreters." Other psychologists conducted family therapy sessions with Spanish translators present. Both commented how necessary, but complicated and time-intensive, it was to involve multiple interpreters in one session.

Current Challenges: Employing Specialized Assessment Techniques

Gathering extensive student background information is especially important because of the impact on selection of assessment measures, translation of assessment materials, and interpretation of results. Once all available background information has been gathered, the task of conducting a culturally and linguistically appropriate assessment begins. "I've been able to re-assess people who were assessed previously by well intentioned people who knew nothing about hearing loss and really misinterpreted

data drastically and have erroneously labeled people as mentally retarded when they were nowhere near that," shared one community mental health practitioner.

Standardized Translations of Assessment Materials. DHH youth are a uniquely complex population to assess, due in part to the challenge of translating materials into ASL. "It's very difficult for mental health clinicians to get anything standardized in ASL. Everyone uses all of their own questionnaires and tools," commented one community mental health practitioner. As Gibbons (2009) asserts, psychologists who specialize in serving DHH youth must know how to make necessary test modifications, how to appropriately translate test material, and must have familiarity with available deaf norms. The professionals acknowledged how difficult and time consuming it is to translate assessments from English to ASL without losing the intended meaning of the item. One school psychologist reported that she signs every item on the BASC parent-rating form so that parents who are deaf have an opportunity to report on their child's functioning. This process can takes several hours to complete. Although this method may be appropriate in the context of general information gathering, true standardization of assessment measures requires multiple rounds of reliability and validity testing. "[A colleague] years ago tried to get the MMPI, 560 questions signed into ASL. It took her over 10 years, and never was able to complete it. So now most of the time when a deaf person takes the MMPI, it looks like they are paranoid because of the way the questions are translated," shared a community mental health provider.

Interpretation of Test Results in Context. The practitioners all struggled with a standard delivery of assessment materials, particularly during the translation of items into ASL. However, the most challenging aspect of the assessment process revealed itself: the

interpretation of results. Comprehensive background information helps to explain why a set of scores or particular profile emerged. 'Deafness' does not inherently cause social or emotional difficulties; rather, broader environmental contexts contribute to the expression of conditions like anxiety or depression. One school psychologist emphasized the following: "I use the different behavior checklists, the BASC, but always interpret that in light of the child's background information...the child may score high on anxiety, well they are just coming to a new [school] system so that would be expected." Another school psychologist added that, "It's tough because you really have to have that understanding of what is 'normal' for a deaf kid. Their social interactions are just a little bit different from hearing kids." This school psychologist suggested that based on her 18 years of experience working at a state school for the deaf, her own internal gauge of normative versus clinical behavior for deaf children because her primary assessment tool.

Current Challenges: Writing Narrative Descriptions of Functioning

Practitioners working with DHH youth synthesize a wealth of idiographic data on child's functioning. As discussed earlier, professionals conducting assessments face challenges with the translation and interpretation of assessment materials. Ultimately, as most of the practitioners described, the final psychological report becomes more descriptive, and less norms-based. One deaf school psychologist reported that she had to learn to write a 'child-specific' and not a 'test-specific' report. Writing a descriptive summary of what a child did in a testing situation, as opposed to a focus on scores and percentile ranks, paints a helpful picture of the child's current functioning. "You know these reports, they were comprehensive and had all these different averages, and I had a lot of information but I didn't have much information *about* the child," shared one

psychologist. This suggests an approach toward report-writing that is more narrative, and person-centered. The challenge here is the time-intensive nature of a person-centered report with the inclusion of as much relevant contextual information as possible.

Current Challenges: Meeting The Therapeutic Needs of DHH Youth

Many of the community mental health providers commented on the difficulty of obtaining accurate data on the prevalence of mental health concerns within DHH populations. It is thought that prevalence rates for DHH youth are higher than hearing youth because of certain environmental risk factors. "You would have to extrapolate," remarked one community psychologist, "you would have to look at the statistics that are out there for the hearing community, and then because of the risk factors, you would anticipate that the rates would be higher within the deaf community." According to those interviewed, risk factors such as having limited ability to communicate with family and growing up in remote parts of the country without early intervention are salient to the etiology of mental health concerns like anxiety and depression. Through an examination of risk factors, it becomes more possible to measure the scope of need, but the interviewees commented on the need to more fully understand this topic. The professionals reported that generalized anxiety, major depression, and trauma-related symptoms were most common socio-emotional difficulties faced by DHH youth. Many commented that the discovery of childhood traumas amongst client populations continues to increase, necessitating specialized approaches such as Trauma-Focused Cognitive Behavioral Therapy (TFCBT) with this population.

Determining Language Skills and Selecting Appropriate Approaches. The professionals who specialized in therapy techniques with DHH youth identified language

abilities as the most salient factor in treatment planning. “I think some of the treatment modalities [are best suited for] not even so much age, but in the group I work with, to their cognitive levels and their language abilities,” shared one practitioner. Youth with higher language capacities in any modality were much more likely to engage in psychotherapy, narrative therapy, and traditional CBT. The professionals commented that this group of youth was more able ‘mentalize.’ “If they have much stronger language skills and are able to do much more of the communication based therapy things like narrative therapy and even CBT can be language based or not so much, depending on the need. It really has absolutely nothing to do with IQ, it’s more what is their fundamental knowledge in terms of language.” For the youth with lower language skills, more concrete approaches to therapy were most successful. Play therapy and direct representation of meaning through symbols, pictures, and models was most helpful. One community practitioner shared that she uses a jello mold of a brain and places small objects or words inside to represent the experience of going through the day with negative or distorted thoughts.

Trauma Focused Approaches. An important issue for all of the community mental health practitioners was the impact of early or recurring trauma experiences, including physical, mental, emotional, and sexual abuse, as well as complex language traumas related to communication gaps that exist in hearing families of DHH youth. One therapist commented on the history of abuse within DHH populations, “There’s a lot of statistics out there that show deaf and hard of hearing are traditionally abused at a higher level [than hearing individuals] because the feeling [for perpetrators] is always that ‘they won’t tell.’” In order to identify trauma history, the practitioners described the specificity with

which they ask the youth various questions. Sometimes abstract concepts like 'trauma' are misunderstood, or clients are uncomfortable answering broad questions about trauma, so it is best to be as specific as possible. "The more we ask, the more trauma we are finding. And we're finding that it's so important to know because it effects [the youths'] ability to regulate themselves, have appropriate social and relationship skills, pay attention and study and learn and if you don't address it then you're not addressing the underlying root of those difficulties for all of those people."

Current Challenge: Interpreter Dynamics

For those professionals who required the services of an interpreter, the use of interpreters presents unique challenges. Of primary concern is boundary-setting and confidentiality around the work being done. All of the professionals commented on the need to discuss confidentiality with interpreters and with clients before beginning any work. Of equal concern was the quality of interpreting. If the interpreter is not qualified, diagnostic errors are likely which will lead to poor evaluation outcomes (Vernon & Leigh, 2007). For example, when the interpreter voices for the student, he or she is likely to reflect the affect of the student. The interpreter may be influencing the assessor by his or her subjective interpretations of the students affect and the assessor must be cautious (Connolley, Rose & Austen, 2006). Additionally, if the assessment is conducted in a rural area with few available interpreters, it may be the case that the student or the student's family already knows the interpreter. This may create a bias in terms of assessment results.

The Importance of Trust. The professionals quickly identified 'trust' as the most jeopardized factor when including an interpreter in an assessment or therapy session. One

of the most important tools any clinician has is the potential to build necessary and lasting rapport with their clients. This is even more important in the context of DHH-related issues where issues privacy are major concerns. “If the interpreter is someone who works with that child every day, do they [the child] trust that person? But if they don’t trust that person, they might be more apt to hold things back.” One school psychologist commented on the ultimate significance of direct communication, “It gives you a relationship…you are not having to go through somebody else to talk to them, you can talk directly to them. It gives you the communication. It gives you the ability to build a relationship to build the trust factor and trust is very important.” Introducing an interpreter to the assessment process creates relational complications for the typical dyad of the assessor and the student (Connolley, Rose, & Austen, 2006; Hoyt, Siegelman, & Schlesinger, 1981). Familiarity with the interpreter also may create interpersonal barriers if the student is afraid that his or her confidentiality will not be respected (Connolley, Rose & Austen, 2006; Harmer, 1999; Pollard, 1998). The student might censor him or herself in ways that would not occur if there was a line of direct communication (Misiaszek, et.al, 1985).

Best practices when working with interpreters. Quality of collaboration defined by honest and effective communication between the psychologist and interpreter emerged as a salient theme. According to those interviewed, the role of the psychologist becomes ‘educator’ as he or she communicates the nature of the assessment task. “The school psychologist really needs to think carefully when working with interpreters if the interpreter understands the goal of the question [during an assessment], so that the correct answer can be given that makes it fair and equivalent to what hearing students would

experience" shared one professional. Another commented, "I'm hoping that the interpreter can understand their role and that they cannot translate to make the student sound either better or worse." Meetings with interpreters before a therapy or assessment session must occur as a best practice; specific goals and intended outcomes for the session must be outlined and understood by both parties.

Current Challenges: The Need for Professional Support and Connection

The experience of professional isolation was salient. Some of the professionals who served smaller numbers of DHH students worked in rural parts of the country and were distant from areas of Deaf cultural concentration. Other experiences of professional isolation occurred as a product of the intensely specialized nature of working with DHH populations; in mainstream settings, speech pathologists served as likeliest professional allies. The professionals all emphasized the importance of building strong professional networks. Resource sharing was another crucial part of this professional sphere. National and state-level conferences as well as online access to the DHH professional community was a main source of professional connection. All of the professionals commented on the importance of this unity; working in 'helping profession' is uniquely hard, and is made even more challenging when working with underserved minority populations. "We understand what's going on and we can vent with each other," commented one professional. The sense of camaraderie, collaboration and support helps to buffer against feelings of overwhelming frustration.

Wearing Multiple Hats. A significant challenge facing all of the professionals was the responsibility of stepping into 'multiple hats' to meet varied needs of their clientele. The pressure to juggle multiple roles and perform duties that fall outside the parameters

of professional training was noted. “There is sometimes extra pressure placed on the personnel at schools for the deaf to do more than they really need to or are trained to do because there is such a shortage of mental health professionals.” The professionals found themselves performing various roles including advocate, mentor, and even parent. The professionals also commented on the pressure to assume an expert role, even when cases were beyond their scope of professional knowledge, simply because they were “the only ones” with any knowledge of DHH-related issues.

Chapter 4 Discussion

The purpose of this study was to explore challenges and the impact of such challenges on professionals' capacity to assess and conceptualize about the social and emotional functioning of DHH youth. The perspectives of 13 professionals were captured through semi-structured interviews and a grounded theory of the most salient challenges facing professionals emerged from the data. Seven thematic categories of challenge emerged from the data: early challenges to acquire effective training and supervision in both assessment and therapy for deaf individuals, challenges in gathering sufficient background information on the youth served, challenges in adapting and employing specialized assessment techniques, challenges in assessing and meeting the therapeutic needs of DHH youth, challenges in writing insightful descriptions of youth functioning, the powerful influences of interpreters on therapy and assessment practices, and the dire need for professional support when working in the field of deaf mental health. The final result of our data was a model depicting the challenges impacting the professionals' capacity to assess and intervene in the social-emotional functioning of DHH youth, as well as the role of ASL, and the broad impact of culture, language, and education on both the professionals and youth.

While healthy discussion focused on solutions to all of these challenges is warranted by this study, the finding that practitioners experience varying degrees of isolation and immense pressure to juggle multiple roles has direct implications for the quality of assessment and therapy work currently conducted with DHH youth. In the same way that DHH youth are exposed to environmental risk factors at rates higher than hearing peers, professionals serving DHH youth also face environmental risks including

but not limited to chronic fatigue, role overburden, and pressure to play a "deaf expert" role.

In many ways, the professionals' expression of isolation parallels the all too common experience of social isolation of deaf individuals. Primarily, the practitioners commented on their dire need to connect with others in the field for support, consultation, and continuing education. Although not directly stated by the interviewees, a major consequence of significant professional isolation is the threat to professional longevity and quality of service provision. As Rupert and Kent (2007) describe, the term *burnout* has been used in counseling literature to refer to a set of negative reactions to work-related stressors including emotional exhaustion, depersonalization of clients, and feelings of personal lack of accomplishment. While findings of overburden have been replicated by other studies examining burnout of workers in 'helping professions' (for a review, see the 2010 meta-analysis by Lim et. al) the uniquely small size of the field of DMH suggests a greater likelihood for feelings of isolation, particularly for those professionals working in remote areas.

Practical implications for working with DHH youth are suggested by the findings of this study. As the professionals discussed, the importance of connecting with other providers in the field to share stories, frustrations, and successes was the most emphasized protective factor. As was highlighted in this study, for these professionals, such connection is necessarily restorative. Given the insufficient numbers of practitioners trained to work in this field, (Leigh & Pollard, 2011; Luckner & Bowen, 2006) and the degree of strain put on the already burdened population of providers, a critical mass of future practitioners will be needed to continue the work of the professionals in this study

to support the social-emotional needs of DHH youth. As Corey, Corey, & Callanan (2007) report, many mental health practitioners are not adequately informed about potential hazards and pitfalls in the 'helping profession.' For future generations of practitioners working specifically with DHH youth, discussion within training programs and amongst colleagues should focus on professional self-care, personal and professional limit-setting, and appropriate coping techniques, may help to promote resiliency and professional longevity. Corey, Corey & Callanan warn that, "if students are not adequately prepared, they may be especially vulnerable to early disenchantment and burnout due to unrealistic expectations (p. 58, 2007).

Limitations

The interpretation of the interviews with those participants who are d/Deaf stands as the greatest limitation to this study. Although all interpreters provided through PEPNet 2.0 were of the highest quality, a lack of direct communication between the researcher and several of the participants was a significant limitation. Interpretation of any language introduces changes to the subtle meanings hidden in word choice and diction. While all participants were provided a copy of their interview transcripts for their review, it is a limitation of the study to require the services of an outside, third party, to provide language access. Thus, the 'in-vivo' coding process was impacted by the use of interpreters, given that the exact wording used by my Deaf participants who used ASL was modified into an English version. Although all but one of the interviews was made possible by the use of Omnijoin, an internet-based distance technology platform, another limitation to the quality of interpreting and to the overall study was the introduction of communication breakdowns at times due to poor internet connections. All of the

participants in this study were gracious and flexible with Omnijoin, however it proved to be an imperfect tool. At times, interpreters' ability to perceive the signs of the interviewees was impacted by the strength of internet connection and Omnijoin's capacity to function under strained connectivity. This further impacted the interpretation of participants' shared experiences.

Future Directions

A number of new research questions and possibilities for further investigation resulted from this study. Primarily, it is of utmost importance for practitioners and clinicians to continue to develop evidence-based practices for effective assessment and treatment techniques, particularly in trauma-related cases. Future research studies are encouraged to examine, under different conditions, which assessment and clinical practices are most effective and most needed by DHH youth. In particular, our study revealed that an additional focus on social and emotional impact of early and pervasive trauma experiences in the lives of DHH youth is warranted. As Glickman (2013) states, "the DMH field presents fertile ground, just begging to be plowed, planted, and reaped" (p. 598). Future qualitative research should also investigate particular strategies and career-sustaining behaviors used by clinicians and practitioners to avoid professional burnout in promotion of professional longevity.

Chapter 5 Conclusion

Professionals assessing the social and emotional functioning of DHH youth are in a unique position as stakeholders in the future of positive youth development. This study provides insight, through the perspectives of the professionals interviewed, to nuances in challenges faced by this overburdened population of service providers. Findings related to the professionals' isolation and experience of pressure suggests that practical considerations should be made for this professional population including discussion related to self-care in promotion of professional resilience and longevity for future practitioners. Findings related to the impact of early and pervasive traumatic experiences in the lives of DHH youth on their social and emotional functioning also suggest a need for deeper understanding of this process and specialization in treatment.

Appendices

Appendix A
Interview Questions for School Psychologists

1. First, I'd like to begin by gathering some background information about your profession. What is your experience working with students who are DHH in areas of social or emotional assessment?
2. What training have you received?
3. What have you learned from other professionals?
4. What specific tools or methods do you use to assess the current social and emotional functioning of your students?
5.What influences social-emotional outcomes in individuals who are DHH?
6. How do you measure social-emotional outcomes for the individuals you work with?
7. How have your tools or methods developed over time?
8. Are the assessments performed in a way that meet the linguistically needs of the student? How?
9. If you cannot communicate directly in the language and modality of your students, do use interpreters? Do you make referrals to appropriately qualified professionals?
10. Is there anything else that you would like to share that we haven't discussed already?

Appendix B
Interview Questions for Community Mental Health Practitioners

1. What is your background in providing mental health services?
2. What are your background experiences working with individuals who are Deaf or Hard of Hearing?
3. Please describe your current client case load
4. What are the age ranges of clients you work with? Do you work with any adolescent clients? If so, how might these clients differ from adult populations?
5. What are typical referral concerns for your clients?
6. Do you typically make additional diagnoses for your clients? If so, what kind?
7. What are assessment practices like in your setting?
8. What are therapy practices like in your setting?
9. Have you worked with clients other than those who are Deaf or Hard of Hearing? If so, do you see any presenting mental health concerns that are unique to Deaf or Hard of Hearing populations?
10. How do issues of mental health impact other areas of functioning for your clients, for example, those in college or the work force?

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