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Speech & Language Services: Examining the Experiences of Deaf / Hard of Hearing People

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Speech & Language Services: Examining the Experiences of Deaf / Hard of Hearing People

by

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Abstract

The purpose of this study is to examine the experiences of Deaf and Hard of Hearing (HoH) adults and parents of Deaf/HoH children related to speech and language services, and their recommendations for service providers. Historically, professionals have focused on the development of speech and aural/oral skills of Deaf and HoH people. As such, when working with families of newly-identified children with hearing loss, hearing professionals may be ill-equipped to provide culturally-responsive, fully inclusive information and education regarding communication options and opportunities.

Method. This study used a qualitative research design to examine participant experiences related to speech and language services and future recommendations for professionals. Fifteen participants (n=15) completed the open-ended nine-question survey. Data was then analyzed with thematic analysis using an inductive approach at the semantic level.

Results. Six themes were identified and the participants provided several recommendations to speech-language pathologists (SLPs) for their future work with Deaf/HoH people. Although most participants reported that speech-language services were not the right fit for them, they reported that such services could be valuable for other people based on skill profile and/or hearing or speech status. Participants also reported the value of trust within the clinician-client relationship

Conclusion. Historically, professionals have not informed parents of all intervention and language options when children are first identified with hearing loss. Ensuring that families receive access to inclusive, culturally-responsive education and information for all communication options is necessary.

Introduction

Research suggests that medical professionals lack evidence-based knowledge regarding intervention and language choices for Deaf/HoH children (Moeller et al, 2006). As such, parents of such children may often receive limited information and education regarding choices for their children's education and language development (Young, 2006). Additionally, few professionals, like SLPs, are fluent in ASL or are informed about Deaf culture (ASHA, 2022; Knight, 2015). Given these issues, one questions, "What are the experiences of Deaf / HoH people with speech and language services and what language choices have they made for themselves?" This paper seeks to address this through a qualitative study.

Literature review

Ninety-six percent of deaf children are born to hearing parents who do not know or use sign language (Humphries et al, 2014). Additionally, hearing parents most often seek educational advice and support from medical professionals, the internet, or friends who may not have access to evidence-based information regarding language development for Deaf/HoH children. Indeed, the most common practice recommended by such sources includes the barring of sign language in hopes the child will learn to speak (Humphries et al, 2014). In reality, the most successful language option for Deaf/HoH children is sign language, whether it is learned only, first, or alongside spoken language (Humphries et al, 2022). Deaf children learning speech only run the risk of language deprivation, however, it is important to note that the 4% of Deaf children born to Deaf parents do not run the same risk, because these children raised within an environment of sign language exposure and taught sign language from infancy (Humphries, 2022).

So why are parents being told to teach their Deaf/HoH child to use only speech? An investigation into hearing screenings and clinician practices can respond to this question.

Currently, 93% of newborns are screened for hearing loss before being discharged from the hospital, and 39 states have legislation related to universal newborn hearing screening (Moeller et al, 2006). Despite the widespread implementation of screenings, less than 10% of physicians feel very confident about varying topics related to deafness, with the least confidence being related to cochlear implants and communication approaches, such as choosing sign and/or speech (Moeller et al, 2006). Parents are asked to make difficult decisions about intervention methods that still do not have sufficient evidence, and later these hearing parents of deaf children report that professionals did not provide a sufficient range of choices to support their deaf child (Young, 2006). It is crucial that parents are given evidence-based information in order to make informed decisions.

In many cases, medical providers advise parents to have their deaf child undergo cochlear implant surgery, despite the inability to accurately predict the benefit of the implant for that deaf child (Humphries et al, 2022). In developed countries, 80% of deaf children are given cochlear implants (Humphries et al, 2012). Often, parents are advised to implant their deaf children and teach them spoken language instead of sign language, which can lead to an unsuccessful oral vocabulary as the child may miss the crucial language learning window; this situation leads to language deprivation and cognitive deficits (Humphries et al, 2014). With the implantation comes the incorrect assumption that the child will gain hearing and have adequate exposure to spoken language which is not always the reality even if the child undergoes years of intensive services provided by audiologists and SLPs (Humphries et al, 2012). Even though cochlear implants have made advances in hearing technology, most deaf children who are learning spoken language as opposed to sign, do not meet age-expected spoken language skills (Caselli et al, 2021). In fact, Deaf children who know sign language are better supported when learning spoken language, regardless of cochlear implant status (Humphries et al. 2022). In summary, parents and professionals may not understand the physical risks and the linguistic consequences when using cochlear implants as a response to deafness (Humphries et al, 2014). There is no reason to only choose spoken language and exclude a signed language, both languages can be taught simultaneously to ensure rich language acquisition (Humphries et al, 2022).

What is accessible to all children, however, is sign language (Humphries et al, 2022). Some argue that a deaf child should not learn sign language because it will hinder any possibility of them learning spoken language, however, that is unfounded (Humphries et al, 2022). The reason why there is a misconception that sign language is not a sufficient language choice and hinders spoken language is due to several flawed studies (e.g., Fitzpatrick et al, 2016 and Geers et al, 2017, as cited in Humphries et al, 2022). For many deaf children who are given access to/instructed only in speech, their ability to learn language can be greatly hindered (Humphries et al, 2016). For some children, the inability to learn spoken language and lack of access to sign language can create cognitive deficits, and the failure to provide deaf children with language exposure and instruction that is visually accessible has been framed as communication abuse (Humphries et al, 2016).

With evidence that sign language provides language development and access for a deaf child, why are medical providers still misinformed? Results of a recent survey of Speech and Hearing Sciences (SPHR) students related to deafness suggested that future SLPs and audiologists are not being taught enough about deafness and the Deaf community (Knight, 2015). Regarding how familiar each participant was with the history of Deaf culture, 4.1% were very familiar, 52.1% were familiar, 41.1% unfamiliar, and 2.7% had no knowledge. Regarding how likely they would be to take more classes on Deaf culture if there was an opportunity, 17.8%

said very likely, 46.6% said likely, 34.2% said unlikely, and 0% said never. Of interest, despite 34.2% of SPHR students reporting that it would be unlikely of them to take a Deaf culture class, and almost half of the students being unfamiliar or unknowledgeable about Deaf culture, a majority of students also said that it is either important (43.8%) or very important (52.1%) when asked “How important is it to know about Deaf culture in order to be a Speech-Language Pathologist or Audiologist?” Thus, although many SPHR students reported limited knowledge of Deaf culture, almost 100% of students reported agreement that the topic was of importance (Knight, 2015).

Jones and colleagues (2024) investigated professionals’ advice to caregivers of deaf children. They found that 64.62% of SLPs promoted both sign and speech, 4.62% promoted choosing between sign or speech, 30.7% advised using speech only, and 0% advised signing only. Perhaps speech-focused advice from SLPs is also influenced by the experience and knowledge of the professionals related to Deaf culture and ASL. According to the American Speech-Language Hearing Association (ASHA; the national association and credentialing body of speech & hearing sciences), as of 2022, there are 217,886 audiologists, speech, language, and hearing scientists; assistants; and associates who are ASHA members. Of those 217,886, only 830 (.38%) members report being proficient (*not* fluent) in ASL, and 29 (.013%) members report being proficient (*not* fluent) in other sign languages (ASHA, 2023).

Given these factors, it seems that professionals, such as SLPs, often do not have the evidence-based knowledge needed to give a proficient range of language options to parents, and there are not enough professionals, like SLPs, who know sign languages to provide language-rich, fully supportive services with Deaf clients. Although this evidence is unfortunate, it is not surprising given the history of deafness, Deaf culture, and access to language.

Historical review

The conference of 1880 in Milan Italy is a significant event in Deaf history, as this is what influenced the change from sign language to oralism, the “advocacy or use of the oral method of teaching the deaf” (Merriam-Webster, n.d.). At this conference, after the decision was made that all Deaf students were no longer allowed to learn sign language and instead were required to use speech only to communicate (Lane, 1984), Adolphe Franke is quoted as saying “with regard to sign, I don’t have to change my opinion for I realized that it was a source of dangerous illusions for the pupil and had the serious drawback of disturbing and confusing his intellect” (Lane, 1984, p. 396). Oralism was being taught even before this time, and a memoir from famous Deaf teacher, Laurent Clerc, can be seen as one of the oldest records of a Deaf person being taught the oralist method. Shortly after arriving at the National Institution For The Deaf in 1797, Laurent recounts his first experience with a speech teacher, whom he refers to as “abbe”:

> The abbe would pull his chair up to my stool so close that our knees were touching and I could see the fine network of veins on his bulbous red-blue nose. He held my left hand firmly to his voice box and my right hand on my own throat, and glowered down at me through beady, rheumy eyes. Then his warm garlic-laden breath would wash over my head and fill my nostrils to suffocating."Daaa,' he wailed, exposing the wet pink cavern of his mouth, his tongue obscenely writhing on its floor, barely contained by the picket fence of little brown-and-yellow teeth. “Taaa,' he exploded and the glistening pendant of tissue in the back of his mouth flicked toward the roof, opening the floodgates to the miasma that rose from the roiling contents of his stomach below. “Taaa, daaa, teee, deee,' he made me screech again and again, but contort my face as I would, fighting back the tears, search as I would desperately, in a panic, for the place in my

mouth *accurately* to put my tongue, convulse as I would my breathing -- I succeeded no better. One day he became so impatient he gave me a violent blow on the chin; I bit my tongue and dissolved in tears…(Lane, 1984, pp. 15-16).

When oralism became the standard practice in schools for the Deaf, it was a complete failure: Teaching oralism, as opposed to signed language, led the average Deaf student to have much lower test scores, with 17-year-old students having math scores at a 6th-grade level, and reading being at a 4th-grade level (Lane, 1984).

The medical model of disability is an important factor to consider with regard to oralism and the history of deafness. The medical, or individual model of disability, views disability only as impairments and/or diagnoses that need to be prevented and/or eradicated, and also views disability as an issue of the individual (Nario-Redmond, 2019). Because of this belief, the only solution to disability is what is provided by medical professionals, such as drugs, surgeries, therapies, etc (Nario-Redmond, 2019). The medical model of disability is the most prevalent model among medical professionals, such as SLPs (Nario-Redmond, 2019). Medical professionals expect disabled people to comply with whatever “solution” they have for their disability, even if it brings them harm (Nario-Redmond, 2019).

A contrasting model of disability that originates in the political movement of the disability community over the last four decades is the social model of disability. Many in the Deaf community espouse this model. The social model of disability views society’s limits to access, agency, and self-determination as the disabling factor for people. What is often referred to as the social hybrid model acknowledges the fact that people may experience challenges with physiological, neurological, mental, or emotional issues (Nario-Redmond, 2019).

To help illustrate these models, a wheelchair user is presented with a set of stairs. The social model views the stairs as disabling the wheelchair user, but the medical model views the person as being disabled and the reason they can't use the stairs- when in reality a ramp could exist instead, which any person regardless of disability status could use. Many in the disability rights movement do not espouse the medical model of disability, yet this is the most prominent model used in society, especially in the medical and educational fields (Nario-Redmond, 2019).

Sign languages are natural, support the same brain functions as spoken language, and regardless of cochlear implantation, are consistent with high literacy attainment (Humphries et al, 2022). However, given the prevalence of the medical model across society and within the medical and education professionals, many hearing parents of deaf children receive advice that may lead them to seek a"cure" for their child's deafness (i.e., speech as a barometer of success and/or exclusive use of hearing technology), rather than learning sign language to ensure communication between themselves and their child (Caselli, 2021). However, when hearing parents do learn sign language and begin to teach their deaf child sign language by the age of 6 months, that child develops vocabulary at the same rate as native-signing Deaf children (Deaf children born to Deaf parents; Caselli, 2021). If hearing parents of deaf children are still concerned about their child learning spoken language, there is evidence that sign language supports spoken language acquisition, and sign language will give that child a good foundation for learning spoken language (Pontecorvo et al, 2023). In summary, there is sufficient evidence that learning sign language only, before, or alongside spoken language is better for a deaf child than only learning spoken language.

Given the issues with lack of evidence-based education and paucity of culturally-informed service providers, many Deaf/HoH adults report experiences of childhood speech and language challenges. A recent qualitative study by Green and colleagues (2023) examined 17 Deaf adults' experiences with school-based SLPs. Some of the overarching themes discussed by the participants included: their parent's choice/involvement, positive experiences, and negative experiences. While there were 11 accounts of benefiting from the skills learned, there were many negative outcomes as well, including four accounts of being teased by peers, three accounts of being touched on their face or throat by the SLP, eight accounts of a feeling of conflict with their identity, five accounts of being drilled on skills they could not learn, and two accounts of people upset about missing class time. Other negative experiences included the use of ASL being discouraged by SLPs. Eleven of the participants said that they stopped attending speech and language services once they had body autonomy/agency and could make their own decisions. None of the participants attend speech and language services as an adult (Greene et al, 2023).

Green et al (2023) provides insight into the experiences of Deaf/HoH people related to speech and language services; however, the inclusion criteria to be a participant were very narrow. The qualifying participants had to be adults, had to receive speech and language services for 3 years, and the services must have been received within school settings. It is important to gain knowledge from Deaf people of all ages, as well as those who received services for only a limited time or not at all. For Deaf people who will never choose to receive speech and language services, it is important to inquire about their rationale. Perhaps the largest drawback to this study is that an unanswered number of participants were recruited by the authors of the study who *knew* these participants had more positive experiences with speech and language services. Thus, the purpose of the current research study is to examine the experiences of Deaf/HoH people related to speech and language services, as well as recommendations they may have for service providers. This research aims to answer the following questions:

1. What were the experiences of Deaf/HoH people or parents of Deaf/HoH children related to speech and language services?
2. What recommendations do participants have for service providers?

Method

Ethical Considerations

Under the original thesis advisor's direction, the survey was not submitted to PSU's Institutional Review Board for review prior to development, recruitment, and data collection. Although no identifying information was collected, had the current advisor been in place from the initial stages, the study would have been submitted to the IRB for consideration as an exemption, and study activity would have proceeded only after receiving approval or exempt status from the IRB.

Research Design

A qualitative research design was used to examine the experiences of Deaf and HoH people (and/or parents of Deaf/HoH children) related to their use of speech and language services. A 9-question survey was used to investigate past and/or current experiences of participants related to speech-language services, as well as any recommendations for service providers moving forward. The full survey is located in the appendix.

Survey Development

A series of questions were created to examine the experiences of Deaf/HoH related to speech and language services and their recommendations for service providers. The survey was developed by the first author in collaboration with a member of the Deaf community. The written survey used open-ended questions that allowed participants to answer at any length. All answers were recorded through Google Forms. No identifying information was collected and only the qualifying demographics needed to take the survey were queried (i.e., one or both factors: Participants had to be Deaf or HoH, or be a parent of a Deaf or HoH child, and fill the questionnaire out regarding that child).

Procedure

This preliminary study was intended to examine the experiences of Deaf/HoH people related to speech and language services as well as gain feedback for SLPs on what they can continue to do or change to better serve Deaf/HoH clients. With permission from an admin, the questionnaire link was posted to the Facebook group titled “Transform Deaf Education”. The posting included a brief description of the study and its aims, as well as a description of the qualifying demographics required to participate in the survey. There was the recruitment of one person, and it is unknown if they took the questionnaire.

Participants

Between 12/13/23-12/28/23 16 responses were collected. Each participant answered the required questions, and there were no partial completions of the survey, however, some participants gave one-word responses.

Demographic data: Deaf or HoH: thirteen participants consider themselves Deaf or HoH and filled out the questionnaire regarding their experiences. Two participants were parents to a Deaf or HoH child and filled out the questionnaire regarding their child’s experiences. One participant was not Deaf or HoH and did not have a Deaf or HoH child, therefore their responses were excluded from the rest of the study (n=15). *Primary Language:* Nine participants reported ASL as their primary language. Three participants reported both ASL and English as their primary languages. Two participants reported English as their primary language. One participant reported both ASL and PSE (Pigeon Sign Language) as their primary languages. *Received Services from an SLP:* Fourteen participants reported receiving SLP services at some point in their lives.

Data Analysis

Data was analyzed using a thematic analysis inductive approach at the semantic level (Braun & Clark, 2006). Survey questions and responses were first organized into individual participant Google documents. Responses were then analyzed using a thematic analysis following Braun and Clark procedures (2006). Initial codes were created across the entire data set and reviewed repeatedly by the author and advisor. Categories were developed after thorough readings of the initial coding data. The author and advisor grouped codes into categories according to related phrases and experiences described by participants. Once categories were identified, all data was transferred to a Google spreadsheet for further analysis. Throughout several reviews, themes were identified and categories were organized into each related theme. For example, we identified a) power imbalance/hierarchy b) loss in SLP trust c) perception of services - positive / trust / relationship d) violation of privacy and trust / internalized audism. These were categorized under the theme “Trust” because of the underlying premise of valuing trust with an SLP. Themes were then organized and quotes identified according to each theme.

Results

Once again, the aim of this study is to examine the experiences of Deaf/HoH people related to speech and language services, as well as gain feedback for SLPs on what they can continue to do or change to better serve Deaf/HoH clients. Six themes surfaced from the participant’s responses: a) “Not the right fit for me” b) “why isn’t it the right fit?” c) agency d) trust e) Deaf/HoH f) parent views. Participants also included their recommendations for SLPs to better understand and serve their Deaf/HoH clients.

“Not the right fit for me”

The first theme identified is called “Not the right fit for me” meaning that some participants found that SLP services were not a good option for them, but might still find value in services for others. Participants who fit in this theme made statements about not enjoying or not finding value in SLP services, but who still reported that it may be helpful to others. Participant 11 reported, “[SLP] might benefit others”. The participants who found value in services for others most often stated very specific circumstances in which the SLP would provide value, such as participant 2 who reported, “Good for hard of hearing, not Deaf “ or participant 13 who said, “Only forca [for a] child with obvious lisp to learn how to make the sounds correctly.”

“Why isn’t it the right fit?”

The second theme identified is “Why isn’t it the right fit?”, with participants explaining why SLP services were unhelpful, unenjoyable, or why they would not go again. Within this theme are two subcategories: physical and perceptual challenges, and clinician practices. For physical and perceptual challenges, participants reported reasons why they could not physically and emotionally succeed in speech services, such as participant 1 who reported “I could not hear /f,s,k/ and some other letters well when I was wearing BTE [Behind The Ear] hearing aids. It was a struggle to do what was being asked of [me].” Some participants discussed their frustration over not having ASL as a language option during services, such as participant 9 who reported, “no resources available...to learn how to read with signing.” The second subcategory is clinician practices, where participants described specific practices that took place during sessions that were unhelpful, unenjoyable, or harmful, such as participant 10 who reported, “Avoid covering your mouth with paper and have the student try to guess what SLP says. I did not like that part." Another example is participant 4 who reported"Never harm, express anger, frustration or consequences on clients trying so hard to learn to speak accurately. That's what happened to me when I was a kid."

Agency

Many participants discussed agency, whether it was something they lacked or possessed. Some participants discussed lacking agency as a child, and parents or professionals having them receive cochlear implants, hearing aids, or attend SLP services against their wishes. Other participants discussed being given agency as a child or having agency as an adult regarding services and hearing tools. Participant 6 reported it was "Not my choice [to attend services in HS]" Participant 3 reported, "My parents were encouraged by a SLP that I had the ability to speak after 2 years of mumbling." Some participants were granted agency before adulthood, such as participant 10 who reported, "Then my parents gave me the choice to quit wearing the Cochlear Implant and speech classes so I opted to quit because I was content in communicating in ASL 100%." Other participants talked about gaining agency as an adult and discussing their hearing and language preferences with their newfound agency, such as participant 5 who reported, "I like nature to hearing better than hearing aid."(i.e., preference for natural hearing vs. hearing aids) or participant 7 who reported, "I just got a CI 5 years ago [as an adult]".

Trust

The next theme identified in the responses was trust. Trust refers to the idea that participants expressed either a lack of trust or a feeling of trust toward their service providers. The survey revealed accounts of participants reporting a lack of trust for SLPS, such as participant 14 who reported:

"[The SLP who] almost destroyed my life was the gal that was so impressed by my lip reading skills in 7th grade, she made a movie of me, without my knowledge - which she then showed in the lower grades. She also - against my express wishes, told everybody I was deaf... I never trusted them again."

Participant 1 also identified a lack of trust with their SLP and reported, "I also practiced pronouncing "CHOCOLATE" and SLP said I said it correctly. then I ordered hot chocolate at a ski resort, they couldn't understand what I said. Was it fake?" Several participants also reported feeling trust in their interactions with an SLP, such as Participant 3 who said "My speech therapist and her family became our family for over 45 years."

Deaf/HoH

The next theme identified within the survey responses was Deaf/HoH Culture, referring to participants' responses related to their experiences and speech and language choices related to Deaf/HoH culture. Language choice was a subcategory that was noted within many responses. That is, participants identified their use of ASL as an important aspect of their identity and how they related to and responded to speech-language services. For example, participant 5 stated, "ASL before English". Similarly, participants discussed their cultural identity related to language use, as noted by participant 13 who reported, "I struggle to keep with one identity at times[referring to switching between American Sign Language, Pidgin Sign English, and Total Communication]". There were also a few instances of Audism reported, as indicated by participant 14,"[SLP made them feel]...There seemed to be a general drive to make a case for their treatment. Extolling deficits in a way that seemed further shaming - towards how broken I was." Or participant 13 who reported "[in relation to communication] it's much more than being able to speak. If somebody does not expect communication it won't matter what you say. they won't understand.”

Parent views

The two parents of Deaf children who took the questionnaire have had their responses separated because there is no way to ensure that what the parent perceives and what the child experiences are the same. Therefore, the last theme identified in the survey is parent views, referring to parents’ perception of services for their child. For parent views, participant 15 perceived their child as having a mixed experience, reporting “Private SLP- Positive. Public school SLP- negative [experience].” Participant 12 reported they perceived their child having a negative experience, explaining that “[SLP services were] almost always with distracting noise (noisy heater - 3 feet away from student) or in a hallway with other children theoretically receiving services at the same time ... with other teachers/students walking, chatting, goofing off in the halls.” Despite the negative experience, participant 12 still finds value in SLP services, reporting that “A SLP can help kids learn to use their hearing.”

Recommendations

At the end of the survey, participants were asked “Is there anything you wish you could tell SLPs?” and “Is there anything else you'd like me to know?” to elicit recommendations for SLPs. All responses to these questions as well as related responses regarding desired service practices and outcomes were all grouped below as “recommendations.” Almost every participant gave recommendations for SLPs, with the most common recommendation involving the wish that SLPs be fluent in ASL. Recommendation quotes can be found below.

“USE ASL. It should be required as part of the curriculum for any SLP who intends to work with deaf people."- Participant 8

“Just do not withhold information about the availability of ASL resources [to families]” -Participant 9

“Take Motivational Interviewing, to learn if a patient is still ambivalent before demanding skill building. Consider the attitudes of others that maybe unkind”- Participant 14

“Never set up high expectations whether or not clients have the ability to speak and/or hear” -Participant 4

“...[SLPs should be] teaching how to communicate with the public using phone, written communication, etc. rather than speaking”- Participant 1

Discussion

This study aimed to examine the experiences of Deaf/HoH people related to speech and language services and to provide recommendations for service providers. The theme “Not the right fit for me” aligns with Crow and colleagues (2014) finding that over one-third of SLPs advised parents to teach their child speech only. However, as indicated by our participants, this practice does not support bi-culturalism and bilingualism. Deaf/HoH people who receive SLP services may feel as though such services are not created with them in mind, resulting in these clients perceiving services as not the right fit for them.

Further, Deaf/HoH participants reported physical and perceptual challenges during speech and language services, or challenges with clinician-specific practices. Participants were limited in their communication because of SLPs trying to teach spoken language when these participants were physically unable to hear certain speech sounds and felt unsupported when clinicians pushed practices that were nonsensical with a Deaf/HoH child (e.g., the practice of a clinician covering their mouth and trying to have Deaf/HoH child guess words). These results align with current practices described by Humphries et al (2022) that many medical professionals promote speech and hearing over using sign language, and will teach signing only as a last resort. Multimodal language is beneficial to children; thus, teaching only speech to a Deaf/HoH child when sign language is more accessible and multimodal language (sign and speech) is beneficial may limit their communication (Humphries et al, 2022). Because of these current speech-centric practices, Deaf/HoH children may be deprived of language growth to their fullest potential.

The theme of agency revealed that many participants received speech and language services and hearing-related tools (i.e., cochlear implants, hearing aids) at a young age when they did not have the option to choose for themselves. Several participants described their experience of having agency related to speech, language, and hearing only as an adult, and choosing to use ASL only for their language or choosing CI. This aligns with a recent qualitative study by Greene et al (2023) examining the experiences of Deaf/HoH people with school-based SLPs. They found that parent choice is a main theme, as well. In Young (2006), hearing parents of Deaf children reported that providers did not inform them of all intervention and language options at the time of hearing loss diagnosis, the result of this being an issue of parents choosing intervention options for their Deaf child that does not align with what the Deaf child desires or what is best for their communication needs.

The theme of trust revealed that participants value trust with an SLP and that some felt trust or a lack of trust with their service providers. Those participants reporting distrust with their SLP indicated that it stemmed from the hierarchy that comes with a client-professional relationship. Within the medical model of disability, medical professionals are seen as experts, and often their goals are to “eradicate” a disability. Professionals expect those with disabilities, such as Deafness, to comply with therapies even if they are harmful (Nario-Redmond, 2019).

This hierarchy harms those with disabilities, and the effect this has creates a lack of trust between clients and professionals, as reported by participants.

The theme of Deaf/HoH culture in relation to identity and language choice revealed that participants view ASL as an important aspect of their identity and that cultural identity is related to their language choice. This aligns with research from Humphries et al (2016) which reports the possibility of psychosocial harm for Deaf/HoH people who are forced into a speech-only culture- essentially, language is an important aspect of culture. The topic of audism was also reported by participants, which further aligns with Green et al (2023) whose participants in their study had similar experiences, such as being teased by others their age and receiving unwanted touch on their faces and throats by SLPs.

For the theme of parent views, it was revealed that parents of Deaf/HoH perceived their children as having mixed and negative experiences with SLPs, and one participant reported believing that SLPs can help a child learn to make the most of their hearing. These reports align with Jones and colleagues (2024) findings which report that families are often dissatisfied with the support they receive from professionals and believe professionals present information that is highly biased toward a specific or one method of communication. The same study reports that 74% of parents believe it is very important to them that their Deaf/HoH child is part of the hearing world.

Participant recommendations of wanting SLPs to know sign language and teach other forms of communication align with ASHA (2022) data that showed a drastically low number of SLPs are proficient in sign language. It also aligns with data from Knight (2015), which shows not enough SLP students are being taught about Deaf culture. This evidence is negatively affecting Deaf/HoH clients, as reported by participant results.

Limitations

This investigation has several limitations. The most important is that the original advisor assigned to this study advised not to seek out IRB approval before beginning this research and one which now, after further consideration and consultation with the current advisor, is recognized as a significant limitation that would have been handled differently under different advising. Second, data such as race and ethnicity were not collected, which would be an important aspect to investigate when considering client and professional relationships. Third, this study was conducted in English. As mentioned earlier, only 2/15 participants use English only as their language choice. ASL is its own unique language, so for many participants, English is a second language. The questionnaire was conducted in English, leaving some participants confused in the content of the question, and sometimes answering in ASL GLOSS. With the help of a member of the Deaf community, they translated some of these statements to the best of their ability.

Conclusion

Promotion and use of ASL should not be a "last resort" for Deaf/HoH children and instead should be taught first or alongside a spoken language in order to reduce the risk of harm (Humphries, 2022). Not enough SLPs are knowledgeable or promoting the use of sign language and other forms of communication for Deaf/HoH children (ASHA, 2022; Knight, 2015). These factors directly impact Deaf/HoH people negatively in regards to finding value and benefit in speech and language services for themselves, having agency around services, and feelings of trust with professionals and their practices. SLPs should be learning sign language, especially if they intend to work with Deaf/HoH people, and SLPs need to reflect on and work to deconstruct any internalized oralism and audism to aid in their search for evidence-based knowledge regarding services for Deaf/HoH clients.

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Appendix A

Survey

1. Do you consider yourself Deaf or HH?
2. Are you the parent/guardian of someone who is Deaf/HH? (Please also indicate here if you are filling out this questionnaire about yourself or someone else)
3. What is your primary language/languages? (ASL, Spanish, English, etc.)
4. Have you received services from a speech-language pathologist (SLP)? Why? (If no, please explain why you have not, then skip to question 7.)
5. Describe your experience with a SLP. Was it positive or negative?
6. Would you go to a SLP again? Why?
7. Would you recommend seeing a speech pathologist to a friend? Why?
8. Is there anything you wish you could tell SLPs?
9. Is there anything else you'd like us to know?