

YCRA RESEARCH BRIEF:

AN EXPLORATORY STUDY OF PSYCHOSOCIAL RISK BEHAVIORS OF ADOLESCENTS WHO ARE DEAF OR HARD OF HEARING: COMPARISONS AND RECOMMENDATIONS

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Summary: This study compared psychosocial risk behaviors of adolescents who are deaf or hard of hearing with their hearing peers in a residential treatment facility. Statistically significant differences emerged between groups. Adolescents who are deaf or hard of hearing demonstrated clinically higher scores on psychosocial risk behaviors of risk to others, social and adaptive functioning, structure needed, aggression, and destruction of property, theft, and rules violation, than their hearing peers. Implications and suggestions for helping professionals are included.

Key Points in the Literature Review:

- An alarming number of adolescents who are deaf or hard of hearing are referred to residential treatment centers because of perceived difficulties in communication and co-occurring mental health disorders (Willis & Verdon, 2002; Zieziula & Harris, 1998).
- Van Gent et al. (2007) noted that adolescents who are deaf or hard of hearing are inadequately or inaccurately identified, and are often not provided adequate resources compared to their hearing peers that would have allowed for earlier intervention.
- Gilman, Easterbrooks, and Frey (2004) suggested that youth who are deaf or hard of hearing collectively experience lower life satisfaction across most domains in comparison to their hearing peers.

- Utilizing clinical and multi-source information, Van Gent et al. (2007) examined emotional and behavioral correlates in a large sample of adolescents and found that the prevalence of psychopathology in adolescents who are deaf or hard of hearing is significantly greater than for hearing adolescents, especially in regard to emotional disorders.
- Hintermair (2008) specified that psychological adjustment and the development of maladaptive behaviors in adolescence are primarily influenced by interaction between individuals and their environment.
- Luetke-Stahlman, (1995) denoted that interaction among hearing adolescents and those who are deaf or hard of hearing in minimal, and close friendships are rare.
- The behavioral effects of peer rejection are often demonstrated through a lowered sense of self-reliance, poor self-esteem, and high external locus of control by deaf or hard of hearing youth (Osterman, 2000; Stinson & Whitmore, 2000, Weiner & Miller, 2006).
- Individuals who are deaf or hard of hearing identify themselves to be a distinct culture and linguistic minority (Filer & Filer, 2000; Lala, 1998). Although psychosocial development is considered a life process, the current consensus in literature suggests that, "identity is consolidated in youth, and remains a fixed constant for coping with the demands of later life" (Hintermair, 2008, p. 278). Osterman (2000) noted the way in which adolescents who are deaf or hard of hearing examine their cultural identity may lead to internalization of negative stereotypes.
- An unusually high proportion of youth who are deaf or hard of hearing reside in residential treatment centers (Bat-Chava, 2000; League for the Hard of Hearing, 2004; Martinez & Silvestra, 1995).

Purpose of the Study: The purpose of this study was to examine the differences in psychosocial risk behaviors between adolescents who are deaf or hard of hearing and their hearing peers in a residential treatment facility. The aim of this exploratory study was twofold. First, we intended to investigate how the two groups differed in risk behaviors of self-harm, risk to others, social and adaptive functioning, structure needed, aggression, and destruction of property, theft and rules violation. Second, we

intended to provide recommendations for adolescents who are deaf or hard of hearing in residential settings.

Methods: Data collection consisted of trained professionals, fluent in ASL, who systematically gathered information to form clinical judgment related to six areas of risk behaviors: (a) risk to self, (b) risk to others, (c) social and adaptive functioning, (d) substance abuse/dependency, (e) family resources, and (f) degree of structure needed.

Participants: The Deaf or hard of Hearing (DHH) group (N=26) consisted of adolescents who are deaf or hard of hearing exhibited by moderate to profound hearing loss with onset of hearing loss ranging from birth to age five in residential treatment. 77% were male, and 23% are female with a mean age of 14.9 (range 12-18 years). The Hearing (H) group (N=302) consisted of hearing adolescents in residential treatment who were demographically similar to the DHH group (75% male, 25% female, mean age of 14.4).

Instruments Used: The Youth Comprehensive Risk Assessment (YCRA) and the Conduct Disorder checklist were used in this study.

Key Results: Overall, the DHH group demonstrated significantly higher ratings on measures of risk to self and others, social and adaptive functioning, need for structure, and aggression. Consistent with Willis & Vernon (2002), this study discovered that aggression and assault were significant factors in a majority of deaf adolescents referred for residential treatment, whereas substance abuse was a key reason for referral in hearing adolescents. The results of this study are also consistent with a growing body of research that indicates the importance of positive identity formation in adolescence.

Key Conclusions/Recommendations for working with Deaf or Hard of Hearing Youth in Residential Treatment:

- Establishing positive *cultural identity* as early as possible provides a strong foundation for developing quality of life (Hintermair, 2008). Wakefield and Hudley (2007) agree that parents who expose children to their culture initiate the process of identity exploration toward a more positive cultural identity. Promoting 'Deaf

Culture' as a positive term is indicative of pride and communal identity. Therefore, it is of critical importance for parents and counselors to understand and promote 'Deaf Culture'.

- *Parent education and family programs* provide a context for schools and parents to work collaboratively to promote cultural identity, and reduce the risk of maladaptive behaviors (McEntree, 1993).
- Among the biggest indicators of positive deaf cultural identity development is whether adolescents who are deaf or hard of hearing are able to *speak or use ASL* (Fusick, 2008, Weiner & Miller, 2006).
- *Classrooms* should be organized to facilitate critical thinking and empowerment. When students are provided opportunities to develop opinions and investigate solutions to problems, they take critical steps toward positive identity formation.
- *Therapy should focus on* building resilience, promoting positive thought patterns, stress management, decision making, goals setting skills, fostering positive self-definition, and social skills. It is particularly important to encourage adolescents who are deaf or hard of hearing to *challenge the negative beliefs* they may have internalized about themselves as individuals with disabilities.
- *Aggression should be addressed by* emphasizing the basics of rules and structure, and taking measured steps in this process. Specific suggestions for dealing with social adaptive functioning include (a) role-playing immediately after a deaf youth is observed missing a social cue, (b) using affect identification and regulation techniques (Coll, Thobro, & Hass, 2004), and (c) spending extra time training staff in restraint alternatives and in fostering greater understanding of cultural differences between adolescents who are deaf or hard of hearing and their hearing peers.