MAKING *SOUND* DECISIONS: UNDERSTANDING THE COMMUNICATION CHOICES OF BLACK HEARING CAREGIVERS OF DEAF/HARD OF HEARING CHILDREN

by

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Two to three out of every one thousand children born in the United States are born with a detectable level of hearing loss (National Institute on Deafness and other Communication Disorders, 2024). For the less than ten percent of these children born to Deaf parents, this is of little concern, but for the more than ninety percent of these children born to hearing parents, communication difficulties often emerge.[1] Unlike their Deaf counterparts, hearing caregivers and their deaf/hard of hearing children do not immediately share an accessible language.[2] A lack of language access early in a child's life can lead to language delays and social-emotional difficulties later in life (Murray et al., 2019). Therefore, it is critical that hearing caregivers of deaf/hard of hearing children quickly decide how they want to communicate with their child.

This thesis aimed to investigate how Black hearing caregivers of deaf/hard of hearing children decide the mode of communication to use with their children.[3] Though previous studies

[1] In this paper, Deaf with a capital D will *only* refer to those who identify with the Deaf community, where deaf/hard of hearing will be reserved for those with the condition of hearing loss, as it is more inclusive of the largest number of deaf people (Gallaudet University Department of Publications and Production, n.d.).
[2] 'Caregivers' will be used in this paper to remain inclusive to different child-raising scenarios.
[3] In this thesis, "Black" will be capitalized and "white" will not be, though it conflicts with the American Psychological Association style and grammar guidelines. This choice is intentional, and reflects the "essential and shared sense of history, identity and community among people who identify as Black," an experience not shared by white people since they "generally do not share the same history and culture, or the experience of being discriminated against because of skin color" (Associated Press, 2020).

have examined how caregivers choose their communication method, these studies have often largely excluded the experiences of those from underrepresented groups. It is important to examine the experiences of marginalized communities to ensure that standard practices consider the unique challenges these groups face that are not common to the dominant group. This thesis will describe (1) how Black hearing caregivers of deaf/hard of hearing children choose their method of communication with their child, (2) what the factors influencing these decisions may reveal about this group's unique decision-making process, and (3) how professionals specializing in communication disorders and sciences can work to meet the needs of this group.

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Introduction

Congenital hearing loss affects two to three of every thousand children born in the United States (National Institute on Deafness and other Communication Disorders, 2024). From the ages of three to seventeen, the number of children with moderate to profound hearing loss rises to about six out of every thousand (CDC, 2025). Early childhood is a period of great physical, emotional, and linguistic development in children. The vast majority of children with hearing loss are born to hearing parents, so it can be difficult for them to access a language-rich environment due to the combination of a lack of auditory access to spoken speech and their parents' lack of knowledge of a visual language. Parents must quickly decide how to communicate with their child, a decision that can have strong effects on their child's development, identity, and understanding of the world. For communities already marginalized by the dominant culture in America, this decision can be especially difficult.

This thesis examines the decision-making process of Black hearing parents of deaf/hard of hearing children. Existing research into the experiences of deaf/hard of hearing children largely underrepresents this group, despite the knowledge that can be gained from understanding how race and disability intersect and inform the choices people make for themselves and their families. With the findings presented in this thesis, speech and hearing professionals may be able to understand their clients better and improve systems of support for this group.

The "90% Rule"

The "90 Rule" in Deaf studies refers to the estimation that (a) 90% of deaf children are born to hearing parents and (b) 90% of the children of deaf parents are hearing, giving way to the term Child of Deaf Adults (CODA) (Mitchell & Karchmer, 2004). Jerome D Schein brought this

rule forth in 1989 in his book *At Home Among Strangers: Exploring the Deaf Community in the United States*. However, Mitchell and Karchmer later challenged this statistic, suggesting that the proportion of deaf children born to hearing parents was even *greater* than previously understood and arguing that only about four percent of deaf children are born to deaf/hard of hearing adults (2004).

This thesis centers mostly around the first application of the 90% rule. This statistic is most significant when the comparing the educational abilities and quality of life of deaf/hard of hearing children born to hearing parents with those of deaf/hard of hearing children born to deaf/hard of hearing adults. The 90% rule, being closer to a 96% rule in reality, emphasizes the importance of supporting the majority of deaf/hard of hearing children who are not immediately in a language-rich environment.

Early Hearing Detection and Intervention Program

In 1989, the Surgeon General of the United States, Dr. C. Everett Koop, sounded the alarm on the importance of identifying congenital hearing loss early. He acknowledged, "[Children with hearing loss] who receive early help require less costly special education services later" (White et al., 2010, p. 170). Since then, policy initiatives, federal financial support, improvements in technology, legislative initiatives, and the proven results of early hearing detection and intervention (EHDI) programs have helped facilitate nationwide EHDI programs in the United States.

Though advocacy groups, including the American Speech-Language-Hearing Association, the American Academy of Pediatrics, and the American Academy of Otolaryngology, formed the Joint Committee on Infant Hearing (JCIH) in 1969, it was not until the end of the 20th century that the National Institutes of Health declared, "All [children with

hearing loss] should be identified and treatment initiated by 6 months of age" (White et al., 2010, p. 171). Even then, it was not until 2001 that EHDI programs were established nationwide in all 50 states (White et al., 2010).

Currently, EHDI programs are still running in all fifty states and Washington, DC. However, questions about the programs' longevity remain as federal funding is under threat. As of late 2025, EHDI avoided elimination and is slated to receive funding in the upcoming year (Houk, 2025). EHDI is critical to quickly identifying infant hearing loss so families can determine which treatment and intervention options are available to them before their child faces language delays. The CDC reported that, in 2022, 95.6% of infants born were screened by 1 month of age, and 40.7% of infants diagnosed as deaf/hard of hearing were enrolled into early intervention by 6 months of age (2025b). While there is clearly work to do to ensure all children have access to hearing screenings and intervention, the EHDI program has greatly reduced the number of children with unidentified hearing loss, giving their caregivers adequate time to make decisions on how to treat their child's hearing loss and communicate with their child.

Early Language Development

Early language development is highly variable due to many factors, including genetics, socioeconomic status, infant phonological discrimination, and early experience. Early experience with a high volume of rich vocabulary and gestures accounts for much of the variability in language learning within and across socioeconomic groups (Weisleder & Fernald, 2013). Children need exposure to language early to improve their language processing skills.

Language processing goes beyond words; children also learn the patterns of language flow (prosody) and the turn-taking style of conversation (Owens, 2021). For typically developing hearing children, parents can expect to hear babbling beginning as early as four months,

imitation of others' communication beginning at eight months, and jargon babbling beginning at nine months. Jargon babbling is often unintelligible, but it mirrors the prosody and intonation of adult speech, an indication that babies understand language far before they are able to produce it accurately (Owens, 2021).

For children learning to sign, whether deaf or hearing and born to Deaf adults, early exposure to signed languages provides the same crucial, language-rich environment as exposure to spoken language provides to children learning to speak. In fact, in an albeit limited study of sign language acquisition in children, Orlansky and Bonvillian found that learning a visuomotor system like American Sign Language as a first language produced accelerated vocabulary and syntactic development in children (1985). When comparing the language acquisition speed of signing children with speaking children, the researchers found that the average age a signing child acquired a 10-word vocabulary was 13.2 months of age, statistically significantly earlier than their speaking peers, who achieved this milestone at an average of 15.1 months (Orlansky & Bonvillian, 1985). If nothing else, this finding affirms the value of signed languages in the development of deaf children and emphasizes the importance of exposure to an *accessible* language to these children.

American Sign Language

American Sign Language (ASL) is a manual language central to American Deaf culture and gives deaf/hard of hearing children access to a language designed for them (Allen et al., 2014), but ASL is far from the only method of communication used by deaf/hard of hearing children and adults. Other forms of communication include Seeing Essential English (SEE I) (Luetke-Stahlman & Milburn, 1996), Total Communication (Hawkins & Brawner, 1977), Signing Exact English (SEE II) (Moeller & Luetke-Stahlman, 2018), Cued Speech (LaSasso et

al., 2010), Contact Sign or Pidgin Signed English (Coryell & Holcomb, 1997), spoken language (Geers & Schick, 1988), and home signs, a gestural communication system unrelated to ASL. Though each form of communication is highly valuable, this research will focus primarily on ASL and spoken language because these methods are the most used among deaf/hard of hearing children and their hearing caregivers.

ASL officially "emerged" in 1817 when Laurent Clerc, a Deaf teacher from Paris, arrived in the United States to help found the American School for the Deaf with Thomas Hopkins Gallaudet (Neidle & Nash, 2015). Due to Clerc's involvement, ASL's development was heavily influenced by French Sign Language, but the language also represented an amalgamation of signs from other North American signing communities like that of Martha's Vineyard where an unusually high proportion of deaf individuals lived (Neidle & Nash, 2015). ASL provided access to language for deaf children living outside of the communities within which signing was a main form of communication, improving their quality of life and ability to thrive.

Unfortunately, controversy has followed ASL since its conception. From the late nineteenth into the majority of the twentieth century, the concept of "oralism" dominated deaf education (Anglin-Jaffe, 2015). Oralism is a policy in which deaf education through sign is rejected in favor of oral or aural techniques, positioning speaking and listening as the ideal outcomes for deaf students (Anglin-Jaffe, 2015). Anglin-Jaffe describes the restriction of signed languages in deaf education due to oralist beliefs as akin to the oppression of indigenous languages and peoples through colonialism. This description encourages scholars to imagine the Deaf community as a cultural and linguistic minority, facing similar disadvantages and discrimination as other ethnic and linguistic groups that differ from the dominant culture like the Black community.

Today, a relatively small number of schools for the deaf exist throughout the country that provide instruction in ASL. For students placed in mainstream classes, the Americans with Disabilities Act and Section 504 of the 1973 Rehabilitation Act require that public school activities, including school board meetings, extracurricular programs, and parent-teacher conferences, be accessible to deaf/hard of hearing students and parents by providing resources such as interpreters, real-time captioning, or written materials (U.S. Department of Justice, Civil Rights Division, 2025).

American Sign Language is inextricably linked to Deaf culture in the United States. ASL can be a unifying force for members of the Deaf community across different identities. ASL is the language of instruction at the foremost pillar of Deaf education, Gallaudet University, the first and only university in the world entirely devoted to the experiences and education of Deaf students. ASL has developed in tandem with American Deaf culture, and it is with this in mind that this paper considers how language interacts with identity.

History of Deaf Education in America

Deaf education in America began in 1817 with the founding of the American School for the Deaf, but over the last two centuries, pedagogical practices have been shaped by the changing cultural and political landscape in the United States.

On April 15th, 1817, the first students arrived at what was originally named the Connecticut Asylum for the Education and Instruction of [Deaf][4] Persons (Cerney, 2007). The school was founded by Thomas Hopkins Gallaudet and Laurent Clerc, and its success in the education of deaf/hard of hearing children spurred a boom in the development of residential

[4] At the time of the school's founding, a different term was used to refer to deaf people. Since this term is now considered pejorative and extremely offensive, it was omitted from this thesis.

schools for the deaf beginning in 1820. By 1858, Deaf teachers represented more than 40 percent of educators of the deaf, and deaf education was thriving (Cerney, 2007).

However, by the mid-19th century, the practice of oralism began to emerge. Advocates for oralism pushed for the use of lipreading and speech in education, often prohibiting signing in the classroom. Oralism gained international dominance in 1880 after educators of the deaf convened in Milan, Italy and declared the superiority of oralism to manualism and passing a resolution banning the use of sign language in schools (Cerney, 2007). Despite protest by American educators for the deaf, oralism began to spread due to efforts of prominent and influential figures of the time. In fact, famed inventor Alexander Graham Bell is infamous in the Deaf community due to his eugenicist ideas regarding deaf people —specifically attempting to prohibit the intermarriage of deaf people—and his insistence on oralism as the best pedagogical approach to deaf education (Mitchell, 1971). Bell even went as far as to suggest eliminating residential schools for the deaf (cultural and linguistic hubs for ASL and Deaf culture) and removing all Deaf teachers of the deaf (Mitchell, 1971). Despite being a fluent signer and being married to a deaf woman, Bell called for a total ban on sign language, even going as far as to call deaf people, “a defective race of human beings” and a “great calamity to the world” (Cerney, 2007, p. 12). Bell enlisted the National Education Association to lobby for oralism, and, by 1920, 80 percent of deaf students were educated without the use of sign. Deaf educators of the deaf decreased in proportion from over 40% to just 14% of the workforce, and oralist methods, including forcing deaf children to sit on their hands or tying their hands behind their backs, became the principal methods of instruction (Cerney, 2007). This period resulted in a deep divide between proponents of sign language, also known as manualists, and their speaking counterparts,

known as oralists. Deaf students began moving from residential schools to day schools and integrated classes.

The late 20th century came with even more changes to deaf education in America. Though the 1960s saw a resurgence of sign language in deaf education once more, deaf education was unintentionally impacted by the Education for All Handicapped Children Act of 1975 (Cerney, 2007). This act mandated that all children should receive a free, appropriate public education in the least restrictive environment. The act was a success in the broader Disabled community, a community within which children were often refused an education because of their disability status, but the legislation also deeply wounded residential schools for the deaf, the Deaf community, and Deaf culture. As a result of the mandate, residential schools for the deaf began receiving less funding and saw enrollment decline (Cerney, 2007). Though educators agreed that inclusion in education is important, the effects of forced inclusion for deaf students raise the question of whether inclusion is the right model of instruction for all students, or if requiring deaf students to learn in mainstreamed settings hinders their potential to achieve academic excellence.

In 2009, the Stanford Achievement Test showed that the majority of 17- and 18-year-old deaf high school graduates read at a fourth-grade level, and only three percent of deaf high school seniors read at the same level as their hearing peers (Cerney, 2007). This represents a large, systemic failure of the education system to properly address the needs of deaf learners and provide quality, communication-based education programs to this population. The result of the Education for All Handicapped Children Act of 1975 is an example of why making policies for a community one does not thoroughly understand is problematic. A central goal of this thesis is to

learn directly from the experiences of a community to avoid making assumptions and advocating for legislation that does not align with their needs.

Access to Speech and Hearing Specialists Across the Black and Deaf Communities

Barriers to accessing speech and hearing specialists exist alongside other healthcare disparities in America. Parallels exist between the Black community and the Deaf community in that accessing quality, empathetic speech and hearing services is a challenge. Pope et al. report that, "Black children are more likely to be diagnosed with a communication disorder but less likely to receive speech-language pathology services than their white peers", and Black parents of children with developmental disabilities are less likely to have access to intervention services and family-centered services (2022, p. 2163). It is also noted that these racial disparities continue across time. Deaf Americans report their interactions with healthcare professionals as fearful, frustrating, and lacking trust, often due to the communication barrier between hearing clinicians and their Deaf patients (Kuenburg et al., 2016). Further, tension exists between the Deaf community and speech and hearing specialists due to the medical model of disability inherently upheld by the fields of speech-language pathology and audiology that automatically assign hearing loss and resulting speech-sound disorders as impairments, a view that can be insulting to the Deaf community (Holcomb, 2012). For Black hearing parents of deaf/hard of hearing children, the barriers affecting each community individually compound, making accessing services even more difficult and frustrating.

Literature Review

Previous Research on Decision-Making for Deaf Children

A Review of Mainstream Research

Previous research on communication choices by hearing caregivers of deaf/hard of hearing children by linguists and communication disorders professionals has focused on three main topics: (1) the ethics of cochlear implants, (2) best practices for language development, and (3) the challenges of teaching hearing caregivers American Sign Language. While important, these topics typically do not focus on the human experience of families but instead take a clinical approach.

Research about cochlear implants has typically focused on debates on the ethics and importance of this hearing technology. Controversy exists between the Deaf community and the mainstream hearing world because some members of the Deaf community consider cochlear implants to be detrimental to Deaf culture and an insult to the Deaf identity (Cooper, 2019). In contrast, some hearing professionals and those without strong connections to the Deaf community do not understand the controversy behind cochlear implants but instead view them as a miraculous innovation. While caregivers of deaf/hard of hearing children attempt to consider both perspectives before deciding whether or not to implant their child, for best communication results, a decision must be made before the age at which a child can consent to the procedure or indicate a communication preference (Mayberry et al., 2002). Stephenson (2018) and Brodsky (2024) document the tension in this decision in their respective works. Conversely, Byrd et al. (2011) argue that it may instead be unethical for caregivers to *refuse* hearing rehabilitation for their children with hearing loss. Research into these differing perspectives can help clinicians

best support caregivers in decision-making. Still, ultimately, the decision to implant a child with a cochlear implant is made by caregivers juggling a variety of complex factors.

Research into early language development has been paramount to creating early intervention programs to detect newborn hearing loss and increase language exposure. Researchers are in consensus that language access in whatever form — whether signed, spoken, or otherwise — is best. Interestingly, even within clinician circles, there is controversy over which language is best for children with hearing loss. On the one hand, some clinicians advocate that signed languages should be the primary mode of communication for all children with hearing loss, regardless of whether they have a cochlear implant (Murray et al., 2019). On the other hand, some clinicians argue against the use of signed language for children with cochlear implants, claiming that signed languages inhibit the development of oral language skills (University of Texas at Dallas, 2017). Importantly, there is tension between medical doctors and PhDs[5] in these recommendations, with the former advocating against sign language after cochlear implantation and the latter rallying for signed languages regardless (Napoli et al., 2015). Language development research is critical because early access to language is essential for language and social-emotional development, yet this research does not consider the complex factors that shape caregivers' communication decisions beyond clinicians' best practice recommendations, which themselves are complex and riddled with controversy.

Lastly, researchers Smith (2017), Bodner-Johnson (2001), Lieberman et al. (2022), and Napier et al. (2007) have examined the challenges in educating hearing caregivers in a manual language such as American Sign Language. This research is important because, as proven by research done by Humphries et al. (2016), Mayberry et al. (2002), and Napoli et al. (2015),

[5] PhDs surveyed belonged to a variety of fields connected to Deaf studies, including sociology, linguistics, education, and the study of signed languages

American Sign Language is a true language accessible to both the hearing parent and the child with hearing loss, and early learning of American Sign Language can lead to typical language development. Unfortunately, this research focuses on only one form of communication among the many possible for hearing caregivers of deaf/hard of hearing children, ignoring why hearing caregivers may choose different modes of communication for reasons unrelated to access.

"Speech, Sign, or Both? Factors Influencing Caregivers' Communication Method Decision Making for Deaf/Hard of Hearing Children" by Maranda K. Jones and Megan Y. Roberts

In their research paper, "Speech, Sign, or Both? Factors Influencing Caregivers' Communication Method Decision Making for Deaf/Hard of Hearing Children" (2023), Maranda Jones and Megan Roberts replicated a study originally performed by Crowe et al. in 2014. The original research was conducted in Australia, a country with an entirely different sociocultural context, healthcare system, and government. Jones and Roberts used a modified version of the "Making Decisions About Sign, Speech, and Multilingualism Survey" (Crowe et al., 2014) to collect their data on the factors influencing the communication decisions of caregivers of deaf/hard of hearing infants and toddlers in the United States of America. Due to the unique nature of the United States, this research was relevant to understanding how families developing in an American culture respond to communication challenges. Crowe's questionnaire and Roberts' and Jones' research and served as the catalyst for this thesis, as a modified version of Crowe's questionnaire was the method of data collection and the limitations regarding racial and ethnic diversity within Roberts' and Jones' research prompted this research into how intersectionality shapes decision-making.

This thesis focuses on Black hearing caregivers of deaf/hard of hearing children and what factors influence this group differently than the dominant white majority. In the United States,

healthcare, educational, and financial disparities exist between Black Americans and their white counterparts, and this research aims to examine whether these factors contribute to caregiver communication choices.

Jones and Robert found that caregivers most frequently received advice to use both speech and sign with their children. When choosing to use speech with their children, caregivers considered factors such as their child's academic success, literacy success, and access to higher education. When choosing sign language, caregivers considered their child's ability to form friendships as well as their academic and literary success (Jones & Roberts, 2024).

Caregivers placed a high value on speech-language pathologists' input in making these decisions, but they also considered input from nonprofessionals such as Deaf/hard of hearing adults or other caregivers of deaf/hard of hearing children (Jones & Roberts, 2024). This means that caregivers are seeking both clinical recommendations and community support in their decision-making, and clinicians should consider this to understand why decisions made may not always follow their guidance so they can better shape their recommendations to clients and their families. The findings presented in their research paper are consistent with a universal caregiver desire for their children to lead happy, fulfilling lives.

The research presented in this thesis examined where differences may lie for Black caregivers of deaf/hard of hearing children so clinicians can recognize systemic and cultural differences in how to support this unique population. Due to constraints imposed by Jones' and Roberts' research question, such as the age of the respondents' children and their specific hearing status, a sample size of 105 respondents was collected. Demographic information collected showed that more than three-quarters of respondents identified as white, while less than 5% identified as Black (Jones & Roberts, 2024). Though thorough and detailed, Jones' and

Roberts' paper revealed a gap in research specifically regarding the experiences of Black, Indigenous, and People of Color (BIPOC) in comparison to their white counterparts. Research into the experiences of BIPOC, and more specifically, the Black experience, is important because of the concept of intersectionality. Originally coined by Kimberlé Crenshaw (1989), intersectionality refers to how marginalized identities can intersect and overlap, resulting in levels of oppression greater than the sum of the original discriminatory factors. This theory also applies to the intersection of race and disability. Chambers (2025) noted that BIPOC experience police brutality at higher rates than white people, and disabled people experience police brutality at higher rates than nondisabled people. Therefore, Chambers writes, "Being Deaf [or hard of hearing] and a BIPOC individual can lead to an increased risk of experiencing violence in general, but especially violence from police" (2025, p. 41). In addition to police violence, other risks, such as workplace discrimination and incarceration rates, are also amplified for Black people and disabled people. With these facts in mind, it is understandable that Black hearing caregivers of deaf/hard of hearing children may need to consider different factors than their white counterparts when deciding how to communicate with their children.

Additionally, over 95% of respondents had at least some college education. This data provides evidence of a limitation in research representation arising from sampling exclusively from WEIRD societies. Coined by Heinrich et al. in 2010, WEIRD stands for Western, Educated, Industrialized, Rich, and Democratic societies and cultures. Findings from research performed on WEIRD societies are often generalized across the human population despite differences emerging when even one letter of the acronym changes.

This thesis faced similar challenges in researching WEIRD societies due to the nature of research in the United States. Still, the study aimed to incorporate often underrepresented voices

into the research regarding race, education, income level, and cultural beliefs. Further, by broadening the age range of eligible respondents' children, the researcher hoped to gather a large sample of experiences despite limitations in the research design, such as the time frame and racial identity requirements.

While previous research by Crowe et al. (2014), Jones, and Roberts (2023) has examined the factors influencing caregivers' decisions about which communication methods work best for their families, this thesis argues that this approach has overlooked underrepresented populations like the Black community and how factors uniquely faced by this community shape their communication decisions. This research is significant because understanding the nuances of decision-making for this group can help clinicians better support language acquisition goals for deaf/hard of hearing children from underrepresented groups, rather than simply applying solutions that have been successful for the dominant white majority.

The Black Deaf Experience

"Examining the Intersectionality of Deaf Identity, Race/Ethnicity, and Diversity Through a Black Deaf Lens" by Lindsay Moeletsi Dunn and Glenn B. Anderson

In their paper, "Examining the Intersectionality of Deaf Identity, Race/Ethnicity, and Diversity Through a Black Deaf Lens" (2019), Dunn and Anderson explore the history and complexity of the Black Deaf identity in America and beyond. The authors began by chronicling Black Deaf history, then addressed the intersection of being part of a linguistic and racial minority, and concluded with a call to research this topic further.

Dunn and Anderson begin by recognizing that no single Black Deaf individual's experience can encapsulate the experiences of all Black Deaf people, and that no single Black Deaf historical figure can represent the history of all Black Deaf people. This admission is

especially true when considering the authors' backgrounds. Both identifying as Black and Deaf, Dunn was born and raised in apartheid South Africa, and Anderson grew up in the South Side of Chicago. They explain that modern understandings of Deaf history have exclusively centered on the experiences of white Deaf people, impacting the self-perception and community formation of Black Deaf people. The following is a recount of several, but by no means all, important moments in American Black Deaf history.

Though Thomas Hopkins Gallaudet and Laurent Clerc established the American School for the Deaf (ASD) in Connecticut in 1817, it was not until 1824 that the first Black students are known to have attended. Between 1824 and 1833, at least three Black students enrolled in the school (Dunn & Anderson, 2019). In 1833, Connecticut passed a law banning the education of Black students who were not from Connecticut, excluding Black Deaf students from gaining an education. Due to this law, Black students were not admitted again to ASD until the 1840s, years after the law was rescinded. Sometime before the 1850s, the P.H. Skinner School for Colored Children opened as the first American school to educate Black Deaf children during the era of slavery (Dunn & Anderson, 2019). In 1867, the North Carolina School for Colored [Deaf] and Blind opened as the first state-supported school in America dedicated to educating Black Deaf children, an alumnus of which went on to become the second Black student to graduate from Yale Law School and remains the only Black Deaf student with this honor. From 1858 to 1938, 17 states founded educational programs specifically for Black Deaf students, contributing to the existence of Black Deaf culture (Dunn & Anderson, 2019). Further, the existence of segregated schools for the deaf in the 19th and 20th centuries led to the creation and persistence of Black American Sign Language (BASL).

Dunn and Anderson spend most of their chapter exploring how Black and Deaf identities intersect in different spaces. They begin by dissecting the hierarchy and in- and out-groups formed within the Deaf community, primarily the hierarchy determined by race. They immediately assert that the shared experience of being Deaf and experiencing audism has not been enough to prevent further race-based discrimination in the Deaf community. Evidence of this divide is apparent in multiple sectors of the Deaf community. First and foremost is the formation of segregated schools for the deaf from the 1850s until the 1970s, a practice that may be responsible for derailing the connection between Black and white Deaf people to this day (Dunn & Anderson, 2019). Next, microaggressions stemming from racial animosity have plagued Gallaudet University's campus since it opened its doors to Black students in the 1950s after the landmark *Brown v. Board of Education of Topeka* Supreme Court ruling mandating the end of legal race-based educational segregation.[6] These fractures within the Deaf community between white and Black Deaf people led to the formation of three "types" of Black Deaf people, as described by James and Woll (2004) in their chapter entitled "Black Deaf or Deaf Black? Being Black and Deaf in Britain", in *Negotiation of Identities in Multilingual Contexts*. The first type, "Aspirers", have a strong racial awareness and identity within Black and Deaf spaces. They are considered potential leaders of the Black Deaf community. Members of the next group, "In-Betweeners", are described as supporters of Aspirers with a well-established racial identity but who occasionally side with the third group, the "Drifters". Drifters have a weaker sense of racial identity and align themselves more with white Deaf culture (James & Woll, 2004). These three

[6] The author would like to emphasize that the *Brown* ruling only ended *legal* segregation of schools. CNN reports that desegregation in the South has been on a downward trend for the past 40 years and that "recent policies have resulted in more 'intensely segregated' schools, where 10% or fewer of students are White" (2024).

identities are examples of how racial tension and discrimination can divide an already marginalized community into even smaller communities.

However, this disconnect exists between the Black community and the Black Deaf community as well. Dunn and Anderson wrote of a study done on Deaf students of color, "A common issue mentioned by several of the respondents involved conflict and tension between the cultural heritage of their predominantly hearing families and their identity as culturally Deaf individuals" (2019, p. 294). Participants attributed this conflict to the lack of easy communication with their families, hindering their ability to deeply understand and connect with their racial or ethnic culture. Further, regardless of whether they are in racially diverse spaces at home or at predominantly white, hearing universities, Deaf people of color reported facing more issues related to audism than racial discrimination (Dunn & Anderson, 2019). Black Deaf individuals stand at the intersection of two marginalized identities, and being forced to forgo their racial and ethnic identity due to communication barriers is harmful and isolating.

Dunn and Anderson acknowledge the separate challenges of being Black in white Deaf spaces and being Deaf in Black hearing spaces, but even more challenging is navigating the intersection of these identities. Importantly, they dispel the notion that the shared experience of being deaf is enough to overcome societal differences based on other identities, instead acknowledging the racism, sexism, xenophobia, and even audism existing within this space. In a 2012 study on the experiences of Black Deaf college students, noting this difficulty of this intersection, multiple students indicated that "they often felt like 'outsiders' in either Black hearing or [white] Deaf social situations" (Dunn & Anderson, 2019, p. 295). This sense of isolation within two communities that should feel supportive and familiar is an unfortunate reality for many Black Deaf people. Of course, this is not to say the Black Deaf experience is all

negative. Anderson recounted his positive experiences as a Black Deaf youth in the South Side of Chicago, where he connected with other Black Deaf youth at school and in his community, affirming his identity as a Black man and a Deaf man. Dunn and Anderson sum up the Black Deaf identity as "an interaction between a Black Deaf individual and his or her surrounding social structures" and that either identity "can be drawn out in response to a particular set of situational and/or societal conditions" (2019, p. 299).

Dunn and Anderson finish their chapter by highlighting the pressing need for research on the Black Deaf community. Current research on the Deaf community has been monolithic in nature and has almost exclusively focused on white Deaf individuals. The authors specifically emphasize the importance of continued research in two areas. The first call to action is to research how Black Deaf people navigate their Black and Deaf identities separately and together. The other suggested area of focus is particularly relevant to this thesis and asks academics to investigate the experiences of Black Deaf people raised in predominantly hearing families that do not use ASL, specifically the impact that this language difference has on their establishment of a strong Black identity (Dunn & Anderson, 2019). Though this thesis may not fully capture the intricacies of the Black Deaf identity, it aims to contribute to the limited scholarship about the Black Deaf experience.

Methods

To answer the research question, qualitative data were collected through a questionnaire on the experiences of Black hearing caregivers of deaf/hard of hearing children around the country.

1. IRB Approval

The Institutional Review Board at the University of Oregon reviewed all study and recruitment materials and deemed the research as exempt due to the minimal risk involved with participation. This process was completed in May 2025.

2. Recruitment and Participants

2.1 Recruitment

Participants were recruited by contacting parent groups and organizations directed towards caregivers of deaf/hard of hearing children and/or Black families of children with communication disorders. All schools for the deaf in the United States were also contacted. Target organizations included Hands & Voices, the John Tracy Center, My Baby's Hearing, MyDeafChild, National Black Deaf Advocates, the National Black Association for Speech, Language, and Hearing, and the National ASL Early Childhood Education Coalition.

2.2 Participants

Participants were required to (1) be adults (18+), (2) be proficient in English, (3) identify as Black or African American, (4) be the caregiver of a deaf/hard of hearing child, and (5) not be diagnosed with hearing loss. Minors were not eligible for this study, as it focused on *caregivers'* experiences, rather than children, and surveying minors who are caregivers would require more complex IRB considerations. Proficiency in English was required because the researcher is not

bilingual and can only conduct the research well in English. Requirements 3-5 are criteria central to answering the research question.

3. Survey Design and Distribution

3.1 Survey Design

The questionnaire used in this study was modeled after the "Making Decisions About Sign, Speech, and Multilingualism Survey" (Crowe et al., 2014). The survey's creator, Katherine Crowe, was contacted for permission to use the questionnaire and obliged. This questionnaire investigates factors influencing caregiver decision-making about language use and communication modes (Crowe et al., 2014). Communication modes included American Sign Language (ASL), Black American Sign Language (BASL), Seeing Essential English (SEE I), Signed Exact English (SEE II), Cued Speech, Keyword Signing, and Fingerspelling. Descriptions of each communication method can be found in Appendix A. The questionnaire included both multiple-choice questions and short-answer questions. No identifiable information was collected. The survey consisted of three parts. Part A asked questions about the respondent's child and themselves, including their opinions on deaf/hard of hearing people. Part B investigated their decision-making about using speech and/or sign. Part C asked additional questions.

3.2 Survey Distribution

The survey was hosted on Qualtrics, a secure platform for response collection. Quick Response (QR) codes and URLs (Uniform Resource Locators) for the survey were provided to the recruitment organizations at the time of contact. The researcher's contact information was

also provided at that time. Over ninety different individuals, groups, and schools were contacted for distribution.

4. Data Collection and Analysis

4.1 Data Collection

Data were collected through a survey on Qualtrics. Informed consent was obtained on the first page of the survey. The survey opened for responses on May 21st, 2025, and closed on January 4th, 2026. In this time, the survey yielded 32 valuable responses. Valuable responses were responses in which the participant had completed at least the first and second pages of the survey. The first page collected participants' acknowledgement of informed consent to participate, and the second page collected basic information about the participants' child and their attitudes towards deaf people.

4.2 Data Analysis

Data analysis was performed using R data analysis software version 4.5.2. Packages beyond base R were used for data visualization. Statistical tests were run through Qualtrics Stats iQ program to determine if certain factors (region, income, education, parent's age, and child's age) impacted results in statistically significant ways.

Results

1. Demographic Information and Language Use of Caregivers and Their Children

Table 1. Caregiver-child demographic and language use information.

Child characteristics	
Age (Years)	*n=31*
2 Years or Younger	6 (19%)
3 to 5	13 (42%)
6 to 10	6 (19%)
11 to 15	3 (10%)
16 to 20	2 (6%)
21+	1 (3%)
Geographic Region	*n=31*
West	6 (19%)
Southwest	9 (29%)
Midwest	7 (23%)
Northeast	5 (16%)
South	4 (13%)
Languages Used Now or Previously	*n=28*
Spoken English	22 (79%)
Spoken Foreign Language	15 (54%)
American Sign Language (ASL) in ASL Grammatical Order	22 (79%)
ASL in English Word Order	22 (79%)
Black American Sign Language (BASL) in BASL Grammatical Order	19 (68%)
BASL in English Word Order	16 (57%)
Keyword Signing	20 (71%)
Cued Speech	15 (54%)
Signed English	17 (61%)
Gesture/Home Signs	18 (64%)

Caregiver Characteristics	
Relationship to Child	*n=31*
Parent	28 (90%)
Caregiver or Guardian	3 (10%)
Caregiver Age	*n=20*
18 to 24	3 (15%)
25 to 34	5 (25%)
35 to 44	12 (60%)
Highest Degree of Education	*n=20*
Certificate	2 (10%)
Associate's Degree	5 (25%)
Bachelor's Degree	9 (45%)
Graduate Diploma and Graduate Certificate	1 (5%)
Postgraduate Degree	3 (15%)
Annual Household Income	*n=20*
Below $10k	3 (15%)
$10k - $50k	4 (20%)
$50k - $100k	9 (45%)
$100k - $150k	3 (15%)
Over $150k	1 (5%)

Table 1. Basic data on the participants and their children, including age, region, language use, education, and income. Since no survey questions beyond the informed consent page were required, participant responses ranged from 20 to 31 for each question.

2. Participants' Attitudes Toward Deaf People and Their Capabilities

Figure 1. Participants' attitudes toward deaf people and their capabilities.

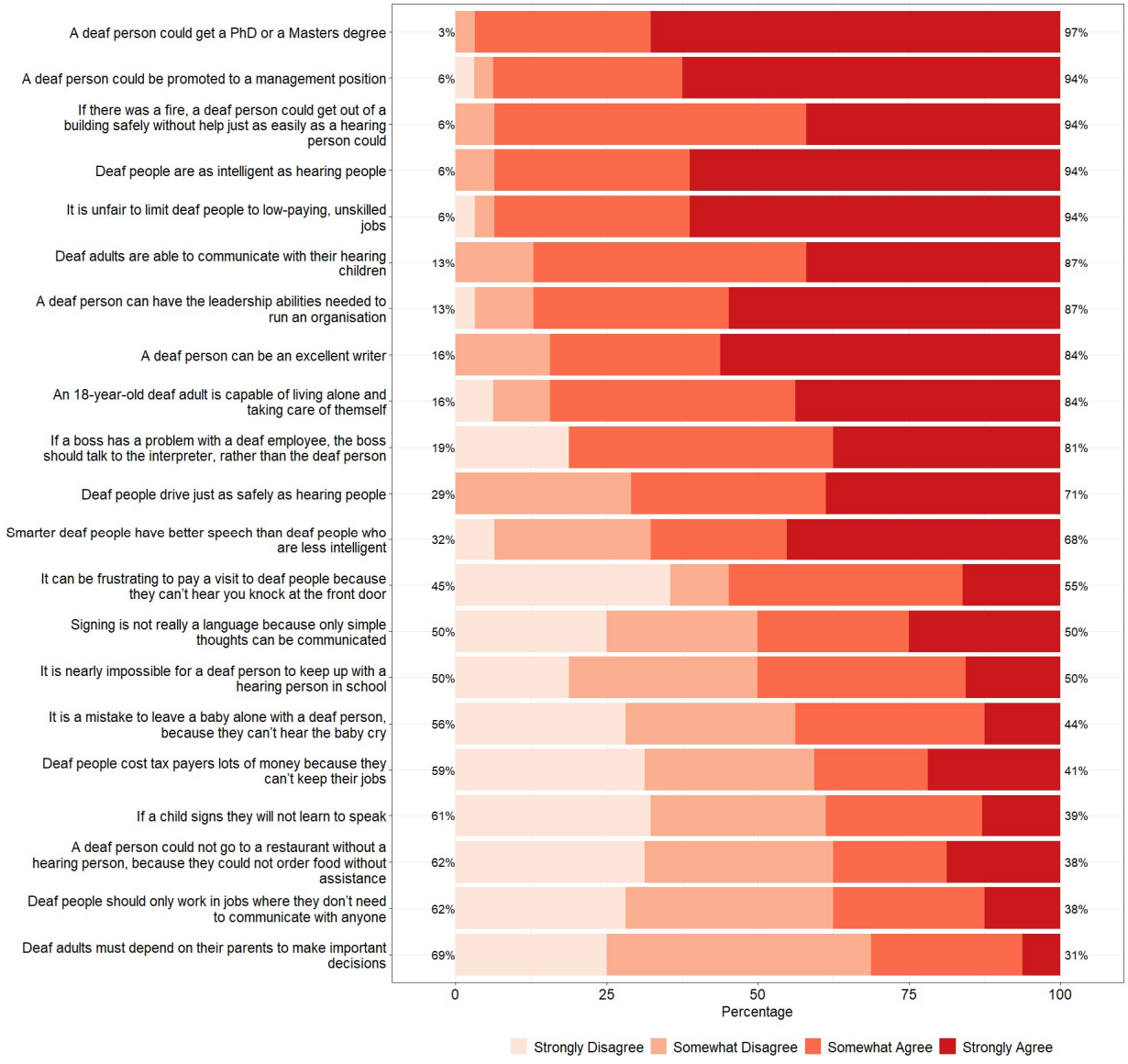

Fig. 1. Participants were presented with a series of statements and asked if they strongly disagreed, somewhat disagreed, somewhat agreed, or strongly agreed with each. Generally, participants tended to agree more with deaf-positive quotations than deaf-negative quotations. Responses collected from 32 participants.

3. Most Influential Factors When Deciding Whether to Use Sign Language or Speech

Figure 2. Most influential factors for caregivers when deciding whether to use sign language with their child.

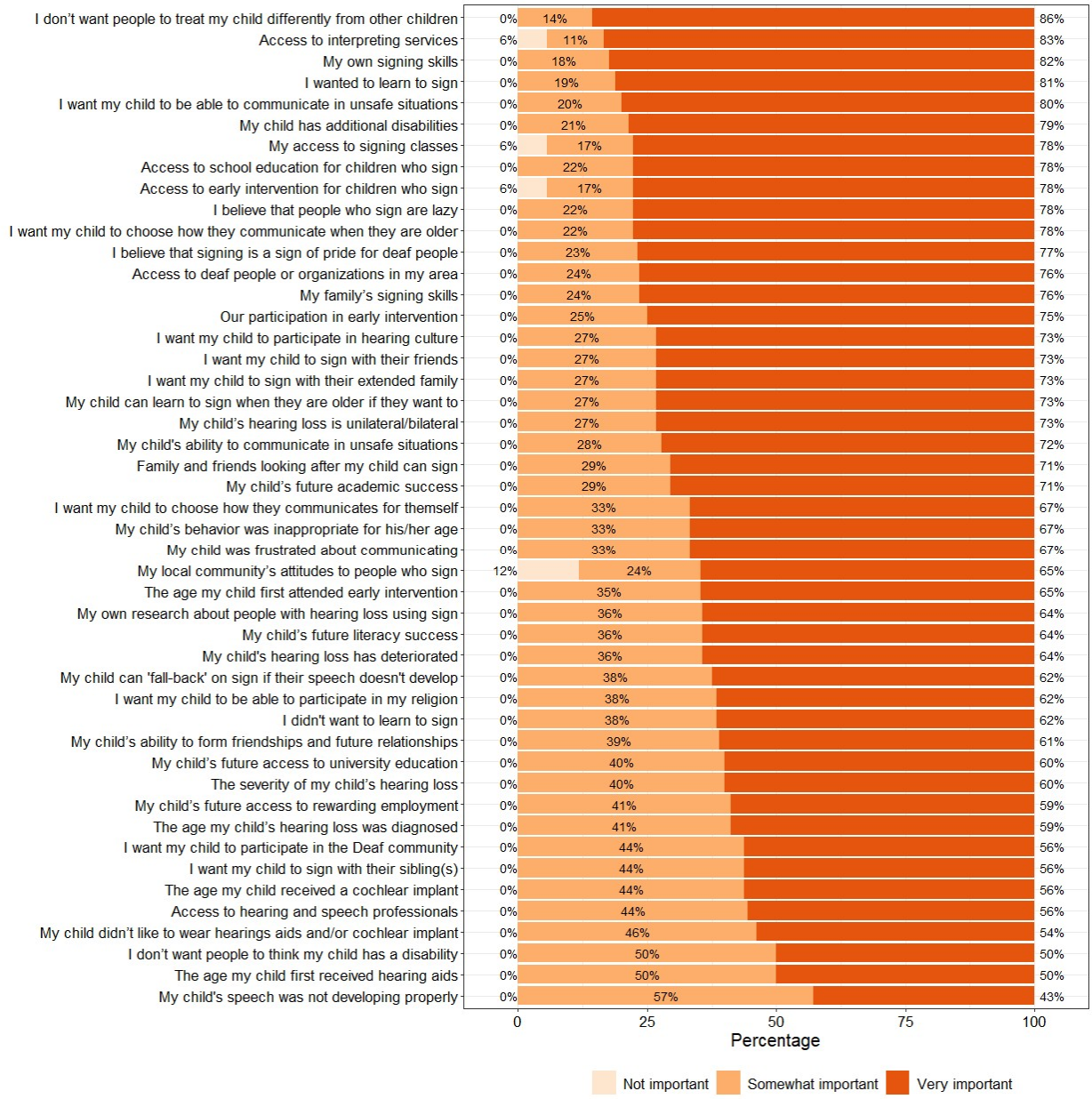

Fig. 2. Participants were asked to rank the importance of each factor in a list in determining whether to use sign language with their child. The most valuable factors were caregivers not wanting their child to be treated differently (86%), access (or lack of access) to interpreting services (83%), and caregivers' signing skills (82%). Responses collected from 21 participants.

Figure 3. Most influential factors for caregivers when deciding whether to use speech with their child.

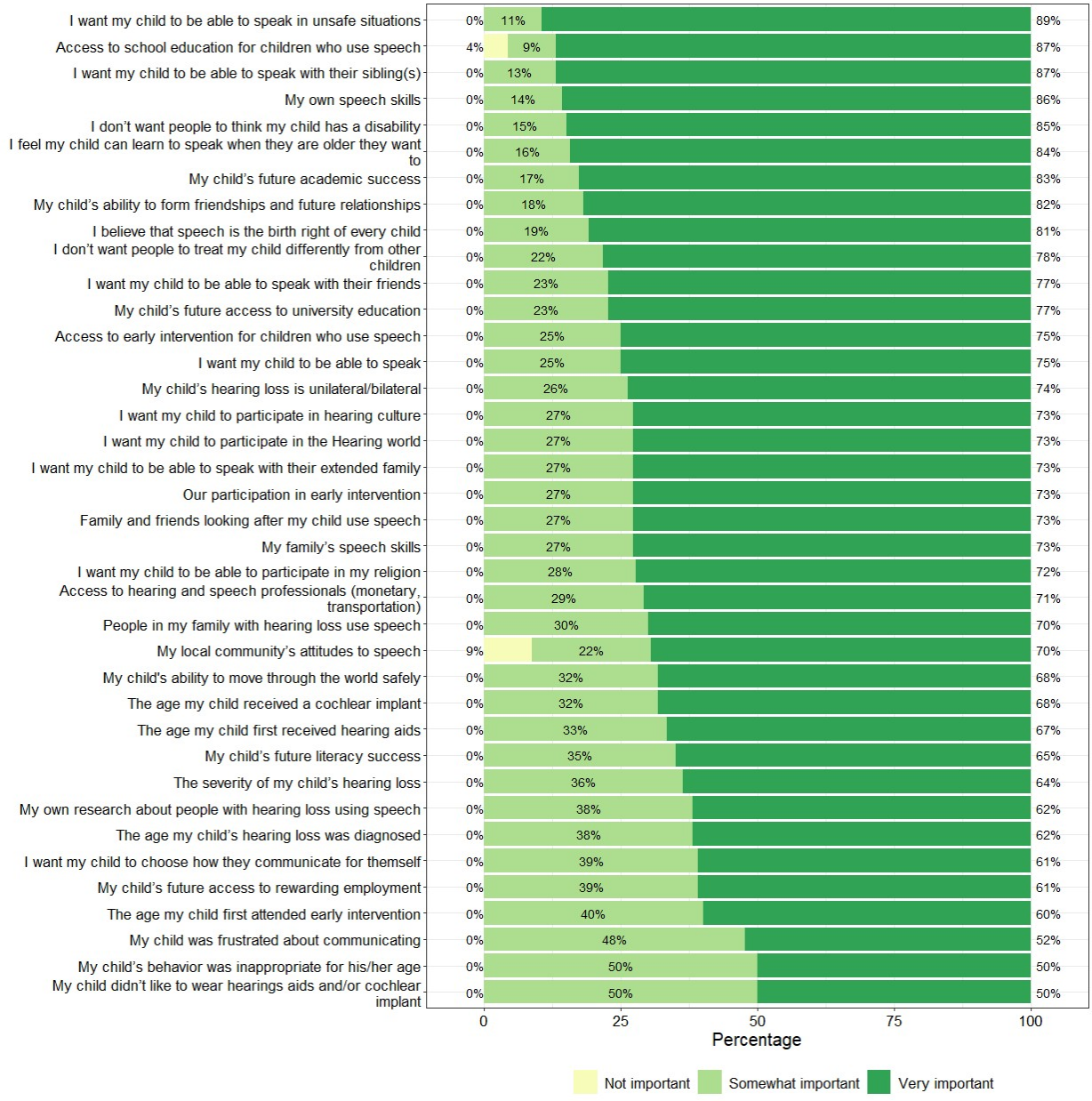

Fig. 3. Participants were asked to rank the importance of each factor in a list in determining whether to use speech with their child. The most valuable factors were caregivers wanting their child to be able to speak in unsafe situations (89%), access to school education for children who speak (87%), and a desire for their child to be able to speak with siblings (87%). Responses collected from 25 participants.

4. Professionals' and Nonprofessionals' Impact on Decision-Making

Figure 4. Advice caregivers received from professionals and nonprofessionals on whether they should use sign language with their child.

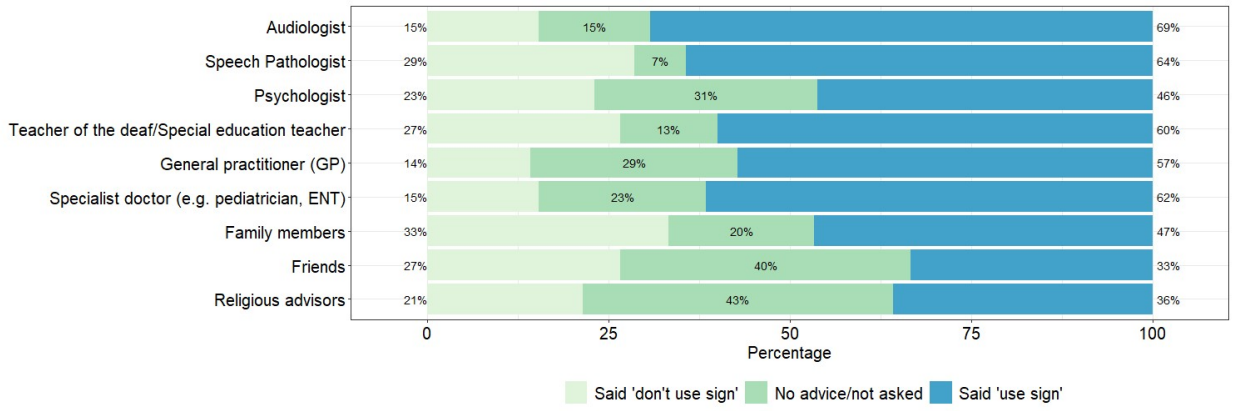

Fig. 4. Participants were asked what advice they were given by professionals and nonprofessionals when deciding whether to use sign language with their child. Audiologists (69%), speech-pathologists (64%), and specialist doctors (62%) were most likely to advise using sign language. Responses collected from 17 participants.

Figure 5. Importance of advice from professionals and nonprofessionals as perceived by caregivers.

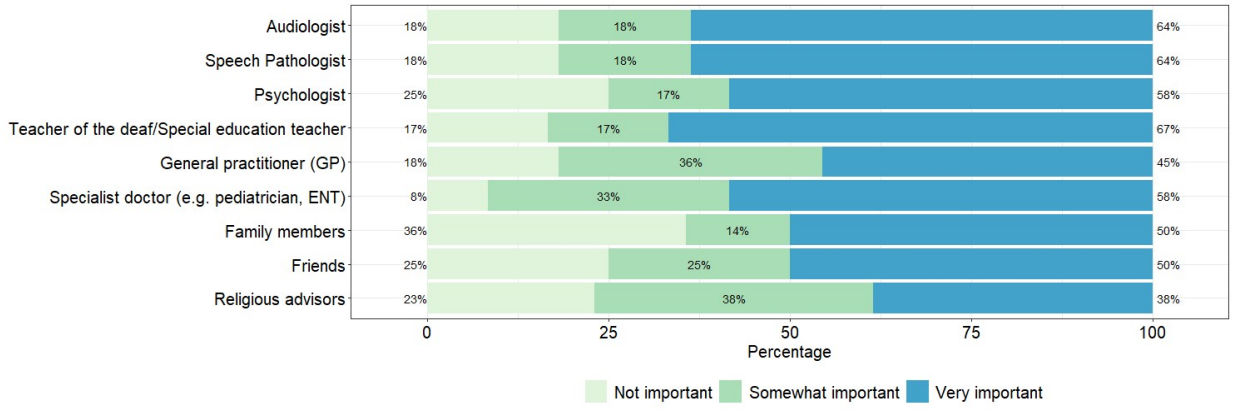

Fig. 5. Participants were asked to assess the importance of advice given by professionals and nonprofessionals when deciding whether to use sign language with their child. Teachers of the deaf/special education teachers (67%), audiologists (64%), and speech pathologists (64%) were found to have given the most valuable advice. Responses collected from 14 participants.

Figure 6. Advice caregivers received from professionals and nonprofessionals on whether they should use speech with their child.

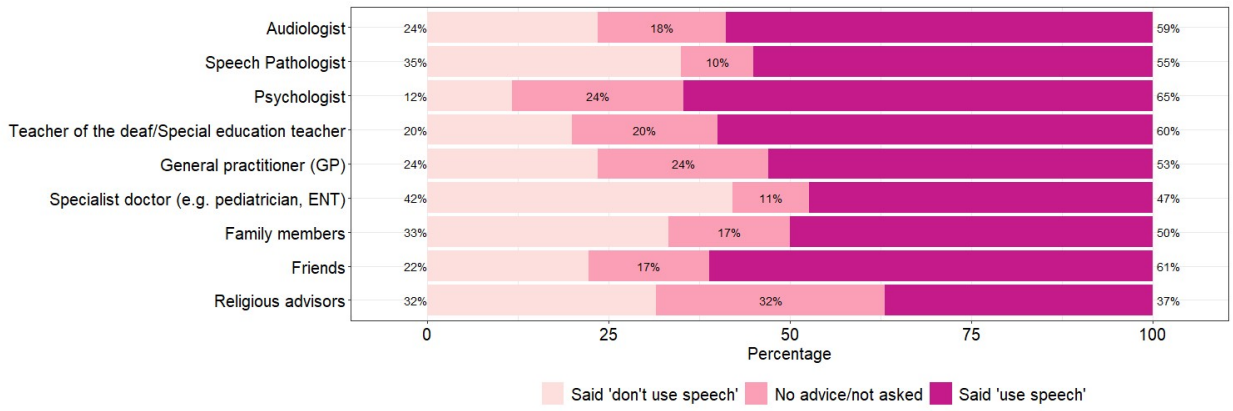

Fig. 6. Participants were asked what advice they were given by professionals and nonprofessionals when deciding whether to use speech with their child. Psychologists (69%), friends (61%), and teachers of the deaf/special education teachers (60%) were most likely to advise using speech. Responses collected from 22 participants.

Figure 7. Importance of advice from professionals and nonprofessionals as perceived by caregivers.

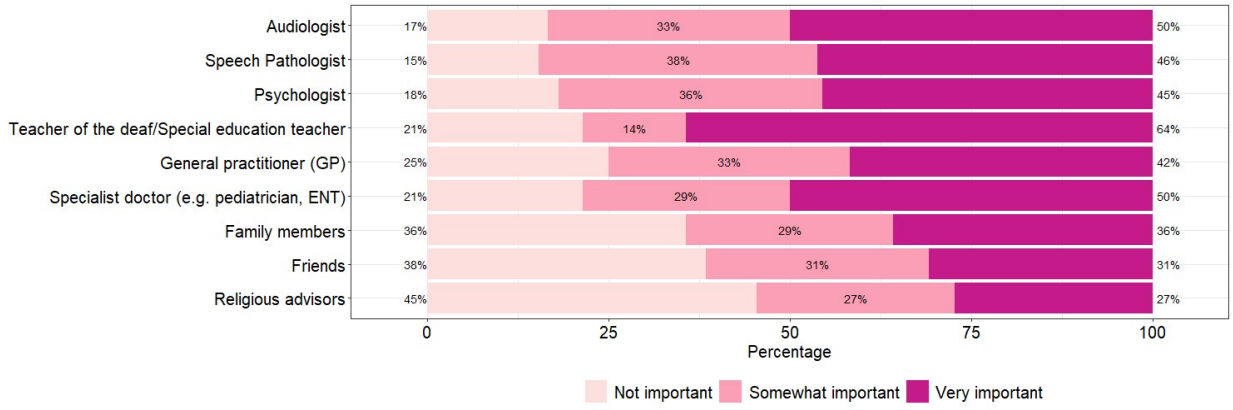

Fig. 7. Participants were asked to assess the importance of advice given by professionals and nonprofessionals when deciding whether to use speech with their child. Teachers of the deaf/special education teachers (64%), specialist doctors (50%), and audiologists (50%) were found to have given the most valuable advice. Responses collected from 16 participants.

Discussion

This study aimed to identify the most salient factors for Black hearing caregivers of children with hearing loss when deciding how to communicate with their child. Data collection included gathering basic information about caregivers and their children as well as identifying implicit biases held by caregivers, the factors most commonly rated as important when making communication decisions, and the most valuable sources of guidance on the matter.

Figure Discussion

Table 1. Caregiver-child demographic and language use information.

The data displayed in Table 1 reports basic demographic information from participants. Of the caregivers surveyed, most described themselves as parents rather than guardians or caregivers, though the latter was chosen for this survey to be inclusive. Most participants were in their thirties and forties, had earned a bachelor's degree or higher, and had a household income of at least $50,000. Most of their children were school-aged or younger and had attempted to use different modalities of communication.

Figure 1. Participants' attitudes toward deaf people and their capabilities.

The data displayed in Figure 1 shows participants' agreement and disagreement with statements about deaf people. Overall, participants tended to look upon deaf individuals favorably as evidenced by a majority agreement with the ten statements representing deaf individuals in a positive light (statements 1-9, 11) and a majority disagreement with the eight more obviously ableist statements (statements 14-17, 19-21). Most notable are responses to statements 10 and 12.

Statement 10 reads, “If a boss has a problem with a deaf employee, the boss should talk to the interpreter, rather than the deaf person.” 81% of respondents indicated that they either somewhat agreed or strongly agreed with the statement. However, this practice goes against the wishes of the Deaf community. The National Deaf Center on Postsecondary Outcomes, a collaboration between the University of Texas at Austin and the United States Department of Education, reports that best practice is to “always speak directly to the deaf person, not the interpreter or support staff” (NDC, 2025). The University of Oregon’s Accessible Education Center expands on this, explaining, “The interpreter is not part of the conversation and is not permitted to voice personal opinions or enter into the conversation. Face the D/deaf individual and speak to them in a normal manner” (UO AEC, n.d.).

Statement 12 reads, “Smarter deaf people have better speech than deaf people who are less intelligent.” 68% of respondents indicated that they either somewhat agreed or strongly agreed with the statement. However, again, this statement is rooted in ableism, specifically audism. Gallaudet University defines audism as, “The notion that one is superior based on one’s ability to hear or behave in the manner of one who hears” (“Audism Resources - Deaf Studies Digital Journal,” n.d.). The Deaf community rejects the idea that adhering to hearing culture, and therefore using speech, is an indication of intellect rather than a sign of cultural assimilation.

While participants generally aligned with the Deaf community in affirming deaf-positive statements and rejecting outright ableist or factually incorrect statements (statement 18), minor differences between the hearing world and the Deaf community are evidenced in statements 10 and 12, proving that biases against the Deaf community and deaf people as a whole are present even in participants who undoubtedly and wholeheartedly love their children. Proximity to the Deaf community and the biases emerging from distance from the Deaf community may help

explain the variability in language decision-making for well-intentioned hearing caregivers of deaf/hard of hearing children.

Additionally, data were analyzed through the Qualtrics Stats iQ program by categorizing statements into two bins: statements in which agreement aligned with positive representations of Deaf people (Deaf Positive) and statements in which agreement aligned with negative representations of Deaf people (Deaf Negative). Of the 32 respondents to this question, 68.8% (22 people) were more likely to give answers aligning with Deaf Negative statements. This section of the survey was meant to illuminate any implicit biases against the Deaf community within participants, and the results show how deeply pervasive negative sentiments about the Deaf community can run, even influencing parents of deaf and hard of hearing children. This analysis further emphasizes the need for increased Deaf visibility in media and more education on Deaf people and their capabilities.

Figure 2. Most influential factors for caregivers when deciding whether to use sign language with their child.

When deciding whether to use sign language with their child, as seen in Figure 2, the top five most important factors generally fell into the category of access to sign language. Three of the top five most important factors were "Access to interpreting services", "My own signing skills," and "I wanted to learn sign." The fifth-most important factor ("I want my child to communicate in unsafe situations") was also found to be highly important when participants were deciding whether to use speech with their child, speaking to the idea of total communication echoed throughout participants' responses, in which multiple modes of communication are used, depending on the child's abilities and needs (Hawkins & Brawner, 1977). When describing factors they found most important in deciding whether to use sign

language with their child, a caregiver wrote that the most important factors were "the same as my reasons for wanting him to learn speech. I want him to have every [advantage] possible to learn to communicate efficiently."

At the bottom of Figure 2, the five factors found to be less important when deciding whether to use sign language were more related to the services provided by speech pathologists and audiologists. Four of the bottom five factors were "My child's speech was not developing properly" (speech pathologists), "The age my child first received hearing aids" (audiologists), "My child didn't like to wear hearing aids and/or cochlear implant" (audiologists), and "Access to hearing and speech professionals" (both). The relative unimportance of these factors suggests that participants were not having any difficulties with them. Access to speech, language, and hearing services and technology may have been robust enough for participants to avoid being of concern in communication decision-making.

Finally, two factors in the top and bottom five most important factors appeared at first glance to be at odds with one another but may instead reflect disability justice framework. The number one most important factor for participants when deciding whether to use sign language with their child was "I don't want people to treat my child differently from other children," while the third-to-last factor on the importance scale was "I don't want people to think my child has a disability." Participants' relative disregard of whether people in society view their child as disabled suggests a movement towards disability neutrality. Rather than seeing disability status as something to hide or be ashamed of, disability neutrality allows people to accept disability as part of the human experience, acknowledging its existence without celebrating *or* mourning (Silvers, 2003). In the same vein, participants' concern that their child will be treated differently than others speaks to the idea of the social model of disability in which the disabling factor to

one's existence is not their physical or mental 'impairment' but rather the structural and societal influences that bar them from accessibility (Barnes, 2019). Parents can accept their child's disability but remain concerned about the discriminatory ways that society treats those perceived to be disabled. Interestingly, the social model of disability somewhat mirrors the experience of the Black community. In the same way that proponents of the social model of disability argue that the 'impairment' is not disabling without the social and structural barriers that uphold disability, Black people recognize that Blackness itself is not a negative state; rather, it is the systemic injustices and generational disenfranchisement that have led to negative associations with being Black in America.

Figure 3. Most influential factors for caregivers when deciding whether to use speech with their child.

When deciding whether to use speech with their child, as seen in Figure 3, the top five most important factors centered familial connections and access to education. Three of the top five most important factors were "Access to school education for children who use speech", "I want my child to be able to speak with their sibling(s)," and "My own speech skills." When asked about these rankings, participants wrote, "I want my child to always feel heard, cared for, and emotionally connected to me," and "Talking during everyday routines (mealtime, play, bedtime) feels natural and makes our relationship stronger." These quotations emphasize the importance of family connections for participants and reflect the general trend of hearing parents choosing to use speech with their children. It makes sense that a parent would prefer to show love and develop relationships in a language that they are fluent and familiar with, such as spoken English. If sign languages feel unfamiliar, inaccessible, and like a more difficult mode by

which to communicate important linguistic purposes (care and love), then it is only natural that speech will be preferred.

At the end of Figure 3, the five factors indicated to be of least importance were focused on the child's behavior and future success. Four of the bottom five factors were "My child didn't like to wear hearing aids and/or cochlear implants", "My child's behavior was inappropriate for [their] age", "My child was frustrated about communicating," and "My child's future access to rewarding employment." The lowered importance put on these factors again suggests that participants were not concerned with them. Using speech seemed to be associated with success in behavior and language, as evidenced by a quote from one of the participants reading, "I know that using speech helps my child learn words, communicate better, and build confidence."

The overall most important factor in deciding to use speech was of no surprise to those familiar with how often innocuous situations can become dangerous for Black Americans. The top-rated factor in importance was "I want my child to be able to speak in unsafe situations." In the context of police violence and intersectionality, this ranking makes sense. Despite only making up twenty percent of the population, up to fifty percent of people killed by police are disabled or Deaf (Carter-Long & Perry, 2016). Further, looking back to 2014 and 2015, many of the catalysts of the highly influential #BlackLivesMatter Movement were Black and disabled, including Eric Garner (2014, diabetes, asthma), Freddie Gray (2015, chronic lead poisoning), and Sandra Bland (2015, depression, epilepsy) (Carter-Long & Perry, 2016). Deafness, particularly signing, presents unique challenges in unsafe situations with police unfamiliar with sign language. Consider the stories of three deaf individuals' encounters with law enforcement.

First, in 2013, Jonathan Meister, a white deaf man in Hawthorne, California was confronted by police after a neighbor reported him for suspected burglary while he was moving

boxes from a friend's home. Police arrived on the scene and Meister approached them, gesturing that he could not hear (Mazza, 2014). Nevertheless, police officers grabbed his wrists, prompting Meister to pull his hands back and hop over a fence to create distance between himself and the police so he could once again use his hands to communicate. Police followed and attempted to handcuff him before shooting him with a stun gun and tasing him twice (Mazza, 2014).

Next, John Williams, an Indigenous woodcarver with severe hearing loss was walking down the street in Seattle when was confronted by Officer Ian Birk in 2010 for legally holding a small knife and a block of wood (Carter-Long & Perry, 2016). While approaching him from behind, Officer Birk ordered Williams to drop his knife, a command he could not obey because he could not hear it. Birk then shot Williams five times, killing him (Carter-Long & Perry, 2016).

Finally, in 2012, Lashonn White, a Black deaf woman, called 911 through an interpreter to report a home intruder. During the call, she told the operator that she could only communicate using sign language and an interpreter, but upon arrival, police Tasered White and jailed her for nearly three days without an interpreter (Carter-Long & Perry, 2016). In the ensuing lawsuit, White only received $1 despite the jury's acknowledgement that her "rights were violated when she was arrested" (Carter-Long & Perry, 2016).

These three instances show the unique ways in which deafness and the language of the Deaf community can make one immediately more a risk of police violence. Countless other stories of police brutality against deaf people, such as those of Pearl Pearson[7] and Magdiel Sanchez[8], have hit the headlines only to fade from the mainstream memory (Chuck & Connor, 2017; Lohr, 2014). When compounded with another identity often perceived to be 'dangerous' like Blackness, one's existence can become an everyday battle to survive. With this context in

[7] 64-year-old Black Deaf man in Oklahoma City who was violently confronted by Highway Patrol officers in 2014
[8] 35-year-old Deaf man in Oklahoma City who was Tasered and shot dead by police in 2017

mind, it is understandable that the number one priority for the majority of participants surveyed in this research was their child's safety in unsafe situations, a safety that can more reliably be ensured through the use of speech.

Figure 4. Advice caregivers received from professionals and nonprofessionals on whether they should use sign language with their child.

The data displayed in Figure 4 reports what advice caregivers received from professionals (audiologists, speech pathologists, psychologists, teachers, general practitioners, specialist doctors) and nonprofessionals (family members, friends, religious advisors) on whether they should use sign language with their child. When a child is diagnosed with hearing loss, the professionals most central to intervention are audiologists, speech pathologists, teachers, and specialist doctors, specifically the child's pediatrician or an otolaryngologist if the child is to receive cochlear implants. Importantly, these professionals were the four most likely to advise caregivers to use sign language with their children. Psychologists were the only professionals to advise sign language less than 50% of the time, a break from other professionals that may stem from less training specifically geared towards deaf and hard of hearing clientele. Non-professionals were more split on their advice.

Figure 5. Importance of advice from professionals and nonprofessionals as perceived by caregivers.

The data displayed in Figure 5 resulted from asking caregivers to rank the *importance* of advice received from professionals (audiologists, speech pathologists, psychologists, teachers, general practitioners, specialist doctors) and nonprofessionals (family members, friends, religious advisors) on whether they should use sign language with their child. Following a trend shown in Figure 4, professionals most central to intervention for deaf and hard of hearing

children were assessed to give very important advice on whether to sign. However, psychologists, family members, and friends were also found to give very important advice in at least 50% of instances, suggesting that clinical expertise is only one factor in determining advice importance and credibility for caregivers of deaf and hard of hearing children.

Figure 6. Advice caregivers received from professionals and nonprofessionals on whether they should use speech with their child.

The data displayed in Figure 6 reports what advice caregivers received from professionals (audiologists, speech pathologists, psychologists, teachers, general practitioners, specialist doctors) and nonprofessionals (family members, friends, religious advisors) on whether they should use speech with their child. In deviation from the previous figures, the entities most likely to advise using speech were, in descending order, psychologists, friends, teachers, then audiologists. Speech pathologists, general practitioners, and family members also advised speech in at least 50% of instances. Specialist doctors were most likely to advise against using speech, with 42% of their advice leaning this way.

Figure 7. Importance of advice from professionals and nonprofessionals as perceived by caregivers.

The data displayed in Figure 7 resulted from asking caregivers to rank the *importance* of advice received from professionals (audiologists, speech pathologists, psychologists, teachers, general practitioners, specialist doctors) and nonprofessionals (family members, friends, religious advisors) on whether they should use speech with their child. Interestingly, the only group whose advice was ranked very important over 50% of the time was teachers of the deaf/special education teachers. Audiologists, speech pathologists, and specialist doctors

followed behind, but none of these groups gave advice related to using speech ranked as very important more than 50% of the time. The importance of advice from family members and friends dropped noticeably from results in Figure 5 in which they were found to give very important advice over 50% of the time.

Statistical Testing and Significance

Upon doing analysis on the data using Qualtrics Stats iQ, there appeared to be a statistically significant relationship between income and advice from professionals and community members. Participants with lower income levels were statistically more likely to report that their friends advised them to use speech with their child than their wealthier counterparts. Despite the small number of participants (14), the p-value for this relationship was 0.0231 and the effect size was 0.636, indicating statistical significance and that the relationship may be meaningful in a practical sense. Similar results were found in the relationship between low income and advice from psychologists (p-value 0.0225 and effect size 0.720) and specialist doctors (p-value 0.0181 and effect size 0.735), though these questions had an even smaller sample size (11). Though the very limited sample size makes generalizing difficult, the statistical significance suggests the potential for a relationship to exist, and this potential relationship should be investigated in further research on this topic.

Additionally, there appeared to be a statistically significant relationship between income and the choice to use homemade signs (gesture) or Keyword Signing. Within the 50-100k annual income group, strong statistical significance suggests the possible rejection of the null hypothesis that income is in no way related to caregivers' decisions to use gesture (p-value 0.0272 and effect size 0.657) or Keyword Signing (p-value 0.0361 and effect size 0.642) with their child.

Though this question had more responses (20), it is still not very generalizable, and the relationship should be investigated in further research.

Overall, the statistical tests were not able to indicate generalizable results from this study due to the limited number of participants. However, they did provide some guidance as to avenues that future research on this topic could go down to further investigate how caregivers' identity and socioeconomic status contribute to their decisions on communicating with their deaf/hard of hearing child.

Implications for Society

In response to the findings of this research, much must be done to change the way dominant society views communication, the Deaf community, and the Black Community.

Firstly, caregivers' embracing different communication modalities, as evidenced by Table 1, suggests that they view communication as multi-faceted. They acknowledge that speech and sign language are not opposites and that communication does not need to take the form of strictly one or the other. This contrasts with prominent myths surrounding language acquisition for deaf children, specifically the idea that it is best to pick only one language for deaf children and that teaching a child sign language will interfere with their English language learning skills. In fact, the brain is built for language *especially* during early childhood, and using sign language as a basis for further language learning can be extremely helpful (Fasano et al., 2016). Clearly, raising their deaf/hard of hearing child has helped caregivers in this study understand that communication comes in many forms, and though these forms are different, they are not necessarily at odds with each other. However, the persistent prominence of these myths suggests that entities beyond those directly raising or working with deaf/hard of hearing children need to

be educated about language development as to avoid spreading misinformation to families of deaf/hard of hearing children when asked for guidance on communication methods to use.

Next, families' connection with, or disconnection from, the Deaf community and Deaf culture may be the cause of variation in opinion towards deaf people and, ultimately, variation in decision-making when choosing how to communicate with their child. This is most clearly illustrated in Figure 1, where statements 10 and 12 faced widespread agreement from participants despite conflicting with core tenets of the Deaf identity. Those with a close relationship with culturally Deaf people would be most likely to recognize the controversy in those statements, but for those without access to or a deep understanding of the Deaf community, these intricacies can remain unknown. Therefore, to reduce casual forms of ableism and audism, more Deaf-centered media and representation is imperative to educate not only families and communities but also young deaf/hard of hearing children as well. Recently, in partnership with the National Deaf Children's Society and Hearing Loss Association of America, the children's show Peppa Pig introduced a diagnosis of moderate hearing loss to the titular character's younger brother George. This move was intentional, and the National Deaf Children's Society explained, "Representation is vital for deaf children, helping to develop a stronger sense of self and supporting them with understanding their deafness" (Colosi, 2026). This increase in visibility is a step in the right direction, and the outcome has proven that discussing disability in children's media is simpler and more advantageous than previously imagined.

Finally, the results shown in Figure 3, specifically the top factor being "I want my child to be able to speak in unsafe situations" shows how much work needs to be done for Black Americans to feel safe in this country. Black children deserve to grow up feeling supported and protected. Currently, the intersection of racism and ableism compounds the individual dangers of

being either Black or deaf in threatening situations, making those situations more likely to go from threatening to dangerous to fatal. People in high-intensity positions of authority, like police officers and other first responders, must receive better training on complex communication and using cues beyond verbal commands when approaching civilians.

Implications for Clinicians

In addition, the findings brought forth from this research suggest needed changes for clinicians in the way they approach care for deaf/hard of hearing Black children and their families.

To begin, it is clear that caregivers are willing to try different communication modalities. That being said, caregivers' access to sign proved to be an important factor in deciding how to communicate. In figure 2, the most important factors when deciding whether to use sign language were all related to one's access to sign language itself. When asked to elaborate on responses displayed in Figure 3 about deciding whether to use speech with their child, participants' quotations all indicated that the familiarity of spoken language and the ability to communicate essential emotions to their children were prominent factors. If caregivers are willing to try different modalities of communication but are discouraged by unfamiliarity with sign and barriers to sign language learning, clinicians must keep this in mind and make concentrated efforts to increase access to sign language learning for hearing caregivers of deaf/hard of hearing children.

Further, the findings show how the clinician-client connection impacts care. Only 2.7% of audiologists and 3.8% of speech-language pathologists identified as Black in 2024 (American Speech-Language-Hearing Association, n.d.). Over 90% of clinicians identify as white. Especially in America, cultural and experiential differences between races can have a strong

impact in forming connections. Figure 5 showed the importance of connection in decision-making, as evidenced by the high importance caregivers attributed to advice from family members and friends when choosing whether to use sign language with their child. To give more weight to their clinical expertise, it is imperative that clinicians forge *real* connections with their clients and families. Though credentials give clinicians the license to treat communication disorders, they do not give them the automatic power to be listened to.

Conclusion

Solutions and Next Steps

Firstly, this thesis proved that more research needs to be done on this population and other similar groups. Researchers must consider how intersectionality affects treatment and outcomes for families of diverse backgrounds. To do this, clinicians and researchers must take the time to learn about the communities they serve and how their clients' experiences shape them during and beyond treatment. This is the only way to ensure that clients' full needs are being met and that their unique circumstances are being honored.

Next, it is clear that access to American Sign Language learning and interpreting should be improved for all hearing caregivers of deaf/hard of hearing children. Families' decision-making abilities become limited when access is a barrier to language. Until access becomes widespread, it is unlikely that trends in American Sign Language use by hearing caregivers of deaf/hard of hearing children will change.

Finally, much must be done to increase the visibility of the Deaf community and Deaf culture in the media. An increase in media presence would help lessen stigma around communicating with Deaf people and help hearing people better understand the impacts of ableism and audism. Clinicians should encourage new hearing caregivers of deaf/hard of hearing children to seek out the Deaf community and familiarize themselves with Deaf culture and the disability justice movement. Just as adoptive parents of children from different ethnicities are encouraged to learn about their children's heritage and culture, the same must be done for hearing parents of deaf children. Additionally, professionals outside the world of speech-language pathology and audiology, specifically first responders, should also learn more about the Deaf community and how to interact with Deaf people. The numerous instances of police

brutality against Deaf people has proven that first responders are not trained well enough to safely interact with complex communicators. The addition of race to the mix puts Black deaf individuals at a higher risk of danger than their white deaf counterparts. Clinicians must advocate for more exposure to the Deaf world not only for hearing parents of deaf/hard of hearing children, but also for anyone who may encounter deaf people, especially those who respond to crisis situations.

Research Limitations

This thesis was created under some limiting circumstances. First, the author operated under a condensed timeline due to her accelerated graduation. Because of this, less time could be allotted to survey distribution, data analysis, and idea generation. In the future, a repeated study should allow more time between initial development and total output, as this thesis was developed in less than one year.

Next, a limited number of participants restrict the generalizability of the results and conclusions of the research. While a longer timeline to collect participants may have helped, the researcher also could have benefitted from closer contact with the target population in survey distribution. Further research should aim for a higher number of quality responses to more closely mirror the model study which collected over 100 responses.

Finally, prior to writing this thesis, the researcher had limited experience in using the software R and no experience in survey development. Limited experience with R meant that the resulting figures may not depict the full picture of the data story, and a lack of experience in survey development may have led to challenges for potential participants in filling out the materials or understanding the structure of questions. For example, multiple participants seemed to misunderstand questions related to Figure 2, so conflicting results were removed to preserve

the integrity of the question.[9] In future, researchers may want to work alongside a data scientist and survey methodology expert to avoid skewed data or less efficient figures.

[9] When asked what factors influenced their decision on whether to use sign language with their child, multiple respondents selected both "I want my child to be able to sign" and "I don't want my child to be able to sign" as very important factors, indicating confusion with the question.

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Appendix - Description of Common Methods of Communication

Black American Sign Language

Black American Sign Language (BASL) emerged in the 20th century and is typically used within Black Deaf communities in the United States. BASL emerged from the physical isolation and social segregation associated with the establishment of different schools for white d/Deaf students and Black d/Deaf students during segregation (Smith et al., 2020). During segregation, students in white schools were required to use lip-reading and speech to communicate, but students in Black schools were instructed using sign language. Ironically, due to this separation, southern Black Deaf students received a better ASL education than most white students of the same era (Smith et al., 2020). The time spent in different education settings led to eight key features differentiating BASL from mainstream ASL: (1) two-handedness vs. one-handedness, (2) the sign's location, (3) a larger signing space, (4) the influence from spoken African American English (AAE), (5) sign repetition, (6) the use of role shifting, (7) the use of mouthing, and (7) vocabulary use (Smith et al., 2020).

Seeing Essential English (SEE I)

Seeing Essential English (SEE I) was developed in the 1960s by David Anthony, a Deaf educator of the deaf (Luetke-Stahlman & Milburn, 1996). The goal of SEE I was to manually code English to improve deaf/hard of hearing children's understanding of English grammar and syntax. SEE I works by assigning signs to basic English words, known as "pivots", and adding affix signs onto pivots to form longer words. For example, a pivot would be the word "strong", and the SEE I affix sign "er" could be added to form the word "stronger" (Luetke-Stahlman & Milburn, 1996). SEE also attempts to assign a single sign to each English word by using the two-

out-of-three rule. This rule asserts that, if two out of three of the word's characteristics (spelling, meaning, and sound) align, the words can be signed in the same way (Luetke-Stahlman & Milburn, 1996). This deviates from ASL, a highly contextual language in which the same word with the same meaning and sound *must* be signed differently depending on its context. It is important to note that, unlike ASL and BASL, SEE I is not a language in its own right, nor are the following communication systems listed in this appendix. However, in some studies, SEE I has been shown to improve English reading comprehension scores in deaf/hard of hearing children (Luetke-Stahlman & Milburn, 1996). SEE I is currently used primarily in Texas, and SEE II is now the more commonly used manually-coded English system.

Signing Exact English (SEE II)

Signing Exact English (SEE II) was developed in the spring on 1972 by a committee of people dedicated to creating a manual English system more efficient than SEE I. Still motivated by their original dissatisfaction with the state of Deaf education and literacy rates, the creators of SEE II were motivated by ten basic tenets, described by founding contributor Gerilee Gustason, including a need for visual input, making ASL the basis for the new system, and signing English as it is spoken (1990). Three types of modifications were added to ASL signs: (1) the addition of affixes, (2) the creation of new signs, and (3) the use of initials to distinguish synonyms in English. Further, to make word formation simpler, SEE II divided English words into three categories of simple, complex, and compound words (Gustason, 1990). Though SEE II has been found to be more successful in ease of use and increasing English literacy in deaf/hard of hearing children, the system is not without its issues. Gustason has identified excessive breaking up of words, rapid signing rates, lack of consistency, colorless signing, using SEE II among ASL users, and negative attitudes as among the common problems associated with SEE II (1990).

Cued Speech

Cued Speech was developed in 1965 and 1966 by R. Orin Cornett with the goal of teaching deaf/hard of hearing children English through speech (1967). Cornett intended for Cued Speech to be compatible with the teaching practices of oralist deaf educators and to provide clear communication methods to deaf/hard of hearing children. Cued Speech uses 12 cues that give the deaf/hard of hearing communication recipient enough information to identify the specific phoneme used (Cornett, 1967). Speech accompanies these cues. In his original publication introducing Cued Speech to the world, Cornett expected Cued Speech to: (1) eliminate the emotional distress emerging from oral communication difficulties between hearing parents and deaf children, (2) provide mental and linguistic development for deaf preschoolers that mirrored that of hearing preschoolers, (3) ensure that deaf/hard of hearing children think in phonemic English (as in, he hoped they would not think in sign), (4) eliminate communication opportunities not tied directly to speech and speech-reading, (5) maintain communication dependence exclusively on information visible on the lips, and (6) provide deaf/hard of hearing people a means of correcting their own mispronunciations (1967). However, in the same publication, Cornett admitted that deaf people using Cued Speech "must wage a never-ending battle to prevent deterioration of [their] speech" and must work with a hearing person to ensure they eliminate gradually acquired mispronunciations (1967, p. 10).

Keyword Signing

Keyword Signing is an alternative and augmentative communication (AAC) method in which a speaker supplements their spoken communication with manual signs for key words (Rombouts et al., 2020). Keyword signing emphasizes key content words that are essential to understanding a phrase. While less commonly used by deaf/hard of hearing people, keyword

signing has been a popular communication strategy for people with normal hearing with other communication difficulties (Rombouts et al., 2020). Keyword signing is a very simple manual communication system, and it was included in this study in the unlikely event that a participant chose to use it with their deaf/hard of hearing child.

Fingerspelling

Fingerspelling is the use of a manual alphabet system, a practice that dates back to *at least* 1592 (Morere & Roberts, 2012). Today, fingerspelling is an important component of ASL and uses handshapes to represent the written forms of the spoken English language. Typically, fingerspelling has represented names, places, and words without sign equivalents, but its use goes even further (Morere & Roberts, 2012). For example, fingerspelling can convey emphasis, signify distinct meanings in signs, and increase English literacy among deaf/hard of hearing learners by introducing English vocabulary through sign. Fingerspelling became more integral to ASL as access to education expanded through Gallaudet University and the establishment of schools for the deaf across the country in the 20th century (Morere & Roberts, 2012). Fingerspelling may have also been used to combat pushes for oralism during this time. Researchers estimate that 10-15% of words in a signed phrase are fingerspelled by ASL users, depending on the context and topic, and that native signers fingerspell more than non-native signers (Morere & Roberts, 2012). However, it is important to note that fingerspelling's integration into ASL does not mean fingerspelling itself is a complete language. Those attempting to communicate in ASL are encouraged to learn more than just the manual alphabet, since fingerspelling can be inefficient when overused and lacks its own grammar and syntax.