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Deaf Group Identification and Sexual Esteem

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DEAF GROUP IDENTIFICATION AND SEXUAL ESTEEM

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF

**THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY**

BY

ANNE WILLIS, Psy.M.

**IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY**

Dayton, Ohio

September, 2012

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July 10, 2011

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY ANNE WILLIS ENTITLED **DEAF GROUP IDENTIFICATION AND SEXUAL ESTEEM** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

The purpose of this study was to examine sexuality in persons who are deaf. Specifically, it examined group identification and sexual esteem, sexual satisfaction, and sexual preoccupation. Deafness was viewed in this study as not only a level of hearing loss, but as a source of identity and culture. While varying levels of group identification are well defined in the literature, it is unclear as to how this impacts the individual's experience. Analysis of the current sample (N = 68) suggested that there was a slight difference in sexual esteem between subjects who identified as Bicultural, Immersed, Marginalized, and Hearing. Individuals who are Immersed or Bicultural were more likely to report feeling better sexually; view themselves as sexual beings, and confidence in their sex life. Regression models were considered building on the observed bivariate correlations for Bicultural and Immersed identity and Sexual Esteem to determine the most significant factors related to sexual esteem. Among participants who identified as Bicultural, associations held for the Sexual Esteem of the individual when Age, Education, and Immersed identity score were controlled for. There were no differences in the level of sexual depression and preoccupation between participants.

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CHAPTER 1

Purpose of the Study

The disability experience has been long ignored and misunderstood in psychological research. People with disabilities are frequently not included in samples, and more importantly, not involved in the research that is being done on their identifying group. This is particularly true in the area of sexuality research. As people with disabilities are commonly thought of as asexual, there has been a noticeable gap in the literature concerning sexual health, knowledge, and beliefs of persons with disabilities (Crawford & Ostrove, 2003; Milligan & Neufeldt, 2001). As people with disabilities are a vast and diverse group of individuals, it would serve the psychological community to better understand sexuality and disability. The purpose of this study is to examine sexuality in persons who are deaf. Specifically, it will look at group identification and sexual esteem, sexual satisfaction, and sexual preoccupation. Deafness is not only a level of hearing loss, but a source of identity and culture as well (Kannapell, 1994). Thus, while some people who are deaf identify with Deaf culture, others view their deafness as a disability. While varying levels of group identification are well defined in the literature, it is unclear as to how this impacts the individual's experience. Research has demonstrated that people who are deaf that identify with Deaf culture have higher rates of global self-esteem (Bat-Chava, 1994). A clear area of neglect has been how one's group identification impacts *sexual* esteem. While global self-esteem and sexual esteem are

related, they are not interdependent concepts. This project will focus on the currently unexplored area of group identification and sexual esteem in persons who are deaf.

It is predicted that deaf people who identify as immersed or bicultural will have higher rates of sexual esteem than those who are culturally hearing or culturally marginal, or isolated from all cultures. The target population is persons who are deaf, including those who identify with the majority hearing culture and those who consider themselves culturally Deaf. Potentially, this project could impact our understanding of the psychological benefits of disability culture, here Deaf culture. Further, this project will allow psychologists to better understand the sexual experience of people who are deaf. An online survey, presented in both written English and American Sign Language (ASL), was created. The ASL portion was signed by a Deaf individual involved in the Deaf community whose primary language is ASL. Items covered demographic information, deaf group identification, sexual esteem, sexual satisfaction, and sexual preoccupation. Participants were contacted through several list serves at organizations that serve people who are deaf. Further, the survey was taken to the Deaf and Hard of Hearing Health Fair as an additional means to recruit participants. Participants completed the informed consent and survey completely online with an option to contact researchers with questions or concerns.

CHAPTER 2

Literature Review

The purpose of this project was to examine deaf group identification and sexual esteem, sexual satisfaction, and sexual preoccupation. While researchers currently understand the impact of group identification and global self-esteem, it is unclear how group identification may impact one's sexuality. Thus, this chapter begins by reviewing the existing research in this area: the complexity of deafness, attitudes towards disability and deafness, sexuality and deafness, and group identification and self-esteem.

The Complexity of Deafness

A common erroneous belief placed on racial-cultural minorities is that all members of a particular group are homogeneous. Deafness is not only a level of hearing loss, but a source of identity and culture as well. The upper-case D is significant, as it serves as a proclamation that Deaf individuals share a culture rather than merely a medical condition (Senghas & Monaghan, 2002). Thus, for the purposes of this discussion *Deaf* is capitalized when referring to the social, cultural, and political affiliation with the Deaf community. Conversely, *deaf* refers to all individuals with a level of hearing loss. Several unique aspects of Deaf culture include Deaf identity, common knowledge, shared rules of behavior and values, and Deaf pride. While a degree of hearing loss is generally a criterion for membership in the Deaf community, linguistic competence in American Sign Language (ASL) is an equally important factor in Deaf communities (Kannapell,

1994). In fact, hearing individuals, such as Kids of Deaf Adults, referred to as KODAs within the Deaf community, are considered part of the Deaf community due to their competence in ASL, involvement in the Deaf community, and absorption of the shared values of Deaf culture.

For members of the Deaf community, a shared value may be the importance of American Sign Language. A common experience may be the constant worry of communication and culture clash when interacting with the majority hearing culture. Common knowledge that is disparate from the hearing community may be knowledge of major events in the Deaf community, such as Deaf President Now (DPN), and a nationwide protest for a Deaf president at Gallaudet University, a university for Deaf individuals. DPN occurred in 1988 and is commonly thought of as a major thrust in the Deaf pride movement, meaning that individuals who are Deaf accept and value their social identity as a Deaf individual. Deaf children whose parents or siblings are members of the Deaf community are more likely to be exposed to the cultural model of deafness through their interactions.

Despite the presence of a Deaf community, the community does not represent all individuals who are deaf. Others may identify themselves as *deaf* or *hard of hearing*, using oral language and identifying with the majority hearing culture. These individuals who are deaf likely view deafness from the medical perspective, as a loss of hearing. Further, deaf individuals are likely to have similar values to hearing culture, such as proficiency in oral language. Group identification certainly impacts what values, norms, and beliefs are held by individuals who are deaf.

Several variables impact whether a deaf individual identifies with the Deaf or hearing culture. Familial history of deafness, type of educational system attended, and preferred mode of communication are just a few of these variables. For example, most deaf children are born to hearing parents. In 2008, 77.3 % of deaf youth in the nation had both hearing parents (Gallaudet Research Institute, 2008). Further, in over three-fourths of the sample the deaf children had no deaf siblings. As most deaf children are not born into culturally Deaf families, they and their parents must actively seek out the Deaf community. This is true for other non-ethnic minorities while members of ethnic minority groups are surrounded by people who share their stigmatizing attribute from birth, i.e., African-American person with an African-American family. In contrast, members of non-ethnic minorities must actively seek out a community (Bat-Chava, 1994). Thus, this active decision to affiliate with other group members likely produces varied levels of identification among deaf people.

In terms of school histories, deaf individuals attend a wide variety of school settings. In 2008, a majority of deaf students were mainstreamed, meaning they attended a school with hearing students (GRI, 2008). Approximately one quarter of deaf students were in Schools for the Deaf. Students that attend Schools for the Deaf are likely to have increased opportunity for communication with other deaf students and consequently greater involvement in Deaf culture. Not only do mainstreaming and Schools for the Deaf vary in the integration of deaf culture, they vary in the language that is predominately used in the classroom. At Schools for the Deaf, the majority of instruction and socialization is likely in a signed language, mainly American Sign Language (ASL). However, in mainstreaming, the child either must use his or her oral skills to

communicate or have a language interpreter in the classroom. This linguistic isolation reduces the amount of communication the deaf student may have with others. Several researchers have posited that school setting (Mainstreaming vs. School for the Deaf) and language used (English vs. ASL) greatly impact the child's identification with Deaf culture (Bat-Chava, 2000; Job, 2004; Nikoiraizi & Makri, 2005). It is most commonly theorized that deaf students who attend Schools for the Deaf have increased opportunity to socialize and identify with Deaf culture.

In addition to type of school attended, age of onset of deafness also seems to have an impact on cultural identification. Persons who lost their hearing before age 2, termed prelingually deaf, tend to be more culturally deaf (Fischer & McWhirter, 2001). Many individuals who lose their hearing postlingually have already identified with the hearing culture and view their deafness as a loss, rather than a cultural variable. Thus, several variables seem to impact one's experience of deafness, particularly whether it is seen as a disability or a cultural difference.

Persons' experience with deafness impacts the way in which they view themselves, their world, and their future. Importantly, deaf persons' identity differentiates their views and attitudes regarding Deaf people. In order to better understand the complexity of deaf identity, several researchers have attempted to identify and categorize the varying levels of deaf identity. Bat-Chava (2000) created four distinct groups of people with a hearing loss based on their cultural identity: culturally Deaf (immersed), culturally hearing, bicultural, and negative (culturally marginalized) identity. People with culturally deaf identities (immersed) value signing, do not value speech, are a part of the Deaf community, and have neutral attitudes towards the Deaf. People with culturally hearing

identities value speech, do not value sign, do not feel a part of the Deaf community, and have negative attitudes towards deaf people. People who have bicultural identities feel both sign language and speech are important, have average identification with the Deaf community, and have the most positive attitudes towards deaf people. People with negative identities (culturally marginal) feel sign and speech is unimportant, have below average levels of deaf identity, and positive attitudes towards Deaf people.

Bat-Chava's model of Deaf identity Development is similar to that of the Deaf-identity-development model presented by Glickman (1993). Glickman proposed four types of Deaf identity based on the Cultural and Racial Identity Development model (C/RID; Sue & Sue, 1990). The C/RID model provides an understanding of how minority people commonly feel, think, and act while discovering individual and collective freedom. The four types of Deaf identity identified in this model are: (a) *culturally hearing*: the individual identifies with the hearing culture only and defines deafness as a medical pathology or disability, (b) *culturally marginal*: the individual does not identify with either hearing or Deaf culture, (c) *immersion*: the individual is immersed in the Deaf culture and has a negative view of hearing culture, (d) *Bicultural*: the individual feels comfortable in and identifies with both the Deaf and hearing cultures. For the purposes of this discussion, Glickman's model of Deaf-identity-development will be used to understand the diversity of deaf identities.

Attitudes towards Disability and Deafness

Although deafness can be seen as a complex variable and represent a cultural difference or a disability, the majority hearing population is likely to continue to view deafness as a disability. For that reason, it is to be expected that stereotypes, myths, and

misconceptions about people who are deaf are common. In fact, people who are deaf are generally thought to be more reserved, more solitary, slower mentally, and more unsure of themselves than individuals without a sensory disability (Cambra, 1996). Further, it is thought that people who are deaf are less kind, less communicative, and less confident than people without a sensory disability. Overall, two major stereotypes are typically applied to individuals who are deaf, that they are non-social and less intelligent. As one's self-perception is influenced by the attitudes and acceptance of significant individuals in one's environment and society as a whole, it can be inferred that stereotypes of low intelligence and sociability impact a deaf person's self-concept.

The impact of the majority hearing culture's biases against people who are deaf does not impact the community uniformly, however. People who are deaf that identify with hearing culture may be more likely to incorporate culturally hearing beliefs in their self-concept. In fact, deaf individuals that consider themselves Oral, using speech to communicate rather than ASL, are more likely to rate the abilities of people who are deaf less positively (Nikoiaraizi & Makri, 2005). Conversely, culturally Deaf people are more likely to rate the abilities of people who are deaf higher than hearing and culturally hearing people. Hearing persons often site the lack of hearing as a barrier in deaf ability, such as the ability to drive a car or exit a burning building in case of an emergency. This reflects an acceptance of the medical model of disability, suggesting that deafness is defined by its lack of hearing. Not only are these beliefs common in hearing people, but also in deaf people who are culturally hearing/oral. It is suggested that they may be more likely to believe this model due to mainstreamed education and being surrounded by a hearing culture. Culturally hearing people are likely to feel marginalized as a result of the

power differences between themselves and the dominant hearing culture, without an outlet to increase their feelings of power. Culturally Deaf people report that they were raised in an environment in which they interacted with Deaf role models, attended schools for the Deaf, and socialized with culturally Deaf children and adults (Nikoiraizi & Makri, 2005). Culturally Deaf individuals have ideologically approached the role of language and cultural identification as a key component of their identity, while culturally hearing people likely view the loss of hearing as the major component of their deafness. Consequently, culturally hearing deaf individuals internalize the importance of hearing culture and oral language, thus rejecting Deaf culture and sign language. Placing the importance on their loss of hearing leads to lower rates of self-esteem and self-concept in these individuals (Nikoiraizi & Makri, 2005). In sum, one's level of hearing loss does not define his or her experience as a deaf person; rather, the group identity better explains one's experience.

Sexuality, Disability, and Deafness

The general population has several beliefs about the sexuality of people with disabilities; negative beliefs about sexuality are also seen in people who are deaf. Much research has focused on the ineffectiveness of current sexuality education of students who are deaf. Deaf youth are more apt to gain information from their peers than from formal education, leading to the transmission of myths and misinformation (Gabriel & Getch, 2001). Embarrassment or discomfort, lack of proper information about sexuality, and communication issues have been cited as reasons that parents do not talk to their youth about sex; these may be more prominent within the Deaf community. Parents are not receiving the assistance they need in their role as sexuality educators for their children. It

is thought that effective education can occur if parents and schools serving children who are deaf form a strong alliance with one another. The barriers to sexual information for deaf people have left them with insufficient opportunities to acquire information. Parental reluctance to provide sexuality education, due to embarrassment, the graphic nature of sexual sign language, and belief that it is the school's job, is found in the Deaf community. Further, inadequate school-based information leaves many deaf youth looking to peers for information about sexuality.

It is suggested that part of the reason for the lack of education of this community is due to sexual misconceptions still held regarding deaf people. While it is more extensively researched on people with disabilities than on the deaf community specifically, it is well documented that a myth of asexuality exists about people with disabilities (Cuskelly & Bryde, 2004; Cuskelly & Gilmore, 2007; DiGiulio, 2003). Although not all deaf people consider themselves to have a disability, most people in society at large consider them to have a disability (Job, 2004). Thus, misconceptions and stereotypes of other individuals with disabilities are likely also applied to people who are deaf. The misconceptions of Persons with Disabilities (PWD) are varied; in terms of sexuality, PWD are disenfranchised by a society that inaccurately perceives them as asexual beings (Milligan & Neufeldt, 2001). Paternalistic attitudes towards PWD represent the socialization from birth to assume that the disabled role is essentially asexual. This has been seen in the avoidance of sexuality education and information in Schools for the Deaf; in fact, until the 1970's most residential programs had no sexuality education (Fitz-Gerald & Fitz-Gerald, 1998). This is significant in that most residential students have very limited opportunities to see their family, thus reduced opportunity to

gain sexual information from outside sources. On a larger scale, before the 1970s, clinical and empirical literature on sexuality and disability was absent; this reflects a failure of the sciences to recognize the legitimacy of sexuality of those with a disability (Milligan & Neufeldt, 2001). It should be noted, however, that deaf individuals may not be as impacted by this stereotype due to the invisibility of their disability. Hierarchies of disability acceptability have been created; persons with more severe disabilities are ranked less sexual than less visibly disabling conditions (Nisbett & Kunda, 1985). Nonetheless, the lack of education and attention towards sexuality in the deaf community reflects this pervasive stereotype of asexuality.

The internalization of such misconceptions about disability and sexuality can lead to negative consequences for the sex lives of persons with disabilities. In a study using the Sexuality Scale (Snell & Papini 1989), a measure to examine sexual esteem, sexual preoccupation, and sexual depression, women with a physical disability had the same sexual preoccupation as women without a disability. Despite this, their body image, sexual esteem, sexual satisfaction, and life satisfaction were significantly lower (Moin, Duvdevany, & Mazor, 2009). In fact, 43% of the variance in life satisfaction among women without a disability was explained by one variable, sexual satisfaction. This demonstrates that the social isolation and belief of the non-sexuality myth of women with disabilities damages the women's self-perception as a sexual partner and an attractive person. Negative attitudes, lack of opportunities, and social isolation are the most prominent barriers impacting the sexual identity of women with physical disabilities.

Likewise, seven mythconceptions regarding deafness and sexuality have been identified; these mythconceptions are based on models of sexuality in people with

developmental disabilities (Job, 2004). Most relevant to this discussion, deaf individuals are seen as children and asexual. This is reinforced by a lack of family modeling of meaningful social and sexual expectations when children sleep away from home at Schools for the Deaf. Further, dating is not typically allowed in residential schools for the deaf, distorting the development of male-female relationships. In deaf students who are mainstreamed, the lack of relationships may be due to the lack of sexual partners due to hearing people not wanting to be sexually involved with a PWD. Another mythconception is that deaf people should be sterilized because they will give birth to children who are also disabled. As a majority of deaf children are born to hearing parents, this mythconception has no validity; yet, it still influences the opinions and sexual interactions of people who are deaf. Finally, deaf individuals are viewed as sexually different from other people and are more likely to develop deviant sexual behavior, be promiscuous, or sexually dangerous. These stereotypical beliefs about the sexuality of deaf people are thought to not only influence deaf people's quality of sexuality education, but their social interactions throughout their lifetime.

In fact, societal misconceptions about people with disabilities can cause PWDs to internalize negative assumptions regarding themselves into their own identity. Women with physical disabilities have noted that society sees them as universally intellectually challenged, asexual, helpless and incompetent, and invisible (Crawford & Ostrove, 2003). Women with physical disabilities may encounter dismissive treatment from potential partners, sexual isolation, and loneliness. Oftentimes, sexual relationships can be more positive when with another person with a disability who might share those same experiences. In fact, women with disabilities perceive lack of similarity as a barrier to

relationships with able-bodied individuals, meaning that they feel their lack of similar experiences, body type, or sexual beliefs make it difficult to form a sexual relationship with a person without a disability. This sentiment has been found in the Deaf community, as most culturally Deaf individuals form sexual relationships with other Deaf individuals (Bat-Chava, 2000). Overall, one's group identification impacts the ways in which sexual misconceptions about PWD are internalized in the individual.

Group Identification and Self-esteem

Group identification not only impacts one's sexuality, but also all other aspects of the individual's life. Research has demonstrated a relationship between cultural membership and several variables, such as self-concept and self-esteem. Bicultural deaf individuals are found to have high levels of self-concept, while marginal deaf individuals are found to have low self-concept (Cornell & Lyness, 2004). Further, bicultural identification is positively correlated with total self-concept, social self-concept, personal self-concept, physical self-concept, and academic self-concept. The integration of two cultural worlds, hearing and deaf, can lead to a more flexible identity and social skills that enable the person to function in a variety of contexts. It is suggested that identifying primarily as bicultural will have the most positive outcomes for a person with a hearing impairment, leading to increased social interaction with both groups, a strong sense of self, and a complete exploration of the conflict between Deaf and hearing cultures (Cornell & Lyness, 2004). Negative effects of identifying with mainly a hearing culture are that the individual may avoid social situations and have lower self-concept due to the lack of communication avenues and lowered chance to feel socially competent. Likewise, marginal identification can lead to depressed social competence due to little or no

positive interaction with any group. Interestingly, age of hearing loss is a predictor of low self-concept scores. Individuals who lose their hearing after they have learned spoken language have likely already established a hearing identity. Thus, they may view their hearing status as a disability, rather than a culture, due to their perceived loss of ability.

Similarly, culturally Deaf and bicultural individuals had higher self-esteem scores than those with culturally hearing or marginalized identities (Bat-Chava, 2000). People in the Deaf culture may employ several psychological mechanisms, such as emphasizing the importance of dimensions on which the group excels, such as signed language, to reject society's negative perception of deafness and emphasize the positive aspects of being deaf and having a strong group identity. Some theorize that members of stigmatized and oppressed groups who are aware of their group's stigma should incorporate those negative attitudes into the self-concept and be lower in self-esteem (Crocker & Major, 1989; Gecas & Schwable, 1983). These researchers assume that minority group members are passive recipients of the majority's messages and thus they will internalize the negative stereotyping to which they are subjected by the majority. Other theories posit that minority groups may in fact be active agents who can choose to accept or reject the majority's labeling and negative attitudes (Crocker & Major, 1989). In fact, research has demonstrated that minority members that are either bicultural or immersed in their minority culture do not have these lower rates of self-esteem (Bat-Chava, 2000; Cornell & Lyness, 2004).

Several self-protective properties of social stigma have been identified to explain these findings. Several mechanisms appear to buffer the self-esteem of members of stigmatized or oppressed groups from the prejudice of others. In fact, Crocker and Major

(1989) suggested several psychological mechanisms supported by minority group membership that enhance group members' self-esteem: (a) comparing their performance with that of other in-group members rather than that of the advantaged out-group; (b) attributing negative interpersonal and performance feedback to prejudice against their group; (c) emphasizing those dimensions on which their group excels; (d) selectively devaluing those dimensions on which their group fares poorly.

Attributing negative feedback to one's group membership rather than to internal, stable, and global causes can consequently lead to higher rates of self-esteem and self-concept. People tend to have higher self-esteem after receiving negative feedback on a task if they also believe that they had been discriminated against (Dion, 1975). When one can attribute positive feedback to oneself, despite the prejudice against the group, the individual might have more positive feelings towards oneself and one's ability level. Members of stigmatized groups may also have the tendency to make in-group social comparisons. They are likely to compare themselves with others as a consequence of segregated environments, to obtain accurate self-evaluations, or to avoid painful social comparisons. Even when the outgroup constitutes a large numerical majority, people tend to compare themselves to distant, more similar in-group members. Lastly, members of minority groups are more likely to selectively devalue, or regard as less important for their self-definition, those dimensions in which their group fares poorly and selectively value those dimensions in which their group excels. The internalization or rejection of the stereotypes placed on minorities from the general society greatly impacts the group members' experiences, thoughts, and behaviors. The internalization of negative stereotypes can then shade the way in which a person views his or her world. Likewise,

participating in psychological coping mechanisms, such as comparing oneself to ingroup members, provides the person with a lens with which to view the world. This lens is used to screen the reality and make decisions on how their world operates. These psychological coping mechanisms are seen in the various group identifications in deaf persons. Culturally Deaf people tend to place higher importance on signed language, while culturally Hearing individuals tend to place higher importance on spoken language (Bat-Chava, 2000). For culturally Deaf individuals, this may buffer against the lowered self-esteem of focusing on one's flaws or inabilities. Conversely, if a person who is deaf accepts the negative attitudes that others hold towards persons who are deaf, he or she will have lower self-esteem. People who are culturally Deaf or Bicultural tend to see deafness as a cultural variable, rather than a disability. Thus, they are less likely to believe the negative stereotypes placed on them by the outgroup. The appreciation and acceptance of deafness as a culture can act to buffer against the internalization of negative stigmas, such as the stigma that deaf people are asexual. While global self-esteem and group identification have been explored, it is unclear how group identification impacts the specific dimensions that make up global self-esteem. Global self-esteem can be distinguished from several related concepts, including dimension-specific self-evaluation. Evaluations of the self on specific dimensions such as academic ability, social skills, and physical appearance tend to be correlated with global feelings of self worth, although they are not conceptually nor empirically identical. Thus, although studies of self-esteem in Deaf individuals have demonstrated that group identification leads to higher self-esteem, it is unclear how group identification and sexual esteem are related.

It is important to examine sexual esteem, rather than simply global esteem, so that we can begin to understand its role in sexual decision making, knowledge, and sexual satisfaction. Research demonstrates that group identification impacts one's global self-esteem. In turn, high global self-esteem has a strong relation to happiness, whereas low self-esteem is more likely than high to lead to depression (Baumeister, et al., 2003). What is not known, however, is how group identification impacts a specific facet of global self-esteem, such as sexual esteem. Further, it is unknown how sexual esteem impacts the sexual satisfaction, sexual knowledge, and behaviors of persons who are deaf. The consequences of lack of education and knowledge are well documented. Persons who are deaf tend to have inaccurate beliefs about sexual diseases such as AIDS, such as believing that they do not need to change their sexual behaviors as a result of the AIDS epidemic (Woodroffe, et.al, 1998). Deaf adolescents were consistently unable to recognize that HIV/AIDS can be transmitted even if one knows one's sexual partner well, is married, or always has sex with the same boyfriend/girlfriend (Bistol et al., 2008). Additionally, higher rates of sexual abuse are well documented in persons who are deaf (Kvam, 2004; Plann, 2008). An understanding of the impact of group identification on sexual esteem might allow researchers to begin to explore what specific aspects of group identification help lead to high sexual esteem. High sexual esteem, in turn, can be researched to determine its impact on sexual behaviors and knowledge.

While it is beyond the scope of this project to examine all aspects of sexual esteem, the first step is to look at group identification and sexual esteem. This study connects cultural group identification of deaf individuals and sexual esteem, sexual-preoccupation, and sexual-depression. Rather than examining global self-esteem or self-concept, this

study looks at how differences in cultural identification affect sexual self-perception. It is predicted that deaf people who identify as immersed or bicultural will have higher rates of sexual esteem than those who are culturally hearing or culturally marginal.

CHAPTER 3

Method

Sample

Participants were recruited through an email campaign and live recruitment. An email calling for participants was sent to various list serves for the Deaf (Appendix A). Events for the Deaf community in Dayton, Cincinnati, and Columbus were attended to recruit participants (Appendix B). Participants were further recruited through several speech and hearing organizations, such as audiology and speech and hearing centers. A wide range of organizations, representing both culturally hearing and culturally deaf attitudes, was used in the recruitment of participants. Due to the nature of the study, participants were limited to individuals that were above the age of 18.

The total sample was 68 individuals ($N=68$) who completed the online survey. A total of 9 participants began, but did not complete, the online survey and these data were not used in this analysis. All selected participants identified as Deaf or hard-of-hearing, or reported that they had a hearing loss (Table 1). A majority of respondents ($n = 42$) were women. Level of education for participants ranged from a high school degree to a master's degree, with a majority of participants holding a bachelor's or master's degree ($n = 38$). Respondents ranged in age from 21 to 73. A majority of the participants were married ($n = 46$), with other participants being single ($n = 22$) and widowed ($n = 1$). The sample consisted of both heterosexual ($n = 50$) and homosexual ($n = 16$) individuals (no response, $n = 2$).

Table 1

Characteristics of the Sample

N = 68	
<i>Means and Standard Deviations</i>	
Age	42 (4.2)
Years of Education	14 (1.6)
<i>Proportions</i>	
Ethnic Group	
Caucasian	.85
African American	.14
Other	.07
Gender	
Female	.62
Male	.38
Relationship Status	
Married	.68
Single	.32
Widowed	.01
Sexual Orientation	
Heterosexual	.74
Homosexual	.24
No Response	.03

Materials

The total sample (N = 68) completed an online survey. Participants were called to participate with an email invitation (Appendix A), and viewed a Consent form Cover letter (Appendix B and C). Survey Instructions were presented in both English and American Sign Language (Appendix D). Volunteers were included if they reported a degree of hearing loss, including prelingually deaf, postlingually deaf, and hard-of-hearing people. The survey was presented in both written English and video American Sign Language (ASL). The participant had two options to view the questions, (a) in written English only, or (b) in written English with an option to view signed questions. Survey questions were translated and signed by a prelingually deaf, American Sign Language user (Appendix E).

Background information. Participants provided their age, gender, ethnicity, marital status, sexual orientation, and education level. Participants provided information specifically relevant to people who are deaf, such as the age of hearing loss, level of hearing, disability status (other than deafness), and preferred mode of communication (Appendix F).

The Sexuality Scale. Participants completed the Sexuality Scale, a measure of sexual esteem, sexual preoccupation, and sexual depression (Appendix G) (Snell & Papini, 1989). Sexual esteem is defined as a generalized tendency to engage in nonspecific internal reinforcement toward oneself, as a result of one's capacity to relate sexually to another person. Sexual depression is defined as the tendency to feel saddened and discouraged about one's capability to relate sexually to another individual. Finally, sexual preoccupation is defined as a persistent tendency to become so absorbed in,

obsessed with, and engrossed in sexual cognitions and behaviors, that one virtually excludes thoughts of other matters. Response options of the 30-item measure are on a 5-point scale of 1 (*agree*) to 5 (*disagree*). Alphas for the *sexual esteem*, *sexual-depression*, and *sexual-preoccupation* scales have demonstrated adequate subscale internal consistency (.92, .90, .88 respectively).

The Deaf Identity Development Scale. Participants completed the Deaf Identity Development Scale (DIDS), a 48-item questionnaire that assesses one's deaf cultural identity (Appendix H) (Fischer, 2001; Glickman, 1993). The DIDS is a list of items organized by subscales: *Hearing* (10 items), *Marginal* (12 items), *Immersion* (12 items), and *Bicultural* (13 items). In the hearing identity group, the individual adopts the mainstream hearing society's frame of reference and strives to function similar to a hearing person in attitude, behavior, and communication style. In the marginal identity, the person is ambivalent about his or her deafness and about which cultural frame of reference, hearing or deaf, to adopt. In the Immersion identity, the individual has a high level of involvement with the Deaf community. Finally, a person with bicultural identity recognizes the strengths and weaknesses of both deaf and hearing people while achieving a sense of inner security with his or her own deafness. Response options are on a 5-point scale of 1 (*strongly disagree*) to 5 (*strongly agree*). Internal reliability of each scale is acceptable, ranging from .76 to .86.

Procedure

Individuals identified during the recruitment process were directed to a link to the survey and consent form (Appendix A, B, C). Survey and consent forms were presented via an online survey engine, Survey Gizmo, and the survey was completed online

(Appendix E). Participants recruited at live events, such as the Deaf Awareness Day, followed the same procedure on a private laptop provided at the event. Researchers continued contacting participants by email for up to 4 weeks after the original call for participants.

CHAPTER 4

Results

Sexual Esteem, Depression, and Preoccupation

Total scores were calculated for the variables of sexual esteem, sexual depression, and sexual preoccupation. There were no significant differences in these variables related to the gender or educational level of the participants. Relationship status was not significantly related to sexual esteem, depression, or preoccupation. There were no significant differences between sexual esteem, sexual depression, and sexual preoccupation within participants in the four Deaf Identity groups, Immersion, Hearing, Bicultural, and Marginalized. Differences between groups will be discussed below.

Deaf Identity

Total subscale scores were calculated for each Deaf Identity group. A majority ($n = 31$) of the participants identified themselves as Bicultural, meaning that they identify with both hearing and Deaf cultures. Other participants identified as either Immersed ($n = 21$) or Hearing ($n = 10$). Only 6 participants identified as Marginal, or not connected with either hearing or Deaf culture.

Analyses were conducted with each scale, using the total score that each participant received on that scale. Both high and low scores are meaningful on each scale. For example, a low score on the marginal scale was related to high investment in some culture, hearing, Deaf, or both.

The following relationships were found: Participants with high scores on the Immersion scale were more likely to score low on the Hearing scale, indicating that

persons who associate primarily with Deaf culture are less likely to feel connected to hearing culture, $r = -.33$. A low but significant correlation was found between the Deaf and Bicultural scales, which likely reflect both scales' measure of strength of connection to Deaf culture, $r = .28$. There were no other significant correlations between scales.

Deaf Identity and Sexual Esteem

Participants who identified as being strongly connected to Deaf culture (Immersed) were more likely to indicate high levels of sexual esteem, $r = .35$. Further, participants who identified as having a strong connection to both Deaf and hearing cultures (Bicultural) were more likely to feel better about themselves sexually, feel like a viable sexual partner, and report their sexual experiences as rewarding (Sexual Esteem), $r = .39$.

No significant correlations were found for respondents with Hearing or Marginal identities and sexual esteem. Further, there was no significant correlation between cultural identity (Hearing, Immersed, Marginal, Bicultural) and sexual depression or sexual preoccupation.

Regression Analyses

Regression models were considered building on the observed bivariate correlations for Bicultural and Immersed identity and Sexual Esteem to determine the most significant factors related to sexual esteem. In these regressions, Sexual Esteem was examined as an independent variable and the score on either the Bicultural or Immersed identity scales as the dependent variable. Age and education level were controlled. Among participants who identified as Bicultural, associations held for the Sexual Esteem of the individual. Persons who identified as Bicultural were more likely to feel good

about themselves as a sexual being when age, education level, and Immersed identity score was controlled (Table 2).

Table 2

Regressions Predicting Participant's Level of Sexual Esteem

Predictors	<i>B</i>	<i>SE</i>	<i>t</i>
Constant	0.00	0.80	2.34*
Bicultural Identity	-0.41	0.26	-3.67*
Immersed Identity	-0.12	0.23	-1.11
Age	0.14	0.02	1.01
Education	-0.10	0.14	-0.90
<i>R</i> ²		.11	
<i>F</i>		3.07*	

*p <.05

CHAPTER 5

Discussion

Analysis of the current sample (N = 68) suggested that there was a slight difference in sexual esteem between subjects who identified as Bicultural, Immersed, Marginalized, and Hearing. It was hypothesized that deaf people who identified as Immersed or Bicultural would have higher rates of sexual esteem than those who identified as culturally hearing or culturally marginal. The current study confirmed this hypothesis by demonstrating that individuals who are Immersed or Bicultural were more likely to report feeling better sexually, viewed themselves as sexual beings, and described confidence in their sex life. This association held for individuals who identified as Bicultural when age, education level, and Immersed identity scale score were controlled. There were no differences in the level of sexual depression and preoccupation among the identity groups. However, discussion and conclusions based on the limited sample should be interpreted with caution, and may not be representative of the Deaf and hard of hearing populations in general. While no correlation was found between Marginalized and Hearing cultural identities and sexual esteem, it is noted that these groups represented the smallest sample sizes. Nonetheless, this research demonstrated an important connection between involvement in Deaf culture and sexual esteem.

Current results support literature that demonstrates a relationship between Deaf cultural membership and self-concept and self-esteem. Bicultural deaf individuals are found to have high levels of self-concept, while marginal deaf individuals are found to

have the lowest self-concept (Cornell & Lyness, 2004). Research has demonstrated that Bicultural identification is positively correlated with total self-concept, social self-concept, personal self-concept, physical self-concept, and academic self-concept. The current study builds on this research by demonstrating that Bicultural and Immersed cultural identities lead to high levels of sexual esteem.

This preliminary examination of examine sexual esteem, rather than global esteem, can help researchers begin to understand the role of sexual esteem in sexual decision making, knowledge, and sexual satisfaction. High global self-esteem has a strong relation to happiness, whereas low self-esteem is more likely than high to lead to depression (Baumeister, et.al, 2003). These conclusions suggest that higher rates of sexual esteem are related to feelings of well-being. Further, future research could determine if higher rates of sexual esteem are related to better sexual decision making and knowledge.

Participants who identified as Bicultural had the strongest relationship to sexual esteem. Involvement in Deaf culture may buffer against the lowered esteem caused by focusing in one's flaws or inabilities. A person who is deaf that accepts the negative attitudes that others hold towards persons who are deaf is more likely to have lower self-esteem. People who are culturally Deaf or Bicultural tend to see deafness as a cultural variable, rather than a disability. Thus, they are less likely to believe the negative stereotypes placed on them by the out-group. The appreciation and acceptance of deafness as a culture can act to buffer against the internalization of negative stigmas, such as the stigma that deaf people are asexual. Those participants with a Bicultural identity likely had the most positive outcomes for sexual esteem due to protective factors

identified within this group, including increased social interaction with both groups, a strong sense of self, and a complete exploration of the conflict between Deaf and hearing cultures (Cornell & Lyness, 2004). Persons with the flexibility to interact within both the Deaf and hearing worlds have higher rates of sexual esteem than their Deaf counterparts. This research fills the gap in the literature regarding cultural deafness and sexual esteem, and has several implications for clinical work with persons who are deaf.

Limitations

There were several limitations that impacted the results of the current study. First, the sample represented a highly educated group, with a majority of participants holding bachelors and masters degrees. General demographics of the Deaf and hard of hearing communities are typically less educated due to lack of educational and linguistic opportunities for these persons. Thus, the results from this sample should be interpreted with caution. One might expect that the identities and level of sexual esteem of persons who have received a high level of education differ from those who receive a high school diploma or less education. The procedure and method of the study, an online survey, likely attracted educated participants that were familiar with computers and regularly checked email accounts. Further, the sample was recruited through individuals in the Deaf and hard of hearing community that this researcher came in contact with throughout her doctorate program. Thus, participants were involved, in some capacity, with the University setting, leading to a highly educated sample. The second phase of recruitment, at Deaf Awareness Day on September 11, 2010, was added to reach a broader range of participants. The festival is open to all Deaf and hard of hearing persons in Ohio, and attracted a wide range of persons with varying levels of education. Despite this,

individuals that chose to stop and complete the survey were typically college educated. Further research should consider the impact of the use of computer-based surveys for individuals with low levels of education, and the possibility of including an optional paper-based survey.

Another limitation of this study is that participants that chose to complete the survey to completion were likely more comfortable with sexuality than those who chose to exit the survey. The researchers received feedback from a few potential participants, specifically from persons who were above 50 years old, that they did not feel comfortable answering questions about their sexuality. These potential participants generally believed that sexuality is personal and private and should not be discussed in “public.” Consequently, researchers must assume that, while persons chose to exit the survey for varying reasons, a percentage of those potential participants did not complete the survey due to conservative attitudes towards sexuality. Thus, the sample that did chose to complete the study may reflect persons that hold more modern, liberal views on sexuality.

A third limitation to this study was the length of the measures used to quantify sexual esteem and Deaf identity. The measures that are currently available to assess for sexual esteem and Deaf identity are lengthy, over 30 items each, and deterred some participants from completing the survey in its entirety. The length of the survey, 45 minutes, and the fact that participants were not compensated for their time was cited as a reason for participants not completing the survey once they began. However, when creating the survey, researchers were not able to identify valid, reliable measures of sexual esteem and Deaf identity that were shorter in length. The length of the survey may

also have contributed to the fact that the participants were generally highly educated individuals. Consequently, future research should focus on creating and validating updated measures of sexual esteem and Deaf identity.

A final limitation to the study was an underrepresentation of the hard of hearing community, culturally hearing persons, and marginalized persons in the sample. During live recruitment and completion, this researcher was given feedback from hard of hearing respondents that the Deaf Identity Development Scale (DIDS) used in the survey was overly focused on Deaf/deaf individuals, and did not sufficiently reflect the attitudes, experiences, and beliefs of those who are hard of hearing. Similarly, the hard of hearing community has increasingly asserted its independence from the Deaf cultural experience, including different group norms, experiences, and attitudes towards their hearing loss. In fact, within the last five years models of hard of hearing cultural development have been developed. Although this researcher did not receive feedback from marginalized or culturally hearing persons, it is likely that the heavy reliance on deafness on the identity scale may not have reflected their day-to-day living.

Clinical Implications

The current sample size is sufficient for statistical analyses, although the sample reflects a highly educated, small subsection of the Deaf and hard of hearing populations. Further, a majority of participants identified as Deaf/deaf with a small number of participants identifying as hard of hearing. Consequently, the following clinical implications and directions for future research are offered tentatively and broadly, particularly when generalizing to the hard of hearing community.

Results also point to the validity of cultural identity development for persons with disabilities. This sample demonstrated that individuals who viewed their disability as a cultural variable, rather than a disability, and were involved in the Deaf community in some form felt better about themselves sexually. Further, those that were able to identify with and find value in both cultures were the most likely to have highest sexual esteem. These results echoed previous research suggesting that culturally Deaf people had higher rates of self-esteem than culturally hearing persons with a hearing loss. The findings of this study, and previous research, support the incorporation of disability identity development and its positive impact on self- and sexual esteem. Culturally, factors that likely impact the connection between high sexual esteem and Deaf cultural identity include the availability of partners and chances for positive sexual experiences. Participants who had higher rates of sexual esteem and Deaf involvement may have had better access to romantic partners and sexual experiences than those that identified as hearing or marginalized. Socialization in deaf culture improves an individual's chances of having positive sexual experiences; positive sexual experiences is related to greater rates of sexual esteem, confidence about oneself as a sexual being, and greater likelihood the person will engage in positive acts in the future. Additionally, for those that identified as Bicultural, the flexibility, confidence, and comfort in interacting with either the Deaf and hearing culture might lead to the higher rates of sexual esteem.

Another factor likely impacting the results of this study is the positive emotions related to the attitudes of the Deaf community. Persons who are deaf that identify with the Deaf community are more likely to feel positively about their deafness, feel that members of their group are competent, and have less negative beliefs about disability and

American Sign Language. These positive beliefs about the self, rather than a deficit-based model of deafness, likely influence one's global and sexual esteem. Clinically, this calls for the mental health community to support and foster the Deaf community and other cultural views of disability. The Deaf community, like other minority communities, is often financially and structurally ignored by members of the majority community. Rather than a passive stance towards these disability communities, these findings suggest that the support and continuation of Deaf community, through participation in events, funding, and other support, will help support and maintain the sexual esteem of the group. The incorporation of hearing individuals in understanding and supporting the Deaf community is essential in persons with a hearing loss developing a Bicultural identity.

Conceptually, this research suggests that clinicians should consider deaf cultural identity when understanding client's global and sexual esteem, sexual behaviors, and sexual attitudes. For clients who identify as having a hearing loss, their understanding of their identity and group involvement will likely impact their sexual esteem. Rather than conceptualizing low esteem as a personal, individual variable, clinicians should consider the impact of Deaf identity and experiences of sexual oppression on their group. Further, clinicians can encourage the client to develop protective factors identified in Bicultural Deaf persons, such as in-group comparisons and a full examination of Deaf and hearing worlds, as part of the clinical work of improving sexual esteem.

Research Implications

The design of this study lends itself to suggestions for persons researching Deaf and hard of hearing individuals. It is essential to conduct research that is driven by the population of interest. Studies that have Deaf individuals involved in the process, from

design to completion, likely best reflect the ideas, thoughts, and behaviors of that group. In this study, Deaf individuals drove the design of the research by contributing to the topic chosen and surveys utilized. Further, all participants were Deaf and hard of hearing, representing the sample being examined. Thus, one research implication from this study is the idea that consumer driven research, as well as consumer driven therapy and treatment, is the ideal way to work with persons with disabilities.

Another research implication of this study is the accessibility and languages used for the study. As a researcher attempting to collect data from the Deaf community, it is essential to use American Sign Language (ASL) as a means of presenting survey questions, instructions, and even results if applicable. Despite a short recruitment time and long (45 minute) survey, this study was able to recruit 68 participants. Over 35 of the participants chose to have the survey presented in ASL. As persons who use a minority language, Deaf individuals are often asked to read English and communicate in this second language by the majority culture. By presenting survey questions in ASL, Deaf participants reported feeling respected and relieved that they did not have to read the survey in English. Researchers conducting research on this population would benefit from utilizing ASL survey measures.

It is not enough, however, to continue to research the phenomenon of Deaf and other disability identities and sexual esteem. These findings suggest that clinicians should focus on developing theory, interventions, and other tools for discussing and fostering disability cultural identity in therapy. Issues of diversity, particularly disability, are often difficult for clinicians to address directly in therapy. These findings suggest that

psychologists should take an active stance in developing and implementing interventions focused on individuals with disability fully developing a disability cultural identity.

Future Research

Based on the results and limitations of this research, future research in the area of Deaf group identification and sexual esteem is warranted. In terms of methodology, future research in this area may benefit from an increased reliance on live recruitment to increase the variability of the sample. Live recruitment at additional Deaf festivals, as well as hard of hearing organizations, would likely increase the number of participants with lower levels of education who may not feel as comfortable completing the survey on the computer. Further, additional attention should be placed on actively recruiting individuals from hard of hearing organizations and audiologists to increase the number of individuals who are marginalized or culturally hearing.

Another area of further research suggested by this study is the development of new measures to quantify sexual esteem and Deaf identity. The length of the measures used in this study was a deterrent for individuals to complete the survey in its entirety. Further, both measures were created and validated over 15 years ago, suggesting that updated measures might be a better indicator of the constructs of sexual esteem and Deaf identity. As our society changes, and our views about sexuality develop and change over time, updated measures will better capture individuals' beliefs about their sexuality. Finally, measures specifically targeted at the hard of hearing community are needed to more accurately reflect the uniqueness of this community's experience and identity development.

An essential area of future research is the connection between sexual esteem and sexual behavior and knowledge with Deaf and other disability communities. The lack of knowledge about sexuality, higher rates of HIV, and high rates of sexual abuse are well documented within Deaf and other disability communities (Kvam, 2004; Plann, 2008). It is necessary to explore what impact, if any, cultural identity and sexual esteem have on knowledge and behavior.

Conclusion

The purpose of this study was to examine sexuality in persons who are deaf. Specifically, it examined group identification and sexual esteem, sexual satisfaction, and sexual preoccupation. Deafness was viewed in this study as not only a level of hearing loss, but as a source of identity and culture (Kannapell, 1994). While varying levels of group identification are well defined in the literature, it is unclear as to how this impacts the individual's experience. Previous research demonstrated that people who are deaf that identify with Deaf culture have higher rates of global self-esteem (Bat-Chava, 1994). While global self-esteem and sexual esteem are related, they are not interdependent concepts. Thus, this project focused on the currently unexplored area of group identification and sexual esteem in persons who are deaf. It was predicted that deaf people who identify as Immersed or Bicultural will have higher rates of sexual esteem than those who are culturally hearing or culturally marginal.

Analysis of the current sample (N = 68) suggested that there was a slight difference in sexual esteem between subjects who identified as Bicultural, Immersed, Marginalized, and Hearing. Individuals who are Immersed or Bicultural were more likely to report feeling better sexually; view themselves as sexual beings, and confidence in

their sex life. There were no differences in the level of sexual depression and preoccupation between participants.

These results highlight the importance of understanding and fostering Deaf identity development in persons with a hearing loss. Further, it calls for future research to help clinicians understand the impact of cultural identity, sexual esteem, and sexual behavior. As a minority community, persons who are Deaf are at greater risk than persons without a disability to be sexually abused, hold misinformation related to sexuality, and have lower rates of self-esteem. While the current research demonstrated that identification with Deaf culture is related to higher rates of sexual esteem, much research still needs to be done to fully understand how sexual esteem impacts that sexual decision making and safe sex practices. Nonetheless, the current research does support the development of Deaf cultural identity and connection to both hearing and Deaf cultures as means of increasing feelings of global and sexual esteem.

Appendix A

Recruitment Email

TO: Persons with a hearing loss, members of the Deaf community, and members of the hard-of-hearing community

Anne Willis, a doctoral student in the School of Professional Psychology at Wright State University, is conducting a research study to examine the connection between Deaf identity and sexuality. This research is being conducted under the supervision and advisement of Dr. Julie Williams.

You have been asked to evaluate the survey because of your affiliation with one of several list-serves for persons with a hearing loss, members of the Deaf community, and members of the hard-of-hearing community. If you decide to participate, you will be asked to fill out a secure, online survey that should take approximately forty-five minutes to complete. You may view the survey in written English only, or written English and American Sign Language (ASL).

If you are interested in participating, please click on the following link which will take you to the study:

For further information about this research study, you may contact Anne Willis or Dr. Julie Williams, at willis.54@wright.edu or julie.williams@wright.edu.

Appendix B

Consent Form (Online)

Sexual Esteem and Deaf Identity

This consent page is to certify my willingness to participate in this research study.

Anne Willis, a doctoral student in the School of Professional Psychology at Wright State University in Dayton, OH, is conducting a research study to examine the connection between Deaf Identity and Sexuality. I am being asked to participate in this study because of my affiliation with one of several list-serves for persons with a hearing loss, members of the Deaf community, or members of the hard-of-hearing community.

My participation in this study will involve completing an online survey which should take approximately forty-five minutes to complete. I will be asked to answer several questions about sexuality related issues, including my own personal experiences and knowledge. I will be asked questions about my identity as a person with a hearing loss. I will also be asked some questions about my demographics, such as my age and race. This information will not be used in any way to identify me personally. Information that I provide will be kept strictly confidential and any responses I provide will not be associated with my identity in any way.

It is possible that my participation in this study may elicit mild psychological distress related to the disclosure of information of a personal and potentially difficult nature. If I experience psychological distress that is intolerable or beyond what I expect, I may choose to contact the Deaf Community Resource Center at (937) 227-3272 V or (937) 641-8177 direct VP.

There will be no direct benefit to me from participating in this study. However, the information that I provide may help to identify what types of sexuality related issues are associated with my identity as a Deaf or hard-of-hearing person.

Any information about me obtained from this study will be kept strictly confidential and I will not be identified in any report or publication. **PARTICIPATION IN THIS RESEARCH IS VOLUNTARY.** I am free to decline to be in this study, or to withdraw from it at any point. If I choose to withdraw from the study, I may exit the study at any time by closing my internet browser on any page of the survey. Completion of the survey implies my consent to participate.

If I have questions about this research study, I can contact the researcher, Anne Willis, at 937-775-3407, or willis.54@wright.edu or Dr. Julie Williams, faculty advisor, at 937-775-3407 or julie.williams@wright.edu. If I have general questions about giving consent or my rights as a research participant in this research study, I can call the Wright State University Institutional Review Board at 937-775-4462. If I would like a copy of the group (not individual) results of this study, I can contact Anne Willis at the e-mail address provided above. These results will be available by September 2010.

I have read and understand the above statements, and by clicking on the "Submit" button below, I indicate my consent to participate in this study.

Appendix C

Consent Form (Live Recruitment)

Sexual Esteem and Deaf Identity

This consent page is to certify my willingness to participate in this research study.

Anne Willis, a doctoral student in the School of Professional Psychology at Wright State University in Dayton, OH, is conducting a research study to examine the connection between Deaf Identity and Sexuality. I am being asked to participate in this study at Deaf Awareness Day on September 11, 2010.

My participation in this study will involve completing an online survey which should take approximately forty-five minutes to complete. I will be asked to answer several questions about sexuality related issues, including my own personal experiences and knowledge. I will be asked questions about my identity as a person with a hearing loss. I will also be asked some questions about my demographics, such as my age and race. This information will not be used in any way to identify me personally. Information that I provide will be kept strictly confidential and any responses I provide will not be associated with my identity in any way.

It is possible that my participation in this study may elicit mild psychological distress related to the disclosure of information of a personal and potentially difficult nature. If I experience psychological distress that is intolerable or beyond what I expect, I may choose to contact the Deaf Community Resource Center at (937) 227-3272 V or (937) 641-8177 direct VP.

There will be no direct benefit to me from participating in this study. However, the information that I provide may help to identify what types of sexuality related issues are associated with my identity as a Deaf or hard-of-hearing person.

Any information about me obtained from this study will be kept strictly confidential and I will not be identified in any report or publication. **PARTICIPATION IN THIS RESEARCH IS VOLUNTARY.** I am free to decline to be in this study, or to withdraw from it at any point. If I choose to withdraw from the study, I may exit the study at any time by closing my internet browser on any page of the survey. Completion of the survey implies my consent to participate.

If I have questions about this research study, I can contact the researcher, Anne Willis, at 937-775-3407, or willis.54@wright.edu or Dr. Julie Williams, faculty advisor, at 937-775-3407 or julie.williams@wright.edu. If I have general questions about giving consent or my rights as a research participant in this research study, I can call the Wright State University Institutional Review Board at 937-775-4462. If I would like a copy of the group (not individual) results of this study, I can contact Anne Willis at the e-mail address provided above. These results will be available by December 2010.

I have read and understand the above statements, and by clicking on the "Submit" on the computer screen in front of me, I indicate my consent to participate in this study.

Appendix D

Survey Instructions

Thank you for your participation in this survey. Your responses are appreciated and valued. The purpose of this research study is to examine the connection between positive sexuality and Deaf identity.

First, you will complete several questions about your demographics, such as your age and ethnicity. Next, you will respond to several questions about deafness and deaf culture. Finally, you will complete questions about sexual esteem and behavior. At the end of the survey, you will have an opportunity to provide written feedback for anything you thought was missing from the survey.

The total time estimated to complete the survey is 45 minutes. Remember, you may exit the study at any time by closing your internet browser. Thank you for your participation.

Appendix E

Online Survey Examples



Figure 1.

Online Survey (ASL): What is your age?



Figure 2.

Online Survey (ASL): I enjoy both Deaf and hearing cultures.

Appendix F

Survey- Background Information

1. Age
2. Gender
 - a. Male
 - b. Female
3. Level of Education
 - a. Less than high school
 - b. High school graduate
 - c. Some College
 - d. Associates Degree
 - e. Bachelors Degree
 - f. Masters Degree
 - g. Doctorate
4. Relationship status
 - a. Single
 - b. Cohabiting
 - c. Married
 - d. Separated
 - e. Divorced
 - f. Widowed
5. Sexual Orientation
 - a. Heterosexual
 - b. Homosexual
 - c. Bisexual
6. Have you been involved in a sexual relationship with another person in the last 6 months?
 - a. Yes
 - b. No
 - c. Prefer not to say
7. If yes on question six, was this person
 - a. Deaf/Hard of Hearing
 - b. Hearing
 - c. CODA- Child of Deaf Adult
 - d. Hearing- Interpreter
8. Age of hearing loss
9. Type of hearing loss
 - a. Congenital
 - b. Acquired
10. Do you have a physical or psychological disability (Do not include deafness)?
 - a. Yes
 - b. No
11. Mode of communication in elementary school (Circle all that apply)
 - a. American Sign Language (ASL)

- b. Oral (Lipreading & Voicing)
 - c. Signed Exact English (SEE)
 - d. Pidgin Signs/Home signs
 - e. Other (Please specify)
12. Current preferred mode of communication (Circle all that apply)
- a. American Sign Language (ASL)
 - b. Oral (Lipreading & Voicing)
 - c. Signed Exact English (SEE)
 - d. Pidgin Signs/Home signs
 - e. Other (please specify)
 - f. Circle all that apply

Appendix G

Survey- Deaf Identity Development Scale

Deaf Identity Development Scale (DIDS)

Fischer, L. C., & McWhirter, J. J. (2001). The deaf identity development scale: A revision and validation. *Journal of Counseling Psychology, 48*(3), 355.

Glickman, N. S., & Carey, J. C. (1993). Measuring deaf cultural identities: A preliminary investigation. *Rehabilitation Psychology, 38*, 275-282.

- a) **Agree**
- b) **Slightly Agree**
- c) **Neither Agree nor Disagree**
- d) **Slightly Disagree**
- e) **Disagree**

1. I enjoy both deaf and hearing cultures.
2. I don't know how I feel about deaf people.
3. Deaf people should use ASL.
4. Deafness is a terrible disability.
5. I support deaf culture without insulting hearing people.
6. Deaf people do not need hearing aids.
7. I feel sorry for deaf people who depend on sign language.
8. It's hard for me to make friends.
9. American Sign Language and English are different languages of equal value.
10. There is no place for hearing people in the deaf world.
11. I call myself "Deaf."
12. I don't like it when deaf people use sign language.
13. I don't know whether to respect or resent deaf people.
14. I want to help hearing people understand and respect deaf culture.
15. I don't know whether to call myself "hearing impaired" or "deaf."
16. Only deaf people should teach deaf children.
17. Deaf people should not marry other deaf people.
18. Hearing people don't help deaf people.
19. When I see deaf people using sign language, I walk away.
20. I can change between ASL and Sign Language.
21. Neither deaf nor hearing people accept me.
22. Deaf people are satisfied with what the deaf world has to offer.
23. I am always alone.
24. I don't understand why deaf people have their own culture.
25. I have both deaf and hearing friends.
26. Hearing people do not understand nor support deaf people.
27. When I am with hearing people, I remember my pride as a deaf person.
28. The focus of deaf education should be teaching deaf children to speak and lip-read.

29. I feel angry with hearing people.
30. The best way to communicate is to speak and sign at the same time.
31. I don't know whether to think of my deafness as something good or something bad.
32. I feel comfortable with my child being either deaf or hearing.
33. It is best for deaf people to communicate with speech and lip-reading.
34. Hearing people express themselves better than deaf people.
35. Teaching deaf children to speak is a waste of time.
36. I only socialize with hearing people.
37. It is wrong to speak while signing.
38. I have thought a lot about what it means to be a proud, strong, deaf person.
39. Sometimes I enjoy other deaf people but sometimes they embarrass me.
40. I would like to have an operation that would give me full hearing.
41. Some hearing people genuinely support deaf culture and deaf ways.
42. Hearing counselors, teachers, and doctors who specialize in treating deaf people can give me the best advice.
43. I feel comfortable with deaf and hearing people.
44. Only deaf people should run deaf schools.

Appendix H

Survey- Sexuality Scale

Sexuality Scale

Snell Jr., W. E., & Papini, D. R. (1989). The sexuality scale: An instrument to measure sexual esteem, sexual-depression, and sexual-preoccupation. *Journal of Sex Research*, 26(2), 256.

- a) **Slightly Agree**
- b) **Neither Agree nor Disagree**
- c) **Slightly Disagree**
- d) **Disagree**

1. I am a good sexual partner.
2. I am depressed about the sexual aspects of my life.
3. I think about sex all the time.
4. I would rate my sexual skill quite highly.
5. I feel good about my sexuality.
6. I think about sex more than anything else.
7. I am better at sex than most people.
8. I am disappointed about the quality of my sex life.
9. I don't daydream about sexual situations.
10. I sometimes have doubts about my sexual competence.
11. Thinking about sex makes me happy.
12. I tend to be preoccupied with sex.
13. I am not very confident in sexual encounters.
14. I derive pleasure and enjoyment from sex.
15. I'm constantly thinking about having sex.
16. I think of myself as a very good sexual partner.
17. I feel down about my sex life.
18. I think about sex a great deal of time.
19. I would rate myself low as a sexual partner.
20. I feel unhappy about my sexual relationships.
21. I seldom think about sex.
22. I am confident about myself as a sexual partner.
23. I feel pleased with my sex life.
24. I hardly ever fantasize about having sex.
25. I am not very confident about my sexual skill.
26. I am sad when I think about my sexual experiences.
27. I probably think about sex less often than most people.
28. I sometimes doubt my sexual competence.
29. I am not discouraged about sex.
30. I don't think about sex very often.

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