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Deaf Adults’ View of having Speech Language Therapy in Early Schooling

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Abstract

Speech therapy and interactions with speech language pathologists (SLPs) during early adolescence are common experiences for many deaf individuals. The decision to attend speech therapy is typically made by their hearing parents in conjunction with medical and educational professionals who hold the view that deaf children need to fit into the hearing world (Harmon, 2013). With the American Speech-Language-Hearing Association (ASHA) showing that most licensed SLPs work in school settings (ASHA, 2018) coupled with the fact that most deaf children receive some speech therapy in their early schooling years, we wanted to know how culturally Deaf individuals felt about their experiences with speech therapy. Therefore, the research questions that guided this study were

1. What attitudes do culturally Deaf adults have toward their experience in speech therapy, and why do they have these attitudes?
2. What suggestions do culturally Deaf people have to help speech language pathologists be culturally competent with culturally Deaf clients?

We used a qualitative design with a thematic content analysis to provide a description of the textual data from participants' stories (Anderson, 2007). Findings from this initial study provided some insight into how culturally Deaf individuals feel about having had speech therapy in school.

Keywords
Therapy, Deaf education, reflections, best practices

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Culturally Deaf Adults' View of Having Speech Language Therapy in Early Schooling

Speech therapy and interactions with speech language pathologists (SLPs) during early adolescence are common experiences for many deaf[1] individuals. The decision to attend speech therapy is typically made by their hearing parents in conjunction with medical and educational professionals who hold the view that deaf children need to fit into the hearing world (Harmon, 2013). Approximately 95% of deaf children are born to hearing parents who use spoken language in the home, which influences hearing parents' decision to seek speech therapy for their deaf children (Mitchell & Karchmer, 2004). Naturally, these families tend to hope for the ability to share a common culture and language with their child (Solomon, 2012), which is reinforced by an early focus on a deaf child as needing to be fixed (Benedict, 2011). Hearing parents tend to receive information about their child's hearing identification from medical professionals, whose recommendations are rooted in the medical model that has the goal of assimilating deaf children into the hearing world (Valente, 2011). Such recommendations tend to include referrals to audiologists and SLPs.

The American Speech-Language-Hearing Association (ASHA) defines SLPs as experts in communication who work with a wide range of individuals of all ages (ASHA, n.d.). However, most licensed SLPs work in school settings (ASHA, 2018). When looking specifically at how school SLPs work with deaf students, the Center for Hearing Communication states that the services provided by SLPs can help deaf students "improve their relationships, self-confidence, mental health, and establish heightened independence and security" (CHC, 2020). Such services provided by SLPs include, but are not limited to, aural (re)habilitation, treatment for speech and language disorders, and interventions including alternative/augmentative communication.

Such services are often recommended for deaf children, as the acquisition of spoken language tends to be difficult because conversational speech sounds are inaccessible to children whose hearing deficit is greater than 50 decibels (Mayberry, 2002). Particularly for children who receive cochlear implants, speech therapy is recommended to assist with aural training and speech intelligibility (O'Donoghue et al., 1999). Interventions with deaf children also focus on remediating common issues that tend to be apparent in "deaf speech," such as high pitch, inappropriate variations in frequency, resonance disorders, substitutions of one sound for another, or omitting a sound (Angelloci et al., 1964; Mártony, 1968; Monsen, 1968). When looking at working with deaf children, the scope of practice for SLPs includes auditory habilitation and listening skills affected by hearing loss (Ukstins & Welling, 2017). As such, the advice many hearing parents receive from SLPs tends to center around the idea that they need to "keep talking" to their deaf child so that the child can continue to focus on audiological skills (Kamble et al., 2020).

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[1] When discussing the population of Deaf and hard-of-hearing individuals, it is critical that cultural sensitivity be exercised. We acknowledge that some prefer to use *deaf* with a lowercase "d" to mean those who are audiologically deaf and *Deaf* with an uppercase "D" Deaf to refer to those who subscribe to Deaf culture and value American Sign Language (ASL) as their primary language (Woodward, 1972). Throughout this paper, to be all inclusive, we use *deaf* to refer to individuals who are deaf, hard of hearing, late deafened, and others who have identities accompanying their deaf identity; *Deaf* is used for research participants, who made their preference to be identified as culturally Deaf clear (Deafhood Foundation, 2017).

Given that many medical professionals hold negative attitudes about deaf individuals who communicate via sign language in lieu of spoken language (Ralston et al., 1996), many older deaf individuals have shared stories of physical manipulation by SLPs during their therapy sessions, including manual manipulation of the child's mouth, touching of the face and throats, and repeated bursts of breath from the SLP's mouth at a close distance. In more extreme situations, deaf students were physically reprimanded for using sign language; in fact, some professionals would forcefully use instruments in deaf children's mouths to shape and mold the tongue positioning during speech production, which would cause the child to bleed (*The British Deaf-Mute*, 1982, as cited in Ladd, 2003). As such, the topic of speech therapy in the Deaf community has long been connected to the "dark times" of oralism in deaf education, where deaf children were required to speak orally and were physically punished for using sign language in the hopes of eliminating sign language (Baynton, 1993). In fact, the title "speech language pathologist" also serves as a reminder of the oralism era and may suggest that being deaf means that one is "broken" (Ladd, 2003).

These beliefs contrast with those held by the Deaf community (Humphries & Padden, 2005), who see the community as a linguistic minority (Higgins & Lieberman, 2016) rather than as being disabled (Banson & Miller, 2002). Whereas hearing individuals tend to approach deaf children with the goal of assimilation (Harmon, 2013), deaf individuals approach deaf children with the goal of providing a strong sense of community and feel strongly that a child does not need to hear or speak to live a fulfilling life.

Some culturally Deaf people have processed their speech therapy experiences on Deaf-centric websites such as Handspeak (n.d.) that show examples of exaggerated lip movements during speech therapy. Their takeaway is that speech is fine for those who want it, but it is not for everyone. Feelings about speech therapy experiences frequently show up in De'VIA or Deaf View/Image/Art (De'VIA, n.d.) where the art reflects Deaf views on the eyes versus the ears, and the mouth versus the hands. One finds pictures of large ears and tied hands, as opposed to the feeling of freedom when they find sign language.

These cultural artifacts reflect a Deaf epistemology where their beliefs and emotional expressions demonstrate their experiences of discrimination based on their communication styles (Cripps et al., 2015). This Deaf epistemology (Cue et al., 2019) includes the comment made on Handspeak (n.d.) by the CODA Brothers that young children in Deaf signing families believe that everyone signs, regardless of being deaf or hearing. In their world, everyone signs, and they believe that those who "cannot" sign are broken. As these children move from this Deaf-centric space to the larger world, their belief changes, and they learn that most hearing people think Deaf individuals are "broken" and that they are the ones that need to be "fixed" (Cue et al., 2019). When considering these cultural artifacts, the research team—which was comprised of Deaf adults, a hearing psychologist, Deaf education specialists, and a SLP—wanted to ask culturally Deaf people their views so they could be shared with faculty in speech, language, and hearing science departments that train future SLPs. Given the narrative found in these examples, we wanted to know how culturally Deaf individuals felt about their experiences with speech therapy.

Therefore, the research questions that guided this study were

1. What attitudes do culturally Deaf adults have towards their experience in speech therapy, and why do they have these attitudes?
2. What suggestions do culturally Deaf people have to help speech language pathologists be culturally competent with culturally Deaf clients?

Methodology

A qualitative study is best suited to collect nonstatistical data on culturally Deaf adults' earlier experiences of going to speech therapy. This type of design is defined by Creswell and Poth (2016) as an inquiry into the processes of a human problem or experience. Furthermore, a thematic content analysis was selected to provide a description of the textual data (Anderson, 2007). Sorting was used to develop a list of the common themes expressed by the participants in their own words.

Procedure

Upon approval from the university's Institutional Review Board (IRB), participants were recruited using snowball sampling, including social media, referrals from others, and direct invitations from us (Creswell & Poth, 2016). Prospective participants completed a demographic survey using electronic survey software. Those meeting the research criteria signed an informed consent form, which was available to them in both written English and ASL upon request. Participants were then invited to complete an interview via Zoom.

The interview consisted of a semistructured list of open-ended questions that focused on the academic background (e.g., *"What type of deaf education setting did you group up in?"*), individual experiences with speech therapy as a child (e.g., "*What was your experience with speech therapy growing up?"*; *"How would you describe your overall experience in speech therapy?"*; *"What could your speech therapist have done better when working with you (if anything)?"*), and emotional response to having speech therapy (e.g., '*as a child, how did you feel about speech therapy?*). Additional questions served to provide us with further insight into the participants' families' attitudes regarding speech therapy (e.g., *"What did your parents think of speech therapy when you were a child"*; *"What advice did your speech therapist give your parents (if known)?*"). We also asked questions to determine the participants' current attitudes regarding speech therapy (e.g., *"Now with your current knowledge, if you could make the choice for yourself as a child, would you have decided to go to speech therapy and/or continue speech therapy?*"). The interviews were conducted in ASL and then translated into written English.

Setting

As this study was conducted during the COVID-19 pandemic, all interviews were conducted virtually using the video conferencing platform Zoom. Each interview lasted approximately an hour. Due to scheduling conflicts between participants, three interviews were conducted in a small group manner whereas the rest were one-on-one interviews. All interviews were done in

ASL with the questions also shared in written English via the chat box feature. The interviewers were either Deaf or hearing with a sign language proficiency equivalent to an American Sign Language Proficiency Interview score of 4 or above. Deaf research team members viewed each video and completed the respective English transcripts. The other research team members reviewed the videos and transcripts for accuracies. Participants were given the opportunity to review their transcripts to verify information had been translated correctly.

Participants

The criteria for participating in this study were that the individual be (a) over 18 years of age, (b) be fluent in ASL, (c) identify as culturally Deaf, and (d) had at least 3 years of speech therapy before the age of 18. This study included 17 participants (male [*n* = 2], female [*n* = 12], nonbinary [*n* = 2], and a transgender man [*n* = 1]) with a mean age of 35.7 (range 22 to 51). Ten participants reported their race as white, three as Asian, two as multiracial, and two as “other.”

Most participants reported that both of their parents were hearing (*n* = 14), one participant reported that one parent was deaf and one hearing, and the remaining two participants reported that both parents were deaf. Most participants reported that they attended a mainstream program (*n* =15), and two participants reported that they attended a residential school for the deaf. Eight participants reported receiving speech therapy for 13 years or more of their schooling years, eight reported receiving speech therapy for 10–12 years, and one participant reported receiving therapy for 3–5 years.

All participants reported using hearing aids (*n* = 14) and cochlear implants (*n* = 3) as a child. When asked about additional assistive listening devices, many participants reported that their assistive listening devices were also supported by FM systems (*n* = 11).

Data Analytical Plan

A thematic content analysis was completed for this data. Transcripts were reviewed independently by team members to determine initial themes to create a code book. The training was conducted prior to beginning coding so that the team would be more consistent. Research team members independently coded each transcript and then compared their codes with an interrater reliability of 92%. Disagreements were discussed until a consensus was reached for 100% agreement.

Results

Three overarching themes were identified: Parent Choice/Parent Involvement, Positive Experiences, and Negative Experiences. Each overarching theme was broken down into 17 subthemes (see Table 1). One subtheme included both positive and negative experiences. The results of this study indicate that there are mixed experiences among participants. Each theme will be discussed next, beginning with Parental Choice/Parental Involvement.

Table 1

Themes Identified in the Content Analysis

Parent Choice/Parent Involvement	
Mom served as a therapist at home	9
Mom provided language access	12
School- and home-based therapy	5
Stopped between middle school and high school	11
Positive Experiences	
Benefited from skills learned	11
Like being able to code switch between sign and speech	5
Have skills if there is no interpreter	5
Allows a family connection	5
Speech therapy was fun	8
“I got to miss class”	5
Negative Experiences	
Teased	4
Touching of face and throat	3
Created conflict with identity	8
Drilled on skills that I could not learn	5
“I had to miss class”	2

Parental Choice/Parental Involvement

> *"I feel like in general, speech is for the parents, not for the child. Parents are typically hearing and want to provide that because their natural language is spoken English. The parents will often push for it because they want that access for their child." —Participant #14*

As children tend to be identified through newborn hearing screenings or at early doctor visits, naturally the decision to begin speech therapy services is made by the parents. Several participants made mention that their mothers, specifically, wanted them to attend speech therapy. In addition, most of our participants (*n* = 12) reported that their mother was their primary language role model and provided the most access. This access varied based on participants and consisted of ASL, Signed Exact English (SEE), spoken English, Total Communication, or sign-supported speech. None of our participants mentioned their fathers playing a large role in speech therapy. Readers should note that while the mothers were the primary language models and the biggest driving force behind the child attending speech therapy, several participants reported that their fathers did "do their best" at communicating.

Nine of our participants reported that their mothers began to take on the role of the speech therapist at home. This role was reflected through various behaviors: correcting the child's speech, emphasizing speaking at home, encouraging the child to use their speech at restaurants and stores, and replicating strategies used by the SLP. Participant #3 reported that their mother took the advice of the SLP and labeled everything in the home with the English word. Their mother's daily actions would include asking the child to pronounce words on items they were using (e.g., "table"). The data shows that these mothers were well supported by the SLPs.

Many participants reported that once they were old enough to have some autonomy, they decided to stop attending speech therapy (*n* = 11). Participant #16, however, lamented that when they wanted to stop attending speech therapy, it became a battle with their mother, who did not want them to stop. Two participants who had chosen to stop attending speech therapy later decided to resume speech therapy in high school with the hopes of acquiring enough speaking skills to fit in with their hearing classmates.

When participants discussed why they chose to stop attending speech therapy, some reported that it was due to feeling as if they had "maxed out" on their abilities and others reported not seeing "the point" of attending any longer due to the change in their educational setting (e.g., mainstream to residential schools). Although most our participants reported that their speech therapy was school based, several (*n* = 5) reported that they had private speech therapy in addition to school-based speech therapy. These five participants reported an overall positive experience and mentioned that they preferred their private SLP over the school therapist. For example, Participant #7 mentioned that their private SLP had more difficult goals whereas the school SLP offered sessions that felt "light" and did not have much purpose. Regardless of what type of speech therapy they received, none of the participants in this study attend speech therapy as an adult.

Positive Experiences

“To be fair, I think that SLPs are generally very misunderstood.” —Participant #7

Regardless of whose decision it was to attend speech therapy, about half of our participants (*n* = 11) reported having overall positive experiences with speech therapy. Upon review of participants’ stories, the participants who reported having benefited from the skills were more likely to report a positive experience with speech therapy. The term *benefit* varied from participant to participant, but overall, participants reported that their SLPs taught and practiced functional skills such as ordering food, communicating basic needs, and essential phrases to help them navigate their environments, such as “Where is the bathroom?” Such functional skills also helped these participants feel as if they fit in with their hearing siblings rather than having to rely on their siblings or parents to help them navigate communicating with others. Participant #1 recalled going to an ice cream shop as a child where their hearing siblings were allowed to order for themselves but that their mother would order for the participant. Their mother then helped them practice giving their order in spoken English at home until they were able to master that phrase. Upon mastery of giving their order in spoken English, they were able to use that skill in the ice cream shop. “At that moment, I was like YES! I was so proud of myself. [It was just].... WOW. I want that experience for other deaf children to learn how to survive in a hearing world.”

In contrast, Participant #16 mentioned wishing their speech therapy taught them functional skills. “For example, if I go to a restaurant with my daughter and try to order something [using spoken English], like margarita, sometimes I will try to pronounce it, then the waiter is like ‘Oh! You mean *margarita* (with an increased enunciation of the word)?’ It’s embarrassing. In those moments I wish I could speak better.” Participant #15 reported that a functional skill their SLP taught them was how to breathe and laugh in a manner that fits with hearing norms. This participant reported being thankful for having that basic skill to help them navigate the world.

Another positive experience that participants reported was the SLP making the sessions “fun.” These sessions did not focus on drills or repetitions, but rather incorporated games, activities, or conversations to provide opportunities for practice. In some situations, the sessions were so fun that participants did not realize that these activities had a targeted purpose. Participant #12 recalls playing computer-based games with speech and reported, “It was fun, yeah. I was able to SEE the results and understand how speech worked. It was a game for me, I didn’t make the connection [at the time] that what I was doing was practicing my speech skills.” Participant #7 reported that their relationship with their SLP made sessions fun because it was “more like communicating with each other instead of boring practice.” Five participants reported that they enjoyed attending speech therapy sessions because they were able to miss class. Participant #15 reported, “I was thrilled when I got pulled out of class! I was like ‘YES‘! Ironically, I’m a teacher now.” For these participants, attending sessions was not a negative experience, but rather a reward.

The functional skills and fun practiced in speech therapy translated into life skills and the ability to code switch between the hearing and deaf worlds, particularly in situations when an interpreter was not available. One example of this situation can be seen in Participant #4’s recollection of being at a doctor's appointment with their spouse. The appointment was for the spouse, and the interpreter did not show up. Instead of canceling and rescheduling, the participant decided to use their speech skills to interpret the appointment. During the appointment, the doctor would refer to the participant as "the interpreter." Participant #4 went on to share "When I speak, they believe I am [spouse's] interpreter. No. Now, I refuse to speak in the doctor's office because then they think I'm hearing. When they think I'm hearing, the office starts to reject interpreter requests. That's a risk, a big risk." This participant went on to share that sometimes they prefer to code switch or use Simultaneous Communication (commonly called SimCom) for the ease of communicating their thoughts, but by doing so they run the risk of being denied accommodations and services they require for full access.

Furthermore, several participants reported that the skills they acquired in speech therapy allowed them to speak with their nonsigning family members. The results appeared to suggest that these participants felt that without the ability to speak verbally, they would not have been able to communicate and/or build a relationship with certain family members. Participant #11 expressed this sentiment when they shared that their dad was not assertive in learning how to sign and, therefore, they felt they had to use their speech skills at home if they wanted a relationship with their dad. Participants #2, 3, and 15 echoed a similar sentiment: they "wanted their family to sign, but they didn't." However, after Participant #3's mother (the signing parent in the family) passed away, their father apologized for never learning how to sign and said he wished he could sign so he could communicate with the participant. Their father took the sign language book that their mother used and a year later, he was beginning to sign. Unfortunately, their time with this experience was short, as their father passed away shortly after.

Negative Experiences

"I hated it. I just hated it."—Participant #4

All experiences carry positive and negative aspects, and as such, some participants had negative experiences with speech therapy. Participants reported being teased about their speech skills (n = 4), the SLP touching their face and throat (n = 3), conflicts with their identity (n = 8), and feeling as though the SLP focused on skills that they simply could not learn (e.g., auditory skills; n = 5). Some of the teasing was reported to be directly due to the information the participants received from the SLP. For instance, Participant #14 was told by their SLP that their articulation was excellent. The therapist encouraged this participant to speak the Pledge of Allegiance one morning over the intercom, after which the participant was teased by their peers because their speech was unintelligible. Similarly, Participant #6 reported that when they were required to stand in front of the class and use spoken English, they would then be ridiculed and mocked by their hearing peers. "That was embarrassing and traumatizing. I felt belittled as a Deaf person." Participant #17 reported that when her hearing peers in class had a birthday, her school SLP would frequently show up wearing a costume to sing Happy Birthday, which led to a deep feeling of embarrassment when the peers would laugh and ridicule her. This participant reported that this behavior occurred in their teenage years, a period when children are trying to navigate and develop their identities and led to their resentment of the SLP.

Although the speech therapy techniques of manually touching and manipulating the child's face and throats are considered antiquated and outdated practices, some participants reported their SLP using those techniques. In these sessions, sign language was often discouraged; Participant #13 recalls being made to sit on their hands to help them learn to use their voice more often. Assumptions are often made that these techniques are no longer allowed in schools. However, Participant #16, an elementary school teacher, reported witnessing their school SLP physically touch elementary-aged children's throats in the recent past, which made Participant #16 uncomfortable. Although the child did not give the SLP consent, Participant #16, as a deaf individual, felt limited to what they could say to the SLP, saying "What could I do? I have to do something, but again my job is on the line. It was clear the student did not want to be touched." This conflict points to the uneven power between the SLP and deaf teacher, as the deaf teacher did not feel empowered to comment on these highly directive behaviors.

Furthermore, some participants reported that they felt the goals and purposes of their sessions were not beneficial. Participant #6 expressed this sentiment when they shared, "I had stopped speech therapy for a while but decided to try again in high school because I thought maybe a new therapist would be better. When she pulled out a board game to play, it just felt very infantilizing and I walked out of the session. I then went home and told my parents I wanted it off my IEP." In a similarly dissatisfied manner, Participant #3 remembered a time when their SLP spent a lengthy amount of time trying to get them to roar like a lion to no avail, saying, "I wish the therapist had demonstrated to me what a lion sounds like. I didn't know what sound I was supposed to make. It wasn't until years later that I heard a lion roar."

Of note is the difference between participants' attitudes about being pulled from class for speech therapy: two participants reported that they disliked being pulled out of class while others thought that it was great to get out of class. Participant #11 admitted that although "sometimes [I] liked being pulled out of class, I also wanted to focus on my education first and push speech aside." This specific topic depended on the individual, as some enjoyed classes and did not like to miss class, while others enjoyed not having to continue with their classwork.

The results of this study suggest that some SLPs still believe in assimilation, and their attitudes during their sessions reflect this philosophy. A few participants mentioned being made to feel that they were less than their deaf peers who were successful in speech therapy, contributing to weak identity development. Participant #2 expressed this sentiment when they recalled doing an auditory-related activity with their deaf peers. One by one, their peers successfully completed the activity, but this participant did not have sufficient access to auditory input to be able to complete the activity. Instead of supporting the participant and providing alternate strategies, the SLP made the participant try "again, again, again, and again" while their peers laughed at them until they ran out of options and correctly guessed the answer. At the time, Participant #2 reported thinking "Why can they, but I can't? There's something wrong with me." These stories of having to rely on auditory and verbal skills to engage with others was also evidenced when Participant #13 shared "I felt, like, pressured in middle and high school, I had to speak better because if I spoke better, I would have more friends." Weak identity development was further demonstrated when Participant #16 reported that since they have a hearing child, they now realize that all deaf individuals should have speech therapy. "What if your kid is hearing? Sometimes they will sign but sometimes they may not. Speech therapy will help that."

Participant #10 had an intriguing response when asked about their identity: "I code-switch. You know, I can be Deaf and sign with my Deaf friends but with the hearing world, I turn on my voice and just speak." When focusing on their identity, Participant #11 reported that they were made to think they were better than the other deaf peers simply because they could "talk." Such sentiments were shared by several other participants as well. This information about their identity was interesting to see, as despite being adults who currently do not attend speech therapy, many of their responses were still centered on their speaking abilities.

Discussion

"It took me to hear that I realized I would rather be Deaf." —Participant #14

The study interviews revealed stories that are not as harsh as those reported by deaf individuals who were in school during the 1950s and 1960s when corporal punishment was a regular part of the school day. The stories did reflected shifts in Deaf culture, SLP practice, and language usage within the home. These shifts may appear insignificant when looked at in isolation, but current trends in the Deaf community indicate a major shift in practice is occurring from dividing the community based on audiovocal (hearing and speaking) skills to embracing the different language needs of individuals. However, there is still ambivalence within the Deaf community regarding speech therapy (Mauldin, 2016), as was seen in this study. Although some participants felt they benefited from speech therapy, others showed attitudes and behavior that have become symbolic of a strong Deaf identity, such as throwing their hearing aids into the toilet. These comments show the ambivalence many deaf individuals experience in terms of passing for hearing (Harmon, 2013) and the desire to find their own identity outside of technology.

As noted by Humphries and Humphries (2011), issues related to identity occur as the Deaf community is embedded in a hearing world, referred to as an island by Cue et al. (2019) that is surrounded by a hearing ocean. As most deaf infants are born to hearing parents (Mitchell & Karchmer, 2004), they are exposed to the hearing life scripts of their families and often find it difficult to live up to these expectations (Wolsey et al., 2017). Hearing people tend to have an audiovocal orientation while Deaf people tend to have a visuotactile (seeing and gesturing) orientation (Bahan, 2009). Due to this situation, deaf people who pass as hearing are seen in a positive light by hearing people but frequently in a negative light by other Deaf people. These ideas can still be seen in some of the participants' stories, particularly one shared by Participant #16, who believed that since their daughter was hearing, they must learn to speak to be a good parent.

Connected to these views about speech therapy was the notion of "being better than," as spoken language permits one to pass as hearing (Harmon, 2017). Comments regarding this issue emerged in about half of the participants' narratives; one participant made the comparison that speech divides the Deaf community in a similar way that racism divides the public. Statements were made that those who were unable to speak often felt "less than" while others noted the privileges that come with the use of spoken language. The idea of "not deaf enough" (Cue et al., 2019) seems to weave itself into the interviews while others appear to try to follow a hearing script.

Interestingly, “noise policing” is a conversation that came up among Deaf participants (Cue et al., 2019; Greene-Woods et al., 2020). When looking at Deaf epistemology, issues related to walking too loudly, chewing too loudly, and bathroom noises are frequently issues of conflict between Deaf and hearing individuals. Some of the participants who had more positive memories of speech therapy reported that their SLP helped them to understand these issues. These participants emphasized providing experiences that would benefit them as they navigated the hearing world, like how to order at a restaurant. They enjoyed when their SLP helped them learn hearing norms and hearing rules for polite behavior, such as controlling their breathing and their vocal levels. Therefore, these findings point out ideas from Deaf clients that they wished their own SLP knew and understood, which are reported as Recommendations for Future Practice below.

Recommendations for Future Practice

1. SLPs should be bilingual and bicultural.
2. SLPs should serve as an ally.
3. SLPs should help parents understand Deaf culture.
4. SLPs should avoid deficit thinking.
5. SLPs should focus on what the child needs.
6. SLPs should support language development rather than speech skills.

Sanzo (2022) suggests that if SLPs monitor language milestones, they can help families with decisions about language options. She proposed that SLPs should also educate parents about the benefits of bimodal bilingualism to capture the early benefits of neurological development. Sanzo notes that not all deaf children benefit from spoken language and that being exposed to both sign and speech at the same time provides the brain the stimulation needed to develop the language areas. Importantly, participants in this study reported the same needs reported by Sanzo that SLPs be allies and communicate with parents about sign language and deaf culture.

As noted above, a common theme was that “SLPs should be bilingual”. The comments pointed to being not only bilingual but also “bicultural”. Some participants wished that the SLP, as a hearing individual, could become an “ally, and help their parents understand Deaf culture” as well as the benefits of having access to sign language. The participants hoped that in this way, if SLPs were seen as allies and involved with the Deaf community, the Deaf community would see them in a positive light, as a “bridge between the two cultures” that enables the sharing of cultural capital between both cultures.

The study participants wanted their SLPs to value the skills and abilities they already possessed and “avoid deficit thinking”. In this way, the SLP would use a holistic approach and look at “what the child needs” rather than seeing them as “broken hearing children.” Looking at the child’s “language development rather than their speech skills” benefits the whole child and increases their self-esteem and promotes positive cognitive and social emotional development. In contrast, focusing only on speech skills tends to split deaf people into two groups, those that can speak and those who cannot, creating a divide within the Deaf community.

Limitations and Future Research

This initial study provided some insight into how Deaf individuals feel about having had speech therapy in school. However, the direct invitation recruitment became a limitation of the study, as personal recruitment targeted individuals that were known to have a more positive experience with speech therapy. Furthermore, it is possible that individuals who had more negative perceptions of their speech therapy experiences might have avoided volunteering to participate in the study. Another possibility is that the number of positive and negative experiences were unintentionally unbalanced. Future research should clearly recruit those with both positive and negative experiences so that the two perceptions can be compared. After clarifying the Deaf perspective, it might be interesting to interview parents, as one of the themes from this study was that parents wanted speech therapy, not the participants. Hearing level is another variable that may affect how deaf individuals feel about speech therapy and should also be included in future research. The hearing level may explain the difference between positive and negative themes. Another potential limitation is the wide range in participant age; future studies should have a tighter focus on age.

Another important area of research would be to understand how SLPs respond to these recommendations. Given that one of the themes was a negative view of having speech therapy, it would be critical to understand how SLPs respond to those comments. Finally, it is critical to determine how SLPs are trained and if these programs include any information about Deaf culture or require courses in ASL.

In conclusion, most participants in this study believed that their SLP had good intentions, but that speech therapy creates trauma for many Deaf people. Themes included both positive and negative feelings that may have reflected on the identity of the participants. Some wanted to fit in with the hearing peers while others were rejected by their peers and felt that speech therapy made them a target of bullying. Having a more fine-grained analysis of how deaf individuals view speech therapy may permit SLPs to customize their treatment, creating a more positive relationship with their clients while promoting healthy identity development. This change could help SLPs see each client as a whole with different needs depending on their skills and abilities.

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