5-15-2015

Listening with the Eyes and Body: An Artistic Inquiry to Explore the Needs of Deaf Adults with Chronic Mental Illness

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

The Department of Creative Arts Therapy

May 15, 2015

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Abstract

This artistic inquiry illuminated the values, beliefs, and strengths of a small group of members of the Deaf community diagnosed with chronic mental illness, in the hopes of providing quality mental health care and bridging a gap between the hearing and Deaf worlds. The participants included five Deaf or Hard of Hearing adults with chronic mental illness attending a day mental health program. This study explored how I, as a dance/movement therapy student intern and the researcher, can embody Deaf or Hard of Hearing culture and chronic mental illness to express the strengths of the individuals as well as the mental health needs of this population. The data was collected each week from dance/movement therapy and Deaf culture groups in the form of art making, journaling, and movement. Upon completion of data collection, Forinash's qualitative data analysis method and creative synthesis were used by this researcher to create a solo movement piece that was then performed for the participants for validation. After receiving feedback from the participants, the piece was then performed live for the community. During data analysis, three strong themes emerged depicting the needs expressed by the participants: 1) use and understanding of American Sign Language (ASL); 2) spiritual beliefs and strong faith; and 3) giving/receiving support from the Deaf community. The findings provided additional knowledge and awareness of this populations' needs in the hopes of developing culturally sensitive and effective dance/movement therapy for Deaf and Hard of Hearing individuals with chronic mental illness.

Acknowledgements

The completion of this thesis would not be possible without the constant support and guidance from several individuals throughout my entire thesis process. I would like to express my endless gratitude and appreciation for the dedication and support of Kristy Combs, my thesis advisor, Kyla Gilmore, my reader, and Laura Downey, the research coordinator. I would also like to thank my wonderful family for always being there in times of need and motivating me to persevere when I felt like I couldn't continue. In addition, I would like to express my appreciation for Robin Shay as she opened my eyes to the beauty of American Sign Language and Deaf Culture. Additionally, I would like to thank Kathy Walden, my childhood speech pathologist, or Dr. Miyamoto, my otolaryngologist who helped me navigate the world as a hard of hearing individual. I would also like to acknowledge the countless amount of support received from the staff and fellow interns at my research/internship site. Last, but certainly not least, I would like to express my eternal gratitude to my participants for opening their hearts and sharing their beauty, strength, and love. I will carry each of you in my heart forever.

Table of Contents

Introduction

Mental illness does not discriminate. It does not take in to account gender, race, ethnicity, or socioeconomic status, and it does not care if it layers itself upon an existing medical condition. As a result, mental illness affects a variety of individuals including those who identify as Deaf or Hard of Hearing (Please see Appendix A for definitions). In fact, the prevalence of Deaf and Hard of Hearing individuals affected by mental illness is very similar to that of hearing individuals (Horton, Kim, Mills, 2012). Despite this statistic, adequate mental health care for Deaf and Hard of Hearing adults diagnosed with mental illness is severely lacking. As a result, many identifying with this culture will avoid seeking therapeutic services. This is why research in regards to Deaf and Hard of Hearing individuals with chronic mental illness is so imperative.

Motivation for study

As my research journey began, I was unsure if I wanted to conduct a study focused on Deaf adults with chronic mental illness. Anger surfaced as I began to review the literature because there was very little to be found. Ultimately, the decision to conduct a study focusing on this population with the hopes of increasing this small pool of literature outweighed the frustration I was initially feeling. In addition, I chose to complete my internship at a day program working with Deaf and Hard of Hearing adults with chronic mental illness. Before working at this site as a dance/movement therapy (DMT) student intern, I had very little hands-on experience working with this population; however, once I began interacting with these individuals, I became increasingly passionate and curious about the best possible methods of providing effective mental

health treatment. I began wondering what type of therapy would be most effective for Deaf and Hard of Hearing adults with chronic mental illness, and more specifically, what DMT techniques would be most effective. What needs were not being met in treatment and why? What were this populations' strongest values and beliefs especially those specific to a treatment setting? Finally, I began to wonder how I could help inform the mental health community of this population's values, beliefs, and needs to possibly assist in providing information that could lead to more effective mental health practices.

Prior to my internship experience, two additional experiences impacted my decision to focus on Deaf and Hard of Hearing adults with chronic mental illness for my research study. The first occurred at my practicum in an inpatient setting the summer before I began my internship. I worked individually with a young, Deaf boy admitted for aggressive behavior and anger management; however, this boy expressed feelings of sadness and decreased self-esteem from lack of an interpreter during the course of his treatment. Without an interpreter, it became extremely difficult to communicate and interact with others leading to increased periods of isolation. It also created confusion during therapeutic groups as the patient could not understand and lead him to being unable to participate. After having the opportunity to meet with him over the course of his treatment, it became apparent the absence of his language and culture were having a negative impact on his mental health.

I also felt inspired to conduct this research because of personal experience. My younger sister and I grew up hard of hearing. I was first diagnosed at the age of five and my sister at the age of three. Our condition is unique because any trauma to our head can cause a fluctuation in our hearing and a steroid medication with severe side effects has to

be taken to regain our hearing due to a condition called Enlarged Vestibular Aqueduct. The vestibular aqueduct is a channel found in the cochlea in the inner ear through which fluids of the inner ear can drain (Reardon, Mahoney, Trembath, Jan, and Phelps, 2000). Reardon, et al (2000) explains, enlargements of vestibular aqueducts can cause "profound congenital deafness, progressive sensorineural deafness, and fluctuating threshold levels of hearing", all which my sister or I have experienced throughout our lifetime and which my sister continues to experience frequently.

We began learning how to lip read and sign exact English (SEE) at a young age with our school's Speech Language Pathologist. I have memories of this being the best or only way of communication for my sister as her hearing loss was much more severe than mine and there were times she would not be able to hear at all. Although my sister and I do not have chronic mental illness, a great amount of effort was put forth from our parents to secure the services and extra equipment needed to ensure effective communication in a school setting. Social settings can still pose difficulties if there are large amounts of background noise or those trying to communicate do not face us so we can see their mouths for lip reading. In addition, we are prohibited from participating in any activities that may cause trauma to our heads such as sports activities, roller coasters, and diving. As a child and teen, this led to some feelings of isolation or feeling left out as others did not understand our own unique experiences.

As I began to review the literature in regards to mental health care options for individuals who are Deaf or Hard of Hearing, I discovered the research was severely lacking. This was the final motivator to conduct a research study for this population with a mental health lens, as it appeared there was a significant need.

Purpose of the Research

The above-mentioned experiences and the opportunity to work with Deaf and Hard of Hearing individuals with chronic mental illness at my internship site helped inform the purpose of my research. The purpose of this artistic inquiry study was to inquire and explore the values, beliefs, and needs of a small group of members of the Deaf community diagnosed with chronic mental illness by embodying their lived experiences and sharing their artistic responses in a dance/movement piece. By doing so, it was my hope to identify and express this group's specified areas of need to potentially inform effective dance/movement therapy (DMT) practices for this population. More specifically, this study aimed to potentially provide hearing individuals working with Deaf and Hard of Hearing individuals in the mental health field with knowledge and awareness of the values and beliefs by presenting the findings through a solo dance performance. Although the results of this thesis were only presented to a small audience, it would be interesting to further explore how these findings could be shared on a larger scale in future research.

Choosing Artistic Inquiry.

This thesis study asked the participants to share and expand on their personal experiences as a Deaf adult with chronic mental illness using artistic modalities; therefore, I felt the best methodology for this study was artistic inquiry. The use of artistic inquiry provided me with the opportunity to explore my participant's culture through DMT and utilizing my own creative lenses. In addition, it was my hope to provide others and myself with aesthetic and visual results to help provide a deeper empathic understanding of the participants' experiences. Focusing on values and beliefs

also speaks to my theoretical framework as an emerging dance/movement therapist. While gaining clinical experience during my internship placement and completing my coursework, I found myself consistently using a humanistic approach while working with clients. According to Pienkos and Sass (2012), humanism focuses on "values, morality, and other aspects of what it means to be human". More specifically, Carl Roger's person-centered therapy, focusing on empathic understanding and unconditional positive regard (Pienkos and Sass 2012), is my preferred approach to working in a therapeutic setting. As a hard of hearing individual myself, I found my ability to empathize with the participants and reflect his or her strengths beneficial to the study and to the group's treatment as this is a population so easily and frequently misunderstood.

Conclusion

The Deaf community is a culture not unlike hearing culture full of diverse, unique people. The only difference is their inability to perceive sound. Their right to proper mental health services is equal to that of any other human being. The communication barrier between the Deaf community and the outside hearing world has the ability to be conquered with the right amount of empowerment from the Deaf and the correct skills and training for the treatment providers. From my own personal experience and observations, it appears lack of knowledge and awareness about Deaf culture could be one of the main issues in providing effective therapy and mental health services for Deaf and Hard of Hearing individuals.

After reviewing the literature, it is clear a gap needs to be bridged between Deaf and Hard of Hearing individuals with mental illness and hearing associates of the mental health community to provide adequate and effective care. As a consequence of this need,

I created my artistic inquiry research study to focus on the values, beliefs, and needs of a small group of members of the Deaf community diagnosed with chronic mental illness. Artistic inquiry would assist me in embodying their lived experiences and sharing their artistic responses in a dance/movement piece. By doing so, it was my hope to identify and express this groups' specified areas of need to possibly help inform future effective dance/movement therapy (DMT) practices for this population. More specifically, this study aimed to provide hearing individuals working with Deaf and Hard of Hearing individuals in the mental health field with knowledge and awareness of the values and beliefs associated with Deaf culture in the hopes of improving mental health services and strengthening the therapeutic relationship through increased cultural sensitivity.

In the following chapter, literature that discusses Deaf culture, deficits in current mental health services for this population, and dance/movement therapy with Deaf adults will be reviewed.

Literature Review

Introduction

In today's society, culture plays a large role in an individual's identity and sense of self. Culture can be defined as "the customary beliefs, social norms, and material traits of a racial, religious, or social group" or "the characteristic features of everyday existence (as diversions or a way of life) shared by people in a place or time" (Merriam-Webster, 2013). Although not always identified as such, a portion of deaf or hard of hearing individuals identify with the Deaf, also known as big "D" deaf, culture. The members of the Deaf community take pride in being deaf and fully encapsulate every aspect of the culture including the use of a separate language, customs, values, and sense of unity (Fileccia, 2011). The pride within this community fuels their ongoing desire to be accepted and treated equally to what they would refer to as "hearing people", not as deaf individuals trying to integrate in to the "hearing world". Being Deaf is a label taken on proudly as an identity and portion of the self. Unfortunately, there are hearing individuals unable to see past the Deaf's inability to hear, thus labeling the community as disabled and failing to identify them as a separate culture. According to Fileccia (2011), one of the greatest difficulties between the Deaf and hearing world is the inability to impart knowledge and bridge the gap between the two cultures, especially where health care services are concerned.

Deaf Culture

Values and Beliefs. To be culturally Deaf is often described as an ethno-linguistic culture with a high emphasis on the use of American Sign Language (ASL). It is estimated there are approximately 35 million people in the United States alone who

identify as deaf or hard of hearing with 500,000 identifying as culturally Deaf. (Hamil and Stein, 2011). There are two views of deafness in today's society: the medical model and the cultural model. The medical model views deafness as a disability whereas the cultural model views deafness as a way of life and a tight-knit community (Hamil and Stein, 2011). In Paddy Ladd's book *"Understanding Deaf Culture: In Search of Deafhood"* (2003), he explains the main reason both models have such opposing views on deafness. The medical model and those in the hearing world view deafness or hearing loss in a negative light because imagining their own world without sound or the ability to perceive sound is frightening and upsetting. Those who align with Deaf culture do not view their deafness this way because often the only world they have ever known is a silent one (Ladd, 2003).

Contrary to what some may believe, not every individual with hearing loss is considered a member of the Deaf community. Several factors contribute to an individual aligning themselves with this cultural minority. Most importantly, a majority of members have little to no residual hearing and experience deafness prelinguistically, or before learning language and how to speak. In addition, members of the Deaf community use American Sign Language as a first language for communication. Finally, Deaf persons are assimilated in to the culture at a young age meaning they share the same beliefs and view their deafness as a positive part of their identity (Fileccia, 2011). It is imperative for the hearing to avoid using phrases such as "hearing impaired", "deaf and dumb", or "deaf mute". These labels carry a negative connotation not only because it insinuates a disability, but also because the Deaf view their inability to hear from a strictly cultural view and find the medical view offensive (Barclay, Rider, Dombo, 2012).

American Sign Language (ASL). ASL is a significant component of Deaf culture as it provides a common language and a visual form of communication. Those unfamiliar with the language tend to believe ASL is a direct translation or signed form of the English language when in actuality ASL is a separate language with its own unique grammatical structure (Barclay, Rider, Dombo, 2012). This language is compiled of hand shapes, facial expressions, and eye gaze which convey grammar (Schiff, 2010). Interestingly, ASL is acquired by deaf babies the same as spoken language is acquired by hearing babies. Consequently, any Deaf individual who wishes to speak must undergo extensive lip-reading and oral training with a speech language pathologist, a trained professional in the mechanisms of spoken language (Trovato, 2013). This is also true for written English because the Deaf do not generally recognize conjunctions and the verb "to be". Signed languages are also not universal; they can vary between neighborhoods, states, and countries (Fileccia, 2011). Signed languages were not always socially accepted, and Deaf individuals were forced to speak or endure ridicule and punishment for using their hands. Trovato (2013) argues the right to use sign language is essential not only for communication purposes but also for the ability to access appropriate social and cognitive development. In addition, Trovato (2013), stresses the importance of ASL knowledge for health professionals and speech language pathologists if they are to provide adequate care to Deaf patients. Health professionals would not attempt to communicate or provide treatment to a primarily Spanish-speaking individual using English because it is not a language he or she would understand. The same should be taken in to consideration for those whose primary language is ASL.

Deaf and the Arts. The creative arts have played a prominent role in Deaf culture and its history. Members of this culture have engaged in creative expression through folk art/storytelling, visual arts, signed songs, dance, theatre, and poetry and place a large emphasis on visualization in order to observe others' work. According to Ladd (1998), Deaf art typically falls into three categories: art that does not relate to or reveal the artist's deafness, art created through a Deaf perspective, or subjects specifically Deaf related. He Ladd states a majority of Deaf art created will fit into the two latter categories.

Two of the most prominent creative arts modalities used by the Deaf are visual arts (painting, sculpture, photography, etc.) and folk art. Oftentimes, visual arts are used to expose aspects of Deaf individual's humanity. Today, a common category of visual art called De'VIA, or Deaf View/Image Art, strives to express Deaf experience through Deaf metaphors, insight, and perspectives, in relationship with the environment (deafart.org). Folk art is also articulately integrated with Deaf culture and manifests itself most frequently in the form of storytelling. Storytelling pairs perfectly with American Sign Language by allowing the storyteller and the audience to experience the story visually and with the entire body (Ladd, 1998). By using art to portray Deaf culture and experience, Deaf individuals are able to preserve their values and beliefs and continue to pass them down throughout history.

Deaf Adults and Chronic Mental Illness

In addition to being unable to hear, Deaf individuals still encounter chronic mental illness just as hearing individuals do. According to Horton, Kim, and Mills (2012), the prevalence of serious mental illness is relatively the same in hearing and Deaf/hard of hearing individuals. Although these individuals may strive for the same

treatment as hearing individuals, there are huge deficits in psychological treatment for Deaf individuals facing chronic mental illness. In reviewing the literature, the lack of mental health services and the difficulties faced by Deaf individuals seeking mental health services became a recurring and repetitive theme. A number of studies have delved further into the subject of mental health services provided for the Deaf by questioning the quality, accessibility, and availability. A majority of the studies utilized interviews with Deaf individuals conducted in ASL to discuss the types of mental health services offered as well as ways quality and access can be improved. In addition, one particular study explored the curiosity developed around the routes mental health workers could take to improve correspondence with these particular patients (Thomas, Cromwell, Miller, 2006).

A study conducted by Steinberg, Sullivan, and Loew (1998), revealed the necessity of American Sign Language (ASL) in mental health care. Not only is it needed to communicate during treatment, but also the study suggested many Deaf individuals do not recognize mental health terms in their English form. Continuing, this study inquired about the use and acceptance of sign language interpreters in the mental health setting. The participants in the study preferred therapy with an interpreter to therapy without an interpreter; however, several were concerned about the protection of his/her privacy and questioned the competency of the interpreter (Steinberg, Sullivan, and Loew, 1998). Finally, the study asks the participants to share their views in regards to integrating both hearing and Deaf individuals in the group therapy setting. Overwhelmingly, these participants preferred groups solely comprised of Deaf/hard of hearing individuals to integrated groups with an interpreter. They expressed several difficulties of integrated

groups including the inability to keep up with the fast-paced nature of English language, the inability to participate in group discussion, and the lack of others' knowledge concerning Deaf culture. Overall, the participants expressed a desire to have others who understand their language and culture involved in therapy and mental health care (Steinberg, Sullivan, and Loew, 1998).

In another study conducted by researchers Kendall, Gutman, and Rosenheck, (2008), they opted to interview caseworkers and administrators on their thoughts regarding similar topics. Out of the several articles, a few recurring themes emerged. Results in one study showcased barriers related to effective mental health care for Deaf adults such as the lack of qualified mental health interpreters, lack of specialized services for the Deaf, and insurance related barriers (Horton, Kim, and Mills, 2012). In Feldman and Kearns' (2007) article, that her participants expressed a desire for separate mental health services for Deaf and hard of hearing individuals altogether. This article was interesting because this was the only literature found suggesting this option when it was assumed it would be more prevalent in other studies. These participants also stated they would not know where to search for or request mental health services if they were to need them (Feldman, Kearns, 2007). In another argument, Vernon and Leigh (2007) agree with the need for more Deaf mental health services, however, they stated these services have improved greatly over the past fifty years.

Unfortunately, these factors combined make it very difficult for Deaf individuals to be screened for mental illness, let alone receive the proper treatment needed. Most will not go through the trouble of seeking services or are misdiagnosed simply because they are not able to communicate symptoms they are experiencing. In Sheppard and Badger's

(2010) research, the Deaf individuals interviewed for the study discuss the difficulty of describing their symptoms of depression to nurses and the difficulty of using the tools used to determine depression due to the language barrier. It is also stated that nurses and health care workers must be sensitive to a Deaf patient's difficulty with English. The failure or inability to verbalize symptoms does not necessarily reflect intelligence or lack of mental illness (Sheppard and Badger, 2010). Glickman and Harvey (2008) believe psychotherapy can be especially rewarding for Deaf individuals when qualified persons are able to deliver the services. They also stress the importance of asking the correct and culturally sensitive questions when determining how to work with Deaf patients with mental illness. They chose not to focus on helping this population "cope" with being Deaf, but how mental health care workers can be aware of their own cultural bias and assuring they have the required skills set to work with the Deaf (Glickman and Harvey, 2008).

Aside from the lack of services in health care and mental health for the Deaf, cultural sensitivity is of the utmost importance and can come up missing in these settings. Fileccia (2011) spoke from her own experience in the health care field and her work with the Deaf as to appropriate and inappropriate actions when working with this community. She mentions the importance of remembering the Deaf do not like to be thought of as disabled, however, many will accept the label in order to maintain the rights and services which come with being disabled. It is also important to recognize asking a hearing family member to interpret is culturally insensitive and could lead to a Deaf patient withholding information necessary for proper diagnosis. Contrary to what some may believe, yelling, speaking loudly, or over-emphasizing speech does not always equate to a Deaf individual

understanding what one may be saying. Not all Deaf individuals are efficient in the skill of lip-reading and many Deaf individuals have no residual hearing and will not be able to hear what is said no matter the volume it is spoken. Finally, the article stressed the importance of recognizing these individuals as a separate culture and a linguistic minority (Fileccia, 2011).

Dance/Movement Therapy with Deaf Clients

In addition to well-known psychotherapy techniques, other types of therapy have been used such as dance/movement therapy or DMT. "DMT uses psychotherapeutic movement to support the cognitive, emotional, physical, and social integration of a person" (Stressel, Cherkin, Steuten, Sherman, Vrijhoef, 2011). Stressel, et. al. (2011) describe the possible benefits of DMT such as reducing symptoms associated with mental illness, reducing stress and anxiety, and increasing mood and self esteem. As the Deaf community uses a movement-based language, it would be interesting to see how dance/movement therapy could allow for communication through movement without a focus on the spoken word.

Although studies conducted exploring the use of DMT with Deaf clients are scarce, the existing literature suggests there are benefits to this modality of therapy. In a Master's level thesis, a study was conducted entitled *"Choreography and Performance with Deaf Adults Who Have Mental Illness: Culturally Affirmative Participatory Research"* (Malling, 2012), Her research study allowed the participants, referred to as co-researchers, to choreograph and perform a piece in a creative space sharing an artistic message. Malling's thesis sought to answer several research questions including how choreography and performance techniques would impact the co-researchers' well-being.

The results suggested many of the co-researchers' treatment goals were addressed by participating in this study. By choreographing, rehearsing, and engaging in the creative process, the researcher observed increased focus and present moment awareness, increased self-esteem, increased capacity for peer support and development of relationships, and decreased isolation in the co-researchers presenting with depressive symptoms. In addition to positive treatment outcomes, the co-researchers were empowered by their ability to make choices about the performance based upon Deaf cultural beliefs and values.

Conclusion

Much of the literature and research focus on the lack of services available to Deaf and Hard of Hearing individuals. What would be the outcome of a research study that focused on the needs of this population rather than the deficits that already exist? Similar to Fletcher-Carter and Paez's (2010) study from a teacher's perspective, speaking to and discussing with their Deaf students about their culture and lived experiences can assist them with affective teaching methods. Allowing and facilitating open discussions about culture and background can provide a better understanding between Deaf/Hard of Hearing and hearing communities. This approach could also be beneficial for those working with Deaf and Hard of Hearing individuals in the mental health field.

In the following chapter, I discuss the methods used to conduct this study including methodology, population/participants, recruitment procedure, setting, data analysis, and data collection.

Methods

Methodology

The methodology I chose for this study is artistic inquiry in the constructivist paradigm using qualitative methods for data collection including journaling, writing, art making, and movement. In Hervey's chapter of *"Dance/Movement Therapists in Action: A Working Guide to Research Options",* artistic inquiry is described as a focused, systematic research method which uses artistic methods for data collection, data analysis, and the presentation of findings, often driven by the aesthetic values of the researcher, allowing the researcher to delve in to a creative research process (Cruz and Berrol, 2012, Chapter 11). Hervey (2000), further explains in her book entitled "*Artistic Inquiry in Dance/Movement Therapy: Creative Alternatives to Research",* artistic inquiry has the ability to engage a dance/movement therapist's skills which are unique and different compared to other professions in the mental health field. Furthermore, art as data is not sufficient. The art created in any artistic inquiry study must focus on or relate to the purpose of the research or research question (Hervey, 2000).

The purpose of this artistic inquiry was to inquire and explore the values, beliefs, and needs of a small group of members of the Deaf community diagnosed with chronic mental illness by embodying their lived experiences and sharing their artistic responses in a dance/movement piece. By doing so, it was my hope to identify and express this group's specified areas of need to help inform effective dance/movement therapy (DMT) practices for this population. More specifically, this study aimed to provide hearing individuals working with Deaf and Hard of Hearing individuals in the mental health field with knowledge and awareness of the values and beliefs associated with Deaf culture in

the hopes of improving mental health services and strengthening the therapeutic relationship through increased cultural sensitivity.

After exploring several methodologies, I determined artistic inquiry was the methodology that best aligned with the purpose of my research for several reasons. First, artistic inquiry research allows the researcher to be therapist and the participants to be therapy clients simultaneously as long as the clients' needs take precedence over the researcher's needs at all times. This was important to my study as I needed to meet the requirements as a DMT intern as well as collect data as a researcher/thesis student. Artistic inquiry also relies heavily on art making. For dance/movement therapists, art making is seen primarily in the form of dance and movement (Cruz and Berrol, 2012, Chapter 11). The primary language used by the participants is ASL, which as mentioned before is a movement-based language; therefore, the best way to analyze my data and present my findings would be through dance and movement, not through spoken word. Using this method additionally allowed my participants to view and validate my findings in a way they would be able to understand. Finally, I was moved by a quote in Hervey's chapter when she states if research depicting inner experiences of participants expects to result in "emotional, intuitive, imaginal, or embodied content, then artistic inquiry that can transform this raw data into communicable, artistic form without losing its authenticity is the best approach" (Cruz and Berrol, 2012). I wanted to conduct a research study to align with my desire to present my findings artistically that was expressive and authentic in order for the audience to focus on the aesthetics of the art as it expressed the beauty of the participants as both potential clients/patients and as human beings.

Methods

Population. This research study included five participants all with diverse backgrounds. I wanted to conduct my research study while completing my internship, therefore the participants were all clients at the internship site. Prior to recruitment, I acted as their DMT intern facilitating multiple treatment groups and building therapeutic relationships for the duration of six months. The treatment facility focuses on treatment for Deaf/hard of hearing and hearing adults with disabilities both living with chronic mental illness. The facility follows a schedule which provides daily services beginning at 9:00 AM and concluding at 2:45 PM. I included Deaf and hard of hearing clients who attend this program regularly. A majority of these clients have attended the program for several years, and receive additional mental health services outside of program. Five participants from the Deaf/hard of hearing program agreed to take part in this study. The final group was comprised of two males and three females, ages 21-56, from varying race/ethnic backgrounds including three Caucasians and two African Americans. Each of these participants had unique lived experiences as Deaf/hard of hearing individuals as well. All were born to hearing parents with some having hearing siblings, however, some had Deaf or hard of hearing siblings with one individual having hearing children. Some only used sign to communicate, while one preferred signing and voiced speech at the same time. Some of the participants attended a school for the Deaf whereas others did not.

Recruitment Procedure. This study relied heavily on the relationship between the researcher and the participants. As mentioned before, I had the opportunity to establish and strengthen these relationships for six months as their dance/movement

therapy (DMT) student intern. As I am hard of hearing and not part of the Deaf community, their insight and first-hand knowledge was imperative to ensure quality and accuracy. As a consequence it was important to me that a prior relationship was established in order to facilitate trust between the participants and myself. I wanted to be sure to embody what they believed was important and what they believed should be shared with the world.

To invite them to my study, I included several steps to ensure and uphold the safety of the participants. I first presented the idea of my study to their first group session at the beginning of the week, a week before I began data collection. Although I know and use American Sign Language (ASL), I sought the help of a dance/movement therapist who is also fluent in ASL to assist me with translating. I chose this therapist to provide support because she had been working with this particular group for a total of three years and uses ASL to communicate with her Deaf twin brother. I wanted to ensure the group members fully understood the study and what I was asking of them for the purposes of this thesis. To present my proposal to the group, I first explained that participating in the study was completely optional and agreeing to participate did not mean he/she had to remain in the study the full twelve weeks. I also directly informed the group that declining to participate would not have any negative impact on his or her services and he/she would continue to attend groups as before. I then provided two forms: a consent form for the prospective participants (See Appendix A) and an information sheet to share with family or group home staff (See Appendix B). Each member is his or her own guardian, however, the information sheet provided more information to the caregivers or respective staff as to what the members had agreed or declined to participate in. After

completing these steps and answering any questions the participants had, I exited the room while the dance/movement therapist fluent in ASL remained with the group members. This way, each member had the opportunity to make the decision to participate or not without feeling pressured and would be able to ask additional questions.

Setting. My research took place at an outpatient day program serving Deaf/hard of hearing adults and adults with disabilities, who both live with chronic mental illness. Members of this program receive a variety of services such as dance/movement therapy (groups and individual sessions), art therapy, cooking skills enhancement, vocational skill enhancement/vocational work opportunities, literary services, individual psychotherapy, social skills, understanding mental health and symptoms of mental health, self-esteem, men's/women's group, budgeting, Deaf culture group, hygiene, and nutrition education. This setting's core values revolved around a recovery model which focuses on improving quality of life by learning to cope with and manage symptoms of mental illness in daily living and functioning. My participants were chosen from the Deaf/hard of hearing portion of the program, totaling eight members at the time of recruitment. Three group members declined to participate in the study.

As I sought to inquire and illuminate the values, beliefs, and needs of the participants in hopes of identifying mental health treatment needs and informing effective DMT practices, I felt it was necessary to conduct research and collect data from dance/movement therapy and Deaf culture groups. The participants attended and provided data in both groups. Each group lasted one hour and took place in two different spaces in the building. DMT was conducted in a dance studio space including ample room for various movements as well as access to different props (balls, scarves,

parachutes, yoga mats, etc.) to allow opportunity for multiple means of creative expression. The second group took place in a more classroom-like space with tables, chairs, and a dry erase board. This space was equipped with art-making materials to create pictures, paintings, poems, and journals as additional forms of expression. The same two spaces were used for the entire twelve-week period and provided privacy to protect client/participant confidentiality.

Data Collection. For this study, the collection phase spanned twelve weeks and data were collected twice weekly: one time in DMT group and one time in Deaf culture group. DMT group and Deaf culture group both took place on Wednesdays so data were collected one day per week. I chose twelve weeks because of the smaller participant group and to make-up for any absences the participants may have from program. I collected data in the form of dance/movement, words, journaling/narratives and pictures. Dance and movement data were collected during DMT groups in the form of movement phrases, gestures, facial expressions and ASL. Words, journaling/narratives, and pictures were collected during Deaf culture groups. I hoped using additional forms of artistic data separate from movement would enhance my knowledge and understanding of the participants, thus improving my ability to fully embody them.

Dance/Movement Therapy Data. To collect dance/movement data, I chose to forgo the use of video recording devices and instead, I chose to use memorization/repetition, kinesthetic attunement, and empathic reflection. Using memorization/repetition, I memorized the movement by repeating the observed salient movements several times throughout the duration of the group. Hervey (2000) states many dance/movement therapists most regularly collect movement data using kinesthetic

attunement and empathic reflection as ways of fully embodying aspects of movement. Empathic reflection allows for the client to feel as if one is seen when a movement or movement quality is reflected back by the therapist/researcher whereas kinesthetic attunement allows the researcher to experience what these movements or movement qualities feel like when felt in one's own body (Cruz and Berrol, 2012, Chapter 11).

Before any data could be collected, it was important as the researcher and dance/movement therapy intern to determine which methodology of dance/movement therapy would be most beneficial for this population. Throughout my internship with this population, the Chace technique, using the group structure of body warm-up, theme development, and closure, proved to be most beneficial. Chace's theoretical framework and techniques provided a balance of therapeutic structure needed for this population and the freedom for the participants to explore his/her own story through a creative process. Her three-part group structure allows for physical warm-up and group development through body warm-up, expansion of movement repertoire (using body action, symbolism, therapeutic movement relationship, and group rhythmic movement) through theme development, and communal movement or processing through closure of group (Levy, 2005). Marian Chace is considered the "Grand Dame" of dance therapy and believed dance is communication that fulfills a basic human need (Levy, 2005). Chace's framework is rooted in the belief every patient has the desire to communicate and be heard as well as a desire to "be well", however small this desire may be (Levy, 2005).

Adapting Chace's technique, I began each DMT group for this research with a body warm-up. This portion of the group provided the participants time to physically warm-up the body and check-in with how he/she was feeling on a deeper, kinesthetic

level. Following the warm-up, this researcher/DMT intern assisted the group in transitioning into theme development by kinesthetically attuning to the group and using the embodied and intuitive knowledge gained to move deeper in to body action. To move deeper into body action and explore the developing theme, I often used symbolism through the use of transitional objects and the therapeutic movement relationship. It was difficult to incorporate aspects of group rhythmic movement using traditional Chacian means because the participants are unable to hear; however, I found the use of eye contact, touch, matching breath, and the natural rhythm of ASL often created its own unique rhythm that could be felt instead of heard. The third and final portion of each group was closure. This consisted of an ending movement done together to process the group's experience. The closing movement often involved connecting back to the breath or a movement that encompassed the theme of the group. Additional processing took place in the form of ASL. Although the closing movement was done as a group, individual processing did not always happen for each member.

Deaf Culture Group Data. Data was collected during Deaf culture groups much differently than dance/movement therapy groups. Data consisted of words, journaling/narratives, and artwork. Dance/movement therapy group and data focused on the embodied experience of the participants whereas Deaf culture group and its data focused on the stories and narratives behind the embodiment for a deeper understanding. Deaf culture group sought to explore and discuss values and beliefs of Deaf culture important to the participants. During my internship, Deaf culture group focused and discussed, a topic suggested and chosen by the participants presented at the beginning of group. Topics included Deaf beliefs and values, American Sign

Language/communicating with the Deaf, schools for the Deaf, Deaf clubs, Deaf entertainment, Deaf vs. hearing culture, and mental health treatment for the Deaf. During the research study, the participants were still given the opportunity to discuss the topic as before, however, they were now directed to create an additional art response.

Organization of Data. After the completion of each group, it was important to organize the data in preparation for data analysis. After each DMT group I took written notes, journaled thoughts/sensations/feelings, and/or reviewed the memorized movements from the day's group. This was imperative to ensure accurate data was used for this thesis. Data from the Deaf culture groups was easier to organize as the artwork or journals were collected from the participants and stored in a safe location to protect the privacy of the participants. At the end of each week, I combined the data from both groups through data analysis and made into one phrase in the form of choreographed movement. By the end of the 12-week data collection period, there were a total of 12 phrases.

Data Analysis. Data analysis for this study was required both during and after the data collection process to create 12 individual movement phrases reflective of each week. A final piece was choreographed by me into one dance. As this was a qualitative research study with findings presented as a dance/movement piece, I used Forinash's Qualitative Data Analysis Method paired with creative synthesis. In *"Dance/Movement Therapists in Action: A Working Guide to Research Options"*, Forinash's chapter provides a five step method to analyze and interpret data relevant to the study (Cruz and Berrol, 2012, Chapter 8). Forinash states that steps one and two of the process require the researcher to first review the data in its entirety while simultaneously recording observations and

feelings and then review the data a second time slowly while fully immersed in the data. Step three encourages the researcher to take the reviewed data and place them in to categories or identify recurring themes (Cruz and Berrol, 2012, Chapter 8). To complete the analysis process, Forinash states in steps four and five the researcher must reconstruct the experience from the newly formed themes and present the findings in a way which provides new information or a new perspective of the phenomena. The final step also allows the researcher to bring the final product back to the participants for feedback and validation before the presentation of findings (Cruz and Berrol, 2012, Chapter 8).

Analysis was first conducted once per week for twelve weeks aligned with the data collection process. At the conclusion of a data collection day, I engaged in steps one and two of Forinash's method to review data from the two separate groups as a whole. Upon completion of these steps, I proceeded to step three to identify prevalent themes and categories found in both the movement and art-making data. Finally, I used creative synthesis to reconstruct my experience as evidenced by the data and created a movement phrase to encapsulate the findings. This process was repeated each week for the duration of data collection and again at the end of the collection process to create the final movement piece. To finalize data analysis, the participants were given an opportunity to view the video-recorded dance and provide feedback in private. The feedback took place in a discussion format using American Sign Language (ASL) and encouraging the participants to discuss thoughts, feelings, and sensations that surfaced while viewing the piece. In addition, I asked the participants if they felt the piece was an adequate representation of themselves and to discuss why they did or did not feel it was an authentic embodiment.

The following chapter states the findings and results of this research study and further explains the feedback provided by the participants.

Results and Discussion

The purpose of this artistic inquiry was to inquire and explore the values, beliefs, and needs of a small group of members of the Deaf community diagnosed with chronic mental illness through a live dance piece that expressed the findings of the research study. By doing so, it was my hope to identify and express this group's specified areas of need to help inform effective dance/movement therapy (DMT) practices for this population. More specifically, this study aimed to provide hearing individuals working with Deaf and Hard of Hearing individuals in the mental health field with knowledge and awareness of the values and beliefs associated with Deaf culture in the hopes of improving mental health services and strengthening the therapeutic relationship through increased cultural sensitivity. Three strong themes emerged as the result of this study: 1) The use and understanding of American Sign Language (ASL); 2) Spiritual beliefs and strong faith; and 3) Giving/receiving support from the Deaf community. After becoming entirely familiar with the data by completing steps 1 and 2 of the data analysis process, step 3 required me to take this data and place it into categories or themes. It was during this time these three themes emerged. Each piece of data could be placed into one of these categories based upon its content or context. For example, one piece of artwork was of the traced hands of one of the participants. This participant explained the importance of the hands in order to use ASL. Another participant frequently used the Sign of the Cross as a movement in DMT groups.

These themes offered this researcher insight into what areas were important to consider and to share through the synthesized dance piece. The themes highlighted both values and beliefs held by the participants while pointing to areas of need that will need

to be considered to ensure culturally competent and effective treatment for the Deaf community. These themes heavily influenced my aesthetic decisions throughout my creative process. It was important I incorporate these themes into the dance piece and I chose to do so by using movements I observed and embodied from my participants that I felt best represented each theme. For example, I shared messages in ASL, held my hands in prayer, and re-created moments of connection between the participants.

The Use of American Sign Language

The findings suggest that clinicians need to be able to use American Sign Language when interacting with Deaf and Hard of Hearing individuals and that the language of movement is not sufficient. When creating art and narratives during Deaf culture group, each participant stressed the importance of ASL in his or her life. One narrative, paired with a picture of the individual's traced hands, described the participant's struggles growing up with hearing parents that did not sign. This individual experienced speech pathology where he was made to learn how to speak English instead of using ASL. This participant never used voiced speech, however, during this particular discussion the participant signed "They made me say", followed by voiced speech "My name is..." followed again by sign "I don't like it". Another participant expressed the preference of ASL and voiced speech used simultaneously. In addition to being hard of hearing, this individual has physical limitations that make the combination of signing and speaking the best form of communication.

When focusing on mental health treatment, the group's creative process unveiled the importance of the treatment team's proficiency in ASL when providing services. Interestingly, not one of the participants had a preference of whether the treatment

provider was hearing or Deaf so long as they were able to communicate. One participant created a letter for a favorite provider to express gratitude. The individual stated it did not matter that this person is hearing because the ASL skill level is high and the participant felt supported and understood. The group also spoke to the use of interpreters expressing different emotions. Overall, the group appreciated the presence of interpreters over a lack of no ASL; however, it was also expressed one may not feel as open to sharing and processing if he or she is not familiar with the interpreter. This suggests the interpreter must also build rapport with clients.

In addition to Deaf culture group, ASL played a prominent role in DMT group. Although body language, gestures, and facial expressions can all be considered forms of communication, ASL was needed to process group and deepen the interventions, especially with those processing grief or trauma. Using ASL, I was able to help the group connect the experience between body and narrative and then provide an intervention based off information gathered through kinesthetic empathy as well as signed communication. ASL was also observed as a way to maintain safety within the space by providing an ability to set boundaries or express a need to take a break. Finally, because the group cannot hear music, ASL provided an alternative common connection with which a rhythm could be felt and followed which seemed to enhance both the participants' relationships with each other and the therapeutic relationship with the dance/movement therapy intern.

Spirituality and Faith

For this study, spirituality and faith were present as themes in both DMT and Deaf culture groups each week. Presentation of spirituality and faith included religious affiliation as an installation of hope, reading The Bible and praying as a coping skill, attending church as a community support, and faith they were never alone because God would always be with them. These aspects of spirituality would reveal themselves during more obvious groups such as those focusing on death and grief but also during groups focusing on love, peace, and support.

During the course of data collection, the group suffered losses of those they knew in the Deaf community. It was during this time, I observed the theme of DMT group revolved around sending messages of love toward Heaven using movement and ASL. Movement using the Sign of the Cross used in Catholicism and hands held together in prayer were chosen by the participants as closing movements for these groups. The group expressed feelings of relief and comfort in the belief their loved one had gone to Heaven to live with God. They further explained this signified the person living in "a better place" and the opportunity to reunite with them again when they eventually passed.

Religion and attending church frequently, or in some participant's cases, every week, were also expressed as an important factor. To some of the participants, attending church provided another community that shared similar beliefs and values in the form of religion. Participating in weekly services and additional church activities introduced outside support and resources to increase socialization and quality of life. Data was collected depicting churches, crosses, and gratitude for priests, nuns, pastors, and individuals from the community belonging to his or her church. The acceptance and

relationships formed at church seemed especially important because it extended outside of their day program and offered another support system as expressed in group.

Deaf Community Support

The participants all communicated their strong connections to the Deaf community. They shared that this community offers support and a sense of belonging. It would be beneficial if the clinician working with this population has awareness of community resources and the ability to help clients make connections within the community. The clients can also be encouraged to support one another through their own community relationships. It was astounding to witness the impact the Deaf community has played in the participants' life as most of the participants were introduced at a young age. The Deaf community is a group that believes being Deaf is a culture and way of life, not a disability needing a solution, which was apparent from participant responses during group.

This community is tight-knit, supportive, and celebrates the language of ASL by focusing on the strengths of its individuals, not the inability to hear. Half of the participants expressed how the experience of attending a school for the Deaf during childhood still continues to have an impact on their lives today. The particular Deaf schools the participants attended were not just establishments for education, but where they lived for the majority of the year as well. The school for the Deaf was a place where the participants felt they could acquire an education surrounded by those sharing the same culture and language. In addition to education, schools for the Deaf provide socialization through sports teams, school dances, and sharing a dormitory-like space with roommates. One participant had plans to travel back to his school for a reunion.

When expressing his excitement through his narrative and art, this participant noted the continued importance of the friendships made years ago while attending Deaf school. In our specific day program, the participants found a sense of deeper belonging with other group members who had attended the same school for the Deaf or could relate to the experience of being constantly surrounded by other Deaf students.

Another example of how important a strong connection to the Deaf community could be found in the participants' expression of membership in an outside organization. This specific organization, separate from the day program, is specifically designed to serve Deaf or hard of hearing individuals with mental illness. Through this organization, the clients are provided with a case manager who then connects the client to services and resources such as psychiatric and medical care, outreach services, employment placements, and housing placements. Social gatherings such as picnics and holiday parties are offered to encourage members to socialize outside of their program or residential settings. In fact, when given the choice, many of the participants would prefer to attend these social gatherings instead of those offered by the day program. The four out of five participants associated with this organization expressed many reasons why they enjoyed their services. Unanimously, the participants explained their love for this organization had to do with each employee's fluency in American Sign Language and knowledge of unique, Deaf cultural needs. Letters and drawings created in Deaf culture group depicted the participants' gratitude and love for the continuous support and understanding from this special organization.

Presentation

In addition to this written thesis, I decided to share my findings via a live solo performance for the community (Appendix D). The piece was the final compilation of the data collected and was comprised of choreography based off of the movements and artistic responses of the participants. The piece used one song entitled "The Light" by The Album Leaf for the duration of the piece as I felt the rhythm of this music represented the rhythm of the participants. I also made the decision to wear mittens at the beginning of the piece which were taken off and thrown on the ground shortly after. These mittens represent the frustration my participants expressed feeling when unable to communicate using ASL. The mittens additionally speak to moments in Deaf history when Deaf individuals were forced to cease the use of signed languages and speak instead.

The dance piece presents several of the participants' movement responses and represented each of the three strong themes. I begin the piece walking onto the stage while holding my hands in prayer to represent the importance of spirituality and faith. To represent the strong connection to the Deaf community, I incorporated movements I witnessed while the participants were supporting one another during group. Finally, as ASL seemed to be the dominant theme, I combined movement with ASL to share the overarching message of what I learned from this study: "Hearing or Deaf, it doesn't matter. Both want love. Both want support. Both want to be understood."

Before the performance, I was incredibly nervous. Prior to performing the piece live, my data analysis method allowed me to present the final product to the participants in a private showing. After viewing, the participants were encouraged to provide

feedback to this researcher in a discussion conducted in ASL. The participants expressed enjoyment of the piece and stated that it was “beautiful” and it made them “feel happy” and “feel better”. This researcher asked the participants if this piece was representative of their culture and needs to which they replied it did. Two of the participants were unable to express why they believed it represented them; however, the other three participants recognized their own movements and stated they enjoyed the signed message at the end. Despite their validation and positive feedback, I still felt anxiety to perform because I was afraid the audience would not receive the message I so desperately wanted to share for the participants. However, when I stepped on stage and began performing, I felt empowered, witnessed, and I imagined that the audience could feel in their own bodies the message I was trying to convey through my dancing. Because this performance was an embodiment of the participants, I felt it possible that the participants felt empowered, witnessed and understood while sharing their experiences and needs throughout this process.

Discussion

I found that I felt angry and frustrated about the lack of services and stigmas my participants experienced. I decided to let go of these feelings and redirected my focus on ways to allow this population to creatively express their own thoughts and beliefs based on their experiences and provide a voice for them through my own artistic expression. In addition, I had to let go of what I believed the participants needed and focus on what they expressed they needed. Keeping an open mind and focusing on the participants’ responses was difficult at times; however, I now feel as if I have an even deeper understanding of Deaf Culture by witnessing it through the eyes of Deaf adults with

chronic mental illness. By focusing less on the negative and allowing myself as the researcher to embody the values, beliefs, and needs of these individuals, I was able to reconstruct a movement piece authentically representative of the data.

This study was able to increase the small amount of literature informing DMT treatment for Deaf adults with chronic mental illness. The prevalence of the three strong themes that emerged in the findings suggest their importance for effective DMT and mental health treatment. In a more general sense, it appears knowledge regarding Deaf culture and ASL skills are imperative not only to communicate, but to also foster therapeutic relationships with mental health staff. I observed an increase in the participants' sense of empowerment and ability to articulate their needs when given multiple modalities to do so.

Using artistic inquiry and embodiment, my participants provided me with the ultimate discovery separate from those three themes. This discovery has kept me motivated throughout this process to share their values, beliefs, and needs and is something I will carry with me forever. Underneath the layers of deafness, hearing loss, and chronic mental illness, below the layers of stigmas and "disabilities", lives a human no different than a hearing person. Although my mind is conscious of this, I think my body needed to be reminded. Empathically and kinesthetically embodying them, my body realized emotions such as depression, anger, grief, happiness, confusion, stress, anxiety, excitement, and annoyance were felt similarly by me. The individuals I embodied desired to be understood and accepted and this was something impossible to ignore. The inability to hear did not make these individuals any less human and certainly should not hinder

their ability to be treated as such while seeking treatment for mental illness or any other time during their lives.

Limitations of the Study

This study was limited due to the small sample size of participants. As a consequence, the results from this study are difficult to generalize and depend upon the individuals providing the data. In addition, artistic inquiry research relies heavily on the intuitive, aesthetic, and kinesthetic impressions felt by the researcher; therefore, results and presentation of results can vary. Furthermore, I played the role of both researcher and therapist while conducting this study. Ethically, the needs of the clients and their treatment took priority over gaining data; therefore, not all of the movement, art, journals, or narratives provided could be used because it did not revolve around the purpose of the research. Additionally, each of the participants identified with Christianity or Catholicism, therefore the impact of spirituality and faith may be different for those identifying differently.

Additional Research

Despite the information discovered from this study, much more research needs to be conducted for this population. Although the results of this thesis were only presented to a small audience, it would be interesting to further explore how these findings could be shared on a larger scale in future research. What results would be found in different parts of the country? The world? Other than Chacian techniques, what DMT practices would be effective for this population? How does DMT affect Deaf individuals in other therapeutic settings such an inpatient setting? For children or adolescents? Are there other avenues of creative arts therapies that could be beneficial? If an interpreter is used in the

therapeutic setting, how can the therapist facilitate trust between client and interpreter? Further research addressing these and other research questions can help continue to increase the knowledge provided to the field of DMT and mental health when working with Deaf and hard of hearing individuals.

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Appendix A

American Sign Language: American Sign Language (ASL) is a significant component of Deaf culture as it provides a common language and a visual form of communication. Those unfamiliar with the language tend to believe ASL is a direct translation or signed form of the English language when in actuality ASL is a separate language with its own unique grammatical structure (Barclay, Rider, Dombo, 2012). This language is compiled of hand shapes, facial expressions, and eye gaze which conveys grammar (Schiff, 2010).

Big D Deaf: This refers to being culturally deaf. To be culturally Deaf is often described as an ethno-linguistic culture with a high emphasis on the use of American Sign Language. It is estimated there are approximately 35 million people in the United States alone who identify as deaf or hard of hearing with 500,000 identifying as culturally Deaf. (Hamil and Stein, 2011).

Chronic mental illness: An illness or disorder which is severe in degree and persistent in duration. The symptoms may be permanent or episodic. There may also be a substantially diminished level of functioning in the primary aspects of daily living (Hamil and Stein, 2011).

Hard of Hearing: Those who have a mild to moderate hearing loss (www.deaftec.org).

little d deaf: This refers to the medical condition of being unable to hear (Hamil and Stein, 2011).

Medical model vs. cultural model*:* There are two views of deafness in today's society: the medical model and the cultural model. The medical model views deafness as a disability whereas the cultural model views deafness as a way of life and a tight-knit community (Hamil and Stein).

Appendix B

Columbia
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Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: "Listening with the Eyes and Body"
Principal Investigator: Malorie McGee
Faculty Advisor: TBD
Chair of Thesis Committee: Laura Downey

INTRODUCTION

You are invited to participate in a research study to explore Deaf Culture and Mental Health through art and movement. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to participate because of your knowledge and personal insight of the Deaf and hard of hearing community and culture.

PURPOSE OF THE STUDY

The purpose of this research study is to address the misconceptions and stereotypes of Deaf and hard of hearing individuals as well as clarifying differences between Deaf/hard of hearing and hearing culture. More specifically, I wish to address the lack of mental health services provided to Deaf individuals with chronic mental illness. I hope to shed light on the strengths of Deaf and hard of hearing individuals and Deaf culture in hopes of gaining more adequate mental health care for those who are Deaf or hard of hearing and live with chronic mental illness.

PROCEDURES

- Each individual will create art (pictures, journals, poems, movement, etc.) during clinical interventions to answer the research questions.
- This research will take place on the fourth floor of (internship site) during Dance/Movement Therapy and Deaf Culture groups. Your participation is requested for 12 weeks.
- No audio or videotape will be used.

If you agree to participate in this study, you will be asked to do the following:

- Attend Dance/Movement Therapy and Deaf Culture groups, every week for 12 weeks.
- Create art (pictures, journals, poems, movement, etc.) during group which will be collected if permission is given.
- Verbally process or discuss any sensations, feelings, thoughts, or images derived from the art making if applicable.

POSSIBLE RISKS OR DISCOMFORTS

The risk(s) in this study are:

- The possibility of triggering unpleasant emotions (anger, frustration, sadness, etc.) due to the culturally sensitive questions proposed or due to personal experiences around the research questions. Clinical processing will be provided for any of these instances and supervision will be sought if deemed necessary.
- Physical fatigue may occur during a Dance/Movement Therapy session, however, participants will be encouraged to take breaks as needed.

POSSIBLE BENEFITS

You may not directly benefit from this research; however, I hope that your participation in the study may increase the knowledge of mental health needs of Deaf and hard of hearing individuals to hearing individuals, specifically in the mental health field. In addition, I hope this research and your participation can provide some bridge between the gap of Deaf and hearing cultures.

CONFIDENTIALITY

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

The following procedures will be used to protect the confidentiality of your information:

- The researcher(s) will keep all study records locked in a secure location.
- Participants may request the return of any art created at any time.
- All electronic files containing personal information will be password protected.
- Information about you that will be shared with others will be unnamed to help protect your identity.
- No one else besides the investigator will have access to the original data.
- At the end of this study, the researchers may publish their findings. You will not be identified in any publications or presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Take as long as you like before you make a decision. We will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator [Malorie McGee (317) 414-9844] or the faculty advisor [Laura Downey]. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312-369-7384.

COST OR COMMITMENT

- There is no cost to participate in this study.
- Time required includes two 1 hour groups, per week, for 12 weeks.

PARTICIPANT STATEMENT

"This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form."

_____ _____ _____
Participant/Parent/ Print Name: Date:
Guardian Signature:

Relationship (only if not participant): _____

_____ _____ _____
Signature of Person Print Name: Date:
Obtaining Consent

_____ _____ _____
Principal Investigator's Print Name: Date

Appendix C

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COLLEGE CHICAGO

To Whom It May Concern,

My name is Malorie McGee and I am currently an intern with (name of internship site). I am a graduate student in the Department of Creative Arts Therapies working toward a Master's degree in Dance/Movement Therapy and Counseling. I will be conducting a research study exploring the strengths and needs of Deaf culture in regards to its effect on mental illness and mental health services. Today, I requested (name of participant) be a part of my research study. This letter is to inform you of the information he/she received and to provide a description of the research study he/she declined or accepted to participate in. I communicated the information using American Sign Language and had the assistance of the dance/movement therapist to assure each participant understood the commitment and details of the study, however, if you feel he/she may not have fully understood or still has questions, I have attached the consent form for you to view. I am also available at (317) 414-9844 or malorie.mcgee@loop.colum.edu if any questions or concerns may arise. If it is more comfortable, you may also reach my supervisor, Laura Downey, at (312) 369-7697. Thank you for your time.

Sincerely,

Malorie McGee

Appendix D

The solo dance performance associated with this study can be found as a DVD separate from this written thesis.