RELATIONSHIP OF HOMEMAKERS' HEARING LOSSES TO FAMILY INTEGRATION

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This is to certify that the

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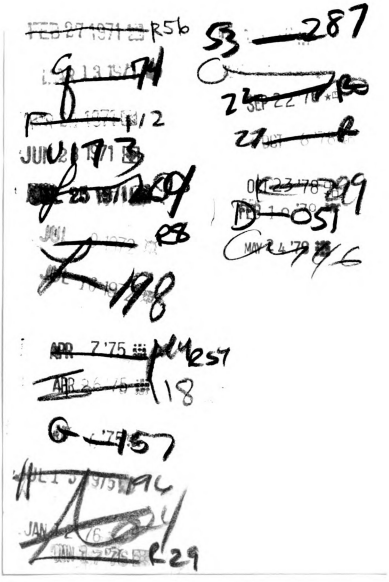

ABSTRACT

RELATIONSHIP OF HOMEMAKERS' HEARING LOSSES TO FAMILY INTEGRATION

By

Ella Jane Oyer

This study is designed to answer basic questions regarding the relationship of homemakers' hearing losses to certain aspects of family integration. Although researchers generally agree that hearing handicaps cannot be regarded as a unitary factor, few have studied them in terms of their implications for the family. Disability is conceptualized as a critical intervention which may necessarily cause modifications in family members' reciprocal role performances.

Thirty families with homemakers who had hearing losses were compared with thirty families with homemakers who had normal hearing. Selection criteria included intact families, presence in the home of children eighteen years of age or younger, no persons other than immediate family residing within the home, agreement of husbands and homemakers to participate in the study, and a defined hearing loss for the thirty homemakers. Data were collected by interviewing husbands and homemakers in their homes.

Ella Jane Oyer

Family integration, a term which describes well-knit or unified families, was measured operationally by six selected indicants: goal consensus, marital tension, rejection of the homemaking role, homemakers' power in decision-making, families' task performances, and parents' agreement on the management of children's behavior.

The Mann-Whitney U test was applied to determine differences in scores between the two groups of families on the variables tested. No significant difference in goal consensus between groups was found. When rankings of the nine goals related to family life were examined by the chi square goodness of fit test, however, homemakers in the two groups were found to differ significantly in the importance they attributed to two goals. Homemakers with normal hearing appeared to consider it more important to have "a nice home for the entertainment of friends." Hard of hearing homemakers appeared to consider it more important that "the home be a place where family members feel they belong."

Analysis indicated no significant difference between groups in marital tension. When the thirty families with homemakers who had hearing losses were divided according to severity of hearing loss, however, husbands of homemakers with the more severe hearing losses were found to have significantly more marital tension than husbands of homemakers with normal hearing.

Homemakers did not differ significantly in their rejection of the homemaking role or in their power in decision-making. There was a trend, however, for hard of hearing homemakers to be less rejecting of the homemaking role, and to have more power in family decision-making. Families of hard of hearing homemakers provided them with significantly more help in the performance of family tasks. Analysis indicated no significant difference between groups on their agreement as to the management of children's behavior.

Hard of hearing homemakers belonged to fewer organizations outside the home and attended fewer meetings per month.

Further research to pin-point causes of husbands' marital tension, and reasons families of hard of hearing homemakers provided them with more help with family tasks is indicated.

The study provided some clues for identifying the relationship of homemakers' hearing losses to family integration. The most conclusive emerging hypothesis seems to be in the relationship of the severity of homemaker's hearing losses to family integration. This factor merits further investigation.

RELATIONSHIP OF HOMEMAKERS' HEARING LOSSES TO FAMILY INTEGRATION

By

Ella Jane Oyer

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CHAPTER I

INTRODUCTION

Health is a vital part of human values and goals. Families and their values and goals are focal points of home management. Although it has been noted that health is important in the complicated maze of factors affecting the family, relatively little attention has been given to relationships between health and other components that determine the quality of family life. The increasing incidence of chronic or disabling diseases constitutes a major concern of those engaged in the social and behavioral sciences. Lee (1) contends that chronic conditions often have a greater impact on the individual, his family, and society than do acute illnesses and injuries that attract more public attention.

Among the concerns of home management is the creating of a home environment that is conducive to the development of the self and social adjustment of family members. The degree to which satisfactory adjustment occurs may be affected by the health and well-being of members of the family group. Many families have members whose health needs impose selective limitations upon their behavior.

Handel notes the reciprocal nature of members' activities when he says that (2, p. 6) "intrafamilial relationships are interlocking and contingent upon one another." That is to say, one member cannot react without evoking responses in others. The health needs of one member also affect his immediate others.

An aspect of health that needs attention is the hearing loss of family members. Auditory deprivation has found few champions who view it as a family problem. Generally the individual has been treated, but his interpersonal relationships in the family have not been considered in the treatment. Some studies of individual personal, social, and vocational adjustment may be found, but deaf rather than hard of hearing persons have usually served as the subjects studied (3, 4, 5).

Hearing loss falls along a continuum from slight to moderate to severe to deaf. While there are many obvious relationships between hard of hearing and deaf, there are many less obvious dissimilarities. Sussman (6) suggests that the deaf person may effect a better adjustment than the hard of hearing person. Deaf persons know they cannot hear, and as a result they are able to define their functional limitations. Hard of hearing individuals, however, fluctuate between the worlds of the deaf and hearing. Expectations of self and others tend to become ambiguous and uncertain placing additional stress upon them.

Hearing loss cannot be regarded as a unitary factor. Oyer (7) comments that the self-adjustment of hard of hearing individuals is affected by the reactions of others to their losses. Doerfler (8) notes the frequency of adverse effects of hearing loss on marital relationships. Hearing impaired subjects have been found to exert a greater dependence upon their families (9). Does increased dependence thrust an additional burden upon other family members? It has been suggested that stress is engendered in most people when engaged in communication with hearing impaired persons (10).

There can be little doubt as to the importance of learning more about the impact of hearing loss upon families when one considers that approximately eight million persons in the United States have hearing losses (11). About 38.1 females per thousand, or 19.9 females between the ages of 17 and 44, have impaired hearing. Data do not reveal the family status of these women, but it seems reasonable to assume that a large number of families is affected.

Objectives

This study is designed to answer basic questions regarding relationships of a homemaker's hearing loss to selected aspects of family integration: goal consensus, marital tension, rejection of the homemaking role, power

in decision-making, family task performances, and management of children's behavior. Families in which the homemaker has sustained a hearing loss will be compared with those in which the homemaker hears normally. Aspects of the homemakers' roles as wife, mother, and housekeeper will be examined. Specifically, answers to the following questions will be sought:

1. Is there a difference in goal consensus between hearing handicapped homemakers and their husbands, and a comparison group composed of normal hearing homemakers and their husbands?
2. Do hearing handicapped homemakers and their husbands expect more quarreling and dissension in marriages in general than do normal hearing homemakers and their husbands?
3. Are hearing handicapped homemakers less accepting of the homemaking role than homemakers who do not have a hearing loss?
4. Does the hearing handicapped homemaker have less power in decision-making than the normal hearing homemaker?
5. Does a different pattern of task performance emerge for the two groups of families being studied?
6. Do the two groups of families express differences in attitudes about the management of children's behavior?

Assumption

The following assumption underlies this study:

1. An individual's hearing loss affects his role in the family.

Hypotheses

The following hypotheses will be tested:

1. There will be a significantly greater degree of goal consensus in families in which homemakers hear normally.
2. Marital tension will be significantly higher in families in which the homemaker has a hearing loss.
3. Hearing handicapped homemakers will exhibit a significantly greater rejection of the homemaking role.
4. Power in decision-making will be significantly greater for homemakers who hear normally.
5. Differences in task performances of family members will be evident in the two groups of families; hard of hearing homemakers will receive less help with tasks from other family members.
6. There will be less agreement on management of children's behavior among families in which the homemaker has impaired hearing.

Theoretical Definitions of Terms

Hearing loss. Davis and Silverman use the term in a social sense to mean (12, p. 85) ". . . an impairment of hearing that does not entirely prevent communication by speech."

Family integration. Bossard and Boll use the term to mean (13, p. 431) ". . . the welding or unification of its (the family's) diverse elements into a complex whole or harmonious relationship. An integrated family means to us a well knit family, one bound together with strong and continuing ties, and functioning smoothly as a unit."

Goal. Fitzsimmons offers this definition (14, p. 69): A goal is ". . . an end toward which a design is directed. It is an aim or purpose." Paolucci (15) says that family goals are members' individual goals tempered by those of others in the family.

Marital conflict. Schaeffer and Bell (16) consider marital conflict to be the amount of tension present in the marital relationship. They measured tension indirectly by securing subjects' judgments as to how much quarreling and dissention they expected to find in marriages in general.

Rejection of the homemaking role. Schaeffer and Bell (16) view this concept as the unhappiness evidenced

by mothers at being shut up in a house and their dissatisfaction with housekeeping and child-care activities.

Power. Power in marital decision-making has been defined by Blood and Wolfe as (17, p. 11) ". . . the potential ability of one partner to influence the other's behavior."

Decision-making. Harzmann says that (18, p. 3) "decision-making may be defined as the amount of control the homemaker has over an activity."

Role. Gross et al. define role as (19, p. 60) ". . . a set of expectations, or . . . a set of evaluative standards applied to an incumbent of a particular position."

Role performance. "The behavior that an actor manifests while acting out a role" is the definition suggested by Winch (20, p. 9). Biddle and Thomas view this concept as (21, p. 11) "the execution of required functions . . . overt activity; role behavior; goal directed behavior."

Parental acceptance of children. Porter defines this quality as (22, p. 158) ". . . feelings and behavior on the part of parents which are characterized by unconditional love for the child, a recognition of the child as a person with feelings who has a right and a need to express these feelings, a value for the unique makeup of the child, and a recognition of the child's need to differentiate and separate himself from his parents in order that he may become an autonomous individual."

Operational Definitions

Hearing loss. For the purposes of this study, hearing loss is defined operationally as an average diminution of acuity in the better ear of no less than 20 decibels or greater than 70 decibels (re: International Standard's Organization) for 500, 1000, and 2000 Hertz (frequency) via air conduction. The speech reception threshold for standardized materials shall be no less than 20 decibels or greater than 70 decibels aided in sound field presentation. The aided speech discrimination score shall be no less than 75 per cent and may reach 100 per cent under sound field conditions, or the clinical records indicate that difficulty in hearing the speech of others constitutes at least a part of the chief complaint of homemakers.

Family integration. The degree of agreement achieved by married couples on the tests employed in the study represents the extent of their family integration. Scores made by homemakers and their husbands on the several components of the tests selected for this study reflect the families' feelings of integration.

Goal consensus. The degree of agreement of couples scores on the Western Reserve University Goal Consensus Scale (23) determines operationally their goal consensus. Correlations of husband and wife rankings of nine family goals will be considered to be the measure of their agreement upon the aims or ends toward which most families work or hope to achieve.

Marital conflict. Tension as measured by the Schaeffer and Bell Marital Conflict Scale (16) is considered to be the measure of marital conflict between couples. Ratings are indirect measures of conflict and indicate the tension present in the marital relationship.

Rejection of the homemaking role. The scores that homemakers achieve on the Schaeffer and Bell Rejection of the Homemaking Role Scale (16) will be considered the extent to which they reject the homemaking role. Rejection is measured indirectly by determining the amount of unhappiness expressed by homemakers with certain aspects of their role.

Decision-making power. The number of decisions that homemakers made or participated in making will operationally constitute their decision-making power as measured by the test instrument selected for this study (24).

Agreement on management of children's behavior. Agreement between couples on the management of children's behavior will be ascertained by computing the differences in their scores for each item of the Porter Parental Acceptance Scale (22) and summing them. This procedure yields a parental difference score for each couple which designates operationally their agreement on management of children's behavior.

Conceptual Orientation

Illness and/or disability, although different concepts, may be viewed as critical interventions which change role relationships. One writer has noted that illness imputes a disturbance to the individuals expected role performance (25). It becomes a problem when it interferes with a group member's capacity to meet the social obligations of his role. There are similarities between the statuses of a child and an ill adult--both are dependent and need assistance. Illness may also provide the means for a family member to escape certain disliked role obligations. Nagi (26, p. 105) believes that ". . . the family structure does not include any specific status or position for a person with a health problem, that is, a position which exists independently of others basic to the system." Members' positions as wife, husband, son, or daughter are not changed when any of them sustains a health problem, but the functional aspects, their roles, may necessarily be modified. Disability or illness are not viewed as roles in themselves, but as conditions better analyzed in terms of impact on performance of normal (family) roles.

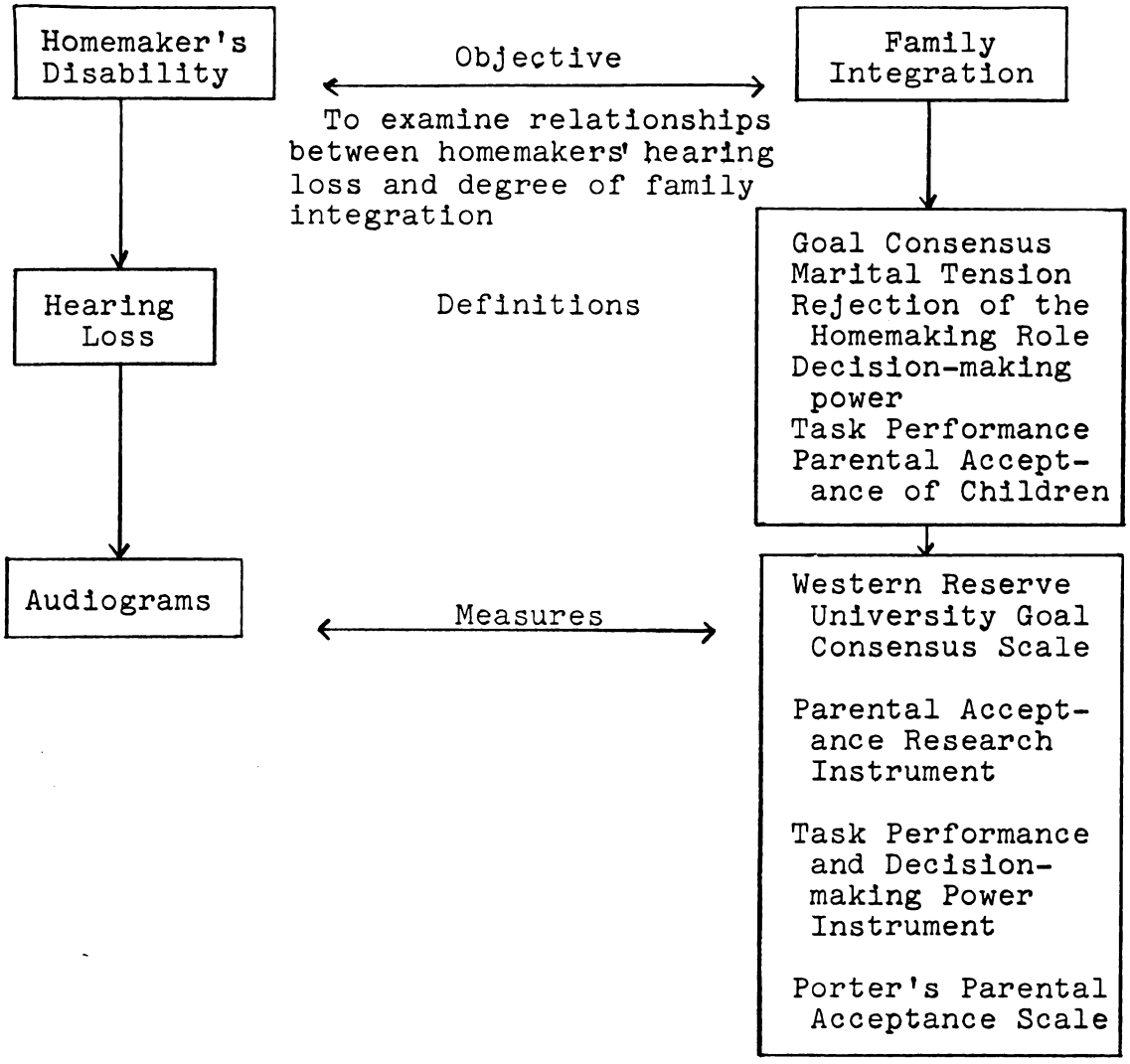

Figure 1.--Model of method for study of homemaker's disability and relation to family integration.

CHAPTER II

REVIEW OF LITERATURE

The research literature pertinent to this study is reviewed under the following general headings: research related to illness and/or disability of a family member and its effect on family integration, and research related to social psychological considerations associated with hearing loss.

The importance of the homemaker's role in the life of the family is generally accepted. Although relationships between the health problems of homemakers and other family members and the functioning of the family have received some attention from researchers, a great need for a stronger research base upon which to build an effective rehabilitation program is evident. At a recent symposium called to explore relationships between sociology and rehabilitation, Myers stated that

> . . . the family is an important social group in any society, yet as an area of research on disability, it is generally neglected. Family structure, family stability, or family integration may serve as conceptual foci to study the consequences of disability (27, p. 40).

Research Related to Illness and/or Disability of a Family Member

Heart Disease

Jacobson (28) investigated the impact made by the husband-father's heart disease upon the family. Four hundred farmers with heart disease were interviewed in 1960. From this group fifty-four families in which the husband had been diagnosed as having hypertensive or arteriosclerotic heart disease were selected for more intensive study. Jacobson interviewed the fifty-four farmers' wives and compared results with data from previous interviews held with the husbands.

The majority of the families viewed the onset of heart disease as a crisis which occurred without warning. Oftentimes the difficulty of re-establishing some sort of equilibrium for family functioning was compounded by other problems such as the poor health of the wife. Problems of intrafamily communication were also reported. Husbands frequently did not wish to discuss their heart disease, and wives felt at a loss to know how they felt. Problems in the family which appear to result from the disease include changes in the man's behavior and personality. He may become more aggressive and egocentric. Helping the husband with his diet, work, and other activities, and interpersonal relationships created problems for the wife. Children sometimes had to adopt caretaker

roles, had to assume increased work loads, and as a result, conflicts arose. Jacobson found that (28, p. 179) "the major resource for coping with heart disease is the family itself . . . the doctor was reported by less than a fourth of the women as a major source of help." A conclusion reached was that the whole family situation must be considered and defined in order to predict and understand the impact that heart disease has upon the family. This conclusion is compatible with the holistic view of rehabilitation which is presently being fostered by leaders in the field.

Degenerative Diseases

Interest has also been shown in the effects of other physical diseases upon family functioning. The relationship between homemakers' degenerative, physically disabling diseases and their decision-making power (control over the behavior of other family members) was the focus of a study conducted by Harzmann (18). Twenty-four homemakers with a degenerative disease were interviewed in their homes. Responses were tabulated according to the division of labor, area of control, and power score of the homemakers. Seventy-nine per cent of the homemakers reported that changes in their households had taken place after the onset of their disability. Work performance, relationships within the family as well as the families' transactions

with other social systems, and the personal living circumstances of the homemaker herself were all affected. Homemakers expressed a need to remain active in order to function as important members of the family group. They felt that other family members' understanding of the medical problems and their implications for all of them was important. Homemakers expressed dissatisfaction with their present roles as well as with those assumed by husbands and children. Harzmann reported that

> . . . one of the major findings of this study was that in general the mother's power score was very low . . . the study indicated that the mother's physical limitations affected the amount of influence she had in the family and her "degree of say" in both everyday and important decisions (18, pp. 62-63).

A need for family research of a longitudinal nature which would indicate changes in participation, performance, and decision-making power before and after the onset of disability was cited. Harzmann suggested there was some indication that the home management specialist should work with all family members since many of the problems resulted from members' interactions. This suggestion parallels opinions and findings of others in the rehabilitation field. Rehabilitation is a holistic concept.

Physical Disability

Family reaction to physical disability was investigated by Dow (29). He interviewed one parent from fifty-eight families with a physically disabled child for whom

hospitalization had been recommended. Thirty-four families reacted to the news of the child's medical diagnosis and prescribed treatment in a balanced way. Although their reaction was severe, it was also purposive in the sense that they accepted the medical reality. Fifteen families reacted in an extreme fashion. They resisted the medical reality which delayed the initiation of necessary treatment and the beginning of realistic adjustment.

Major sociological variables were compared in an attempt to determine differences in families that displayed such polar reactions to crisis. The only significant difference was found in the area of family size. Larger families reacted in a more balanced way. They were involved in extensive networks of interactions and obligations. The investigator suggested that the small family with its limited membership contains the potential for severe disruption should its structure be altered. The large families do not tend toward excessive preoccupation with any one unit. The author suggests that further research is needed, but that

> . . . the apparent relationship would be that the affective, interpersonal, intrafamily crisis is better met by the large family structure, while the material, economic, instrumental crisis is more effectively avoided and/or coped with by the small family structure (29, p. 366).

Dow's study of the relationship of families' reactions to physical disability is of interest to students of family life. It points up the importance of group support during events defined as crises by the family.

Diabetes

Priority is generally given to ill family members with less concern expressed for the needs and problems the illness may precipitate for other members of the family constellation. Recent research points up the need to consider the mother's relationship with the well sibling when another child in the family is ill. Too much attention paid to the ill family member may have a negative effect upon relationships between well persons.

Crain, Sussman, and Weil (30) studied the effects of the presence of a diabetic child in the family on certain family relationships. They hypothesized that diabetic children would have poorer records of social psychological functioning and would have closer relationships with their mothers than non-diabetic siblings.

Nineteen diabetic children between the ages of eight and eleven and sixteen siblings of diabetic children and their mothers served as subjects for the study. Data were gathered in home visits in which mother and child were observed in a behavioral situation. Mothers and children also completed selected questionnaires. Measures were obtained of the child's self-esteem,

satisfaction with his own behavior, and level of aspiration. Subscales of the Parental Attitude Research Instrument (16) that relate to maternal warmth and control were completed by mothers.

No significant difference in the social-psychological functioning of the two groups was found. Findings indicated, however, that the diabetic child had a closer relationship with his mother than did the non-diabetic siblings. The mother's behavior was highly related to the performance of the diabetic child, but this did not hold true for the non-diabetic sibling. Mothers' attitudes measured by the PARI subscales appeared to be far less important than behavior in relation to the performance variables for both groups of children.

From this study it appears that chronic illness may have a greater impact upon another child in the family than upon the child who has sustained the illness. Possibly the siblings perceive the diabetic child as favored since he receives special attention and care. Crain et al. (30) suggested that the ill child be treated as much like the normal child as possible while some extra attention be paid to any non-ill siblings. The finding of particular interest in this research is that the relationship of the non-ill child in the family and the mother was altered more than that of the ill child and the mother. This points up the importance of conceptualizing the

family as a unit, studying the relationships between members, and obtaining data from each member. Had the researchers noted only the relationship between the diabetic child and his mother, they would have found it conformed to established norms of mother-child relationships. The implication would have been that the presence of a diabetic child had no effect upon family relationships--which in reality was not the case.

The same research team conducted another study in which they focused upon the effects of a diabetic child on marital integration and related measures of family functioning. Past research in the area of family responses to crises occurring from within the family points up their disruptive effect upon family integration. This led Crain, Sussman, and Weil (31) to hypothesize that parents of diabetic children would have a lower degree of family integration than parents of non-diabetic children. The parents of fifty-four diabetic children were compared with a matched group of parents of seventy-six non-diabetic children. Data were obtained from both fathers and mothers. Measures were obtained through the administration of the Western Reserve Goal Consensus Scale (23), the Marital Conflict scale of the PARI (16), and Porter's Parental Acceptance Scale (22).

Results supported the hypothesis that parents of diabetic children do have a significantly lower degree

of marital integration. Significant differences in scores of the two groups were obtained on the goal consensus instrument as well as the one used to measure role tension. Scores on the Martial Conflict subscale were not significantly different, but were close to significance and in the direction of lower integration for couples with a diabetic child. Agreement among parents on how to react to the child's actions was also lower for parents of non-diabetic children, but the difference was not of statistical significance.

Crain et al. reported that (31, p. 125) ". . . there is an association between the presence of a diabetic child in the family and the level of parental marital integration. Where there is diabetes in the family the parents have a lower level of marital integration than where diabetes is absent." Diabetes is a chronic disease with no known cure. The investigators suggest that (31, p. 127) "its effect is to reduce the level of marital integration and to sustain this lower level more or less permanently." Since control but no resolution of the condition is possible, the disease produces ambivalence and contradictory behavior which result in a lower level of marital integration.

Behavioral Problems, Mental Retardation, and Blindness

The effects of children who presented marked deviations in behavior or were physically handicapped on the

expressed attitudes of parents toward child-rearing were investigated by Hoffman (32). A total of seventy-six families composed the two experimental groups and the control group. The childrens' physical disability in one experimental group was mental retardation, and blind children were equally represented in the control and behavioral problem groups.

Among the instruments Hoffman used were six scales from the PARI. These included the Marital Conflict scale which refers to a readiness to quarrel when settling personal differences in marriage, and the Rejection of the Homemaking Role scale which is concerned with the discontent over the confinement found in homemaking and dissatisfaction with the duties and responsibilities required of the homemaker and parent. No differences were found in mothers' scores on these two scales when the original three groups were compared. Fathers' scores, however, differed significantly on the Martial Conflict scale. When the grouping of mothers was determined by the presence or absence of a physically handicapped child in the home, both scales showed significant differences between mothers' scores. Fathers scores on these two scales did not differ when the grouping was based upon the latter condition.

On the basis of results from all the measures made in the study which included the Semantic Harmony and

Self-Ideal Differential as well as the other PARI scales, Hoffman found that:

> Significant differences between the groups existed in respect to parental agreement on the PARI, the disparity between concepts of self and ideal parent, marital conflict, irritability, and encouragement of verbalization from children. These differences were attributed to the effects that problem-children had upon their parents (32, p. 78).

When parents were grouped on the presence or absence of a child with a physical disability in the home and the two categories were compared, it was found that problem-behavior in children affected intra-familial relationships to a greater extent than did the presence of a child with a physical disability.

Findings from Hoffman's study differ from those of the Crain et al. (31) study in which the chronic physical disability of children lowered the level of marital integration. Problem-behavior of children had a more negative effect upon parental attitudes than did physical disabilities of children in the Hoffman study. Perhaps direct comparisons should not be drawn, however, since the physical disabilities and the instruments used differed so greatly. Subjects studied by Crain et al. (31) were diabetic children while Hoffman's were mentally retarded and blind. It is of interest in the present study that both researchers found the Marital Conflict scale of the PARI pointed up differences between groups. Although Crain et al. did not find a significant difference, the

"t" score was close to significance and in the direction of less integration for families with diabetic children. Hoffman obtained significant differences in mothers' scores when grouping was based upon the presence or absence of a child with a physical disability. Fathers' scores differed significantly when grouping was based upon presence or absence of a behavioral-problem child in the home.

Because homemakers play a central role in the structure and functioning of the family, an impairment in their role is likely to strain other parts of the family system. The homemaker's role is a family focal point around which most important home activities evolve. When role performance is inhibited by illness, normal satisfaction of individual needs may be frustrated.

Fink, Skipper, and Hallenback (33) were interested in determining need satisfaction and marital satisfaction of each member of a married couple in which the wife was severely disabled.

Results of the correlation between physical mobility and need satisfaction measures did not reach significance at even the 10 per cent level of confidence. The authors stated that (33, p. 66) "this indicates that greater mobility does not automatically result in greater need satisfaction even though in many cases the tendency may be in that direction." This finding was consistent for

husbands whose scores indicated there was no connection between the wife's level of functional mobility, and the satisfaction of his basic needs. Neither the women's nor the men's marriage satisfaction scores correlate highly with the women's physical mobility scores. However, scores indicate that as physical impairment increased, husbands' companionship satisfaction decreased. Data suggest that husbands' miss the companionship of home-bound wives in activities outside the home. Comparisons of mens' and womens' need satisfaction and marriage satisfaction scores pointed up the fact that pain, discomfort, and changes in bodily processes seemed to bear no direct relationship to marital satisfaction.

On the basis of findings from the study, the investigators cautioned rehabilitation practitioners not to make the mistake of assuming that the more severe the disability, the more problems of need gratification the patient will have. All need levels are likely to be present at the same time so that procedures should not focus on specific ones to the exclusion of all others. The disability may have different meanings for family members even though they may not be completely communicated among them.

The authors emphasize that (33, p. 72) ". . . the disability affects the social relationships of other members of the family group as well as those of the

disabled woman herself." That is to say, a change in the disabled woman's role precipitates changes for others in the social system. The importance of family solidarity and support is mentioned as well as the growing realization among rehabilitation professionals that the entire life circumstances of each person must be taken into consideration.

A comparison group of families in which the wife had no physical disability was not included in the research design of this study. On the basis of findings, however, one might hypothesize that the presence of a wife's physical disability did not appreciably lower the level of marital integration. Were this verified by additional research, it would be in partial agreement with the findings of Hoffman who reported that the presence of a child with a physical disability did not affect parents' attitudes negatively.

Low-Income, Chronic Illness, and Family Integration

A family's socio-economic status may have a bearing upon the way it reacts to the presence of a member's chronic illness. Low-income families may find illness a more disorganizing factor than high-income families whose material resources make possible alternative means for coping with disease.

Deacon, Maloch, and Bardwell (34) directed a survey of low-income families in which homemakers had a type of

chronic illness or disability, and compared them with low-income families in which homemakers enjoyed normal health. Objectives of the study were to describe the situations of low-income families with and without chronic maternal illnesses or impairments, and to examine patterns of family functioning. Adjustment of family members to the health problems and effects of the illnesses or impairments on family solidarity and stability were additional objectives of the study.

Families with maternal illness were found to be larger, the parents older and less well educated, fathers more often unemployed and themselves chronically ill, and their incomes were lower. An aspect of family interaction, family solidarity, which was measured by determining the number of meals eaten together, was found to differ significantly between the two groups. Families with maternal illness showed a lower degree of family solidarity.

The groups differed on two items associated with family transactions. Chronically ill mothers made greater use of community resources, but the method of investigation confused this finding. Low-income families without maternal illness had more newspapers available to them. This was interpreted as an indication of the family's communication with society. Reading is important for the diffusion of societal values, and restricted reading may result in an inconsistent acceptance of them.

The lack of newspapers may also by symptomatic of the families' tendencies toward isolation.

Most of the mothers did not report changes in decision-making, but about two-thirds of those with chronic illnesses reported changes within the family of task performances due largely to their own physical limitations. When the actual task performance reports were compared, however, the two groups did not differ in their scores. A positive correlation was found between the chronically ill homemakers' degree of limitation and the solicitude or cooperativeness of her family. This cooperativeness may be an indication of family solidarity.

Deacon et al. concluded that:

> For these intact, low-income families with maternal chronic illness and impairments, the complexity of circumstances apparently had both limiting and compensating features. They were able to function with minimal internal and external resources, although half the mothers reported feelings of depression or worry about their conditions or impairments.
>
> In addition to income needs, conditions surrounding both groups of low-income families might be improved with increases in external resources (such as homemaker services and day care centers), and in internal resources (such as improvement of managerial skills), or both. . . . Further studies should emphasize degree of limitation as an independent variable (34, pp. 75-76).

Findings suggest that modifications in the mother's role performance are the result of chronic illnesses or impairments which limit her physical capabilities. The families with chronic maternal health problems also

appear to be less stable and to be more isolated from the rest of society. A compensating feature of the family group, however, lies in its solicitude or cooperativeness which increased with the degree of impairment. Families might be assisted in coping with their problems through the improvement of their home management knowledge and skills which would include abilities to deal with interpersonal relationships.

Research Related to Social Psychological Considerations Associated With Hearing Loss

Hearing loss creates the potential for interpersonal communication problems. Hard of hearing people are often isolated and lonely because an important link to make them part of a cohesive group has been impaired. Of the limited research available which links psychosocial considerations and hearing loss, most has been conducted with deaf rather than hard of hearing subjects. Perhaps because school children are a more available source of subjects, more of the research deals with their adjustment problems. No research studies which deal directly with homemakers hearing losses were found. Those which appear to be most related to family life will be reviewed.

Emotional Problems

Hard of hearing and deafened servicemen returning from World War II were provided rehabilitation services

directed toward the facilitation of their return to society. Knapp (35) was particularly interested in emotional problems of the hard of hearing men. The majority of the hospital cases had sustained losses of between thirty decibels (the lowest level ordinarily required for conversation) and fifty decibels (the level of a firm conversational voice in the absence of background noise). Two hundred and ten patients were studied by case study techniques. Knapp (35) noted that the different areas of the hearing scale created widely different problems in adjustment. In his opinion there is no one psychology of deafness. He does feel, however, on the basis of his study, that it is a fallacy to subscribe to the notion that hearing loss incurred early in childhood leads to better adjustment. While chronicity may cause a less drastic sense of loss, Knapp considers it to have a more warping effect than hearing loss suffered in adulthood.

The men generally expressed fears of being thought stupid and of feeling lonely. Knapp concluded that (35, pp. 221-222) "the population of this study showed no one 'psychology of deafness,' but the psychology of many individuals defending themselves against sensory handicap which led primarily to difficulty in communication." The nuclear impairment for the hard of hearing is in communication which, in turn, appears to precipitate certain emotional problems for some individuals.

An interesting and perceptive account of some of the emotional aspects of deafness was published by Pochapin (36) who wore binaural hearing aids for nine years prior to restorative surgery. One of the feelings that Pochapin experienced he called shame. He reported feeling shame because when he misheard and responded inappropriately, he appeared stupid and felt ashamed. Another emotion he recalled was one of suspicion that he was being talked about when people dropped their voices or muttered.

Pochapin noted that:

> . . . the miniature electronic amplifier called a hearing aid is a poor--very poor--substitute for normal hearing . . . adjustment to the noisy assaults of the world heard through a hearing aid is not a quick or an easy one . . . it took two years for me to get really accustomed to living with a hearing aid, to the point that my anxiety was greater without the aid than with it (36, p. 59).

Feelings of hostility toward others with hearing losses who did not wear aids were mentioned by the investigator. It is exhausting to constantly talk loudly.

Personality and Emotional Factors

Individuals who have been deaf from early life have had to confront one of the most difficult problems known to man--acquiring language without being able to hear it. Frequently it is through innuendo and inflection that subtleties of meaning are passed from one person to another. Myklebust (9) observed that people deaf from

early life often failed to acquire the same biases and taboos that characterize the normal population.

Relationships between deafness and other personality factors appeared evident to Myklebust, but there was little research evidence upon which to base hypotheses. He was curious about two prominent assumptions frequently made by educators. Some said the emotional adjustment of people deaf from early infancy was better because they did not know what it meant to hear. Others felt the difficulty such individuals met in acquiring language compounded their adjustment problems. The ambiguous position of the hard of hearing--being neither deaf nor hearing normally--placed them in the more stressful position in the opinion of some authorities. Sussman (6) has referred to the hard of hearing person as a marginal man.

Myklebust (9) undertook a study in which he proposed to compare certain emotional and personality factors of deaf and hard of hearing adults. Among the findings of the study was the high incidence of unmarried persons in both sexes. Males and females did not differ in dependency status--that is, the ratio of women who lived away from parents and were self-supporting was about equal to that of the men's. About half of the men and women found hearing aids unsatisfactory. Myklebust noted that (9, p. 128) "there must be various reasons for this feeling. It may reflect difficulties in adjusting to the hearing

loss as well as to the wearing of a hearing aid." Also the adult who experiences a hearing loss near age twenty has normal audition as a frame of reference, and hearing aids do not provide normal auditory capacities.

Subjects were asked to rate on a four-point scale the extent to which their deafness was a handicap. This attitudinal measure indicated that males considered their hearing loss a significantly greater handicap than did women. This was corroborated by scores made on the Minnesota Multiphasic Personality Test where males were found to have more emotional maladjustment.

Each subject was asked to write an autobiographical account about "what my hearing loss means to me." Guidelines were provided to focus on specific areas of daily living. These self-reports indicated that even moderate loss sustained in adulthood had many implications for the daily life of the subjects. It was found that:

> Life became more stressful in various ways. Most of the hard of hearing found their families helpful and sympathetic, but emphasized that it required considerable patience on the part of the family members. Throughout the discussion of family relationships was the indication of greater necessity for dependence, including need for assistance with messages, as well as in seeking employment and in maintaining friends. One of the striking revelations was that very few held the same friendships they had prior to the onset of deafness. The social isolation resulting from impaired hearing was markedly apparent. Some found their loss of old friends one of the greatest hardships associated with deafness and because of this experience many were despondent and cynical regarding "the hearing." It was this circumstance that frequently led them to seek associations and services for the

> hard of hearing. Very few maintained primary identification with the normally hearing. Almost all found it necessary to develop a basic identification with others who had impaired hearing. This highlights the feelings of isolation which occurred, with the need to shift social contacts, friendships, and affiliations. Apparently, even when deafness is sustained in adulthood, and when verbal facility remains at a high level, it is difficult to maintain normal social relationships with the majority group (9, pp. 131-132).

Data revealed that a frequently encountered circumstance was the need to change occupations and hobbies. Those occupations which did not require good hearing were sought. Hobbies chosen reflected a type of withdrawal in that they were usually activities which could be performed alone. The adjustment generally seemed to be a kind of going-it-alone process. Myklebust found that (9, p. 132) "most considered their employers and coworkers fair, but, as with families, mentioned the need for all to have patience, as there was inconvenience and increased tension in most working relationships."

When data obtained from the hard of hearing adults and the deaf students were compared, the investigator stated that (9, p. 137) "on the basis of the total findings . . . it seems more logical to infer that more unfavorable adjustment scores as compared to the normal existed in the population of hearing impaired people."

Both hard of hearing and deaf females showed less emotional maladjustment than their male counterparts. The hard of hearing females showed the least maladjustment,

but the hard of hearing as a group showed more depression than the deaf. Deafness, irrespective of other factors, appears to femininize the male and masculinize the female which indicates that hearing loss adversely affects identification processes. Findings considered as a whole indicate that hearing loss affects personality selectively on the basis of sex, age of onset, and degree of hearing loss.

Myklebust was interested in detecting a personality pattern from the data. He noted that:

> The personality pattern which emerges is a feeling of severe isolation and detachment with aggressive, almost desperate attempts to compensate and thereby maintain interpersonal contacts. The primary conclusion to be drawn from this study, therefore, is that deafness, particularly when profound and from early life, imposes a characteristic restriction on personality but does not cause mental illness. Despite the significance of the impact of deafness on emotional adjustment it is not comparable to conditions such as schizophrenia. What is normal or realistic for a hearing person may not be realistic for an individual who has impaired hearing (9, p. 158).

Some criticism has been made of the study for its direct comparisons of groups so disparate in terms of age, marital status, and educational attainment. However, even the findings of each group taken separately make a very valuable contribution to an area in which there is a paucity of research.

Self-Concept

Communication is a central problem of persons with hearing losses, and it is also a central issue in the theoretical study of self-concept. The self in social interaction assumes the exchange of emotions and ideas which may be difficult for the hearing impaired person to grasp. Some contend that the language process is essential for the development of the self-concept. The thought is that until a person can communicate with others through a common medium which arouses similar meanings and responses, he cannot gain a mental concept of self.

Hearing deficit presents a unique problem for persons who sustain it. Craig (5) was interested in determining whether or not deaf children's self-concepts differed from those of normally hearing children. In order to minimize possible language inequalities, she adapted Schiff's sociometric measure of perceptual-judgmental response sets to a basal language level. Focus was placed on concepts of self and others in the accuracy of others' ratings of self, direction of errors in perception (self effacement or enhancement), general self-acceptance, and tendency to accept others.

Results indicated that the deaf and non-deaf groups differed significantly in self-accuracy. The deaf children were less accurate in predicting how others would rate them. Self-acceptance of the deaf institutional group

was significantly higher than for either of the non-institutional groups. Social expansiveness, the rating of others in the group, differed in all three groups. The deaf institutional children rated their classmates highest, the deaf non-institutional children rated them lowest.

Craig interpreted the results as follows:

> . . . the accuracy of self-concept of the deaf child is hampered by his language deficit, regardless of his residence in an institution or at home. The tendency of high acceptance of self and others in the in-group residential school for the deaf was regarded as a different factor, dependent more upon the institutional living than upon deafness per se (5, p. 472).

Craig found that there were significant differences in self-concept expressed by the samples she studied, with deaf children expressing the greater number of problems associated with self adjustment.

Hardick (37) was interested in comparing the self-concepts and other self-related attitudes of hard of hearing adults with those of normal hearing adults by means of semantic differential scales. He constructed his instrument around nine self or personality related concepts which were evaluated by fifty bipolar adjectival scales.

The development of a hearing loss which interferes with communication tends to make the adult feel less capable than his normal hearing counterpart. Findings indicated he also feels less capable in the future and

under the happiest circumstances. Hardick's findings seem to indicate adjustments to reality that reflect the altered relationship to the environment which hearing loss imposes. The hard of hearing adults in the sample did not differ in self-regard from the normal group. The groups did not differ in their attitudes toward friends, hearing loss, strangers, hearing aids, or failure.

Age appeared to have a bearing upon self-concept in that people over sixty judged themselves to be more genuine. Women judged themselves more genuine than men. Hardick concluded that (37, p. 107) "it cannot be said . . . that the hard-of-hearing adults as a group differed from the normal hearing adults in terms of self-regard."

Although Hardick's self-concept study of hard of hearing adults cannot be directly compared with Craig's study of deaf children, findings do raise questions of conflicting results which await future research.

The deaf live in a world of the hearing majority, and must make some effort to adjust to the hearing community if they are to lead satisfying lives. Furfey and Harte (38) were interested in learning something about deaf persons' adjustment to life in general as well as something of their interaction with the hearing community. They noted that:

> the social aspects of deafness have received remarkably little attention from sociologists, yet it is evident that deafness, with the communication problem it involves, must profoundly affect interpersonal relations. The deaf live in a special sort of social environment (38, p. 1).

Levine (39) notes that in spite of increasing public enlightenment concerning disability, popular stereotypes remain. In the public mind hearing loss seems to be confused with intelligence, and hard of hearing people are frequently treated as if they were not quite bright.

A number of suggestions to facilitate communication with hearing impaired persons were offered by Levine. She cautioned that there is considerable variation in the benefit derived from the hearing aid, and that emotional disturbances and tensions as well as fatigue impair communication skills.

A need to study the effects of family attitudes upon the adjustment of hearing impaired persons is voiced by Levine. Attitudes of parents and siblings, both hearing and hearing-impaired, are mentioned. Another research need lies in the area of marital adjustments of hearing impaired persons. This would include such factors as their problems, separations, divorces, and other significant variables.

Rainer et al. (3) conducted a survey of 968 deaf persons twelve years of age and older in New York State through the use of three mailed questionnaires. Forty-five

per cent of the deaf adults reported they had both hearing and deaf friends. Speech was reported as the preferred communication method for deaf persons living in families with normal hearing persons. The researchers stated that:

> . . . the most urgent recommendations for the average deaf person lie in the area of preventative mental health planning. Conditions leading to frustration, poor adjustment, and sexual and other forms of delinquency arise within the matrix of the family and the early residential setting of the school. Many deaf adolescents grow up and go on to parenthood without any sex education or guidance for marriage. A straight approach to preventative maladjustment would be to center attention on preparation for family living, since it is in this context that most unhappiness and behavior disorders tend to manifest themselves (3,p.244).

Rainer and Altschuler (40) conducted a study of selected deaf mental patients in New York state hospitals. They wished to demonstrate that deaf patients could benefit from psychiatric services which were at least equivalent to those provided for the hearing. Their results were encouraging. They pointed out that (40, p. 141) ". . . the human and economic saving resulting from the rehabilitation of deaf patients can be easily appreciated . . . this alone renders worthwhile the huge efforts that are required." A need made apparent by the project was for better family living education.

In summary, the literature reveals little about the hard of hearing homemaker and family integration, but research from other areas suggests that disease or disability of a family member is a family problem. Authorities stress the need to explore family relationships of persons with impaired hearing.

The literature suggested the following relationships between aspects of family integration ahd homemaker's hearing losses:

Goal Consensus. Research (31) showed that the disability of a family member was related to lowered goal consensus. Hearing loss might also be associated with lowered goal agreement.

Marital Tension. Researchers (8, 31, 32) have suggested that a family member's disability engenders stress in other family members.

Rejection of the Homemaking Role. Because hearing loss is thought to cause social isolation (9), it was hypothesized that the homemaking role would be less accepted by homemakers with hearing losses.

Power in Decision-Making. Harzmann (18) indicated that family decision-making power decreased for homemakers with degenerative diseases.

Family Task Performances. Because communication requires more effort for hearing handicapped individuals, it was thought that hearing handicapped homemakers would find it easier to perform tasks themselves than to ask for assistance.

Agreement on Management of Children's Behavior. Research (31) showed less agreement on this variable as a function of a physical disability. Hearing loss was thought to be similarly related to it.

On the basis of the above, hypotheses for this study were generated.

CHAPTER III

PROCEDURE

The procedures used in the study have been divided into four parts: selection and description of subjects; selection and description of instruments; data collection; and data analyses.

Selection and Description of Subjects

The sample is a non-probability, purposive one selected to conform to established criteria. Selection criteria were: intact families; presence in the home of children eighteen years of age or younger; no persons other than the immediate family residing within the home; and agreement of husbands and homemakers to participate in the study. Thirty families with homemakers who had hearing losses were compared with thirty families with homemakers who had normal hearing.

Families with hard of hearing homemakers (Group A) were compared with families with normal hearing homemakers (Group B) by the following characteristics: ages of homemakers and husbands; years of education of husbands; and family income. An attempt was made to eliminate extremes of variation between groups.

Homemakers in Group A were selected from the files of the Speech and Hearing Clinic of Michigan State University, and the Rehabilitation Medical Center of E. W. Sparrow Hospital, Lansing, Michigan, and the Constance Brown Hearing and Speech Center, Kalamazoo, Michigan.

Seventy-nine names of homemakers were obtained from the two Lansing area clinics. From this number, twenty-three were located who met the criteria and were willing to participate in the study. Of the twenty-four names of homemakers obtained from the Kalamazoo clinic, seven were located who were qualified and willing to be included in the sample.

Names of normal hearing homemakers for the comparison group (Group B) were suggested by families in Group A, families in Group B, and persons known to the investigator. Fifty-one homemakers were contacted in order to locate thirty who met the control criteria and were willing to participate in the study.

The sample was made up of two groups: Group A, hard of hearing homemakers and husbands, and Group B, normal hearing homemakers and husbands. One of the criteria used in the selection of subjects was that they have at least one child presently living at home who was eighteen years of age or younger. Number and sex of children in these families is shown in Table 1.

TABLE 1.--Number and sex of children living at home.

	Number	Range
Group A		
Girls	39	1-3
Boys	48	1-4
Total	87	1-6
Group B		
Girls	47	1-7
Boys	41	1-3
Total	88	1-7

The range, mean and median ages of the children in the groups is shown in Table 2. Girls were somewhat younger than boys in both groups.

TABLE 2.--Range, mean and median ages of children living at home.

	Ages		
	Range	Mean	Median
Group A			
Girls	2-20	11.1	10.5
Boys	2-24	11.2	12.0
Group B			
Girls	1-18	9.1	9.0
Boys	1-21	11.2	11.5

Ages of Homemakers and Husbands

Homemakers with hearing losses were slightly older than those with normal hearing when group averages were considered. The mean age for homemakers in Group A was 40.5 while it was 38.1 for those in Group B. Husbands of hard of hearing homemakers were also slightly older. Husbands in Group A had a mean age of 43.0 while husbands in Group B had a mean age of 39.6. Husbands ages ranged from 29 to 54 in Group A, and from 23 to 58 in Group B. Table 3 shows the age distributions of the two groups.

TABLE 3.--Ages of homemakers and husbands.

	Ages		
	Range	Mean	Median
Group A			
Homemakers	29-51	40.5	42.0
Husbands	29-54	43.0	45.0
Group B			
Homemakers	21-53	38.1	36.0
Husbands	23-58	39.6	37.5

Schooling

Years of education were similar between the two groups. Although husbands' years of education were similar for the two groups, it is of interest that two

husbands of hard of hearing homemakers had to have the interview questionnaire read to them. One husband was a native of Puerto Rico and said he read Spanish much faster than English. The other husband said he had attended school through the seventh grade, but his wife told the investigator he could not read. Both were very cooperative and did not appear to mind the investigator's reading to them. Table 4 shows homemakers' and husbands' years of schooling.

TABLE 4.--Years of schooling of homemakers and husbands.

	Years of Schooling		
	Range	Mean	Median
Group A			
Homemakers	8-19	12.8	12.0
Husbands	6-20	12.6	12.0
Group B			
Homemakers	8-17	12.2	12.0
Husbands	7-20	12.5	12.0

Income

Groups were matched by income. This is shown in Table 5. One-half of each group had incomes of over $10,000.00.

TABLE 5.--Income of families.

Income	Number in Group A	Number in Group B
$2,000-4,999	2	2
$5,000-9,999	13	12
$10,000-14,999	12	13
$15,000-19,999	2	2
Over $20,000	1	1

Church Membership

Church affiliations of the groups is shown in Table 6. Groups had similar numbers who belonged to each denomination. Hearing loss of homemakers did not preclude their church membership.

TABLE 6.--Church membership.

	Group A		Group B	
	Homemakers	Husbands	Homemakers	Husbands
Protestant	17	17	16	16
Catholic	5	5	6	6
Jewish	1	1	1	1
Other	0	0	1	1
None	7	7	6	6

Membership in Organizations and Meetings Attended

Membership of husbands and homemakers in organizations is tabulated in Table 7. Meetings attended per month are shown in Table 8. Homemakers in Group A belonged to a median of one organization, and attended a median of one meeting per month. In contrast, homemakers in Group B belonged to a median of two organizations and attended a median of 2.5 meetings per month. Husbands in the two groups show similar organizational affiliations.

TABLE 7.--Membership in organizations.

	Organizations		
	Number	Mean	Median
Group A			
Homemakers	45	1.5	1.0
Husbands	70	2.3	1.0
Group B			
Homemakers	67	2.2	2.0
Husbands	65	2.2	2.0

TABLE 8.--Meetings attended per month.

	Meetings		
	Number	Mean	Median
Group A			
Homemakers	58	1.9	1.0
Husbands	45	1.5	1.0
Group B			
Homemakers	105	3.5	2.5
Husbands	67	2.2	1.0

Years Married

Since homemakers and husbands in Group A were slightly older than those in Group B, one might expect that they would have been married a greater number of years. Such was not the case, however (see Table 9).

TABLE 9.--Number of years married.

	Years Married	
	Range	Mean
Group A	7-29	16.9
Group B	1-31	16.7

Home Ownership and Years in Present Residence

The two groups were similar insofar as home ownership was concerned. Twenty-four families in Group A reported they owned their own homes as did twenty-six families in Group B. Families in Group A moved an average of 4.1 times during their married years while families in Group B moved an average of 5.0 times. Families of hard of hearing homemakers lived an average of 7.1 years in their present residences, and families of normal hearing homemakers lived an average of 7.0 years in their present homes.

Hobbies

Hobbies sometimes reflect an individual's desire for social exchange or his desire for solitary diversions. Not all homemakers nor husbands reported having a hobby, but the number who did in the two groups appeared to have similar interests. Twenty homemakers in Group A had hobbies of a solitary nature which required no other person for their performance. Five hard of hearing homemakers reported hobbies of a social nature such as bowling with a team. Twenty-four homemakers from Group B reported solitary hobbies, and only one reported a social hobby. Eighteen husbands in Group A reported solitary hobbies, and five reported social ones, while twenty-two husbands in Group B reported solitary hobbies and only two reported social ones.

Homemakers' Employment

Table 10 shows the distribution of the employment status of the two groups. More homemakers with hearing losses were employed full-time than were those with normal hearing. The total number of homemakers employed was similar for the two groups with twelve in Group A and eleven in Group B employed outside the home.

TABLE 10.--Number and per cent of homemakers employed full- and part-time.

	Homemakers	
	Number	Per Cent
Group A		
Full-time employed	8	26.7
Part-time employed	4	13.3
Group B		
Full-time employed	4	13.3
Part-time employed	7	23.3

Homemakers' Hearing Level

Audiograms were obtained for homemakers who had hearing losses. As may be noted in Figure 2, the hearing threshold level of the thirty hard of hearing homemakers (Group A) is represented by a relatively flat curve, varying from 35 decibels at the lowest threshold, 250 Hertz (frequency in cycles per second), to 55 decibels

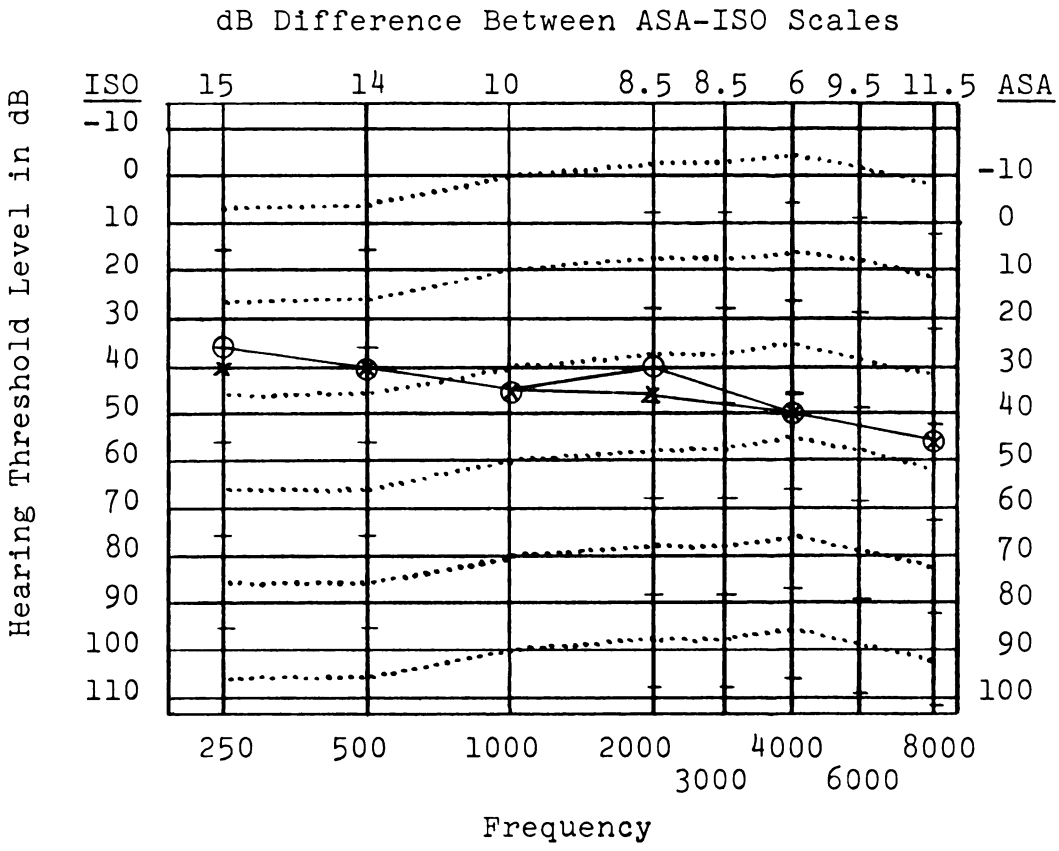

Figure 2.--Composite air conduction audiogram for 30 hard of hearing homemakers (Group A).

Notes: x = left ear
O = right ear
ISO = International Standards Organization
Zero threshold or below represents normal hearing.

at the highest threshold, 8000 Hertz, by the standards set by the International Standards Organization. In only two frequencies is there five decibels difference between ears (250 and 2000 Hertz). The average loss of the group is moderate with a mean of 41.6 decibels loss in the frequencies that are critical for speech hearing (500, 1000, 2000 Hertz) in the right ear, and a mean of 42.5 decibels in the left ear.

The thirty hard of hearing homemakers were divided into two equal groups according to the severity of their hearing losses. Figure 3 shows that the hearing threshold level of the fifteen homemakers with the more severe hearing losses (Group A_1) is also represented by a relatively flat curve. It varied from 45 decibels of loss for both ears at the lowest threshold, 250 Hertz, to 65 decibels of loss for the right ear at the highest threshold, 8000 Hertz, by the standards set by the International Standards Organization. The mean loss for the frequencies that are critical for speech (500, 1000, and 2000 Hertz) is 50 decibels for the right ear, and 53.3 decibels for the left ear.

Years of Hearing Loss and Age at Onset

Homemakers with hearing losses were asked how long they thought they had had this sensory deprivation. Table 11 shows chronological age, years of loss, and age at

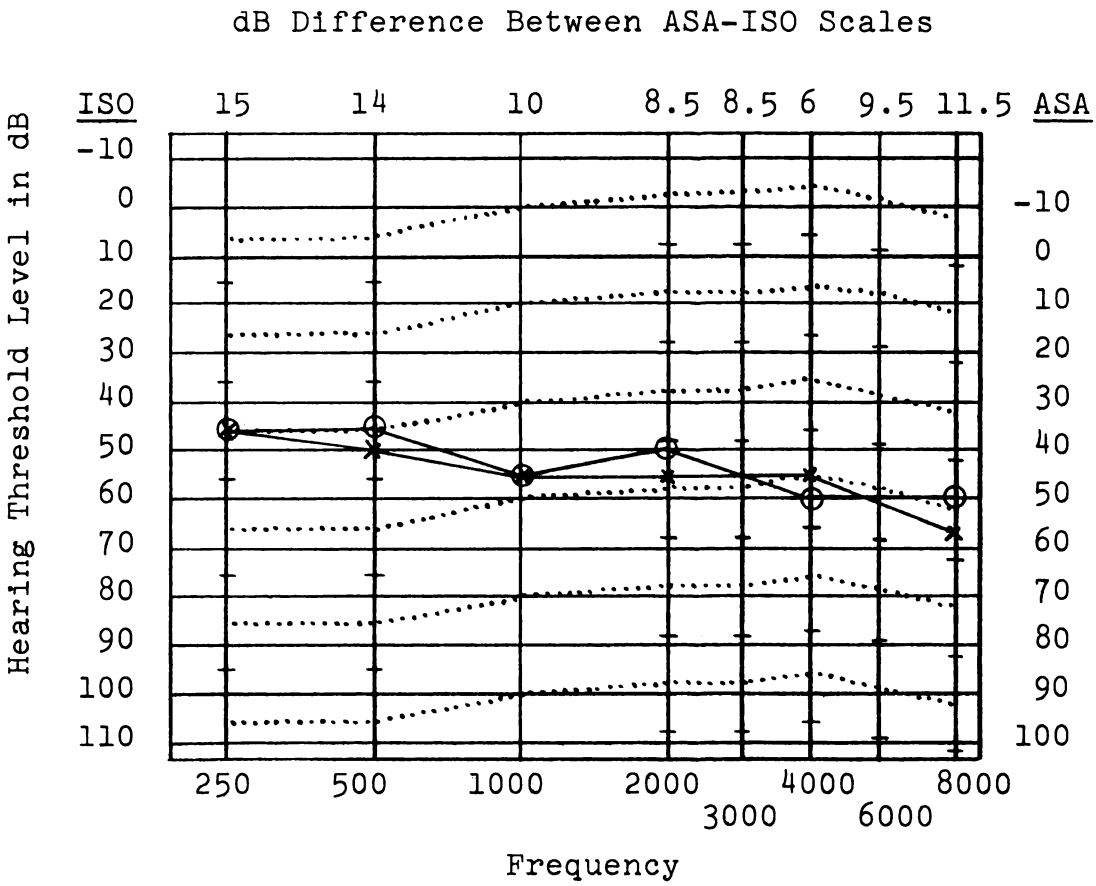

Figure 3.--Composite air conduction audiogram for the 15 homemakers with the more severe hearing losses (Group A_1) (I.S.O.).

TABLE 11.--Chronological age, years of hearing loss, and age at onset.

Age	Years of Loss	Age at Onset
29	29	0
30	Don't know	-
31	30	1
32	31	1
32	2	30
33	7	26
33	2	31
34	34	0
37	32	5
37	5	32
39	29	10
40	8	32
41	29	12
42	41	1
42	42	0
42	24	18
42	25	17
42	36	6
44	5	39
44	5	39
44	Don't know	-
45	44	1
45	42	3
45	10	35
46	46	0
47	Don't know	-
48	38	10
48	7	41
49	45	4
51	45	6

onset for each homemaker. Three of the thirty homemakers reported that they did not know how long they had had hearing losses. The number of years of loss ranged from 2 to 46 for those reported. The average length of loss was 25.6 years. All but nine homemakers mentioned having a hearing loss prior to marriage.

Homemakers Wearing Hearing Aids

Only seven of the hard of hearing homemakers were wearing hearing aids at the time of the interview although four others planned to obtain one in the near future. One mentioned she expected to receive an aid the next week. One homemaker was scheduled to go into the hospital for a stapedectomy two days following the interview. Three homemakers mentioned having worn hearing aids in the past, but were not wearing them presently. One said she could not afford to buy the batteries, one said her old aid did not suit her and that she planned to obtain one as soon as her husband finished school, and another said she had had three hearing aids in the past, but that none of them had helped her very much.

Clinical Complaints About Hearing Problems

Clinical records revealed that all of the hearing handicapped homemakers complained of at least one communication problem. All complained of problems hearing

in groups and in noisy situations. Four people reported difficulty hearing when they could not see the other person. Perhaps they were relying on lipreading or other visual clues which enabled them to understand what persons they could see were saying. Six homemakers reported difficulty hearing over the telephone. Five said they found certain people's voices difficult to hear. One woman mentioned difficulty hearing soft voices, and another mentioned a problem hearing children's voices. Two people mentioned sound localization problems. These people had a troublesome unilateral loss. Two people said that hearing was always difficult regardless of the situation. Three people mentioned that they could not hear the radio or television when the volume was adjusted comfortably for other family members.

Adjustments in the Home

Only nine homemakers reported adjustments which had been made in the home to facilitate hearing. These included six who had telephone amplifiers, one who had a television receiver, one who had lights on both her telephone and alarm clock, and one who kept a house dog who barked when the doorbell rang. One husband suggested that the extension telephone upstairs and the house intercom system had been installed to help his wife hear in the various rooms of the house, but the homemaker said they were installed as a convenience rather than an aid to her hearing.

Selection and Description of the Instruments

During the planning phase of the study, a hard of hearing homemaker, Mrs. D., was visited in her home. She spoke freely of some of the problems she associated with her hearing loss. She mentioned the unintentional offending of friends when she failed to hear their salutations. She worried that she might not hear her babies when they cried at night. Mrs. D. kept a house dog that alerted her when the doorbell rang. She mentioned an occasion when her husband was home during the day and noticed that the furnace fan was running constantly. Such an occurrence posed a fire hazard. She also mentioned that she was apt to turn the volume on the radio and television too high for the comfort of other family members. She said that when she and her husband entertained, she preferred very small groups. The visit with Mrs. D. suggested that her roles as wife, mother, and housekeeper were affected by her hearing loss.

On the basis of this preliminary interview, instruments were selected that would measure the hypothesized relationship between homemakers' hearing losses and family integration. Instruments will be discussed in the order in which they were used to measure the hypothesized relationships.

Western Reserve University
Goal Consensus Scale

This scale was employed to measure goal consensus between husbands and homemakers. It consisted of nine goals which subjects were asked to rank-order. A value of one was assigned to the goal of most importance, and on down to nine, the goal of least importance. Goals were considered objectives toward which most families work and hope to achieve.

The instrument was developed by Sussman and Slater (23), and a copy was obtained through correspondence with Sussman. The scale was based upon an earlier work by Farber (41), and this work supports construct validity for the revised scale. Sussman and Slater claim construct validity for the revised scale. Reliability was established by the test-retest method, and the Spearman rank-order correlation was found to be .908 and was significant ($p < .05$).

Marital Conflict Scale

This scale was one of the twenty-three five-item scales developed by Schaeffer and Bell (16) and known as the Parental Attitude Research Instrument (PARI). The scale may be found in Appendix A, page 106. Items one through five measure marital conflict.

Homemakers and husbands were asked to express their agreement with the five statements on a four-point continuum. A value of four was assigned to statements with

which subjects strongly agreed, and one was assigned when subjects indicated they strongly disagreed. Statements were worded in such a manner that the higher the score, the greater the tension or conflict in the marital relationship. Scale items were designed to reveal the presence of tensions indirectly by obtaining subjects' judgments as to how much dissension they expected in marriages in general.

Schaeffer and Bell (16) cite evidence of content validity for their instrument. Reliability was established by the test-retest method, and a Pearson product-moment correlation coefficient of .64 was reported.

Rejection of the Homemaking Role Scale

This scale is a part of the PARI developed by Schaeffer and Bell (16), and was scored in the same manner with the higher score representing the greater rejection of the role. Items were designed to ascertain the unhappiness of a woman at being shut up in a home as well as her dissatisfaction with the duties of caring for the home and children (see Appendix A, page 108, items six through ten).

Validity statements made for the Marital Conflict scale hold for this part of the instrument. Reliability was established in the same manner, and the Pearson product-moment correlation coefficient reported was .62.

Task Performance Instrument

The task performance instrument was developed by Onorato (24) who built upon earlier works of Herbst (42) and Harzmann (18).

Part one of the instrument consisted of twenty-nine family activities which homemakers and husbands were asked to check according to the members who performed or participated in them. Family task performance scores indicated the amount of help homemakers had received from family members, and were computed by summing the activity columns and compiling the totals.

The second part of the Onorato (24) instrument was designed to measure homemakers' decision-making power. A decision-making power score was computed for each item by the method outlined in Table 12. This method was a

TABLE 12.--Method of scoring homemaker's decision-making power.

Homemaker's Response	Weight
Homemaker decides, other does	3
Homemaker and other decide, others do	2
Homemaker and other decide, mother and other(s) do	1
Homemaker decides and does, father decides and does, both decide and do, neither decides, both do	0
Both decide, homemaker does	-1
Father decides, both or others do	-2
Father decides, mother does	-3

modification of those developed by Hoffman (43) and Harzmann (18). Each homemaker's power in decision-making score was computed by summing item scores.

Parental Acceptance Scale

The instrument used to measure parents' agreement on the management of children's behavior was the Parental Acceptance Scale (PAS) developed by Porter (22). Each of the thirty statements had five alternatives to indicate how parents felt or the action they generally took under the circumstances described. Porter's scoring system assigned a value of five to the alternative which implied the greatest acceptance, and so on down to a value of one, the least accepting of the alternatives.

Parents' scores for each item were subtracted to determine differences in their attitudes. Differences for the thirty test items were summed, and this figure represented parents' agreement on the management of children's behavior.

Construct validity as well as jury validation are claimed for the instrument. Reliability was established through the split-half method using the Pearson product-moment correlation statistic. The coefficient of .766 was raised by the Spearman Brown prophecy formula to .865.

Data Collection

Subjects in the Lansing area were contacted by telephone with the exception of five families who had

unlisted telephone numbers. An attempt was made to reach them by correspondence, one homemaker responded, and was included in the study. The director of the clinic in Kalamazoo provided a letter which was sent to the twenty-four families in that area (Appendix B, page 113). Letters were followed by long-distance telephone calls to determine qualifications and willingness to participate.

Interviews were held in the homes of fifty-nine of the sixty families. One homemaker came to the investigator's home, and took the instruments home for her husband to complete. Data were collected from homemakers and husbands simultaneously in all but five instances. When husbands were not present at the time of the interview, they completed the forms at a later time. They returned them by mail in four cases, and in one, the investigator went to the home for it. Time required for the interviews ranged from forty minutes to two hours with the majority requiring one hour.

The typical situation during the home interviews was for couples and the investigator to sit in the living room. The purpose of the research was explained. Couples were told that the investigator was interested in some of their opinions about family life, and that results of the study would be of value to others as they worked with families. When a hard of hearing homemaker would ask why those with hearing losses had been selected, the reply was that a cross-section of the population was needed.

Couples were first asked to supply the demographic data needed for matching and other factors related to hearing loss (Appendix B, page 110). Then each homemaker and husband was given a copy of the data collection booklet containing the test instruments, and asked to complete it. Couples were asked not to discuss the questions with each other.

After every interview, data about the families were entered in a chart kept to facilitate the matching process. Interviews were scheduled for almost every day of the week, and all sixty were completed within a two-month period (October and November, 1968).

Families were very cooperative, and seemed interested in participating in a research project.

Data Analyses

Data from the collection instruments were transfered to data processing cards. The Control Data Corporation 3600 model computer was used to perform the computations. Table 13 shows the statistical procedures used to test the differences in the scores of the two groups (A and B) with respect to the six hypotheses, and the instrument associated with each of them.

TABLE 13.--Methods used in the analyses of data.

Purpose of Analysis	Data Used in Analysis	Statistic and Computer Program
Principal Analysis		
Descriptions of Homemakers and Husbands By:		
children living at home, age, income, education, memberships in church and other organizations, meetings per month, years married, home ownership, years in present residence.	Demographic data	Frequency count
Hard of Hearing Homemakers By:		
hearing level, years of hearing loss, age at onset, wearing hearing aids, clinical complaints, adjustments made in home.		
Test of Hypotheses 1, 2, 3, 6	Scores on: Goal consensus; Marital tension; Rejection of the homemaking role; Agreement on management of children's behavior	Mann-Whitney U Test (Tech. Report N.45, C.I.S.S.R., John Morris) (44)
Test of Hypotheses 4, 5	Task performances of family members; Decision-making power of homemakers	Chi square (Tech. Report N.14, C.I.S.S.R., Alan M. Lesgold) (45)

CHAPTER IV

FINDINGS

The chapter is devoted to a presentation of the results in relation to each of the six hypotheses.

Hypothesis 1. Goal Consensus

There will be a significantly lesser degree of goal consensus in families with homemakers who are hearing handicapped.

Spearman rank-order correlation coefficients were computed for the scores achieved by each husband and wife in each group on the Western Reserve University Goal Consensus Scale. Scores ranged from -.63 to .895 for Group A, and from -.633 to .9 for Group B. The median score for Group A was .475, and for Group B, .517.

The statistic used to test the difference between scores of the two groups was a nonparametric difference test, the Mann-Whitney U. The value of U is equivalent to the number of times that a score in one group ranks higher than a score in a second group. Table 14 displays the value of U, the rank sum, and the exact probability. Analysis indicates no significant difference between groups ($p > .05$). Thus, hypothesis one is not supported

TABLE 14.--Results of the Mann-Whitney U test for scores (RHO's) of groups A and B, and groups A_1 and B on the Western Reserve University Goal Consensus Scale.

Groups	Value of U	Rank Sum	Probability (1-tailed)
A and B	425.0	890.0	.3558
A_1 and B	190.5	310.5	.2030

Note: Group A_1 = subgroup of Group A (N = 15).

by the findings in this study. Group B did, however, score somewhat higher than (median = .517) Group A (median = .475) which indicates goal consensus was somewhat higher in families in which homemakers had normal hearing even though the difference was not significant. It was in the direction of the hypothesized relationship. In both groups, however, the degree of goal consensus was low (i.e., less than .55).

Hearing losses of homemakers in Group A ranged from mild to severe. It was decided to compare that half of the sample having the more severe hearing losses (Group A_1, N = 15) with the thirty families in which homemakers heard normally. Spearman rank-order correlation coefficients ranged from -.63 to .834 for Group A_1, and the median score fell at .415. The range differed slightly with that of Group A where the range was from .63 to .895. The median scores for the two groups (A and A_1) differed by only .056. The range for Group B is also

somewhat greater than that for Group A_1, ranging from .633 to .9. The median score for Group B is .1 higher than that for Group A_1. Table 14 gives the value of U, rank sum, and probability which resulted from the analysis of the Mann-Whitney U test of correlation coefficients for Groups A_1 and B. It may be noted that the probability figure is smaller than that for Groups A and B, but did not reach significance ($p > .05$).

Of secondary interest was the determination of differences between groups on the nine goals which comprised the goal consensus instrument. These goals were: (1) the family should have a nice home where you can entertain your friends; (2) the family should have a home where members of a family do interesting things together; (3) the family should have a home where you can have as much privacy as you want; (4) the family should have healthy and happy children; (5) the family should not have to worry about money matters; (6) the family should have a home in which to lead your own life; (7) the family should have a home where all members accept responsibility; (8) the family should give you a respected place in the community; (9) the family should have a home where the family members feel they belong.

Rankings of husbands in Groups A and B on the nine goals showed no significant differences when analyzed by the chi square goodness of fit test. Rankings of

homemakers in Groups A and B, did, however, reveal significant differences in the relative importance they attributed to goals one and nine as analyzed by the chi square analysis of contingency (see Table 15).

TABLE 15.--Results of the chi square analysis of rankings of homemakers in Groups A and B on the Western Reserve University Goal Consensus Scale.

Goal	Chi Square	Degrees of Freedom
1	16.048*	8
2	6.997	8
3	4.767	7
4	14.073	8
5	5.743	8
6	7.571	8
7	9.284	7
8	8.613	7
9	17.195**	5

*Significant at .05 level.
**Significant at .01 level.

The contingency table showed the frequency with which each group ranked goals one and nine (Table 16). While the chi square analysis did not indicate how they differed, it may be noted from Table 16 that only two homemakers in Group A, as compared with twelve homemakers in Group B, ranked goal one as relatively important (between first

through fifth place). It appeared that normal hearing homemakers (Group B) considered it more important to have a nice home for the entertainment of their friends.

TABLE 16.--Homemakers' rankings of goals one and nine.

Group	Rankings								
	1	2	3	4	5	6	7	8	9
Goal 1: The family should have a nice home where you can entertain your friends.									
A			1		1	9	6	6	7
B	2	1	1	2	6	1	7	3	7
Goal 9: The family should have a home where family members feel they belong.									
A	16	5	3		4		2		
B	6	11	7		1	5			

Twenty-eight homemakers in Group A, and twenty-four in Group B ranked goal nine as relatively important (between first through fifth place). Sixteen homemakers in Group A ranked goal nine in first place as compared with six homemakers in Group B. It appeared that homemakers with hearing losses attributed the greatest importance to having a home where family members feel they belong.

Hypothesis 2. Marital Conflict

Marital tension will be significantly higher in families in which the homemaker has a hearing loss.

Homemakers' and husbands' scores on the Martial Conflict scale of the PARI were tabulated and combined to produce a group score. Table 17 indicates the range and median for group marital conflict scores. It may be noted that the range for Group A was from 17 to 40, and the median score was 31. The range for Group B was from 22 to 36, and the median fell at 30. From these descriptive measures of the distributions, the groups' scores appear to be similar.

TABLE 17.--Range and median of Groups A and B on the Marital Conflict Scale of the PARI.

Group	Range	Median
A	17-40	31
B	22-36	30

The Mann-Whitney U statistic was utilized to test the difference between groups. The value of U was 444.5, the rank sum was 909.5, and the exact probability was .4675 for the directional test. Thus, hypothesis 2 was not supported ($p > .05$).

Possible differences between homemakers' scores and husbands' scores for Groups A and B were determined.

Table 18 indicates the range and median of these scores which suggest that there was little difference between groups.

TABLE 18.--Range and median of homemakers' and husbands' scores in Groups A and B on the Marital Conflict Scale of the PARI.

Group	Range	Median
Homemakers		
A	9-20	15
B	9-20	16
Husbands		
A	8-20	16
B	9-19	14.5

The Mann-Whitney U test was used to identify differences in homemakers' and husbands' marital conflict scores. Results are shown in Table 19. While a

TABLE 19.--Results of Mann-Whitney U test for homemakers and husbands of Groups A and B on the Marital Conflict Scale of the PARI.

	Value of U	Rank Sum	Probability
Homemakers	384.5	849.5	.1647
Husbands	355.5	820.5	.0795

significant difference is not indicated for either homemakers or husbands, it is of interest to note that the probability for husbands' scores was in the direction of significance ($p = .0795$).

In order to examine marital conflict further, the marital conflict scores of families where homemakers had the more severe hearing losses (Group A_1) were compared with families where homemakers heard normally (Group B). Scores of Group A_1 ranged from 23 to 40, and the median fell at 32. These scores differed very little from those of Group B (see Table 17). Homemakers in Group A_1 had scores which ranged from 9 to 20 with a median of 16. These scores are the same as those for homemakers in Group B as shown in Table 18. Husbands in Group A_1 had scores which ranged from 13 to 20 with a median of 16. These scores differed only slightly from those of husbands in Group B (Table 18).

The Mann-Whitney U statistical test was applied to determine the differences in scores of Groups A_1 and B, as well as of homemakers and husbands for the two groups. Results are shown in Table 20. The difference between total scores of Groups A_1 and B were in the direction of significance. Homemakers' scores did not differ significantly, but the difference in husbands' scores was significant ($p < .05$). In other words, homemakers, regardless of amount of hearing loss, did not differ significantly in the amount of marital conflict they

experienced. Husbands of homemakers with hearing losses, as compared with husbands of homemakers who heard normally, differed significantly in the amount of marital conflict they experienced as revealed by the Marital Conflict scale of the PARI. More marital conflict seemed to be experienced by husbands of homemakers who had the more severe hearing losses.

TABLE 20.--Comparison of marital conflict scores in Groups A_1 and B for homemakers and husbands, homemakers only, and husbands only.

	Value of U	Rank Sum	Probability (1-tailed)
Homemakers and husbands	160.0	280	.0555
Homemakers only	215	680	.4043
Husbands only	144	609	.0244*

*Significant at the .02 level.

Hypothesis 3. Rejection of the Homemaking Role

Hearing handicapped homemakers will exhibit a significantly greater rejection of the homemaking role than homemakers with normal hearing.

The Rejection of the Homemaking Role scale is, like the Marital Conflict scale, a part of the PARI. Scores of homemakers on this scale for those in Group A ranged from 6 to 20 with a median of 12.5. Homemakers in

Group B had scores which ranged from 5 to 20 with a median of 13.

The Mann-Whitney U statistic was applied to test the difference between the scores of homemakers in Groups A and B. The value of U was found to be 412.5, the rank sum was 877.5, and the probability was .2885. On the basis of the results of this statistical test, hypothesis three was not supported.

As a matter of secondary importance, scores of homemakers with the more severe hearing losses (Group A_1) were examined. Their scores ranged from 7 to 20 with a median of 12. When compared with scores for homemakers in Group B, the ranges differed by only two points, and the median by one.

The Mann-Whitney U test results for Groups A_1 and B were: value of U, 205; rank sum, 325; and probability, .3141. Homemakers with the more severe hearing losses did not differ significantly from normal hearing homemakers on their scores for the Rejection of the Homemaking Role scale. Severity of hearing loss of the subjects tested did not appear to contribute to their rejection of the homemaking role as measured by the instrument employed in this study.

Hypothesis 4. Power in Decision-Making

Power in decision-making will be significantly lower for homemakers with a hearing deficit.

Decision-making power, the amount of control one individual had over an activity performed by another, was measured by the "who decides" section of the task performance instrument (see Appendix A, p. 104). Of interest in this study was the amount of power in decision-making exercised by homemakers. Table 21 shows the range and median power scores of homemakers.

TABLE 21.--Range and median of homemakers' decision-making power for Groups A and B.

Group	Range	Median
A	-14 to 18	5
B	-16 to 21	4

Scores were grouped so that low, medium, and high power scores in the two groups might be compared. The range of the two groups (N = 60) was viewed as one (-16 to 21) and roughly divided into thirds. Scores which fell between -16 and -3 were classified in the low category and comprised 31.7 per cent of the total. The medium category had scores which ranged from -2 to 7 and was 35.0 per cent of the total. High scores ranged from 7 to 21 and were 33.3 per cent of the total (see Table 22).

TABLE 22.--Number and per cent of homemakers in Groups A and B with low, medium, and high decision-making power.

Homemakers	Amount of Power					
	Low		Medium		High	
	No.	%	No.	%	No.	%
Group A	10	33.3	8	26.7	12	40.0
Group B	9	30.0	13	43.3	8	26.7

A constant was added to all the scores to eliminate the minus signs. A chi square test was performed to determine the difference in scores of homemakers in Groups A and B. The results of the test were: a chi square of 2.043 with 2 degrees of freedom was not significant ($p > .05$). Therefore, hypothesis four was not supported. Homemakers' power, as measured by the instrument used, did not vary with hearing loss.

An interesting within-category difference may be noted, however. Table 22 shows the percentage of scores in the low category to be close to one-third of the total for both groups (Group A = 33.3%; Group B = 30.0%). The medium category, however, showed only 26.7 per cent of the homemakers represented in Group A, while in Group B it showed 43.3 per cent. The high power in decision-making category was almost a reversal of that proportion shown in the medium group. Group A had 40.0 per cent, and Group B, 26.7 per cent in the high category. The

difference in percentages for the medium category was 16.6, and for the high, 13.3.

Hypothesis 5. Task Performance

Differences in task performance of family members will be evident in the two groups of families; hard of hearing homemakers will receive less help from other family members.

The task performance instrument consisted of a series of twenty-nine typical family activities. The amount of help homemakers received from other family members was determined. Table 23 indicates that the range of family tasks performed by members other than homemakers for Group A ranged from 42 to 115 with a median score of 68.5. Scores for Group B ranged from 33 to 102 with a median score of 57. Variation appeared evident between the two groups.

TABLE 23.--Range and median of number of family tasks performed by members other than homemakers.

Group	Range	Median
A	42-115	68.5
B	33-102	57.0

The range of the scores for the two groups (A and B) was viewed as one, and the range was roughly divided into thirds and categorized. Families whose scores fell

between 0 and 53 (30% of the total) were classified as "low helpers." Families whose scores fell between 54 and 65 (33.3%) were the "medium helpers," and those whose scores fell above 66 (66 to 115) were classified as "high helpers." Table 24 shows the number and per cent of families in Groups A and B according to low, medium, and high help categories.

TABLE 24.--Number and per cent of families in low, medium, and high help categories.

Group	Low-Help		Medium-Help		High-Help	
	No.	%	No.	%	No.	%
A	5	16.7	9	30.0	16	53.3
B	13	43.3	11	36.7	6	20.0

A chi square test was performed to determine the differences between Groups A and B in families' scores by helping categories. A chi square of 8.301 with 2 degrees of freedom was significant at the .02 level ($p < .05$). This indicates that homemakers in Groups A and B differed significantly in the amount of help they received from other family members. Thus, hypothesis five was not supported. While scores of the two groups differed significantly, homemakers who had hearing losses received significantly more help from other family members with family tasks than did the normal hearing homemakers.

Hypothesis 6. Agreement on Management of Children's Behavior

There will be less agreement on management of children's behavior among families in which the homemaker has impaired hearing.

Porter's Parental Acceptance Scale (PAS) was administered to both homemakers and husbands to determine the agreement of parents on the management of children's behavior. Table 25 indicates that the agreement of the scores of parents in Group A ranged from 21 to 52 with a median score of 32.5. Agreement scores for parents in Group B ranged from 20 to 55 with a median score of 33.

TABLE 25.--Range and median for the agreement of parents on the Porter PAS.

Group	Range	Median
A	21-52	32.5
B	20-55	33.0

The Mann-Whitney U statistic was applied to test the difference between parents' scores in Groups A and B. The value of U was found to be 442.5, the rank sum was 907.5, and the probability was .4558. Therefore, hypothesis six was not supported ($p > .05$).

As a matter of secondary interest, scores of families in which homemakers had the more severe hearing losses (Group A_1) were examined. Scores for Group A_1

ranged from 21 to 52 with a median score of 34. These figures do not vary widely from those found for Group B (Table 25).

The Mann-Whitney U statistic was applied to test the difference in scores of Groups A_1 and B. The value of U was found to be 214.5, the rank sum was 679.5, and the exact probability was .4 ($p > .05$). Agreement of parents on the management of children's behavior did not vary significantly as a function of homemakers' hearing losses even when the subgroup (Group A_1) with the more severe diminution in hearing was compared with the group in which homemakers heard normally (Group B).

Summary

Although the data produced no support for the theoretical hypotheses, significant differences were found in two areas. Husbands' marital conflict increased with severity of homemakers' hearing losses, and homemakers with hearing losses received more help from the other family members in the performance of family activities.

Families in both Groups A and B had low goal consensus correlation coefficients as revealed by the Spearman rank-order analysis (i.e., less than .55). Families of normal hearing homemakers had a median rho of .517 while those of hard of hearing homemakers had a median rho of .475. The tendency was in the hypothesized direction, but the difference as tested by the Mann-Whitney U statistic, did not reach significance.

When homemakers' and husbands' ratings of the nine goals which comprised the goal consensus scale were analyzed by the chi square goodness of fit test, husbands of the two groups showed no significant differences in their ratings. Homemakers, however, differed significantly for their ratings of goals one and nine. Homemakers with normal hearing appeared to attribute more importance to the home as a place for the entertainment of friends. Hard of hearing homemakers appeared to consider it more important that the home be a place where family members feel they belong.

Marital conflict scores of families in Groups A and B did not differ significantly. The tendency was, however, in the hypothesized direction with families in Group A having the higher median score, or the greater amount of conflict. Husbands of homemakers with the more severe hearing losses experienced significantly more marital tension than husbands of normal hearing homemakers. Severity of the hearing loss seemed to increase husbands' feelings of conflict or tension.

Little difference existed in the scores of homemakers as measured by the Rejection of the Homemaking Role scale. Normal hearing homemakers rejected the role to a slightly greater extent than did those with hearing deficits. This was in the opposite direction of the theoretical hypothesis, but the difference was not significant.

Homemakers' decision-making power scores did not differ significantly, but hard of hearing homemakers had slightly more power in decision-making.

Families of hard of hearing homemakers provided them with significantly more help in the performance of household tasks.

Hearing losses of homemakers did not appear to be related to husbands' and homemakers' agreement on the management of children's behavior.

CHAPTER V

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

Discussion of Findings

Goal Consensus

Families in both Groups A and B had rather low median goal consensus correlation coefficients as revealed by the Spearman Rank-Order statistic (Group A = .475, Group B = .517). Crain et al. (31), using the same instrument, found that families with diabetic children had mean coefficients of .60, while those with non-diabetic children had .67. These researchers also found that the statistical difference test they applied to the data discriminated significantly between the two groups. The median score of families with normal hearing (Group B) was not as high as the mean of Crain's lower scoring group. The Mann-Whitney U statistic revealed no significant difference between scores of families in which homemakers had hearing losses, and those in which homemakers heard normally.

Factors other than homemakers' hearing losses may have had a closer relationship to families' goal consensus. Although Stevens (46) used a different instrument, she felt that equal weighting could not be given to every

aspiration, goal, or fear in that there was no way to determine the degree of intensity. She found men's aspirations to be related to occupations, and wives' to be more related to the family. Perhaps homemakers and husbands hold complementary goals for the family. Homemakers' roles as wife, mother, and housekeeper prescribe certain role behaviors directed toward the attainment of family goals. Men, in their husband, father, and provider roles, may find that expectations of self and others sanction their striving for goals associated with families' living standards. It is possible that beyond the minimal consensus required for the integration and functioning of the family as a social system, there is a complementary division of goals toward which homemakers and husbands strive. Such goals would complement the social-emotional and instrumental roles socially sanctioned for the position each occupies in the family structure. Value consensus or similarity may be of greater relevance insofar as integration of the family social system is concerned.

It appears that normal hearing homemakers give higher priority to the home as a place to entertain friends. Hard of hearing homemakers seemed to consider the home as highly important to family members. Perhaps the hearing impaired homemakers subscribed to more family-centered values. A reflection of this notion could be

the observation that they belonged to fewer organizations, and attended fewer meetings than normal hearing homemakers. The homemakers with normal hearing attended an average of two and one-half more meetings per month. This observation prompts the notion that the normal hearing group had more interests outside the home while hard of hearing homemakers may have had more home-centered interests.

Marital Tension

There was no significant difference between the groups on marital tension or conflict. However, when scores of husbands of the more severely hearing impaired homemakers were compared with those of husbands of normal hearing homemakers there was a significant difference between groups. Husbands of the more severely hard of hearing homemakers (Group A_1) felt significantly more tension or conflict. Hoffman (32), using the same instrument, found that it discriminated between husbands when the grouping was based upon the presence or absence of children with behavioral problems.

One may only speculate as to possible reasons for husbands' tension. Perhaps in "taking up the slack" by performing some of the mother's usual role-related functions, the father, while still having his own roles to perform, was unduly burdened. He may, for example,

attend school conferences, Parent-Teacher Association meetings, and so forth, to discuss the children's school work when the homemaker feels her communication problem is too great for her to glean all the information, or when she is embarrassed about discussing her hearing problem. His stress may be reflected in the form of marital tension or conflict. He may feel concern for the safety of his wife and children. The homemaker who was interviewed prior to the initiation of the study, Mrs. D., mentioned that the furnace fan had been running constantly, and this was not detected until her husband happened to be home during the day. This could have resulted in a fire or some sort of mishap which the normal hearing homemaker would have been better able to prevent.

Rejection of the Homemaking Role

There was no significant difference in scores of homemakers of the two groups in their rejection of the homemaking role. Hoffman (32), using the same test instrument, found there was no significant difference between homemakers when they were grouped on the basis of presence or absence of either behavioral problem children or physically handicapped children in the home.

Although normal hearing homemakers rejected the role to a slightly greater extent, the difference was very small. It would be interesting to delve deeper

into this facet of the homemaker's role, however. Does the hard of hearing homemaker feel more secure in the home and accept the role to a greater extent than her normal hearing counterpart? More of the hearing handicapped women were employed full-time, but the total number of employed homemakers for the two groups was comparable. Perhaps the hard of hearing homemaker attempts to compensate for her inability to function fully in certain extra-family situations by focusing more of her attention upon life within the family.

Social isolation has been considered a problem of hearing handicapped individuals, and for this reason it was thought that homemakers in Group A would reject the role to a greater extent than those in Group B. It is possible that hearing handicapped homemakers, in fact, feel more isolated in social situations outside the home where they have less control of the environment, and communication may be more difficult. Husbands were not asked to complete the rejection of the homemaking role scale, but they may feel socially isolated if their wives restrict social activities to their own homes and families. This could be a contributing factor to their feelings of conflict or tension, and merits further investigation.

Power in Decision-Making

Homemakers' decision-making power did not differ significantly between groups, but there was a slight tendency for those with hearing losses to have more decision-making power. If hard of hearing homemakers are more family-centered in their role performances, they likely would exercise more control over the behavior of other family members. Decision-making power of normal hearing homemakers might be more diffuse and less concentrated within the family. The hypothesized relationship was that hard of hearing homemakers would have less decision-making power. It was thought that other family members would act unilaterally due to the difficulty of communicating with the hearing handicapped homemaker.

Task Performance

There was a significant difference between family groups insofar as task performance of other family members was concerned. Hard of hearing homemakers received significantly more help from other family members than did those with normal hearing.

Originally it was thought that, due to the communication problem imposed by hearing loss, homemakers would prefer to perform tasks themselves and eliminate the need to communicate. However, if a hearing handicapped homemaker views her family roles as primordial, she may feel

a need to involve other members in home tasks or activities as a way of increasing feelings of solidarity, cohesiveness, or integration. Deacon et al. (34), using a different instrument, also noted that family cooperativeness, as measured by homemakers' responses to their families' feelings toward their illnesses, increased with the severity of the women's limitations.

It is also possible that intrafamily communication is not as much of a problem as it had been thought to be. Non-verbal communication may be used to a greater extent, and family members may be more accommodating than others. Research involving actual observations of family behavior in the homes of hearing handicapped homemakers might be very helpful in answering some of the questions raised by this study.

Agreement on Management of Children's Behavior

The extent of agreement between homemakers and husbands on this variable was almost identical for the two groups. Hearing losses of homemakers did not appear to be related to this component of family integration.

Crain et al. (31) did not find the PAS discriminated between parents when grouped on the basis of the presence or absence of a diabetic child. They hypothesized that when parents agree on the goals of family life, they perceive the child as involved in goal achievement and

thereby agree on the management of the child's behavior. The only support this study could lend to this notion would be that goal consensus of both groups of families was rather low, and neither group was in close agreement on the management of children's behavior.

Factors such as commonality of values, personality characteristics, education, socioeconomic class, and intrafamily communication may be more relevant to the management of children's behavior that homemakers' hearing losses.

Limitations of the Study

1. The sample was a purposive one, and no claim is made for representation of a general population. Generalizations do not pertain beyond the survey sample.
2. Limitations placed upon the sample such as that families be intact may have biased it in favor of those which were more highly integrated.
3. Psychological and physical characteristics other than homemakers' hearing losses were not ascertained. Their influence on scores is unknown.
4. Scores represent respondents' perceptions of behavior. Observations of actual behavior

were not made, and their congruence with reported behavior is unknown.

5. Data were obtained from only homemakers and husbands. Children's perceptions as related to homemakers' hearing losses and family integration were not ascertained.

Conclusions

Within the confines of this study which utilized a purposive sample of thirty families with homemakers who had hearing losses, and thirty families with homemakers who had normal hearing, the following conclusions are warranted:

1. There was no significant difference in goal consensus between groups. Families in both groups had rather low goal consensus scores (correlation coefficients below .55). Homemakers who heard normally appeared to attribute greater importance to the home as a place to entertain friends. Homemakers with hearing losses appeared to attribute greater importance to the home as a place where family members feel they belong.
2. Marital tension did not differ significantly between families, husbands, or homemakers. However, scores of husbands of homemakers with the more severe hearing losses differed

significantly from those of husbands of normal hearing homemakers. Husbands' marital tension or conflict increased with the severity of homemakers' hearing losses.

3. Homemakers' rejection of the homemaking role did not differ significantly between groups.
4. Homemakers' power in decision-making did not differ significantly between groups. There was a tendency for hard of hearing homemakers to have more decision-making power.
5. There was a significant difference between groups in task performances of family members. Hard of hearing homemakers received significantly more help from other family members.
6. Family groups did not differ significantly as to their agreement on the management of children's behavior.
7. Certain demographic data together with a slight trend noted in scores on test instruments suggest that homemakers with hearing losses play roles which are more family-centered. Hard of hearing homemakers belonged to fewer organizations, and attended fewer meetings per month than homemakers with normal hearing. They were slightly less rejecting of the homemaking role, and had more power in decision-making. Family

members provided hard of hearing homemakers with more assistance with household tasks or activities. They appeared to attribute less importance to the home as a place to entertain friends, and more importance to the home as a place where family members feel they belong.

Implications for Further Research

The following questions for further research in rehabilitation are suggested by this study: What bearing do other physical and social factors such as multiple health problems and extra-family transactions have upon the relationship between homemakers' hearing losses and family integration? What are some of the psychological factors such as self-concept and intelligence which bear upon this relationship? How does an invisible handicap such as hearing loss effect expectations of self and others?

What variables seem to be related to families' level of goal consensus? What factors discriminate between families of low and high goal consensus?

At what hearing threshold level is a homemaker's hearing handicap associated with an increase in a husband's feelings of marital conflict?

What factors are associated with a hearing handicapped homemaker's acceptance or rejection of the homemaking role?

What factors seem to discriminate between hearing handicapped homemakers who have high and low power in decision-making?

Although homemakers' hearing losses did not appear to be related to parents' agreement on the management of children's behavior, are there other variables such as education, socioeconomic class, personality characteristics, or intrafamily communication which are relevant?

Would data gathered from children in families of hearing handicapped homemakers produce some clues as to their influence on families' integration? For example, does the mother's hearing loss seem to effect the mother-child relationship?

Only intact families were included in the study, but the effect of a homemaker's hearing loss on marital dissolution or separation would be of interest.

What effects would a program of aural rehabilitation for hearing handicapped homemakers have upon their family integration?

What effect would counseling of other family members have upon their attitudes about the wife-mother's disability?

Home management-related questions stimulated by this study are: Do hard of hearing homemakers employ different structures of family management than normal hearing homemakers? Why did other family members provide

hearing handicapped homemakers with more help with family activities? Was this observation related to a family's management structure, the homemaker's attitude, family members' feelings of cooperativeness, other factors, or to a constellation of factors?

What effects do various intrafamily communication patterns have upon family integration? Does a homemaker's hearing loss restrict or reduce the amount of family communication? Do families whose homemakers have hearing losses make more use of non-verbal communication?

Would special instruction in certain physical adjustments in the home aimed at facilitating the hard of hearing homemakers family activities effect their family integration? Would home management instruction that would include goal clarification, decision-making, and family relationships effect their level of integration?

This study has provided some clues for identifying the relationship of homemakers' hearing losses and family integration. The most conclusive emerging hypothesis seems to be in the relationship of the severity of homemakers' hearing losses to their marital integration. This factor merits further investigation.

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APPENDICES

APPENDIX A

TEST INSTRUMENTS

In studying family management, we need to know what activities members perform in maintaining the home, as well as who makes the decisions as to how the home is run. Here are some questions that need answering. Some concern you personally, others concern your family life situation. Please answer all questions.

The following is a list of home activities. In the boxes below, please place a check mark (✓) to indicate each person who usually does each job.

Activity	(0) No one or does not apply	(1) Father	(2) Mother	(3) Teenage boy	(4) Teenage girl	(5) Younger boy in family	(6) Younger girl in family	(7) Each person does himself	(8) Someone other than family
1. Who gets the family up in the morning?									
2. Who cooks breakfast?									
3. Who goes out to work for pay?									
4. Who makes the beds?									
5. Who does the cleaning and dusting?									
6. Who cooks the main meal?									
7. Who clears the table after the main meal?									
8. Who does the dishes after the main meal?									
9. Who takes care of the garbage and trash?									
10. Who mends or sews the family's clothes?									
11. Who fixes broken things such as electrical appliances, furniture and toys?									
12. Who takes care of the yard?									
13. Who does the family wash?									
14. Who does the family ironing?									
15. Who sees to it that children help with the housework?									

Activity	(0) No one or does not apply	(1) Father	(2) Mother	(3) Teenage boy	(4) Teenage girl	(5) Younger boy in family	(6) Younger girl in family	(7) Each person does himself	(8) Someone other than family
16. Who gives the children spending money?									
17. Who tells children and teenagers what time to come in at night?									
18. Who sees that the children and teenagers practice good manners?									
19. Who cares for family members when they are sick?									
20. Who buys the groceries?									
21. Who goes together on outings, picnics, cookouts?									
22. Who invites visitors to the home?									
23. Who selects large household equipment, such as stove, TV, vacuum sweeper?									
24. Who pays the bills?									
25. Who goes together to visit mother's friends and relatives?									
26. Who selects the programs on the TV?									
27. Who sees to it that children get washed and dressed in the morning?									
28. Who goes together to visit father's friends and relatives?									
29. Who goes together on vacations?									
30. Who locks up at night?									

Please place a check mark (✓) below each person who usually decides who does each activity. Remember this section concerns who makes the decision that each activity be done.

Who Usually Decides Who	(0) No one or does not apply	(1) Father	(2) Mother	(3) Teenage boy	(4) Teenage girl	(5) Younger boy in family	(6) Younger girl in family	(7) Each person does himself	(8) Someone other than family
1. Gets the family up in the morning?									
2. Cooks breakfast?									
3. Goes out to work for pay?									
4. Makes the beds?									
5. Does the cleaning and dusting?									
6. Cooks the main meal?									
7. Clears the table after the main meal?									
8. Does the dishes after the main meal?									
9. Takes care of garbage and trash?									
10. Mends or sews the family's clothes?									
11. Fixes broken things such as electrical appliances, furniture, toys?									
12. Takes care of the yard?									
13. Does the family wash?									
14. Does the family ironing?									
15. Helps the children and teenagers with their homework?									
16. Provides the children with spending money?									

Who Usually Decides Who	(0) No one or does not apply	(1) Father	(2) Mother	(3) Teenage boy	(4) Teenage girl	(5) Younger boy in family	(6) Younger girl in family	(7) Each person does himself	(8) Someone other than family
17. Tells children and teenagers what time to come in at night?									
18. Sees that children and teenagers practice good manners?									
19. Cares for family members when they are sick?									
20. Buys the groceries?									
21. Goes out together on outings, picnics, cookouts?									
22. Invites visitors to the house?									
23. Selects large household equipment such as stove, TV, vacuum sweeper?									
24. Pays the bills?									
25. Goes together to visit mother's friends and relatives?									
26. Selects the programs on the TV?									
27. Sees that children get washed and dressed in the morning?									
28. Goes together to visit father's friends and relatives?									
29. Goes together on vacations?									
30. Locks up at night?									

Almost everyone has an opinion about topics such as the ones mentioned in the statements listed below.

Indicate your opinion by drawing a circle around:

"A" -- if you strongly agree

"a" -- if you mildly agree

"d" -- if you mildly disagree

"D" -- if you strongly disagree

There are no right or wrong answers, so answer according to your own opinion.

	AGREE		DISAGREE	
1. People who think they can get along in marriages without arguments just don't know the facts.	A	a	d	D
2. Sometimes it's necessary for a wife to tell off her husband in order to get her rights.	A	a	d	D
3. No matter how well a married couple love one another, there are always differences which cause irritation and lead to arguments.	A	a	d	D
4. There are some things which just can't be settled by a mild discussion.	A	a	d	D
5. It's natural to have quarrels when two people who both have minds of their own get married.	A	a	d	D
6. Having to be with children all the time gives a woman the feeling her wings have been clipped.	A	a	d	D
7. One of the worst things about taking care of a home is a woman feels she can't get out.	A	a	d	D
8. Most young mothers are bothered more by the feeling of being shut up in the home than by anything else.	A	a	d	D
9. One of the bad things about raising children is that you aren't free enough of the time to do just as you like.	A	a	d	D
10. A young mother feels "held down" because there are lots of things she wants to do while she is young.	A	a	d	D

APPENDIX B

INTRODUCTORY MATERIALS

Interview Number _____ Date _____

Persons in Family	Age	Living at Home
Homemaker		
Husband		

Husband's occupation _____

Describe what he does _____

Wife's occupation _____

Describe what she does _____

Has homemaker ever worked outside the home? Yes_____ No _____

What sort of work did you do? _____

How long have you been married? _____

Homemaker: How many years of school have you completed?

Grade School	High School	College	Graduate
1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4	1 2 3 4

College Degree _____ Major _____

Other special training _____

Husband: How many years of school have you completed?

Grade School	High School	College	Graduate
1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4	1 2 3 4

College Degree _____ Major _____

Other special training _____

Approximately how many times have you moved since you have been married? _____

Do you own or rent your present home? _____

How long have you lived in it? _____

Homemaker: To how many organizations outside the home do you belong?
(P.T.A., Garden Club, Church) _____

Approximately how many meetings outside the home do you attend a month? _____

Husband: To how many organizations outside the home do you belong?
(Labor Union, Service Clubs, Professional) _____

Approximately how many meetings outside the home do you attend a month? _____

Homemaker: Do you have any special hobbies or interests?
(Sew, read, collect, garden) _____

Husband: Do you have any special hobbies or interests?
(Fish, hunt, read, wood working) _____

What sort of activities does your family enjoy doing together?
(Watch TV, camp travel, picnics) _____

H. of H. Homemaker: How long have you had a hearing loss? _____
Does your hearing loss present a problem in any situations? Yes__No__
What situations? _____

_____

Have you made any special adjustments in the home because of it?
(Phone amplifier, doorbell, buzzer or light, child care) _____

_____

Do you wear an aid? Yes_____ No _____

N.H.Homemaker: Have either of you ever had any trouble with your hearing? _____

Are you a member of a church or religious group?
Homemaker: Yes_____ No _____ Husband: Yes_____ No _____

To which church or religious group do you belong?

Homemaker		Husband
_____	Catholic	_____
_____	Protestant	_____
_____	Jewish	_____
_____	Other	_____

Would you please tell me your approximate family income?

_____ A. $ 2,000 to $ 4,999
_____ B. 5,000 to 9,999
_____ C. 10,000 to 14,999
_____ D. 15,000 to 19,999
_____ E. Over $20,000

Telephone Introduction:

I am calling from the Speech and Hearing Clinic (Rehabilitation Medical Center) at Michigan State University (Sparrow Hospital). This department and the Department of Family and Child Sciences are cooperating in a research study of some of the people who have come to the clinic to have their hearing tested.

My name is Jane Oyer, and I am a student who is working on the research project.

First of all, we are interested in talking further to ladies who are living with their husbands and who have children under age 18. Would you qualify in this respect?

We are interested in some of your opinions about family life. For example, you would be asked to check on a chart which family members perform various home tasks. Another aspect involves the opinions of fathers and mothers regarding child discipline.

I would like to spend about one-half hour with you and your husband at your convenience. Would you be so kind as to cooperate with us in our study?

Would you and your husband be home on _____ day at _____ o'clock?

Check to see if any persons other than nuclear family members reside in the home.

Check address:

Dear Mrs. _____

This center is cooperating in a research project with the Speech and Hearing Department of Michigan State University.

Within the next few days you may be contacted by Mrs. Jane Oyer, principal investigator in the project, with a request that you assist in the study. You will be asked to provide about one-half hour of your time in an interview which can be done in your home and at your convenience.

Research studies such as this will help us to help the hearing impaired. I hope you will be willing to volunteer your participation.

Sincerely,

Alvin J. Davis
Director, Constance Brown
Hearing and Speech Center
Kalamazoo, Michigan

Dear Mrs. _____

The Speech and Hearing Clinic and the Department of Family and Child Sciences of Michigan State University are cooperating in a research project. We are wondering if you and your husband would be willing to volunteer about one-half hour of your time.

We are interested in some of your opinions concerning family life. For example, we are interested in knowing which members of the family perform certain tasks. Other areas of interest are such topics as child discipline and family decision-making.

If you and your husband are willing to participate in our study, would you please call _____ at your earliest convenience. I am enclosing a postal card which you may check and return to me if it would be more convenient for you than making the telephone call. Thank you.

Yours truly,

Herbert J. Oyer,
Director,
Speech and Hearing
Clinic