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ROLE FUNCTIONS OF PRIMARY CAREGIVERS IN COMMUNITY-
BASED GROUP HOMES FOR DEAF/HARD OF HEARING YOUTH
WITH BEHAVIOR DEFICITS: A MODEL

presented by

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has been accepted towards fulfillment
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WITH BEHAVIOR DEFICITS: A MODEL

By

Aurles Uneé Wiggins

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ABSTRACT

ROLE FUNCTIONS OF PRIMARY CAREGIVERS IN COMMUNITY-BASED GROUP HOMES FOR DEAF/HARD OF HEARING YOUTH WITH BEHAVIOR DEFICITS: A MODEL

By

Aurles Uneé Wiggins

Deaf/hard of hearing children begin to interact from birth, in relationships with other more knowledgeable peers and adults in their environment. Within these speech-mediated interactive social processes, children are assisted in the acquisition of the signs and tools with which they learn to manipulate the environment, and to direct their own behavior (Vygotsky, 1978). As effective communication skills are built upon from social interactions with others, language is enhanced, cognitive development is supported and individuals become empowered to affect their world and themselves. Vygotsky's theoretical perspective suggests that more knowledgeable adults, in this case, primary caregivers, are a crucial force in nurturing the cognitive and life skills development of the child.

This research examined the issue by exploring perceptions of importance, and current level of co-worker competency ascribed to job skills, tasks, activities and knowledge areas. These items were compiled within six general categories: SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, GENERAL KNOWLEDGE, and PROFESSIONAL DEVELOPMENT. One-hundred and eight deaf/hard of hearing and hearing

Aurles Uneé Wiggins

primary caregivers in public residential schools across the United States participated in the study.

A research questionnaire was formulated based on an extensive literature review by Small and Dodge (1988), which reviewed job functions and responsibilities of persons providing direct care services, to a diverse population of people, within a variety of settings.

The major findings of this study suggest in general that, all composite job skills categories were perceived to be Important to the projected role functions of primary caregivers in community-based group homes for deaf/hard of hearing youth with behavioral deficits. The study also provided findings which generally suggest that, primary caregivers working in residential schools for deaf youth perceive their current job performance as competent to somewhat competent.

Preparation of knowledgeable caregivers is essential to the total life development of deaf/hard of hearing youth. Discrepancies between perceptions of importance and, levels of perceived co-worker competence in current job performance may suggest that, primary caregivers are not aware of the impact their interactions have on the cognitive development of deaf/hard of hearing children. In-service training and education could provide a supportive bridge of knowledge in promoting an understanding of the role primary caregivers play in cognitive and life skills development.

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DEDICATION

This research effort is dedicated to a resilient survivor who weathered the storms of this endeavor, and who maintained a sense of humor, tolerance, and unconditional support— my son, Antoine "Tony" Grady. It is my wish for him that, he will prepare himself through training and education, to make worthwhile contributions to his family, his community and to humanity.

The culmination of this study and fulfillment of requirements for the degree of Doctor of Philosophy, is the deliverance of a promise I made to my mother over three decades ago. "Get an education!" she would say, as she reminisced about her experience as a graduate student at Cornell University. I captured every word and detail, and by her example, I was inspired to pursue this academic challenge.

This study is lovingly dedicated to Roe Mayo Jones, my grandmother. She believed in working hard, she believed in getting an education, and most of all, she believed in me.

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On May 8, 1963, in an elementary school assembly, I was motivated by the speech of Mr. A. H. Peeler, an energetic and forward thinking educator, who challenged us to strive for success in academic and life endeavors. His speech was entitled, "Sail On," and his challenge was presented in the form of a "Sailing Progress Report" to be filled out, and presented to him as each port (academic or life goal) was reached. That form also contained an inspirational poem by Daisy Rhinehart entitled, "Out Where The Big Ships Are" which goes as follows:

I'm tired of sailing my little boat
Far inside of the harbor bar:
I want to be out where the big ships float--
Out on the deep, where the great ones are!

And should my frail craft prove too slight
For storms that sweep those wide seas o'er
Better go down in the stirring fight
Than drowse to death by the sheltered shore!

The progress form is beginning to show the signs of age now, as I am. However, my excitement and energy for academic success are still young and vibrant, as they were when I was given the charge that day in elementary school.

I sailed my little boat into the port of Michigan State University--out where the big ships float, and I have been supported, nurtured, and encouraged by many individuals. I

thank my guidance committee advisor, Dr. Gloria Smith, for taking her position at the helm and guiding me through this process. Dr. Tane Akamatsu (a.k.a. "The Whip"), inherited the task master position from my former dissertation advisor, Mrs. Vivian Stevenson, now retired. I am deeply indebted to Dr. Akamatsu for her invaluable assistance in the development of the dissertation and for her unselfish extension of time, energy, insight and scholarly observations.

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CHAPTER I
INTRODUCTION TO THE STUDY

Introduction

"I can remember playing outside. The sun was bright and it was really nice. I guess I was about four or five. My mother had been calling me to come inside, but I could not hear her. Suddenly she appeared and stopped me from swinging. She was moving her mouth really fast. I could tell from looking at her face that something was wrong-- but I didn't know what it was. Then she spanked me.
(reflective pause) I was so sad and confused. I didn't know what I had done." [Childhood memories of S., an adult deaf female.]

The meaning that S. assigned to the continued swinging was different than the meaning her hearing mother assigned to the same behavior. For S., continued swinging was an acceptable activity, it was something that her parents encouraged her to do, and it was fun. For S.'s hearing mother, continued swinging may have represented unacceptable behavior, given her repeated shouted requests for S. to stop. Both individuals had valid perceptions of the same behavior based on their bank of experiences, language, and social interactions. This helped them to assign meanings to behavior. However, the meaning that each person assigned in

this case was based on incomplete information. That vital piece of information which was missing for S. and her mother, was that S. was deaf.

At least 90 percent of deaf/hard of hearing children are born to hearing parents, who are usually unprepared for interacting with deaf/hard of hearing children (Schein & Delk, 1974). The presence or lack of family and personal support affects the psychological foundation of trust, compassion and positive self-regard; these are vital components in fostering a sense of well-being for deaf/hard of hearing youth. Unless the individuals and family members who are active participants in the deaf child's environment are able to communicate effectively through sign language or other acceptable modes of communication, the child will miss the social cues and life survival messages that are constantly being transmitted within the environment. The social constructivist theory of Vygotsky (1978) emphasizes the critical nature of the relationship between the child and more knowledgeable others in cognitive development and acculturation.

The child with hearing impairment has a diminished auditory capacity which makes it difficult to build an adequate vocabulary under the typical conditions in a speaking/hearing society. This handicapping condition also makes it difficult to incorporate associative symbolisms for words, without assistance from someone who will provide explanations and interpretations of word meanings and

colloquial expressions. Deaf children can be successfully involved in the process of maximizing their potential for growth and development, through interactions with others, who are able to utilize effective communication modes, and who thoroughly understand deafness and the effects of language deprivation. If S.'s mother had been aware that her daughter was deaf, she could have responded more appropriately to the situation. S. would have had a better understanding of what was expected of her, and of how she needed to respond to others to function more knowledgeably within the environment.

Theoretical Framework

The writer attempted to use the social constructivist theoretical perspective of Lev Vygotsky, to provide a conceptual framework for the development of the study. The researcher focused on aspects of the theory which address the evolution of cognitive development with respect to adult/child interactions.

Three ideas in Vygotsky's theoretical approach shaped the perspective and discussion of this study. The first idea addresses the developmental process of exploring and analyzing the origin and means by which psychological processes occur in higher thinking. It is a process which is constantly evolving over time and which is characterized by quantitative and qualitative changes (Vygotsky, 1987). The more information children are able to receive in contact

with others, and internalize (mentally process), the better they should become in mastering their own behaviors. This process extends to the child's ability to effectively and appropriately utilize language to manipulate themselves and others in the environment that surrounds them. Accordingly, in the case of deaf youth, if information has been distorted, conceptually fragmented or missed entirely, the psychological process is potentially adversely affected.

Recall the scenario between S. and her mother. Up to the point when S. was reprimanded for continuing to swing, she learned, through interactions with her parents, that swinging was a positive activity. When S. was scolded for swinging, she became confused. S.'s mother became upset because she assumed that S. was defying her, when, the problem was that S. was deaf. Neither she, nor her parents, was aware that she could not hear what was being said to her. S. did not have a viable means of fully communicating her needs, or her understanding of what was transpiring around her. Therefore, she was denied the opportunity to express her thoughts and feelings about the situation. This interfered in her psychological progression toward higher mental functioning. It also affected how S. formulated perceptions of her surroundings. By S.'s report, this was one of many subsequent incidents that affected her development.

The second idea suggests that the basis for the development of complex human behavior be mediated (actively

modified) by speech in social interactions (Vygotsky, 1987). This has direct implications for deaf/hard of hearing children. Through dialogue (including signing) in social interactions between the child and others in the child's surroundings, language is acquired and initially used as a means of communication for social functioning. The words that the child knows and verbalizes are given by people in the child's environment and are used primarily as a substitute for things, wants, people, or activities. By the time the child is approximately two years old, thinking and speech begins to coincide (Vygotsky, 1987). Words previously used as substitutes for things, wants, people, or activities are actively used to associate meanings, and they are gradually reassigned symbolic significance. In this process the child goes through an inner mental activity to use internalized speech to organize thought. Vygotsky (1987) suggests that this mental function assists the child in advancing to higher levels of thought and behavior.

The third idea suggests that the process of learning will be affected by the ability of the child to move from assisted instruction to independent performance and is based on two developmental levels; actual mental functions that have already developed, and the level of potential for advanced mental development (Vygotsky, 1987). Vygotsky (1978) refers to the distance between these developmental levels as the Zone of Proximal Development (ZPD). "The zone of proximal development defines those functions that have

not yet matured but are in the process of maturation, functions that will mature tomorrow but are currently in the embryonic state . . . the zone of proximal development characterizes mental development prospectively" (p.86).

The importance of recognizing the relationship of ZPD to the instruction of deaf/hard of hearing children is significantly linked to the perceptions and teaching methods of educators. According to social constructivism (Vygotsky, 1987), if effective instruction and guidance are desired, learning should be oriented toward the maturing, evolving stage of the developmental process, not those stages in the developmental process which have already matured.

Deaf/hard of hearing children have generally been labeled and perceived as concrete thinkers. This perception could be a reflection of how they have been taught. Assumptions about their inability to perform abstract thinking may have affected the manner in which they are encouraged to exceed current levels of matured mental development. Unfortunately, for deaf/hard of hearing children, evidence of abstract thinking is sometimes demonstrated by mastery of words, concepts and generalizations. The problem lies in the opportunity for most deaf children to fully access language; whether spoken or signed. If deaf children do not have an understanding of concepts and have difficulty in making generalizations, they may have difficulty in communicating their experiences and their acquired knowledge. They may also have difficulty in

abstract reasoning. Educators and others involved in the development of deaf/hard of hearing children must interact with them in ways to increase their vocabulary and use of language, to foster conceptual understanding.

Vygotsky's emphasis on a developmental approach is not to confine his theory in its strictest sense to a theory of cognitive development. Rather, it is to define the theory from an operational process point of view whereby, the psychology of the individual is analyzed by reconstructing and observing the origin of the behavior, and by charting the course of changes in behavioral and conceptual outcomes (Vygotsky, 1978). In short, development itself is socially constructed within a given time frame.

The significance of social constructivism to this study is grounded in the premise that, more knowledgeable and experienced individuals involved in social interactions with deaf children experiencing behavioral deficits, are critical to stimulating individual assessments/adjustments of behavioral responses. They are also instrumental in exposing these children to opportunities to acquire a repertoire of the signs (number systems, writing) and tools (language) for environmental and internal manipulation, which contribute to the process of higher mental processing (Vygotsky, 1978). Higher mental processing of interactive processes between the individual and the surrounding environment, will contribute to improved behavioral and psychological functioning.

These concepts were explored by observing the perceived importance of job function to perceived levels of competencies in job-related interactions with deaf youth, by public residential school caregivers. Public residential schools have historically provided temporary substitutes of home environments for deaf youth. In this arena, according to Vygotsky (1978), primary caregivers could be identified as more experienced, knowledgeable others. They are the persons who are entrusted with the care, growth, and development of deaf/hard of hearing youth. This includes deaf/hard of hearing youth with behavioral deficits, who may require more extensive involvement with primary caregivers.

Purpose of the Study

In many communities, suggested by the lack of literature, residential facilities or group homes which specifically serve deaf youth with dysfunctional behaviors are extremely limited, or non-existent. These youth are usually served within residential school settings. Primary caregivers in residential schools, or in neighborhood group home facilities, need to be properly trained and educated in communication, child development, first-aid, deafness, behavior management, etc., in order to effectively work with deaf/hard of hearing youth experiencing behavioral deficits. These are general areas of care which will support the growth and increased ability of deaf/hard of hearing youth to gain self-sufficiency. The purposes of this study

address critical job skills from a social constructivist perspective, which stresses the importance of the role of language and interaction with others in cognitive development.

Hypotheses

The hypotheses that the social constructivist theory generate about the study suggest the following:

- (1) Those single or composite job skills which rely heavily on interactions between primary caregivers, and deaf/hard of hearing youth, will be considered more important. Corresponding perceptions of job performance in the same job skills areas will be very competent.
- (2) Observations of differences between job skills areas which are perceived to be very important, with perceptions of job performance in corresponding areas at levels below competency may suggest that primary caregivers may not be suitably equipped to appropriately support deaf/hard of hearing youth in cognitive and life skills development.
- (3) Hearing status of primary caregivers will affect caregiver perceptions of importance of job skills and perceptions of levels of competency.

This exploratory study examined two major areas: perceptions of importance and perceptions of current levels of competency of co-workers job performance according to job

skills, tasks, activities and knowledge area categories. The following discussion will provide a brief overview of the educational/residential settings of deaf/hard of hearing youth.

Background

From the early 1800's, deaf/hard of hearing youth across the United States have lived away from home in residential schools for deaf children (Moore & Kluwin, 1986), schools for the severely handicapped, or large mental institutions (Katz & Martin, 1982). It could be reasoned that the low incidence of deafness in the general population required the establishment of residential schools, in order to educate and train widely geographically dispersed students. Another explanation takes into account the scarcity of qualified educators within the child's school district, who were prepared to educate, test, or evaluate deaf/hard of hearing children. These circumstances influenced the rationale which made it more appropriate to centrally locate educational programming facilities within states. Many deaf children and youth were transported from hometown communities and enrolled in state supported residential schools, where a concentration of skilled personnel, knowledgeable in many aspects of deafness, could attend to their educational and developmental needs.

The American School established in 1817 in Hartford, Connecticut was the first public residential school in the

United States designed to meet the educational and vocational training needs of deaf students (Schildroth, 1980). The climate during the early to mid 1800's was supportive of the development of deaf children in all aspects of their lives. Deaf children were involved in educational and vocational training which prepared them to function in society and to live out productive lives (Moore, 1982; Moore & Kluwin, 1986).

Moore (1982) observed that, by the end of the nineteenth century, the general trend of benevolence and compassion shifted. The effects of the Great Depression and World War II dramatically increased the numbers of persons requiring institutionalization at rates faster than caregivers could be hired, trained, and phased into job responsibilities. Across the country crowded residential facilities for the handicapped became more custodial than educational. This shift in the operational philosophy of facilities for handicapped persons threatened the security of educationally focused residential school programs for deaf children, although, programming priorities were not altered.

Currently, residential school enrollments have declined, as indicated by Schildroth (1988) from data collected by the Center for Assessment and Demographic Studies (CADS) for the Annual Survey of Hearing Impaired Children and Youth. In 1970 the residential school enrollment was estimated at 18,297. By 1985, the estimates,

based on those who responded to the CADS survey, were down to 12,118 deaf children being served in residential school programs across the country. By the 1989-90 school year, approximately 9,946 deaf children were enrolled in public residential schools (Schildroth & Hotto, 1991).

DuBow (1984) gives one reason for the decline as "the emphasis that local and state school administrators and judges are placing on the mainstreaming preference specified in the Education for All Handicapped Children Act of 1975 (P.L. 94-142)" (p. 92). He highlights a portion of the Act, Section 1412(5), which states:

...to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (p. 92).

The impacts of the deinstitutionalization movement, and ramifications of Public Law 94-142 have contributed to reducing the enrollment of deaf/hard of hearing children previously housed in large residential schools. More of these children are being mainstreamed and are participating in educational programs and ancillary services in their home community school districts.

A driving force behind the mainstreaming initiative suggests that handicapped children have the right to learn with able-bodied peers. It is assumed that peer

interactions would be an impetus for handicapped children to incorporate and expand their repertoire of social cues. They would also have opportunities, in the process of forming relationships with able-bodied peers, to demystify their handicapping condition, and promote knowledge and understanding. This is an assumption that is consistent with social constructivism. Increased awareness is generated in the process of conveying thoughts through language to others, or in the observation of differences between oneself and others (Rychlak, 1981). Mainstreamed deaf children are expected to benefit similarly. However, there are limitations.

The effects of language deficiencies and/or the inability of others to converse in sign language, or modes of communication that deaf/hard of hearing children use, interfere with the communication process. A deaf child could miss many incidental opportunities for meaningful exchanges without the assistance of an interpreter or an appropriate method of communicating information. Recall the incident of S. and her mother. Ineffective communication within that interaction introduced misunderstanding, hurt and confusion for both participants. Social constructivism predicts that these circumstances can prevent deaf children from developing "normally." Ineffective interactions in communication foster misinterpretations of cultural expectations, and infuse obstacles in the cognitive development process.

Residential school programs have traditionally provided an atmosphere for deaf students to learn, and to mature within an environment that supports social and emotional adjustment and language development. In the social constructivist theoretical framework, this situation addresses the issue of the importance of cultural environment, and the opportunity for individuals to develop an awareness of social/cultural norms and expectations through interactions with more experienced and knowledgeable peers and adults.

An atmosphere of acceptance which is created by teachers, counselors, houseparents and administrators in residential schools is based on an understanding of deafness, communication skills, and knowledge of what is "normal" for average deaf/hard of hearing youth. This acceptance is established on a foundation of knowledge of demonstrated and potential parameters of functioning. This is extremely important for deaf youth who may present problems for themselves and others in the area of behavioral control and management.

Within the environment of residential school, deaf children have an increased opportunity to access individuals who are aware of the most important handicapping condition of deafness--communication. Vygotsky (1978) emphasizes the importance of communication and language in the cognitive development and internalization process of children and writes;

Prior to mastering his own behavior, the child begins to master surroundings with the help of speech. This produces new relations with the environment in addition to the new organization of behavior itself. The creation of these uniquely human forms of behavior later produces the intellect and becomes the basis of productive work . . . (p.25).

Deaf children within residential schools may also have an increased opportunity to be appropriately assessed for disturbances in behavior and evaluated for potential success in other areas. Professionals trained in deafness are able to correct for variables associated with hearing handicaps under test conditions, to arrive at a clearer picture of the student's abilities.

Deaf/hard of hearing children within community schools could exhibit behaviors that are not viewed as generally accepted parameters of normal behavior for those settings. For instance, an instructor with limited sign language skills, or an understanding of deaf culture, could misinterpret some exhibited behaviors. Flynn and Nitsch (1980) suggest a different approach to evaluating deviant behavior:

Since deviancy is socially, subjectively, and variably defined, and varies from culture to culture and time to time, it is relative. It is not within the person; it is within the imposed social roles, the values, and the perceivers' interpretation. Therefore, deviancy can be reduced or eliminated either by a. changing the perceptions or values of the perceiver, or b. minimizing the differentness or stigma of deviancy that activates the perceivers' devaluation (p. 13).

Well-trained professionals in deafness and deaf education could provide an invaluable resource for teachers in making diagnoses, and in planning individual education goals for

these youth. The child and the educator are able to take better advantage of the instructional environment.

The support of skilled primary caregivers, initiating and maintaining behavior management plans within the therapeutic structure of a specialized residential facility or neighborhood group home, could enhance the effect of behavior management interventions for deaf/hard of hearing children appropriately diagnosed with behavioral deficit disorder. Within this therapeutically nurturing milieu, deaf/hard of hearing youth can be assisted in the integration of new behavioral skills by primary caregivers familiar with deafness. They would have the structure within which to grow in their understanding and acceptance of themselves and others. Families of these youth would have an opportunity to work with primary caregivers, by increasing their understanding of deafness and the role that the family plays in the maturation process of deaf/hard of hearing youth.

A review of the literature revealed extremely limited information about community-based group homes for deaf individuals. The literature review did not reveal information on homes for deaf youth who are experiencing difficulties in managing their behavior. Twelve housing programs were listed in the American Annals of the Deaf (1982) which served the needs of deaf adults or the elderly deaf. Two other listings were found; one, for halfway house transition facilities (Wilson, 1980) which served deaf

adults, and another group home that housed dependent and neglected multiply handicapped deaf children (Cohen, 1975).

The dearth of information regarding community-based resources for youth with behavior deficits was starkly apparent. While the literature offered very little about the issues of behaviorally disordered hearing youth in community-based group homes, it provided even less information about primary caregivers and their responsibilities in those settings. This is a distressing discovery. However, it does not present conclusive evidence that group homes and skilled caregivers for deaf/hard of hearing youth with behavioral deficits do not exist. This lack of information could be an indication that the emergence of community-based group homes for behaviorally disordered deaf/hard of hearing youth and caregivers within those settings is so new that nothing has been published on them to date.

Theoretical Importance of the Study

The establishment of community-based residential facilities and/or group homes for a population of individuals with specialized needs has gained momentum over the past twenty years (Bercovici, 1983; Flynn & Nitsch, 1980; Katz & Martin, 1982). This trend has been motivated by the deinstitutionalization movement (Flynn & Nitsch, 1980), which stresses the concept of normalization and community integration of individuals with handicapping

conditions (Guy, 1985; Vernon, 1980). The impetus behind these movements is characterized by the belief that individuals can reshape negative institutionalized behaviors and benefit from therapeutic intervention, by living within regular community settings and learning from other more capable peers and/or adults (Flynn & Nitsch, 1980).

A variety of populations have benefitted from the deinstitutionalization movement since the 1960's from the establishment of community-based residential facilities, including the mentally retarded (Baker, et. al., 1977), developmentally disabled (O'Connor, 1976), and ex-mental patients (Ridgway, 1986). Previously institutionalized individuals benefit by being able to utilize mental health services within the community. Residing within the structure of smaller residential settings increases positive relationships between residents and staff. The stigma and sense of isolation that institutionalization fosters diminishes in former patients.

The availability of specialized group homes for behaviorally disordered deaf/hard of hearing youth is rare to non-existent. Within community school districts, this sub-population of deaf/hard of hearing youth may find access to therapeutic intervention and support somewhat difficult to find. These students and their families may benefit from participation in extended community residential services, specifically designed to ease the transition back into families and communities. This is especially helpful if

parents are feeling somewhat inadequately prepared to adjust to the daily living demands, which could be presented by reintroducing a deaf child with behavior deficits into the family on an on-going basis.

The need for group homes designed to meet the unique needs of deaf/hard of hearing youth and their families could increase as more deaf children transfer from residential school programs into neighborhood educational programs. Concurrently, an increased need for skilled personnel to staff specialized group homes could coincide with an escalated population of deaf/hard of hearing youth within the community. A seemingly logical career move for former residential school houseparents could involve training for employment in specialized care facilities for deaf youth experiencing behavior control problems. Thus, there is a tremendous need to understand which are the most important job functions primary caregivers should possess, to contribute to the successful comprehensive life development of deaf/hard of hearing youth with behavioral deficits.

Limitations

The study was limited to public residential schools listed in Schools and Classes for Deaf Children in the United States (Schildroth, 1988). The listing was obtained from a survey conducted by the Center for Assessment and Demographic Studies for the Annual Survey of Deaf Children and Youth. The study was further limited to those public

schools that agreed to participate in the research study. These residential schools were located in 34 states in the continental United States and Hawaii.

This study was limited by the ability of the researcher to obtain employment figures for primary caregivers employed at each facility, and the opportunity to exercise exclusive control over the explanation and distribution of research surveys. The researcher relied heavily upon the cooperation of superintendents to make surveys available to primary caregivers willing to volunteer to participate in the research study.

This exploratory research was framed within social constructivist theoretical precepts. It was an effort by the researcher to investigate and report the perceptual observations of primary caregivers along the lines of importance and current competencies in job skills, tasks, activities, and knowledge areas. The results of this study will help individuals and communities interested in developing role function proficiencies of primary caregivers, based on the social constructivist theoretical framework, and job function areas which are perceived most important.

Research Questions

The following research questions were addressed for this study.

1. Is there a statistically significant difference in perceived level of importance among the six composite job skills categories?

2. What are the most important specific job skills, tasks, activities, and knowledge areas perceived to be needed by primary caregivers who would work with behaviorally disordered deaf/hard of hearing youth in community based group homes?

3. Is there a statistically significant difference in primary caregivers' perceptions of the level of competency of co-workers among the six composite job skills categories?

4. What are the perceived competency levels in specific job skills, tasks, activities and knowledge areas of co-workers in residential schools?

5. Is there a statistically significant difference in the perception of importance of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

6. Is there a statistically significant difference in the perception of competence of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

7. Is there a statistically significant relationship between perception of importance of job skills and the respondents' demographic characteristics?

8. Is there a statistically significant relationship between perception of co-worker competence in composite job skills categories and the respondents' demographic characteristics?

9. Is there a significant difference between the level of importance and the competency level of primary caregivers across composite job skills categories?

Definitions

Primary caregiver. An individual who is responsible for monitoring and/or providing basic care in responding to the personal needs of deaf youth in residential care programs. Duties may vary from fundamental custodial care: dressing, feeding and bathing, to include functioning as a therapeutic change agent.

Importance. The degree of value assigned to the significance of job skills, tasks, activities and knowledge areas relative to job functions of primary caregivers.

Competence. The rating assigned by primary caregivers of perceptions of current job performance by co-workers for specific or grouped job skills, tasks, activities, and knowledge areas.

Composite job skills. The arrangement of 36 specific tasks, skills, activities and knowledge areas within six general categories (SUPPORT; EDUCATION; PRIMARY CARE; MANAGEMENT; GENERAL KNOWLEDGE; PROFESSIONAL DEVELOPMENT), which are related in function, purpose and/or end result, as it pertains to the goals of residents and primary caregivers.

SUPPORT. The involvement of primary caregivers within this category is directed toward the development of youth at

an introspective level; generally therapeutically based; activities are focused on encouraging and assisting youth in assuming more responsibility for their behavior and to demonstrate more appropriate ways of responding to stress or conflict.

EDUCATION. The category of activities directed toward educating youth in interpersonal and general social skills; activities which promote self-sufficiency, and increase knowledge about the world surrounding their immediate environment and the extended global environment.

PRIMARY CARE. Activities within this category are centered around the basic care of individuals; planned recreational activities; monitored health needs; conflict intervention; basic cleaning and routine maintenance of the residential unit.

MANAGEMENT. Caregiver activities provide an organized and systematic structure of home operation and resident care; individual goal setting; consultations include those involved in the youths' development; record keeping; documentation.

GENERAL KNOWLEDGE. Job skills category requires primary caregivers to be proficient in total communication; have expertise in issues related to deafness, behavioral disorders, child development and legislation affecting deaf citizens.

PROFESSIONAL DEVELOPMENT. Requires communication with other professionals in caregiving; involvement in

information exchange forums, conferences, seminars, workshops, in-service training; participation in establishing professional standards and criteria, i.e., certification or licensing.

Group home. A moderately sized home within a residential community designed to provide an approximation to family-style living; provides optimum opportunities for healthy development; provides 24-hour congregate care; specially equipped; handicapper accessible; communication assist devices.

Residential School. A large state-supported educational facility which serves deaf/hard of hearing youth within the home region of proximity; a 24-hour boarding program component operates in conjunction with meeting the primary directive of the school which is academic instruction.

Deinstitutionalization. A process of decentralizing care of institutionalized individuals by integrating them into the community, where a system of mental health and other human resource program linkages has been created for the continuation of services.

Mainstreaming. The process of integrating handicapped students into regular school programs with non-handicapped peers.

Deaf/hard of hearing. Refers to the broad category of individuals in which perceivable sounds are difficult to impossible to detect and understand; communication is

severely impaired without the use of an audiological device (hearing aid), interpreter, sign language, written notes, lip reading skills, or other means of conveying information.

Overview of the Study

This study is divided into six chapters. Chapter I, Introduction, included a statement of the problem, theoretical framework, purpose of the study, hypotheses, background, theoretical importance of the study, limitations, research questions and definitions of key terms used in the study.

Chapter II, Review of Relevant Literature, contains an overview of the literature on behaviorally disordered deaf/hard of hearing youth, to include defining deafness, etiology, behavioral interpretations, educational placement, primary caregivers and summary.

Chapter III, Research Design and Procedures, includes the research procedures followed in this study. The instruments used for data collection are described and the procedure for their administration are presented.

Chapter IV, Presentation and Analysis of Data, contains the analysis of data collected in the study.

Chapter V, Summary of Findings and Conclusions, contains a summary of the findings and discussion of conclusions.

Chapter VI, Implications and Recommendations, includes concluding comments on implications for counseling

professionals, recommendations for further research, and
recommendations for a model group home.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

Overview

Very little literature exists on the job skills of primary caregivers in community-based group home facilities serving a specific population of behaviorally disordered deaf/hard of hearing youth. This literature review will include overviews in the following areas: defining deafness, etiology, behavioral interpretations, educational placement, and job functions of primary caregivers. These interrelated topics are considered important to understanding how deafness impacts on individuals and those persons involved in their development. A brief discussion of each of these areas will follow, along with an attempt to encompass them into a total picture of relevancy, for the professional development needs of caregivers providing community-based group home services and care to deaf/hard of hearing youth with behavioral deficits.

Defining Deafness

There have been several attempts to define hearing loss in a concise yet comprehensive manner. It is a difficult task, given the various conditions of hearing loss to be considered. Understanding and defining deafness or hearing

impairment requires input from a broad information base. In an effort to produce a comprehensive framework, informational resources should incorporate medical, psychological, societal, familial, cultural and environmental dimensions and audiological examination data. The combination of these factors is highly important to recognizing and comprehending deafness and in preparing the observer/practitioner with sufficient information to assist in the education and development of deaf children and youth.

Defining and understanding deafness is shaped by the information resources one uses, along with the involvement of the individual with deaf people, issues, culture, and concerns. This is important because of the negative terms and biased descriptors that have been used in the past to label individuals with hearing loss. DiCarlo (1964) and Bender (1981) describe an historical progression of the acceptance of the deaf. DiCarlo (1964) states,

...information about the deaf was transmitted by tradition through literature, reinforced and demonstrated on the basis of anecdotal incidents, and formulated into general principles without factual support...The long, painful, and arduous struggle of the deaf to emancipate themselves from the biases, prejudices, persecutions, inhumanities, and even the maudlin sentimentalities of the hearing populace still continues. Fortunately, it has become somewhat attenuated under the attrition of time's progress (p.8).

Bender (1981) summarized the evolution of the mysticism and erroneous thinking about deafness that was perpetuated throughout the early history of humanity. She describes how the influences of religion, cultural expectations,

educational philosophies, and codes of law impacted upon the lives of the deaf. During the times of early civilization, deaf individuals, in general, were considered mentally defective and unable to assume normal responsibilities (Bender, 1981).

Generally, the formulations of understanding by hearing persons have been shaped by misperception and minimal interaction and communication with deaf people. Tragically there are still people who relate to individuals with hearing loss as "deaf and dumb" or "deaf mutes". While these are archaic terms, some individuals continue to envision that deaf/hard of hearing persons are housed primarily in "asylums", functioning at levels of mental inferiority. These biased connotations categorically impede full access and participation of deaf/hard of hearing individuals in all aspects of society.

A long standing and often quoted definition, established by the Conference of Executives of the American Schools for the Deaf, stated that individuals who are deaf are "those in whom the sense of hearing is nonfunctional for the ordinary purposes of life" (Levine, 1956). This definition seemed to leave out individuals with slight or moderate hearing loss, and who experience difficulty in understanding speech. Liben (1978) used the term deafness to refer to any hearing loss. The application of this terminology seemed to imply the presence of a serious hearing impairment that was unalterable with or without

amplification. These terms were considered imprecise in defining all levels of hearing loss, therefore, for the purposes of this study, the generic term **deaf/hard of hearing** will be used interchangeably with **deafness** to refer to all levels of hearing loss from mild to profound loss (State Mental Health Advisory Council On Deafness, 1990).

Etiology

There are several known causes of deafness: heredity, Rubella, prematurity, Rh incompatibility, and infectious disease. However, in almost half of all cases of deafness, the cause is unknown (Konigsmark, 1972). Konigsmark (1972) notes that there are over 60 types of hereditary hearing loss. Congenital deafness is acquired during the development of the fetus and is not attributable to heredity causes. Under circumstances when the etiology is unknown, deafness has occurred with no explainable cause.

Rubella (German Measles) contracted by a woman early in pregnancy adversely affects the development of the fetus and frequently results in deafness. During the Rubella epidemic in the mid 1960's, hundreds of children were born deaf. The introduction of vaccines dramatically reduced the numbers of children who were affected by this disease (Chess & Fernandez, 1980).

Premature infants are at risk for hearing deficits and other complications resulting from anoxia, the insufficient supply of oxygenated arterial blood supplied by the mother,

and from inadequate physical development (Levine, 1980). An Rh factor complication during pregnancy results in an incompatibility of blood types between the mother and the fetus. This situation induces antigenic reactions which weaken the body's immune system and which reduce its capability to fight off infections and disease. Deafness has resulted from destructive processes which occur during diseases such as meningitis and encephalitis. These diseases, the result of an infection by virus or bacteria, cause an inflammation of the meninges (Mindel & Vernon, 1971; Chess & Fernandez 1980).

The issue of etiology is an important consideration, especially since the recognition of causative factors may facilitate a better understanding of associative behavioral responses. While it is important to understand the cause of deafness, it should be noted that behavioral responses occurring in association with particular etiologies, may not always be manifestations with neurological or genetic implications (Meadow & Trybus, 1979).

The major etiologies (i.e. heredity, maternal rubella, Rh incompatibility and prematurity) are often associated with Central Nervous System (CNS) dysfunction. Frequently these defects predispose individuals to an increased probability for developing emotional and behavioral disturbances (Goulder & Trybus, 1977). Chess and Fernandez (1980) and Hicks (1970) noted higher rates of emotional and behavioral problems in children with rubella as a

contributing factor. Meadow (1980) observed that problem behaviors are more likely to be exhibited in one third to one half of the reported cases of deafness where deafness occurs from an unknown etiology. Data from the 1981-82 Annual Survey of Hearing Impaired Children and Youth (AAD, 1982) on deaf/hard of hearing students showed that 30.6 percent of all deaf children surveyed who were enrolled in public residential schools for the deaf had an additional handicapping condition. Approximately 6 percent of whom were classified as having emotional/behavioral problems. Data from the 1989-90 survey showed 29% of all deaf children reported on from public residential schools had one or more additional handicapping conditions. Of this group 4% were classified as having emotional/behavioral difficulties (Schildroth & Hotto, 1991). It is important to note that although discrepancies in reported percentages of emotional/behavioral difficulties seem to indicate a decline in those problem areas, it could also reflect declining enrollments in public residential schools for deaf students, or an improvement in the diagnostic labeling process.

The degree to which sounds are discriminated as intelligible speech is directly related to the degree those sounds are received and interpreted through the auditory process. Interference in this process, resulting from a physiological malformation or disturbance in the transmission of sound to the brain, affects the individuals' ability to convert sound wave impulses into meaningful

information. If appropriate interpretations of sounds can be perceived, the behavioral response of deaf/hard of hearing persons will be congruent with the intention of the message being transmitted.

In addition to the etiology of deafness, there are varying types and degrees of hearing loss that determine how much of what is aurally transmitted and correctly interpreted. The three types of hearing loss are conductive, sensori-neural, and mixed (Ostby & Thomas, 1984). In a conductive hearing loss hearing impairment is due to damage in the external and/or middle ear. Sensori-neural impairment reflects damage in the inner ear. A mixed impairment involves both sensori-neural and conductive involvement. The loss may affect one ear (unilateral hearing loss) or both ears (bilateral hearing loss).

An audiological examination measures a person's hearing capability. The range of hearing varies: normal - 10-25 decibel (dB); slight - 25-40 dB; mild to moderate - 40-55 dB; moderately severe - 55-70 dB; severe - 70-90 dB; profound - 90 dB plus. Meadow (1980) compares hearing at zero dB as the softest sound discernable; 20 - 30 dB, whispered speech; 60 - 70 dB conversational speech, and sound measuring at 120 dB or greater as being extremely loud.

Decibel loss is indicative of the level of sound which may be aurally interpreted. If an individual has a hearing impairment that affects the range within the dB level of

conversational speech, much of what is said will be non-discernable. The ability to understand, interpret, integrate and respond will be affected. This emphasizes the importance of detecting the impairment early in the development of the individual.

The Auditory Brainstem Response (ABR) is a diagnostic tool used to diagnose hearing loss in infants (Meadow, 1980). It records electrical activity in the brain as it responds to sound. The Crib-o-gram is another method which is used to screen for hearing deficiencies in infants. It is an automated test which involves the use of a motion sensitive transducer to record movements of the neonate.

Measuring hearing loss under the age of three years of age is very difficult to assess given the maturity and developmental level of the child. Testing is usually not routinely done, unless there is a pre-existing condition which would be indicative of a potential for hearing loss in the infant. This introduces a dilemma for parents, since at least ninety percent of children with hearing handicaps are born to hearing parents (Schein & Delk, 1974). The hearing impairment could go undetected for several years before the situation is recognized. Within that timespan, numerous intervening elements could further impede language development and multitudinal facets of the developmental and socialization progress of the child.

Distinctions are made for individuals who become deaf before they acquire language (prelingually deaf), and those

who become deaf after acquiring language and some speech (post-lingually deaf). Knowledge of the onset of deafness provides information about the time frame for language acquisition and the capability to assimilate information. The age of onset of deafness is an important factor in evaluating behavioral responses. It gives an indication of how much time an individual has had to acquire language, to build relationships, to incorporate knowledge about the environment and to be involved in the natural process of socialization that accompanies growth and development.

The age at which deafness is diagnosed impacts the relationship of the child to other members of the family, regarding degree of communication/interaction and acceptance the child within the family unit. General responses to a diagnosis of deafness include denial, anger, grief, over-compensation or over-protection, especially to those parents who are unfamiliar with deafness (Bender, 1981; Heimgartner, 1982; Levine, 1980; Meadow, 1980). S. and her family did not become aware of her deafness until she was almost nine years old. S. reported having a difficult time during those years trying to understand why nobody talked to her, and why they didn't seem to like her. She indicated that this early experience really shook her self confidence, and although her family was very supportive after they discovered she was deaf, it was not enough to erase the years of confusion and hurt she experienced. The struggle to overcome the

ramifications of language deprivation has been a continual process.

Behavioral Interpretations

What constitutes a behavioral problem for deaf/hard of hearing youth? The behavioral aspects of hearing impairment develop within the complex interactions of etiological factors, severity of hearing loss, environment, family support, and age at onset. Identification of behavioral dysfunctioning often depends on the theoretical framework, or professional discipline of the person making the distinction, the etiology, the onset of deafness, the setting, and the "normal" (generally acceptable) functioning of the reference group being evaluated.

One long-standing resource for classifying behavioral problems in the general population, for those professionals who have accepted the medical model for explaining dysfunctional behavior, is The Diagnostic and Statistical Manual of Mental Disorders 3rd Edition Revised (DSM III R), (American Psychiatric Association [APA], 1987). This tool has been used primarily by clinicians to diagnose mental disorders, and has been utilized since 1952.

School psychologists have utilized the DSM III as a tool to categorize the behaviors of students who were experiencing difficulties which interfered in their educational programming, and to justify the necessity to further classify referred students for services offered

through special education programs. The Education for All Handicapped Children Act of 1975, more commonly referred to as Public Law 94-142, set into motion the need to identify children for whom the delivery of services within the regular school setting did not adequately meet their learning needs (Sauer, Layne, Hurley & Opton, 1986; Salem & Fell, 1988). The underlying assumption suggested that mainstream education was the most appropriate educational method and that self-contained specialized programs restricted the growth and development of its participants (DuBow, 1984) as it pertained to social acceptance and integration.

The 1982-1983 Annual Survey of Deaf/hard of hearing Children and Youth conducted by the Center for Assessment and Demographic Studies [CADS] (Wolff & Harkins, 1986) suggests that, conditions in which inappropriate behaviors interfere with normal academic progress and daily functioning constitute a behavioral problem. These behaviors include shyness; aggression; inattention; sudden outbursts; bizarre, unexplainable actions; and chronic, unfounded physical complaints and symptoms. A deaf/hard of hearing child presenting these behaviors to a hearing school psychologist, unfamiliar in assessment procedures for deaf/hard of hearing youth, might observe that these behaviors resemble characteristics in the DSM III-R (APA, 1987) used to diagnose Attention Deficit Disorder; i.e. developmentally inappropriate inattention and impulsivity,

and hyperactivity. Those behaviors might satisfy diagnostic criteria under the category of Conduct Disorder-Undersocialized, which is characterized by failure to establish a normal degree of affection with others, egocentrism, and callous behavior (APA, 1987). Identifying emotional or behavioral problems in deaf children has improved with the revision of the DSM III, however, the process remains subject to diverse interpretation. Some professionals in the field of deafness would insist that situational factors related to hearing impairment and inappropriate contextual conditions foster mislabeling of problematic behavior.

For whom are these behavioral deficit disorder descriptors generally applicable, and under what conditions? Mental health practitioners and counseling professionals have asserted that these descriptors are generally appropriate for children who are consistently exhibiting behaviors outside the realm of societal or environmental boundaries (Coleman, 1986; Rizzo & Zabel, 1988). Some professionals in deafness (Meadow, 1980; Sanders, 1980; Glickman, 1983) have proposed that characteristics which describe behavioral disorders i.e.; impulsivity, aggression, social isolation, irritability, etc., are characteristically observed in deaf/hard of hearing youth. Such an observation suggests that deaf/hard of hearing children need to be evaluated within the context of their environment and

handicapping condition, for a fair assessment of behavioral disorder.

The same psychological, psychosocial, and physiological factors that affect hearing youth, affect deaf/hard of hearing youth (Cohen, 1980), sometimes with differentiated behavioral responses. A plausible explanation may lie in the interactive effect of other factors in relationship to hearing impairment; i.e., age at onset, etiology, severity of hearing loss, lack of family and/or personal support, all of which may contribute to more complex behavioral responses (Bender, 1981; Meadow, 1980; Rodda, 1974; Schildroth, 1980). Bonham, et al, (1981), suggest that inadequate communication affects socialization, acculturation, and psychological health. The degree of severity in hearing loss has been associated with the level of severity of behavioral disorder (Chess, 1975; Rodda, 1974; Schloss, 1982; Schildroth, 1986).

The presence or lack of family and personal support affects the psychological foundation of trust, compassion and positive self-regard; vital components in fostering a sense of well-being for deaf/hard of hearing youth. At least ninety percent of deaf/hard of hearing children are born to hearing parents who typically are unprepared for interacting with a communicatively handicapped child (Schein & Delk, 1974). This handicapping situation makes it very difficult for deaf children to develop to their fullest potential.

Behaviorally disordered deaf/hard of hearing youth present a unique challenge to parents, educators, and others who have responsibility for their care and development. The basis for that challenge can be attributed to a variety of factors. Understanding the etiology of deafness and its impact on the individual can be difficult. Deciphering the complex interaction of deafness with medical and other disorders, often transcends the ability of parents who are grappling to keep their lives together, to find appropriate educational services and other supportive resources.

Counselors can be very supportive to parents during diagnostic evaluations and educational planning for their deaf/hard of hearing child. They could provide information to families and facilitate opportunities for everyone involved to discuss how the handicapping condition of deafness will impact on their lives. Counselors can offer suggestions of other referral resources such as family support groups.

Educational Placement

Historically, those individuals classified as behaviorally disordered deaf/hard of hearing youth have been served within local school districts in self-contained special education classes/programs, residential schools for deaf/hard of hearing youth, or state psychiatric hospitals and mental institutions (Rodda, 1974; Granberry, 1976; and Vernon, 1980).

Placement decisions for educational training, specialized care or psychological treatment of deaf/hard of hearing persons were based on (1) the availability of services within the home community of the child; (2) educational evaluation; and (3) psychological assessment. Placement decisions in earlier times, were sometimes handled by individuals who were unacquainted with hearing impairment, Deaf culture, or the associative effects of accompanying medical or physical disabilities. This very often resulted in inappropriate placements of deaf/hard of hearing individuals in large institutions.

Deaf/hard of hearing persons diagnosed with deviant or difficult to manage behaviors were placed in mental institutions primarily designed to serve those who were mentally retarded, mentally ill or criminally insane (Robinson, 1978). Diagnostic decisions were complicated by difficulties in interpreting abnormal behavioral and communicative responses of deaf/hard of hearing individuals, particularly when the frame of reference was based on the standards of deviant behaviors for hearing individuals. This comparison of "apples to oranges" served to sponsor the inappropriate institutionalization of deaf individuals. Few educators and persons working with deaf/hard of hearing persons possessed the communication skills, or sensitivity to Deaf culture, necessary to make appropriate psychological assessments.

Historically, the development of knowledge and understanding of deaf/hard of hearing individuals has been an arduous process. "Medical knowledge about hearing and speech was scanty and inaccurate and gave little help toward the understanding of the deaf" (Bender, 1981, p.23). Misinformed or uninformed key individuals made institutional commitment during these times relatively easy to accomplish. Unfortunately, the inability of hearing persons to communicate in a mode used effectively with deaf/hard of hearing patients, prevented these deaf/hard of hearing patients from expressing an opposing opinion to their placement.

Robinson (1978) notes that instances of mistaken diagnosis occurred when inappropriate interpretation of symptoms were sometimes considered to be manifestations of psychosis or mental retardation. Ranier and Altshuler (1966) found similar diagnostic discrepancies in a study of deaf patients in hospital treatment facilities. For example, severe language deficiencies could have been diagnosed as the disjointed language pattern of schizophrenia. Low scores on I.Q. tests, which are highly verbal, could have been interpreted as mental retardation. These are the conditions which may have served, although erroneously, to justify institutionalization or psychiatric hospitalization of deaf/hard of hearing individuals.

The treatment response of primary caregivers to deaf/hard of hearing patients within institutional

environments, consisted of little more than basic custodial care. Efforts toward therapeutic intervention with institutionalized deaf/hard of hearing patients were generally unsuccessful due to communication barriers. The majority of treatment facilitators possessed limited sign language skills. Conversely, some deaf/hard of hearing patients were limited to home signs or had not been trained in sign language. This effectively limited progress toward restored mental health for deaf/hard of hearing patients.

The major tool of therapeutic intervention involves verbal interaction between the therapist and the client. Through discussion and interpretation the client is guided toward achieving insight into the development of maladaptive behavior and exploring avenues for change. Communication by counselors, psychologists and therapists, in the language of deaf/hard of hearing clients is a vital component in restoring mental health.

There were indications of progressive reform in the 1920's and the 1930's, but very likely it was the need for the establishment of half-way house programs for rehabilitated deaf/hard of hearing mental health patients in the 1960's that served as initiating effort for addressing the issue of group home living situations for formerly institutionalized deaf/hard of hearing mental health patients (Wilson, 1980).

These facilities differed from large institutions by incorporating into the structure and philosophy of group

home care, support mechanisms that encouraged the development of its residents toward self-actualized functioning. Primary caregivers were fluent in sign language, ancillary service providers were aware of the impact of hearing impairment, participation in the community by group home residents was encouraged, and integration of deaf/hard of hearing citizens into the fabric of society as full citizens was expected.

With the advent of Congressional legislation and the energies of forward thinking professionals and laypersons, the situation of inappropriate placement of deaf/hard of hearing persons is gradually undergoing a facelift. Section 504 of the Rehabilitation Act of 1973, requires expanded services for all people with developmental, physical, learning and other disabilities (Duncan, 1984).

The Americans with Disabilities Act (ADA), PL 101-336 went into effect January 1992 and addresses issues of access for deaf, blind, wheelchair users, and individuals with HIV and AIDS. In general, the ADA requires that individuals with disabilities cannot be discriminated against in employment, access to public services, public accommodations and services operated by private entities, or telecommunications (U.S. Department of Justice, 1991).

The Education of All Handicapped Children Act of 1975 (PL 94-142), supports the provision of education in the "least restrictive environment" (DuBow, 1984; Duncan, 1984). These two legislative initiatives function as catalysts to

support the deinstitutionalization of deaf/hard of hearing persons, and others, and have served to undergird efforts to address the need for more differentiated and appropriate community-based placements.

The decline in residential school enrollments is an issue of critical importance, because it may forecast a need to develop community-based group homes for behaviorally disordered deaf/hard of hearing youth. Those issues which have been discussed are germane to the research problem of developing community-based group homes for behaviorally disordered deaf/hard of hearing youth.

A comparative study of residential group care facilities from 1966-1982 was conducted by Dore, Young and Pappenfort (1984). It reviewed the trends of use which were influenced by legislative and policy changes. The study eliminated facilities for the mentally retarded, physically handicapped and the chronically ill, but included facilities which served children who were dependent or neglected, abused, delinquent, status offenders, emotionally disturbed, mentally ill, abusing drugs or alcohol or pregnant. It could be assumed that behaviorally disordered deaf/hard of hearing residents were placed within those facilities, since the aforementioned are difficulties that this population of individuals experiences as well. However, an accurate account could not be assessed, especially if a deaf/hard of hearing client was given a primary diagnosis based on the categories studied and not deafness.

The problem of establishing a primary diagnosis other than deafness distorts the actual number of behaviorally disordered deaf/hard of hearing children in existing facilities. Furthermore the placement of behaviorally disordered deaf/hard of hearing youth in mainstream settings where hearing impairment is not a primary diagnosis, camouflages the number of youth who might be more appropriately served in other settings. The 1986 study by Schildroth (1988) underscores Dore, et.al.'s (1984) observations of declining enrollments in larger residential setting and a potential for the establishment of community-based residential program facilities within neighborhoods.

Primary Caregivers

Information in the literature about primary caregivers in group homes for deaf youth experiencing difficulties in behavioral control was non-existent. Limited information about caregivers in residential schools for the deaf was provided secondarily, to discussions of responsibilities of teachers, audiologists, social workers and other professionals involved with deaf children and youth. More extensive observations were documented on individuals employed in a variety of other types of institutions which focused on other treatment populations.

Although caregiver responsibilities varied, there were enough similarities along task lines to warrant the following discussion, which utilizes existent information

about the functions of caregivers in a variety of residential settings. This information will establish a general framework for developing an understanding of the functions and responsibilities of caregivers in group homes for behaviorally disordered deaf/hard of hearing youth.

Those persons primarily responsible for the daily living needs of deaf/ hard of hearing children in residential schools are generally referred to as house parents, dorm counselors, dorm mothers, or cottage parents. For consistency, the general title of primary caregiver will be assigned to all categories of individuals who attend to the basic life survival needs of residents, are responsible for functioning in the capacity of surrogate parent, and who are responsible for supervising pre-school and after-school activities of residents.

Residential school living arrangements simulate the traditional family unit on a much larger scale. In families where members are usually related, parents or guardians are the authorities on how family members will function to carry out the best interests of the family. Depending on developmental stages, the children are assigned appropriate tasks for personal care and for contribution to the family. Household chore priorities are established and influenced by factors that include societal expectations, religion and personal philosophies.

At the residential level, parental figures are usually non-related quasi live-in employees of the residential

school, specifically assigned to make sure that each resident has a neat, clean place to live; is monitored in personal cleanliness; is allowed to continue the practice of their particular faith/religion; and has the opportunity for leisure time activities and receives formal education.

Chores are assigned along the same lines as might be expected at the residents' home; i.e., cleaning one's room, emptying the trash, clearing the dishes from the dining room table, gathering clothes to be laundered, etc.

The roles of primary caregivers to deaf/hard of hearing children have been shaped by a variety of factors over time. They are presently being encouraged to interface with other primary caregivers and professionals, who have responsibilities for various developmental aspects of a deaf/hard of hearing youth's life. The primary caregiver at this junction in time is expected to draw corollaries between the etiology deafness and appropriate levels of functioning. Along with increased role expectations of caregivers, there is an increase in the required level of academic preparation and general knowledge in those areas that impact more significantly on the daily lives of deaf/hard of hearing youth.

Unfortunately, for many primary caregivers, the development of caregiving skills has come as a result of learning by doing. Initially, many hearing primary caregivers did not possess adequate signing skills. However, through involvement with deaf/hard of hearing

residential children, they were provided numerous opportunities to increase communication skills; to understand more about the etiology of deafness and additional handicapping conditions; to increase awareness of the effect of the impact of deafness on the deaf child and the family.

Structured educational training programs which are designed to certify primary caregivers in the skills they will be required to utilize with deaf/hard of hearing youth are not readily available. A large portion of performance in job tasks has been extrapolated from a "common sense" repertoire, or transfer of skills and information incorporated from personal life experiences.

Primary caregivers have managed the care of children with little emphasis on identifying the immediate and future rationale for doing so. The concept of structuring development toward the acquisition of independent living skills was clouded by a prevailing attitude that deaf/hard of hearing children would not be able to successfully survive as adults unless they remained under the care of parents and family or were placed in an sheltered environment.

The caregiving function has made tremendous advances theoretically and operationally in the last generation. It is a professionally recognized and powerful way of serving children and others. Caregiving is now seen as comprising nurturant, developmental, preventive, interventive and

therapeutic modalities. It embraces children and families in a variety of settings, and is emerging into a more comprehensive human resource profession that serves persons throughout the life cycle.

Preventive, pro-active activities are now provided by child care practitioners in such ways as educating parents, teaching children problem solving skills, and targeting play activities towards the development of specific social and cognitive competencies. Practitioner roles now include the indirect or contextual functions necessary to deliver service in a systems and ecological context: supervision, administration, training and education, consultation, writing, research and advocacy (VanderVen & Tittnick, 1986). This acquisition of new responsibilities carries with it the indirect effect of increased status and greater respect for the significant role that caregiver professionals perform in the lives of deaf/hard of hearing youth.

Summary

Behaviorally disordered deaf/hard of hearing youth face a myriad of difficulties coping with complex interactions involving their personal response and experiences with deafness, and their external relationship with their life environment. Educators and other professionals utilize numerous informational resources to make decisions about education, and comprehensive life development needs of deaf/hard of hearing youth. Job skills, tasks, activities

and knowledge areas of primary caregivers require that specific attention is paid to interrelationships between medical, etiological, psychological, societal, familial, cultural, and environmental dimensions of deaf/hard of hearing youth.

Professional effectiveness and regard by the deaf community is enhanced when human resource and educational professionals have sign language skills, are willing to support or participate in activities involving the deaf community, and are committed to empowering deaf persons to make informed decisions about what happens in their lives.

According to Vygotsky (1987), shared information from more knowledgeable others, in this case counselors, primary caregivers and other professionals, allows deaf persons an opportunity to manage themselves within the social structure of their environment, while fostering self-reliance and self-confidence.

Legislative initiatives, such as P.L. 94-142, have functioned as catalysts to support efforts to address the need for differentiated and appropriate educational placements and resources. Deinstitutionalization, tempered by P.L. 94-142 and the mandate to educate children within the least restrictive learning environment, has affected educational placement decisions for deaf youth with behavioral-sensory deficits. Former students of state supported schools for deaf children are increasingly being served within community school districts. While these

placements may be perceived as least restrictive educational environments, it could be argued that the environments of residential school programs provided more support for the overall growth and development of deaf youth. Nevertheless, decreased enrollments in residential programs could likely produce concomitant reductions in primary caregiver staff. The need for alternative employment considerations for potentially displaced primary caregivers could present itself. These professionals are equipped with an array of caregiving skills, which could conceivably be used in positions in community-based residential care facilities for deaf/hard of hearing children and youth.

CHAPTER III

RESEARCH DESIGN AND PROCEDURES

Introduction

The research method by which this study was implemented will be discussed in this section. A description of the sample will be presented, along with the process of data collection, and a description of the statistical tests which were utilized.

The exploratory type research design served as the basic framework for the study using individual primary caregivers as the units of analysis. A three-part Group Home Primary Caregiver Questionnaire was designed to elicit quantitative and qualitative data from primary caregivers. A Superintendent/Director Questionnaire was designed to gather descriptive information about participating residential schools.

Population and Sample

The subjects of the study were deaf/hard of hearing and hearing primary caregivers employed in residential school facilities across the United States. Residential schools were drawn from the listing of schools and classes for deaf children which was compiled by the Center for Assessment and

Demographic Studies (CADS) for the Annual Survey of Deaf/Hard of Hearing Children and Youth and reported by Schildroth (1988) in the American Annals of the Deaf. An exact number of primary caregivers was not reported in the demographic data (Schildroth, 1988). The listing included the number of educational staff within residential facilities, but did not specifically enumerate primary caregivers. It should be noted that a break-out of the number of primary caregivers was not a response item which was reported in the listing compiled for the survey.

Primary caregivers are identified as individuals who work in residential components which substitute partially or totally for an individual's home environment, providing congregate care to deaf/hard of hearing youth on a 24-hour basis. The settings for primary caregivers in this study were public residential school programs for deaf/hard of hearing children and adolescents under the age of 26. In general, residential school facilities for deaf children are public and private, have educational programming from infancy to grade twelve equivalent, and serve multiply handicapped deaf/hard of hearing youth.

Instrumentation

A questionnaire was designed to elicit responses from primary caregivers about their perceptions of Importance and co-worker Competency levels of job skills, tasks, activities and knowledge areas.

The first part of the Group Home Primary Caregiver Questionnaire required respondents to rate their levels of perception, by degree of importance, of specific job skills, tasks, activities, and knowledge areas. These ratings were based on primary caregiver insight of the projected need for job skills which should ideally be held, by primary caregivers positioned in community-based group homes for deaf/hard of hearing youth with behavioral deficits.

The first section of the instrument was also a measure of current levels of perceived peer competency in job skills, tasks, activities and knowledge areas. The objective was to obtain information which could be utilized, to determine job performance areas where additional training and education might be recommended, to prepare individuals to assume roles in community-based group homes.

The second area of the questionnaire provided respondents with an opportunity to supply individual demographic information about themselves. Demographic characteristics were compared to specific job skills, tasks, activities and knowledge areas to determine whether a statistically significant relationship exists.

The third area of the questionnaire was designed to elicit suggestions for shaping the structure of the model group home. Responses in this area provided information which added depth to the study.

A Superintendent/Director Questionnaire was designed to gather descriptive information about participating

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residential schools. Questionnaires were mailed to superintendents of residential schools invited to participate in the research study. Descriptive data obtained and summarized from this survey, provides the reader with a general picture of residential schools which were the job sites of caregivers participating in the research. Superintendent/Director responses provided general information about the year the residential school was established, number of employees, number of primary caregivers and total number of students. They were also requested to report on the types of additional disabilities, ethnic composition of the student body and average length of stay.

A review of the literature revealed several major skill areas which were presumed important for the effective functioning of primary caregivers (Small & Dodge, 1988). This research study investigated the perceptions of primary caregivers in residential schools for deaf/hard of hearing youth, utilizing general findings of an extensive literature review by Small & Dodge (1988) which identified major job skills areas for primary caregivers.

Composite job skills categories for this research study were assigned labels which provided clues to the nature of job tasks contained within the category. A brief explanation of each category composition follows.

The specific tasks within the job skills category of SUPPORT are therapeutically based, in that, the goals of the primary caregivers' activities are designed to incorporate therapeutic dialogue within the course of establishing supportive relationships to affect change in the behavioral response of deaf/hard of hearing youth. Behavior modification techniques may be utilized, however facilitating behavioral change is not confined to strict behaviorist methods. In order to effectively perform the job functions within this category, caregivers should have knowledge of behavior management that covers a broad spectrum of theoretical perspectives and application methods. The purpose of supportive therapeutic intervention advances deaf/hard of hearing youth toward self-sufficiency and the acquisition of age-appropriate self regulating behaviors. The primary caregiver is encouraged to perform these tasks from a social constructivist perspective in an effort to direct the youth toward a level of self-acceptance that is more comprehensive. These particular job functions are critical to the youths' overall development.

The primary directives of the tasks within EDUCATION involve teaching skills for daily living and establishing procedures for the acquisition of new information. The caregiver is responsible for guiding the formal and informal information gathering process. Assisting with homework is one example of a formal educational activity. Interpreting colloquialisms and introducing new words and concepts,

broadens the depth and richness of understanding for deaf/hard of hearing youth and is easily accomplished through informal interactions. The energies and goals of primary caregivers are focused toward stimulating youth to acquire information about the world around them which will support personal independence in daily living and decision making.

PRIMARY CARE activities are centered around the basic care of individuals within the structured environment of the residential facility. For example, primary caregivers plan and participate in recreational activities with deaf/hard of hearing youth. They also monitor health needs, and intervene should conflicts occur between residents. Job tasks within this category are also directed toward the upkeep of the living quarters, selection and purchase of general supplies and services, and basic routine maintenance of the total residence facility. Residents are supervised in the completion of daily personal chores and they are encouraged to develop personal hygiene routines.

The primary caregivers' role in MANAGEMENT is essential to the establishment and continuation of appropriate goals for each individual resident. The caregiver is actively involved in consultations with individuals involved in the youths' educational, social, familial, psychological, and total life development. Record keeping is a vital activity to MANAGEMENT, because it provides documentation of a residents' progress and chronicles participation by primary

caregivers. Activities within this composite job skills group focuses the caregivers' attention to those tasks that shape and support the organizational structure of the group home, including budget/accounting; staffing; intake/referral procedures; scheduling; coordination of resident activities; and other duties which contribute to the maintenance of the group home to the progress of deaf/hard of hearing youth in residential care.

Preparation in the GENERAL KNOWLEDGE area requires that primary caregivers are equipped with a formal background of information in deafness, communication modes, behavior disorders and other areas which contribute to their effectiveness with deaf children. Acquisition of this level of information is also attainable by regular association with members of the deaf community. This association confirms the earnestness of professionals who are working with deaf/hard of hearing youth who will eventually live and work within the structure of the deaf community.

PROFESSIONAL DEVELOPMENT activities encourage primary caregivers to communicate with each other by participating in information exchange forums, i.e., conferences, seminars, workshops, in-service training, etc. Further, the acknowledgment of primary caregivers as professionals may require standardized credentialing measures, and a feasibility study to evaluate the implementation of a certification process.

In order to establish questionnaire validity, a draft of the instrument was critiqued by doctoral students and colleagues at Michigan State University. The questionnaires were critiqued for clarity and appropriateness of questions.

The Cronbach's Alpha reliability coefficient was used to estimate the internal consistency measure of the reliability of the questionnaire regarding the Importance and Competence levels of primary caregivers. The following alpha levels were obtained:

Importance of six composite job skills categories (36 items).....	0.89
Importance of SUPPORT (6 items).....	0.58
Importance of EDUCATION (6 items).....	0.72
Importance of PRIMARY CARE (6 items).....	0.78
Importance of MANAGEMENT (6 items).....	0.76
Importance of GENERAL KNOWLEDGE (6 items).....	0.77
Importance of PROFESSIONAL DEVELOPMENT (6 items).....	0.86
Competence of six composite job skills categories (36 items).....	0.91
Competence of SUPPORT (6 items).....	0.77
Competence of EDUCATION (6 items).....	0.78
Competence of PRIMARY CARE (6 items).....	0.76
Competence of MANAGEMENT (6 items).....	0.80
Competence of GENERAL KNOWLEDGE (6 items).....	0.84
Competence of PROFESSIONAL DEVELOPMENT (6 items).....	0.79

With an overall alpha of 0.89 for Importance of all six job skills categories, and 0.91 for the Competence level of the same job skill categories, the instrument was quite reliable.

To enhance the credibility of the study, a cover letter accompanied each questionnaire to explain the purpose of the study. The letter was generated and signed by Ms. Gail Faulkner, State Consultant for Deaf Services and Program Development for the State of Michigan.

Data Collection

Introductory letters were sent to residential facility superintendents, explaining the purpose of the study, and its importance to behaviorally disordered deaf/hard of hearing youth in mainstream educational programs, who might be able to benefit from therapeutic support and intervention in community-based residential care. Invitations to participate in the research study were sent to superintendents of 85 public residential schools across the United States (see Appendix A.). Superintendents were requested to make questionnaires available for the voluntary participation of deaf/hard of hearing and hearing primary caregivers in the study. Packets of information containing self-administrated Group Home Primary Caregiver Questionnaire (See Appendix E.) survey instruments were sent to superintendents, and directed to be made available to deaf/hard of hearing and hearing primary caregivers who would anonymously volunteer to participate. The questionnaires were completed and returned by individual respondents in pre-addressed, stamped envelopes. The

questionnaires were then coded for data entry and statistical analysis.

Follow-up requests were made by letter for the first return request and by post card for second and third requests. The identification of respondents was unknown to the researcher. Follow-up requests and additional questionnaires were forwarded to superintendents when cross checks revealed that surveys had not been returned according to Zip Code postmarks.

Research Questions

Research activities centered around the following research questions:

1. Is there a statistically significant difference in perceived level of importance among the six composite job skills categories?

2. What are the most important specific job skills, tasks, activities, and knowledge areas perceived to be needed by primary caregivers who would work with behaviorally disordered deaf/hard of hearing youth in community based group homes?

3. Is there a statistically significant difference in primary caregivers' perceptions of the level of competency of co-workers among the six composite job skills categories?

4. What are the perceived competency levels in specific job skills, tasks, activities and knowledge areas of co-workers?

5. Is there a statistically significant difference in the perception of importance of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

6. Is there a statistically significant difference in the perception of competence of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

7. Is there a statistically significant relationship between perception of importance of job skills and the respondents' demographic characteristics?

8. Is there a statistically significant relationship between perception of co-worker competence in composite job skills categories and the respondents' demographic characteristics?

9. Is there a statistically significant difference between the level of importance and the competency level of primary caregivers across composite job skills categories?

Data Analysis

The response total of 36 job skill needs, activities and knowledge areas on the questionnaire represents six (6) composite job skills categories: SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, GENERAL KNOWLEDGE, and PROFESSIONAL DEVELOPMENT. Within each major category there were six specific job task items which related to the category heading. Means and standard deviations were computed and individual job skills characteristics and composite job skills categories were ranked according to the magnitude of

the means. Mean importance and competence ratings will range from the lowest, 1.00, to the highest, 4.00. For example, on the Importance scale, a mean close to 4.00 would indicate that the characteristic is perceived to be Very Important, whereas a mean close to 1.00 would indicate that the characteristic is perceived as Not Important. The same range applies to the Competency scale where a mean close to 4.00 would indicate that the observed competency level of others is perceived as Very Competent and a mean close to 1.00 would indicate that the performance of peers was perceived as Not Competent.

In order to be consistent with the ordinal scale of measurement used in the survey instrument, the perceived mean importance and competence ratings in the study were interpreted as follows:

MEAN	<u>Importance</u>	<u>Competence</u>
1.00 - 1.49	Not Important	Not Competent
1.50 - 2.49	Somewhat Important	Somewhat Competent
2.50 - 3.49	Important	Competent
3.50 - 4.00	Very Important	Very Competent

In addition to the descriptive statistics, Analysis of Variance (ANOVA) was used to determine whether significant differences exist in the perceptions of Primary Caregivers on the level of Competence and Importance among the six composite job skills categories.

Multivariate Analysis of Variance (MANOVA) was also used to examine the significance of the differences between hearing and deaf/hard of hearing respondents' perceptions of Importance and Competence of the six composite job skills categories.

A paired t-test was used to determine whether or not statistically significant differences exist between perceptions of the level of Importance and level of Competence in: SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, GENERAL KNOWLEDGE, and PROFESSIONAL DEVELOPMENT.

Summary

Chapter III presented the research design and the methodology of the study. The sample, survey instrument, and data collection were described, together with a presentation of questionnaire reliability estimates. An overview of the method of data analysis were presented. Detailed data analysis and the study findings are presented in Chapter IV of the dissertation.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The data presented in this chapter were collected from June 1989 to September 1990 through a survey of primary caregivers of deaf/hard of hearing students in residential schools across the United States. One hundred and eight primary caregivers employed in 44 schools across 35 states, including Hawaii, accepted the invitation to participate in the survey.

Thirty five superintendents out of 85 public residential schools responded to a Questionnaire for Directors and Superintendents (See Appendix F.). These questionnaires provided descriptive data about their respective schools. More than half of the 35 residential schools on which information was provided, were founded in the 1800's. Of approximately 6,045 staff employees, nearly 37% were staffed in primary caregiver positions. These residential school components housed approximately 4,045 out of a total reported student enrollment of 5,939. 40% of the total number of students in attendance at the residential schools were identified with additional handicapping conditions. Approximate percentages by impairment are given in Table 4.1.

Table 4.1 Approximate percentages of student disability by handicapping condition

CONDITION	PERCENTAGE
physical handicap	15
mental retardation	11
behavior disorder	7
visual impairment	5
cerebral palsy	2
other conditions	2

The ethnic breakdown of students was 22% African American/Black; 4% Latino/Hispanic; 2% North American Indian and 1% Asian/Pacific Islander. White students comprised 57% of the reported student enrollment. Students were generally enrolled in residential school programs from 2 to 15 years.

The purpose of the research study was to investigate the perceptions of respondents providing direct care to deaf/hard of hearing children in residential schools. The first survey area required respondents to indicate how Important they perceived job skills, tasks, activities and knowledge areas would be to their roles if they worked in a community-based group home for behaviorally disordered deaf/hard of hearing youth. Respondents were asked to rate their perceptions of the level of importance according to the following ordinal Likert-type scale:

- 4 - Very Important (VI)
- 3 - Important (I)
- 2 - Somewhat Important (SI)
- 1 - Not Important (NI)

The second area solicited a response on the perception of competency of the average co-worker in the respondents' current residential facility. The perceived competency levels of peers was rated according to the following ordinal Likert-type scale:

- 4 - Very Competent (VC)
- 3 - Competent (C)
- 2 - Somewhat Competent (SC)
- 1 - Not Competent (NC)

In addition to perceptions of Importance and Competence, demographic data on primary caregivers were collected and assessed for statistical significance to perceptions of importance and competence of job skills, tasks, activities and knowledge areas.

Demographic information included:

- Gender
- Salary
- Ethnicity
- Age Range
- Hearing Status
- Marital status
- Direct Care Hours
- Level of Education
- Specialized Training
- Years in the Field
- Method of Communication
- Career Continuance Plans
- Primary Job Responsibility

Additional qualitative information was gathered from primary caregivers which provided a basis for recommendations for the development of an ideal model community-based group home for behaviorally disordered deaf/hard of hearing youth. Research findings in relation

to the nine research questions are presented in the remaining part of this chapter.

Presentation and Analysis of Quantitative Data

Research Question 1: Is there a statistically significant difference in perceived level of Importance among the six composite job skills categories?

Scores for composite job skills categories were computed by averaging the mean Importance levels attached by the respondents to specific job skills within each of the six composite job skills categories. An analysis of variance was used to determine whether or not statistically significant differences exist in the Importance levels of composite job skills categories as perceived by primary caregivers. Respondents perceived all composite categories Important to projected job functions of caregivers in community-based group homes. Results are presented in Table 4.2.

Table 4.2 One-way analysis of variance (ANOVA) results for differences in perceived levels of Importance of composite job skills categories.

Category	Mean	S.D.	Rank
SUPPORT	3.60	.32	1
EDUCATION	3.54	.35	2
MANAGEMENT	3.50	.39	3
GENERAL KNOWLEDGE	3.49	.44	4
PRIMARY CARE	3.40	.44	5
PROFESSIONAL DEVELOPMENT	3.08	.62	6

F-Value = 45.44, p-value = 0.0001*

*significance at 0.05 level

From Table 4.2 it is shown that statistically significant differences in mean Importance ratings of composite job skills categories was observed at $p = .0001$ level. Job skills categories were grouped together where results of ratings on perceived Importance of composite job skills categories were observed to be similar, according to the interpretation of the mean Importance rating outlined in Chapter III. For instance, **SUPPORT** (mean = 3.60, rank = 1), **EDUCATION** (mean = 3.54, rank = 2) and **MANAGEMENT** (mean = 3.50, rank = 3), were composite job skills categories perceived to be Very Important, whereas, **GENERAL KNOWLEDGE** (mean = 3.49, rank = 4) and **PRIMARY CARE** (mean = 3.40, rank = 5) were perceived to be Important and were considered an intermediate group. **PROFESSIONAL DEVELOPMENT** achieved the lowest mean on Importance (mean = 3.08, rank = 6), although it was still considered Important.

Research Question 2: What are the most Important specific job tasks, activities, and knowledge areas perceived to be needed by primary caregivers who would work with behaviorally disordered deaf/hard of hearing youth in community based group homes?

Respondents were asked to rate their perceptions of the Importance of specific tasks, activities, and knowledge areas projected for primary caregivers, who would be employed in community-based group homes which serve behaviorally disordered deaf/hard of hearing youth. Table 4.3 presents response percentages, means, standard deviations, and rank of responses for each specific job

characteristic within the category (See Appendix E for more complete descriptions).

According to the mean rating scale which was presented in Chapter III, Very Important skills were identified as those which achieved a mean of at least 3.50. Using these criteria, specific characteristics for each composite job skills category which are Very Important will be identified.

In the category of **SUPPORT**, all items, with the exception of conducting therapy (mean = 3.15, rank = 6), were observed to be Very Important. **Helping the child to manage their own behavior; controlling aggression** (mean = 3.90, rank = 1), achieved the highest Importance mean rating of all 36 specific job skills, tasks, activities and knowledge areas.

Three items were noted in the category of **EDUCATION** where the percentage of responses was in the Very Important range: **providing learning opportunities; responsibility and decision making** (mean = 3.75, rank = 1); **teaching the child basic daily living skills** (mean = 3.73, rank = 2); and **teaching social skills** (mean = 3.60, rank = 3).

In the composite job skills category of **PRIMARY CARE** only one specific item was considered Very Important; **disciplining children** (mean = 3.57, rank 1).

The specific job skills items which were found in the category of **MANAGEMENT** were **communicating with parents, school teachers, psychologists, social workers, and others involved with child** (mean = 3.80, rank = 1); **keeping**

informed of child's progress or difficulties (mean = 3.64, rank = 2), and **communicating with group home staff** (mean = 3.59, rank = 3).

Within the job skills category of **GENERAL KNOWLEDGE**, **being able to communicate utilizing (ASL) American Sign Language** (mean = 3.77, rank = 1), **knowledge about behavior disorders in deaf children** (mean = 3.66, rank = 2), **knowledge about deaf child and adolescent development** (mean = 3.58, rank = 3), and **knowledge about deaf people, their culture and community** (mean = 3.54, rank = 4) were perceived as Very Important.

None of the specific job skills, tasks, activities and knowledge areas in **PROFESSIONAL DEVELOPMENT** were perceived to be Very Important. However, all items were considered Important.

Table 4.3 Percentages and means for Importance levels of specific job tasks, activities, and knowledge areas as perceived by primary caregivers.

CATEGORY ITEMS	RESPONSE PERCENTAGES				MEAN	SD	RANK
	VI	I	SI	NI			
SUPPORT							
manage behavior	89.8	10.2	0.0	0.0	3.90	.30	1
positive emotional climate	76.9	22.2	0.9	0.0	3.76	.45	2
coping w/anxiety	63.0	34.3	2.8	0.0	3.60	.55	3
maintain behavior at home	63.0	33.3	2.0	0.9	3.58	.60	4
problem solving	62.0	34.3	2.8	0.9	3.57	.60	5
conducting therapy	38.9	40.7	14.8	4.6	3.15	.85	6
EDUCATION							
promote learning oppor.	75.9	23.1	0.9	0.0	3.75	.46	1
basic living skills	75.0	23.1	1.9	0.0	3.73	.49	2
teach social skills	61.1	38.0	0.9	0.0	3.60	.51	3
drug and alcohol info.	57.4	35.2	6.5	0.9	3.49	.66	4
stimulate to seek knowledge	51.9	39.8	8.3	0.0	3.44	.65	5
assist w/homework	36.1	53.7	10.2	0.0	3.26	.63	6
PRIMARY CARE							
disciplining child	58.3	39.8	1.9	0.0	3.57	.53	1
monitor health needs	57.4	33.3	9.3	0.0	3.48	.66	2
first-aid skills	47.2	47.2	4.6	0.9	3.41	.63	3
recreation activity	42.6	51.9	5.6	0.0	3.37	.59	4
supervise daily routines	46.3	43.5	10.2	0.0	3.36	.66	5
maintenance	37.0	48.1	13.9	0.9	3.21	.71	6
MANAGEMENT							
comm. w/ professionals	80.6	18.5	0.9	0.0	3.80	.43	1
info child progress	64.8	34.3	0.9	0.0	3.64	.50	2
comm. w/home staff	63.9	31.5	1.9	1.9	3.59	.63	3
planning goals	50.9	42.6	6.5	0.0	3.44	.62	4
record keeping	39.8	46.3	13.9	0.0	3.26	.69	5
planning activities	36.1	51.9	10.2	0.9	3.24	.67	6
GENERAL KNOWLEDGE							
communication	81.5	13.0	3.7	0.9	3.77	.56	1
behavior disorders	70.4	25.9	2.8	0.9	3.66	.58	2
child development	60.2	36.1	2.8	0.0	3.58	.55	3
deaf culture	63.9	27.8	6.5	1.9	3.54	.70	4
etiology	46.3	38.9	12.0	2.8	3.29	.79	5
legislation	37.0	46.3	13.9	1.9	3.20	.75	6
PROFESSIONAL DEVELOPMENT							
professional development	38.9	51.9	8.3	0.9	3.29	.66	1
personnel practices	37.0	46.3	5.6	6.5	3.19	.83	2
certification	40.7	38.9	11.1	6.5	3.17	.88	3
supervise trainees	37.0	38.0	14.8	8.3	3.06	.93	4
current issues	31.5	41.7	24.1	1.9	3.04	.80	5
comm. w/caregivers	21.3	43.5	27.8	6.6	2.80	.85	6

VI: Very Important I: Important SI: Somewhat Important
 NI: Not Important

Research Question 3: Is there a statistically significant difference in primary caregivers' perceptions of the level of Competency of co-workers among the six composite job skills categories?

Scores for composite job skills categories were computed by averaging the mean Competence levels attached by the respondents to specific job skills within each of the six composite job skills categories. Analysis of Variance (ANOVA) was used to determine if statistically significant differences exist in the perception of co-workers' competency levels among job skills categories. Table 4.4 shows the results of the analysis of variance.

Table 4.4 One-way Analysis of Variance (ANOVA) results for the differences in perceived level of Competence in composite job skills categories.

CATEGORY	MEAN	SD	Rank
PRIMARY CARE	3.03	.49	1
MANAGEMENT	2.83	.56	2
EDUCATION	2.79	.52	3
SUPPORT	2.42	.51	4
GENERAL KNOWLEDGE	2.39	.62	5
PROFESSIONAL DEVELOPMENT	2.36	.58	6

F-Value = 73.58, p-Value = 0.0001*

*significance at 0.05 level

The results indicate that respondents do not perceive any of the six composite job skills, tasks, activities and knowledge areas where co-workers are perceived to be Very Competent. Respondents perceived **PRIMARY CARE** (mean = 3.03, rank = 1); **MANAGEMENT** (mean = 2.83, rank = 2); and **EDUCATION** (mean = 2.79, rank = 3) to be composite job skills

categories where co-workers are Competent in the performance of these job functions.

Primary caregiver responses, according to mean ratings for Competence, positioned the three remaining categories at levels that were only Somewhat Competent: **SUPPORT** (mean = 2.42, rank = 4); **GENERAL KNOWLEDGE** (mean = 2.39, rank = 5); and **PROFESSIONAL DEVELOPMENT** (mean = 2.36, rank = 6).

Research Question 4: What are the perceived Competency levels in specific job skills, tasks, activities and knowledge areas of co-workers?

Respondents were asked to rate their perceptions of the current level of Competency of co-workers in specific tasks, activities and knowledge areas. For the purpose of this study, the skills were identified on Competency levels according to a mean rating scale presented in Chapter III. Co-workers were not perceived as Very Competent on any specific job skills characteristic.

Primary Caregivers generally perceived co-workers' job performance between Competent and Somewhat Competent on all 36 specific job skills characteristics, with the exception of a characteristic under **SUPPORT: conducting group/individual therapy** (mean = 1.87, rank = 6). This mean rating indicated that co-workers' job performance in that activity was perceived as Not Competent.

Primary Caregivers rated all specific job skills, tasks, activities and knowledge characteristics within the composite categories of **PRIMARY CARE** and **MANAGEMENT**, as

areas where job performance was perceived to be Competent.

In EDUCATION, all characteristics were perceived as job skills where Primary Caregivers were Competent, with the exception of **stimulating child to seek knowledge** (mean = 2.46, rank = 6), which was rated Somewhat Competent. By contrast, all characteristics in PROFESSIONAL DEVELOPMENT were perceived as job skill areas where Primary Caregivers were performing at Somewhat Competent levels. The exception; **participating in seminars, workshops and other professional development activities** (mean = 2.51, rank = 1), achieved a Competent mean rating.

Competent mean ratings were achieved for **creating positive emotional climate for child** (mean = 2.85, rank = 1), and **helping child manage own behavior; controlling aggression** (mean = 2.70, rank = 2). These specific job skills characteristics are found in the composite category of SUPPORT.

The remaining specific characteristics in which job skills were perceived at Competent levels are found in GENERAL KNOWLEDGE: **being able to communicate using ASL (American Sign Language)** (mean = 2.72, rank = 1), and **knowing about deaf people, their culture and community** (mean = 2.53, rank = 2).

Table 4.5 presents the response percentages, mean, standard deviations, and rank for each job skill item (See Appendix E for complete wording of each item).

Table 4.5 Percentages and means for Competency levels of co-workers across specific job skills, tasks, activities and knowledge areas as perceived by primary caregivers.

CATEGORY	ITEMS	PERCENTAGE OF RESPONSES				MEAN	SD	RANK
		VC	C	SC	NC			
SUPPORT								
	positive emotional climate	14.0	57.4	23.1	2.8	2.85	.69	1
	manage behavior	12.0	46.3	37.0	1.9	2.70	.71	2
	coping w/anxiety	5.6	38.0	49.1	4.6	2.46	.68	3
	problem solving	5.6	41.7	38.9	11.1	2.43	.77	4
	maintaining behavior	3.7	29.6	47.2	15.7	2.22	.76	5
	conducting therapy	3.7	16.7	39.8	37.0	1.87	.83	6
EDUCATION								
	daily living skills	34.3	51.9	9.3	0.9	3.24	.66	1
	assist w/homework	19.4	54.6	18.5	4.6	2.91	.76	2
	teach social skills	19.4	47.2	29.6	0.9	2.88	.73	3
	promote learning oppor.	12.0	50.9	29.6	4.6	2.72	.74	4
	drug and alcohol info.	13.0	34.3	38.9	10.2	2.52	.86	5
	stimulate to seek knowledge	9.3	32.4	49.1	6.5	2.46	.76	6
PRIMARY CARE								
	supervise daily routine	30.6	58.3	8.3	0.0	3.23	.59	1
	maintenance	32.4	52.8	9.3	2.8	3.18	.72	2
	recreation activity	29.6	51.9	13.9	1.9	3.12	.72	3
	monitor health needs	33.3	40.7	20.4	2.8	3.08	.82	4
	disciplining children	12.0	60.2	20.4	4.6	2.82	.70	5
	first-aid skills	15.7	47.2	25.0	7.4	2.75	.83	6
MANAGEMENT								
	informed child's progress	21.3	51.9	20.4	3.7	2.93	.76	1
	comm. w/grp. home staff	22.2	48.1	20.4	4.6	2.92	.80	2
	comm. w/professionals	22.2	45.4	27.8	1.9	2.91	.77	3
	planning activities	21.3	45.4	24.1	4.6	2.87	.81	4
	record keeping	16.7	46.3	31.5	2.8	2.79	.76	5
	planning goals	11.1	39.8	38.9	7.4	2.56	.80	6
GENERAL KNOWLEDGE								
	communication	18.5	43.5	21.3	12.0	2.72	.92	1
	deaf culture	12.0	37.0	38.9	9.3	2.53	.83	2
	child development	7.4	34.3	48.1	7.4	2.43	.75	3
	behavior disorders	8.3	25.0	47.2	16.7	2.26	.84	4
	etiology	5.6	30.6	43.5	17.6	2.25	.82	5
	legislation	3.7	28.7	46.3	18.5	2.18	.78	6
PROFESSIONAL DEVELOPMENT								
	professional develop.	7.4	41.7	41.7	6.5	2.51	.74	1
	certification	8.3	40.7	29.6	13.9	2.47	.86	2
	personnel practices	7.4	38.0	31.5	13.0	2.44	.84	3
	supervise trainees	5.6	36.1	31.5	17.6	2.33	.86	4
	comm. w/caregivers	6.5	22.2	44.4	16.7	2.21	.83	5
	current issues	2.8	28.7	50.0	13.9	2.21	.72	6

VI: Very Competent I: Competent SI: Somewhat Competent
 NI: Not Competent

Research Question 5: Is there a statistically significant difference in the perception of Importance of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

Multivariate Analysis of Variance (MANOVA) and Univariate Analysis of Variance (ANOVA) were used to examine differences between hearing and deaf/hard of hearing respondents' perceptions of Importance on composite job skills categories. Table 4.6 shows the results of the Multivariate Analysis of Variance for perceptions of Importance of composite job skills categories.

No statistically significant differences were found at the .05 level. Non-significant multivariate F-tests across the six job skills categories indicate no difference in overall perceptions of Importance between hearing and deaf/hard of hearing caregivers in composite job skill categories.

Univariate F-tests were conducted on skills within each of the six composite job skills categories. Statistically significant differences were also not found at the .05 level.

Table 4.6 Multivariate and univariate Analysis of Variance results for the differences in perception of Importance of composite job skills categories between hearing and deaf/hard of hearing respondents.

Multivariate Results:					
	Test Name	Value	Exact F	p-Value	
	Pillais	.05045	.832	.548	
	Hotellings	.05314	.832	.548	
	Wilks	.94955	.832	.548	
	Roys	.05045			
Univariate Results:					
Category	Condition	Mean	SD	F	p
SUPPORT	Deaf/H H	3.55	.33	.820	.852
	Hearing	3.62	.33		
EDUCATION	Deaf/H H	3.56	.36	.035	.852
	Hearing	3.54	.36		
PRIMARY CARE	Deaf/H H	3.42	.47	.006	.940
	Hearing	3.41	.43		
MANAGEMENT	Deaf/H H	3.55	.39	.509	.477
	Hearing	3.48	.39		
GENERAL KNOWLEDGE	Deaf/ H H	3.56	.38	.688	.409
	Hearing	3.48	.46		
PROFESSIONAL DEVELOPMENT	Deaf/H H	3.14	.72	.211	.647
	Hearing	3.08	.60		

*significance at 0.05

Research Question 6: Is there a statistically significant difference in the perception of Competence of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

Multivariate and univariate F-tests were conducted for each of the six composite job skills categories. Non-significant multivariate F-tests across six job skills categories indicate no difference in overall perceptions of Competence between hearing and deaf/hard of hearing caregivers in job skill categories.

Univariate F-tests were conducted on skills within each category. The results of the univariate F-tests indicate a significant difference in perception of competence between hearing caregivers and deaf/hard of hearing caregivers in the category of **PRIMARY CARE**.

The means and standard deviations of hearing and deaf/hard of hearing caregivers responses are presented in Table 4.7.

Table 4.7 Multivariate and univariate analysis of variance of Competence of composite job skills categories as perceived by hearing and deaf/hard of hearing respondents.

Multivariate Tests of Significance					
	Test Name	Value	F	p	
	Pillais	.06789	1.117	.359	
	Hotellings	.07283	1.117	.359	
	Wilks	.93211	1.117	.359	
	Roys	.06789			
Univariate F-tests with 1,99 degrees of freedom					
Category	Condition	Mean	SD	F	p
SUPPORT	Deaf/H H	2.31	.55	1.285	.260
	Hearing	2.45	.50		
EDUCATION	Deaf/H H	2.68	.45	1.247	.267
	Hearing	2.82	.55		
PRIMARY CARE	Deaf/H H	2.83	.47	5.611	.020*
	Hearing	3.10	.50		
MANAGEMENT	Deaf/H H	2.66	.59	2.835	.095
	Hearing	2.88	.54		
GENERAL KNOWLEDGE	Deaf/ H H	2.35	.67	0.041	.840
	Hearing	2.38	.62		
PROFESSIONAL DEVELOPMENT	Deaf/H H	2.24	.51	1.285	.260
	Hearing	2.40	.60		

*significance at 0.05

Research Question 7: Is there a statistically significant relationship between perception of Importance of job skills and the respondents' demographic characteristics?

Analysis of Variance (ANOVA) was used to compare the six composite job skills categories in the respondents perceptions of Importance of SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, and PROFESSIONAL DEVELOPMENT by demographic variables. Table 4.8 presents the analysis of variance results for differences in the perception of the Importance of SUPPORT by certain demographic characteristics.

From Table 4.8 it is shown that statistically significant differences were observed among the demographic characteristics of **Job Responsibility** ($F = 2.46, p < 0.05$), and **Specialized Training** ($F = 5.21, p < 0.05$).

Within the demographic characteristic category **Job Responsibility**, interpretations of the means indicate that **counselors** (mean = 3.80), **teachers** (mean = 3.62), **supervisors** (mean = 3.61) and **dorm counselors/houseparents** (mean = 3.59) perceive SUPPORT job skills, tasks, activities and knowledge areas Very Important. The exception in this category were **other administrators** (mean = 3.42) whose mean rating for SUPPORT was Important.

The interpretation of the mean rating for Primary Caregivers who either had **Specialized Training** or not, suggests that both groups perceived SUPPORT Very Important.

Table 4.8 Analysis of Variance results for the differences in the Importance of SUPPORT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.62	.31		
counselor	3.80	.22		
supervisor	3.61	.30	2.46	.050*
dorm counselor/house parent	3.59	.33		
other administrator	3.42	.38		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.55	.36		
20 - 39 hours	3.53	.36	.44	.726
40 hours	3.62	.31		
>40 hours	3.60	.33		
YEARS IN THE FIELD				
1 - 5 years	3.70	.26		
6 - 10 years	3.55	.36	1.30	.279
11 - 19 years	3.59	.32		
20 years >	3.54	.33		
GENDER				
male	3.60	.28	.00	.961
female	3.60	.34		
AGE				
18 - 30 years	3.70	.26		
31 - 40 years	3.55	.34	1.14	.338
41 - 50 years	3.59	.35		
>50 years	3.65	.32		
HEARING STATUS				
hearing	3.62	.33	.82	.367
deaf/hard of hearing	3.55	.33		
DEGREE				
GED or Diploma	3.60	.34		
Associate	3.72	.42	.58	.629
B.A., B.S.	3.56	.29		
M.A., M.S., Ph.D., Ed.D.	3.61	.33		
DEGREE AREA				
education	3.56	.29		
counseling, psychology, social work	3.65	.28	1.26	.294
deaf education	3.46	.41		
other	3.60	.32		

Table 4.8 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
SPECIALIZED TRAINING				
yes	3.57	.33	5.21	.025*
no	3.79	.20		
UTILIZE A S L				
yes	3.62	.33	.22	.640
no	3.58	.32		
TOTAL COMMUNICATION				
yes	3.58	.32	.53	.468
no	3.64	.36		
ORAL				
yes	3.64	.39	.10	.752
no	3.59	.32		
ETHNICITY				
white	3.60	.32	.38	.540
non-white	3.67	.35		
SALARY				
\$0 - 9,999	3.58	.34		
\$10,000 - 19,999	3.66	.31		
\$20,000 - 29,999	3.51	.37	.84	.503
\$30,000 - 39,999	3.61	.32		
\$40,000 >	3.57	.25		
MARITAL STATUS				
single	3.63	.31	.81	.372
married	3.57	.34		
CAREER CONTINUANCE				
yes	3.59	.34	.17	.684
no	3.64	.21		

*significance at .05 level

Table 4.9 presents the analysis of variance results for differences in the perception of the Importance of EDUCATION by certain demographic characteristics. From Table 4.9 it is shown that statistically significant differences were observed among the demographic characteristics of **Age** ($F = 2.71, p < 0.05$), and **Salary** ($F = 2.84, p < 0.05$) to perception of Importance of the composite job skills category EDUCATION.

The range for the demographic characteristic **Age**, begins at age 18 and extends to individuals aged 50 and older. Primary Caregivers who perceived EDUCATION as Very Important were age 18 - 30 (mean = 3.71); those respondents who were between the ages of 41 - 50 (mean = 3.55); and those over 50 (mean = 3.60). Middle aged respondents, 31 - 40 (mean = 3.45), had a mean rating which indicated that they perceived EDUCATION to be Important.

Salary was also statistically significant to EDUCATION. Primary Caregivers whose salaries were below \$20,000: \$0 - \$9,999 (mean = 3.71); \$10,000 - \$19,999 (mean = 3.63), perceived EDUCATION as Very Important. While, those whose salaries were over \$19,999: \$20,000 - \$29,999 (mean = 3.44); \$30,000 - \$39,999 (mean = 3.41); and \$40,000 > (mean = 3.40), perceived EDUCATION an Important job skills category.

Table 4.9 Analysis of Variance results for the differences in the Importance of EDUCATION by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.62	.26	1.03	.394
counselor	3.61	.38		
supervisor	3.49	.31		
dorm counselor/houseparent	3.62	.40		
other administrator	3.45	.41		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.45	.45	1.84	.145
20 - 39 hours	3.43	.36		
40 hours	3.62	.26		
>40 hours	3.52	.33		
YEARS IN THE FIELD				
1 - 5 years	3.58	.40	.21	.889
6 - 10 years	3.56	.35		
11 - 19 years	3.51	.34		
20 years >	3.54	.32		
GENDER				
male	3.59	.35	.42	.516
female	3.53	.36		
AGE				
18 - 30	3.71	.29	2.71	.049*
31 - 40	3.45	.38		
41 - 50	3.55	.37		
>50	3.60	.30		
HEARING STATUS				
hearing	3.54	.36	.04	.851
deaf/hard of hearing	3.56	.36		
DEGREE				
GED or Diploma	3.64	.40	1.17	.325
Associate	3.52	.42		
B.A., B.S.	3.55	.28		
M.A., M.S., Ph.D., Ed.D.	3.47	.37		
DEGREE AREA				
education	3.57	.30	.26	.854
counseling, psychology,				
social work	3.50	.34		
deaf education	3.48	.41		
other	3.50	.33		

Table 4.9 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
SPECIALIZED TRAINING				
yes	3.53	.36	.69	.409
no	3.62	.33		
UTILIZE A S L				
yes	3.59	.34	1.26	.264
no	3.51	.37		
TOTAL COMMUNICATION				
yes	3.55	.35	.08	.775
no	3.53	.38		
ORAL				
yes	3.33	.35	2.31	.131
no	3.56	.36		
ETHNICITY				
white	3.53	.36	2.50	.117
non-white	3.71	.26		
SALARY				
\$0 - 9,999	3.71	.27	2.84	.028*
\$10,000 - 19,999	3.63	.30		
\$20,000 - 29,999	3.44	.43		
\$30,000 - 39,999	3.41	.33		
\$40,000 >	3.40	.33		
MARITAL STATUS				
single	3.59	.30	1.04	.311
married	3.51	.40		
CAREER CONTINUANCE				
yes	3.56	.37	1.15	.286
no	3.44	.25		

*significance at .05 level

The specific demographic characteristic, utilization of **American Sign Language (ASL)** ($F = 4.24$, $p < 0.05$), was statistically significant in perceived Importance, for the composite job skills category of PRIMARY CARE. Individuals indicating that they utilized **ASL** (mean = 3.52), perceived this category to be Very Important. Those who **did not utilize ASL** (mean = 3.34), generally perceived PRIMARY CARE to be an Important composite job skills category.

None of the other demographic characteristic categories were found to be statistically significant in Importance to the composite job skills category of PRIMARY CARE.

The results presented in Table 4.10 show the analysis of variance results for differences in the perception of Importance of PRIMARY CARE by the demographic characteristic **utilize ASL**.

Statistically significant results were not found between demographic variables and Importance of the composite job skills category MANAGEMENT. These results are shown in Table 4.11.

Table 4.10 Analysis of Variance results for the differences in the Importance of PRIMARY CARE by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.28	.47		
counselor	3.39	.47		
supervisor	3.38	.57	.35	.841
dorm counselor/house parent	3.45	.50		
other administrator	3.46	.39		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.40	.30		
20 - 39 hours	3.27	.47	1.16	.330
40 hours	3.47	.43		
>40 hours	3.35	.46		
YEARS IN THE FIELD				
1 - 5 years	3.47	.49		
6 - 10 years	3.35	.42	.61	.612
11 - 19 years	3.43	.41		
20 years >	3.32	.45		
GENDER				
male	3.41	.46	.00	.975
female	3.42	.43		
AGE				
18 - 30 years	3.57	.29		
31 - 40 years	3.34	.44	1.45	.233
41 - 50 years	3.37	.48		
>50 years	3.47	.47		
HEARING STATUS				
hearing	3.42	.43	.01	.940
deaf/hard of hearing	3.42	.47		
DEGREE				
GED or Diploma	3.59	.47		
Associate	3.30	.55	2.22	.091
B.A., B.S.	3.36	.37		
M.A., M.S., Ph.D., Ed.D.	3.34	.43		
DEGREE AREA				
education	3.42	.40		
counseling, psychology,				
social work	3.31	.45	.30	.824
deaf education	3.40	.38		
other	3.37	.36		

Table 4.10 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
SPECIALIZED TRAINING				
yes	3.41	.43	.25	.620
no	3.47	.43		
UTILIZE A S L				
yes	3.52	.37	4.24	.042*
no	3.34	.47		
TOTAL COMMUNICATION				
yes	3.38	.46	1.20	.276
no	3.49	.37		
ORAL				
yes	3.17	.43	2.02	.158
no	3.43	.44		
ETHNICITY				
white	3.40	.44	1.62	.206
non-white	3.58	.38		
SALARY				
\$0 - 9,999	3.54	.37	.80	.531
\$10,000 - 19,999	3.40	.49		
\$20,000 - 29,999	3.42	.38		
\$30,000 - 39,000	3.26	.47		
>\$40,000	3.31	.41		
MARITAL STATUS				
single	3.41	.36	.00	.957
married	3.41	.50		
CAREER CONTINUANCE				
yes	3.44	.45	2.65	.107
no	3.21	.36		

*significance at .05 level

Table 4.11 Analysis of Variance results for the differences in the Importance of MANAGEMENT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.45	.42		
counselor	3.64	.39		
supervisor	3.45	.40		
dorm counselor/houseparent	3.49	.37	.53	.714
other administrator	3.51	.39		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.53	.45		
20 - 39 hours	3.51	.45	1.00	.394
40 hours	3.53	.36		
>40 hours	3.50	.39		
YEARS IN THE FIELD				
1 - 5 years	3.55	.34		
6 - 10 years	3.51	.34	.32	.814
11 - 19 years	3.47	.42		
20 years >	3.44	.47		
GENDER				
male	3.54	.39	.37	.544
female	3.48	.39		
AGE				
18 - 30 years	3.63	.33		
31 - 40 years	3.45	.36	.93	.430
41 - 50 years	3.50	.45		
>50 years	3.46	.45		
HEARING STATUS				
hearing	3.48	.39	.51	.477
deaf/hard of hearing	3.55	.39		
DEGREE				
GED or Diploma	3.56	.45		
Associate	3.54	.40		
B.A., B.S.	3.47	.30	.38	.766
M.A., M.S., Ph.D., Ed.D.	3.46	.43		

Table 4.11 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	3.46	.32		
counseling, psychology				
social work	3.46	.37		
deaf education	3.59	.43	.45	.716
other	3.47	.32		
SPECIALIZED TRAINING				
yes	3.48	.40	.72	.400
no	3.58	.34		
UTILIZE A S L				
yes	3.57	.40	2.62	.109
no	3.44	.38		
TOTAL COMMUNICATION				
yes	3.48	.39	.82	.369
no	3.56	.41		
ORAL				
yes	3.31	.40	1.54	.217
no	3.51	.39		
ETHNICITY				
white	3.50	.38	1.49	.700
non-white	3.54	.45		
SALARY				
\$0 - 9,999	3.59	.33		
\$10,000 - 19,999	3.54	.34		
\$20,000 - 29,999	3.48	.40	1.12	.349
\$30,000 - 39,999	3.41	.48		
\$40,000 >	3.26	.42		
MARITAL STATUS				
single	3.51	.36	.14	.714
married	3.48	.42		
CAREER CONTINUANCE				
yes	3.51	.40	1.19	.278
no	3.38	.32		

*significance at .05 level

Perception of Importance by the demographic characteristics of **Age** ($F = 3.45, p < 0.05$), and those with **knowledge of A.S.L** ($F = 4.60, p < 0.05$), were statistically significant to the composite job skills category **GENERAL KNOWLEDGE**. These results are presented in Table 4.12.

All age range groups perceived **GENERAL KNOWLEDGE** to be Very Important, with the exception of individuals aged **31 - 40** (mean = 3.37). They perceived the composite job skills category of **GENERAL KNOWLEDGE** to be Important, according to the mean rating scale.

Individuals who **utilize ASL** (mean = 3.61) perceived **GENERAL KNOWLEDGE** Very Important to projected role functions of Primary Caregivers in community-based group homes. Whereas, respondents who **did not utilize ASL** (mean = 3.42), perceived **GENERAL KNOWLEDGE** job skills Important.

Table 4.12 presents the analysis of variance results for differences in the perception of the Importance of **GENERAL KNOWLEDGE** by certain demographic characteristics.

Table 4.12 Analysis of Variance results for the differences in the Importance of GENERAL KNOWLEDGE by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.32	.56	1.51	.206
counselor	3.71	.29		
supervisor	3.53	.37		
dorm counselor/houseparent	3.50	.51		
other administrator	3.36	.44		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.27	.38	1.61	.192
20 - 39 hours	3.42	.48		
40 hours	3.54	.44		
>40 hours	3.58	.42		
YEARS IN THE FIELD				
1 - 5 years	3.62	.37	1.00	.397
6 - 10 years	3.42	.46		
11 - 19 years	3.52	.46		
20 years >	3.44	.47		
GENDER				
male	3.57	.41	.94	.334
female	3.48	.45		
AGE				
18 - 30 years	3.74	.26	3.45	.020*
31 - 40 years	3.37	.45		
41 - 50 years	3.53	.49		
>50 years	3.55	.42		
HEARING STATUS				
hearing	3.48	.46	.69	.408
deaf/hard of hearing	3.56	.38		
DEGREE				
GED or Diploma	3.61	.55	1.06	.368
Associate	3.35	.49		
B.A., B.S.	3.49	.35		
M.A., M.S., Ph.D., Ed.D	3.46	.40		

Table 4.12 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	3.50	.36		
counseling, psychology,				
social work	3.49	.39	.08	.973
deaf education	3.44	.43		
other	3.47	.33		
SPECIALIZED TRAINING				
yes	3.46	.45	1.49	.225
no	3.61	.31		
UTILIZE A S L				
yes	3.61	.42	4.60	.034*
no	3.42	.44		
TOTAL COMMUNICATION				
yes	3.48	.42	.42	.519
no	3.54	.52		
ORAL				
yes	3.26	.50	1.91	.170
no	3.51	.44		
ETHNICITY				
white	3.49	.42	.81	.370
non-white	3.62	.59		
SALARY				
\$0 - 9,999	3.61	.42		
\$10,000 - 19,999	3.59	.38		
\$20,000 - 29,999	3.38	.49	1.28	.285
\$30,000 - 39,999	3.43	.42		
\$40,000 >	3.26	.42		
MARITAL STATUS				
single	3.56	.39	1.77	.187
married	3.45	.47		
CAREER CONTINUANCE				
yes	3.53	.46	.63	.429
no	3.41	.31		

*significance at .05 level

The general demographic category **Hours Providing Direct Care** ($F = 3.71$, $p < 0.05$) was statistically significant in perception of Importance to PROFESSIONAL DEVELOPMENT. These results are presented in Table 4.13.

All respondents perceived PROFESSIONAL DEVELOPMENT as Important. The following descending ordering of means was observed on the mean ratings for specific demographic characteristics related to **Hours Providing Direct Care**: **40 hours** (mean = 3.23); **greater than 40 hours** (mean = 3.13); **20 - 39 hours** (mean = 2.81); and **under 20 hours** (mean = 2.70). This ordering indicated that Primary Caregivers providing 40 or more hours of direct care had slightly higher mean ratings on perceived Importance than Primary Caregivers working 39 hours or less, even though all respondent means were rated Important.

Table 4.13 presents the analysis of variance results for differences in the perception of Importance of PROFESSIONAL DEVELOPMENT by the demographic characteristic **Hours Providing Direct Care**.

Table 4.13 Analysis of Variance results for the differences in the Importance of PROFESSIONAL DEVELOPMENT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	2.68	.76		
counselor	3.29	.54		
supervisor	3.01	.56	1.47	.217
dorm counselor/houseparent	3.16	.68		
other administrator	3.05	.59		
HOURS PROVIDING DIRECT CARE				
under 20 hours	2.70	.65		
20 - 39 hours	2.81	.65	3.71	.014*
40 hours	3.23	.56		
>40 hours	3.13	.54		
YEARS IN THE FIELD				
1 - 5 years	3.23	.54		
6 - 10 years	3.04	.66	.56	.644
11 - 19 years	3.05	.58		
20 years >	3.05	.72		
GENDER				
male	3.16	.59	.41	.521
female	3.07	.64		
AGE				
18 - 30 years	3.27	.54		
31 - 40 years	3.00	.59	.82	.487
41 - 50 years	3.10	.68		
>50 years	3.10	.72		
HEARING STATUS				
hearing	3.08	.60	.21	.647
deaf/hard of hearing	3.14	.72		
DEGREE				
GED or Diploma	3.21	.80		
Associate	3.03	.73	.52	.670
B.A., B.S.	3.09	.50		
M.A., M.S., Ph.D., Ed.D.	3.01	.55		

Table 4.13 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	3.03	.53		
counseling, psychology, social work	3.11	.56	.08	.972
deaf education	3.08	.54		
other	3.09	.49		
SPECIALIZED TRAINING				
yes	3.03	.63	3.01	.086
no	3.36	.54		
UTILIZE A S L				
yes	3.18	.56	1.52	.220
no	3.03	.67		
TOTAL COMMUNICATION				
yes	3.08	.63	.12	.730
no	3.13	.63		
ORAL				
yes	2.94	.66	.36	.551
no	3.10	.63		
ETHNICITY				
white	3.08	.61	1.13	.291
non-white	3.29	.71		
SALARY				
\$0,000 - 9,999	3.15	.68		
\$10,000 - 19,999	3.24	.63		
\$20,000 - 29,999	3.00	.57	1.37	.249
\$30,000 - 39,999	2.91	.70		
\$40,000 >	2.82	.48		
MARITAL STATUS				
single	3.07	.53	.12	.736
married	3.11	.69		
CAREER CONTINUANCE				
yes	3.11	.65	.40	.529
no	2.98	.42		

*significance at .05 level

Research Question 8: Is there a statistically significant relationship between perception of co-worker Competence in composite job skills categories and the respondents' demographic characteristics?

Analysis of Variance (ANOVA) was used to compare the six composite job skills categories in the respondent's perceptions of Competence of SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, and PROFESSIONAL DEVELOPMENT by demographic variables. Table 4.14 presents the analysis of variance results for differences in the perception of Competence of SUPPORT by certain demographic characteristics.

From Table 4.14 it is shown that statistically significant findings were observed on SUPPORT by the following demographic characteristic categories: **Primary Job Responsibility** ($F = 4.15, p < 0.05$); **Degree Held** ($F = 2.77, p < 0.05$); and **Specialized Training** ($F = 5.74, p < 0.05$).

The demographic category of **Primary Job Responsibility**, revealed that **Counselors** (mean = 2.82) and **teachers** (mean = 2.55), perceived co-workers at the Competent level of job functioning in the composite job skills category of SUPPORT, according to mean ratings for competency. **Supervisors** (mean = 2.45), **other administrators** (mean = 2.29), and **dorm counselors/house parents** (mean = 2.18) rated co-workers at levels that were Somewhat Competent.

Possession of a **GED or high school Diploma** (mean = 2.62) was the only demographic characteristic under **Degree**

Held where Primary Caregivers perceived co-worker's performance to be Competent. Individuals with post-secondary degrees: **B.A., B.S.** (mean = 2.42); **M.A., M.S., Ph.D., Ed.D** (mean = 2.29); and **Associate** (mean = 2.20), perceived co-workers functioning at levels that were only Somewhat Competent.

Within the demographic characteristic **Specialized Training**, individuals who **did not have specialized training** (mean = 2.70) perceived co-workers to be Competent in SUPPORT job skills activities. Individuals who **did have specialized training** (mean = 2.34) perceived co-workers to be Somewhat Competent in SUPPORT job skills activities.

Although **Utilize A.S.L.** was not significant, it approached significance which suggests there may be a tendency toward a difference in perceptions of competence between hearing and deaf/hard of hearing caregivers.

Table 4.14 shows the demographic variables in which there is a statistically significant relationship between perception of co-worker competence and the job skills category of SUPPORT.

Table 4.14 Analysis of Variance results for the differences in the Competence of SUPPORT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	2.55	.40		
counselor	2.82	.58		
supervisor	2.45	.45	4.15	.004*
dorm counselor/houseparent	2.18	.47		
other administrator	2.29	.47		
HOURS PROVIDING DIRECT CARE				
under 20 hours	2.42	.33		
20 - 39 hours	2.45	.39	.33	.802
40 hours	2.46	.53		
>40 hours	2.34	.61		
YEARS IN THE FIELD				
1 - 5 years	2.58	.59		
6 - 10 years	2.39	.36	1.58	.198
11 - 19 years	2.30	.52		
20 years >	2.47	.56		
GENDER				
male	2.36	.57	.42	.518
female	2.43	.49		
AGE				
18 - 30 years	2.57	.49		
31 - 40 years	2.39	.46	2.30	.082
41 - 50 years	2.18	.53		
>50 years	2.53	.57		
HEARING STATUS				
hearing	2.45	.50	1.28	.260
deaf/hard of hearing	2.31	.55		
DEGREE				
Associate	2.20	.58		
GED or Diploma	2.62	.58	2.77	.046*
B.A., B.S.	2.42	.39		
M.A., M.S., Ph.D., Ed.D.	2.29	.50		

Table 4.14 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.15	.40		
counseling, psychology, social work	2.51	.42	2.48	.068
deaf education	2.25	.52		
other	2.33	.54		
SPECIALIZED TRAINING				
yes	2.34	.47	5.74	.018*
no	2.70	.58		
Utilize A S L				
yes	2.30	.55	3.87	.052
no	2.50	.46		
TOTAL COMMUNICATION				
yes	2.45	.48	1.03	.313
no	2.33	.58		
ORAL				
yes	2.56	.40	.47	.493
no	2.41	.52		
ETHNICITY				
white	2.41	.52	.08	.784
non-white	2.37	.49		
SALARY				
\$0 - 9,999	2.52	.63		
\$10,000 - 19,999	2.53	.52		
\$20,000 - 29,999	2.38	.32	1.35	.256
\$30,000 - 39,999	2.25	.61		
\$40,000 >	2.19	.59		
MARITAL STATUS				
single	2.46	.44	.65	.421
married	2.38	.55		
CAREER CONTINUANCE				
yes	2.43	.53	.04	.838
no	2.39	.36		

*significance at .05 level

Age ($F = 3.13$, $p < 0.05$) was the only demographic characteristic which was statistically significant in perception of co-worker Competency to EDUCATION. Table 4.15 presents these results.

More specifically, all age groups; **18 - 30** (mean = 3.03), **greater than 50** (mean = 2.90), **31 - 40** (mean = 2.72), and **41 - 50** (mean = 2.56) perceived their co-workers to be functioning at Competent levels within the job skills category of EDUCATION.

Only one general demographic category, **Hearing Status** ($F = 5.61$, $p < 0.05$), was statistically significant to the composite job skills category PRIMARY CARE on perception of co-worker competence. **Hearing primary caregivers** (mean = 3.10) perceived co-workers to be Competent, as well as **deaf/hard of hearing primary caregivers** (mean = 2.83). Although both groups perceived their co-workers to be competent, closer observation of the means shows that deaf/hard of hearing caregivers' perceptions are somewhat lower for co-workers, than hearing caregiver perceptions.

Table 4.16 presents the analysis of variance results for differences in the perception of Competence of PRIMARY CARE by the demographic characteristic **Hearing Status**.

MANAGEMENT job skills, tasks, activities and knowledge areas were statistically significant to perceived Competence by the demographic characteristic of **Job Responsibility**. Table 4.17 shows these results.

All respondents with the following **Job Responsibility** characteristics: **teachers** (mean = 3.13), **counselors** (mean = 3.11), **supervisors** (mean = 2.83), **other administrators** (mean = 2.82), and **dorm counselors and house parents** (mean = 2.55), perceived co-workers job performance in **MANAGEMENT** to be **Competent**.

Statistically significant results were not found for the composite job skills category of **GENERAL KNOWLEDGE**, when compared to demographic characteristics and perception of **Competence**. These results are presented in Table 4.18.

Table 4.15 Analysis of Variance results for the differences in the Competence of EDUCATION by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	2.92	.49		
counselor	3.04	.56		
supervisor	2.82	.44	2.42	.053
dorm counselor/houseparent	2.55	.56		
other administrator	2.74	.49		
HOURS PROVIDING DIRECT CARE				
under 20 hours	2.90	.59		
20 - 39 hours	2.73	.49	.49	.690
40 hours	2.83	.52		
>40 hours	2.72	.53		
YEARS IN THE FIELD				
1 - 5 years	2.85	.59		
6 - 10 years	2.77	.43	1.02	.388
11 - 19 years	2.68	.57		
20 years >	2.92	.46		
GENDER				
male	2.81	.52	.08	.783
female	2.77	.53		
AGE				
18 - 30 years	3.03	.46		
31 - 40 years	2.72	.54	3.13	.029*
41 - 50 years	2.56	.55		
>50 years	2.90	.44		
HEARING STATUS				
hearing	2.82	.55	1.25	.267
deaf/hard of hearing	2.68	.45		
DEGREE				
Associate	2.53	.60		
GED or Diploma	2.93	.61	1.59	.196
B.A., B.S.	2.78	.45		
M.A., M.S., Ph.D., Ed.D.	2.74	.47		

Table 4.15 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.60	.35		
counseling, psychology,				
social work	2.86	.45	1.34	.269
deaf education	2.67	.61		
other	2.81	.53		
SPECIALIZED TRAINING				
yes	2.73	.51	3.70	.057
no	3.04	.56		
UTILIZE A S L				
yes	2.67	.54	3.57	.062
no	2.87	.50		
TOTAL COMMUNICATION				
yes	2.82	.50	1.59	.210
no	2.67	.58		
ORAL				
yes	2.69	.22	1.80	.672
no	2.79	.54		
ETHNICITY				
white	2.81	.53	2.03	.158
non-white	2.57	.45		
SALARY				
\$0 - 9,999	2.86	.70		
\$10,000 - 19,999	2.86	.52		
\$20,000 - 29,999	2.76	.44	.87	.485
\$30,000 - 39,999	2.56	.59		
\$40,000 >	2.76	.51		
MARITAL STATUS				
single	2.88	.50	2.99	.087
married	2.70	.53		
CAREER CONTINUANCE				
yes	2.79	.54	.04	.840
no	2.76	.30		

*significance at .05 level

Table 4.16 Analysis of Variance results for the differences in the Competence of PRIMARY CARE by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.05	.36		
counselor	3.14	.55		
supervisor	3.05	.46	1.28	.284
dorm counselor/houseparent	2.84	.56		
other administrator	3.13	.47		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.25	.53		
20 - 39 hours	2.88	.47	1.73	.166
40 hours	3.09	.50		
>40 hours	2.95	.47		
YEARS IN THE FIELD				
1 - 5 years	2.96	.64		
6 - 10 years	3.14	.42	.93	.430
11 - 19 years	2.96	.51		
20 years >	3.09	.31		
GENDER				
male	2.97	.46	.60	.439
female	3.06	.52		
AGE				
18 - 30 years	3.13	.48		
31 - 40 years	3.01	.52	.45	.718
41 - 50 years	2.94	.58		
>50 years	3.06	.43		
HEARING STATUS				
hearing	3.10	.50	5.61	.020*
deaf/hard of hearing	2.83	.46		
DEGREE				
GED or Diploma	3.24	.46		
Associate	2.93	.68		
B.A., B.S.	2.95	.45		
M.A., M.S., Ph.D., Ed.D.	2.96	.49	2.24	.088

Table 4.16 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.83	.45		
counseling, psychology,				
social work	3.03	.47	.79	.504
deaf education	2.87	.64		
other	3.03	.45		
SPECIALIZED TRAINING				
yes	3.01	.51	.54	.465
no	3.12	.58		
Utilize A S L				
yes	2.95	.58	1.58	.211
no	3.08	.44		
TOTAL COMMUNICATION				
yes	3.04	.45	.22	.642
no	2.99	.64		
ORAL				
yes	2.89	.29	.48	.492
no	3.04	.51		
ETHNICITY				
white	3.03	.50	.00	.995
non-white	3.03	.52		
SALARY				
\$0 - 9,999	3.06	.73		
\$10,000 - 19,999	3.02	.47		
\$20,000 - 29,000	3.11	.42	.48	.752
\$30,000 - 39,000	2.89	.62		
\$40,000 >	2.95	.45		
MARITAL STATUS				
single	3.13	.46	3.02	.085
married	2.95	.55		
CAREER CONTINUANCE				
yes	3.03	.51	.01	.904
no	3.01	.46		

*significance at .05 level

Table 4.17 Analysis of Variance results for the differences in the Competence of MANAGEMENT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	3.13	.48		
counselor	3.11	.66		
supervisor	2.83	.46	3.25	.015*
dorm counselor/houseparent	2.55	.54		
other administrator	2.82	.62		
HOURS PROVIDING DIRECT CARE				
under 20 hours	3.08	.65		
20 - 39 hours	2.68	.39	1.53	.211
40 hours	2.89	.53		
>40 hours	2.74	.65		
YEARS IN THE FIELD				
1 - 5 years	2.79	.49		
6 - 10 years	2.96	.46	.85	.468
11 - 19 years	2.74	.49		
20 years >	2.87	.53		
GENDER				
male	2.69	.52	2.10	.151
female	2.87	.57		
AGE				
18 - 30 years	2.93	.61		
31 - 40 years	2.88	.52	.96	.417
41 - 50 years	2.70	.68		
>50 years	2.69	.50		
HEARING STATUS				
hearing	2.88	.54	2.83	.095
deaf/hard of hearing	2.66	.59		
DEGREE				
GED or Diploma	3.03	.50		
Associate	2.60	.77	1.94	.127
B.A., B.S.	2.78	.50		
M.A., M.S., Ph.D., Ed.D.	2.77	.56		

Table 4.17 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.49	.48		
counseling, psychology,				
social work	2.90	.51	2.07	.113
deaf education	2.79	.75		
other	2.81	.49		
SPECIALIZED TRAINING				
yes	2.81	.56	.18	.674
no	2.89	.64		
Utilize A S L				
yes	2.71	.62	2.82	.096
no	2.90	.50		
TOTAL COMMUNICATION				
yes	2.87	.52	2.17	.144
no	2.68	.66		
ORAL				
yes	2.78	.33	.04	.847
no	2.82	.57		
ETHNICITY				
white	2.83	.58	.12	.735
non-white	2.77	.39		
SALARY				
\$0,000 - 9,999	2.71	.78		
\$10,000 - 19,999	2.86	.56		
\$20,000 - 29,999	2.93	.44	.71	.589
\$30,000 - 39,999	2.73	.57		
\$40,000 >	2.62	.68		
MARITAL STATUS				
single	2.89	.48	.97	.327
married	2.78	.61		
CAREER CONTINUANCE				
yes	2.82	.55	.00	.990
no	2.83	.55		

*significance at .05 level

Table 4.18 Analysis of Variance results for the differences in the Competence of GENERAL KNOWLEDGE by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	2.17	.65		
counselor	2.76	.81		
supervisor	2.39	.51	1.80	.135
dorm counselor/houseparent	2.22	.60		
other administrator	2.41	.67		
HOURS PROVIDING DIRECT CARE				
under 20 hours	2.50	.59		
20 - 39 hours	2.30	.39	.39	.759
40 hours	2.43	.64		
>40 hours	2.33	.71		
YEARS IN THE FIELD				
1 - 5 years	2.51	.68		
6 - 10 years	2.22	.51	1.07	.364
11 - 19 years	2.41	.71		
20 years >	2.45	.46		
GENDER				
male	2.42	.64	.16	.688
female	2.36	.62		
AGE				
18 - 30 years	2.34	.58		
31 - 40 years	2.42	.61	.95	.420
41 - 50 years	2.17	.78		
>50 years	2.50	.55		
HEARING STATUS				
hearing	2.38	.62	.04	.840
deaf/hard of hearing	2.35	.67		
DEGREE				
GED or Diploma	2.56	.62		
Associate	2.32	.65		
B.A., B.S.	2.38	.54	1.34	.266
M.A., M.S., Ph.D., Ed.D.	2.22	.70		

Table 4.18 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.17	.51		
counseling, psychology,				
social work	2.39	.64	2.18	.098
deaf education	2.03	.55		
other	2.55	.70		
SPECIALIZED TRAINING				
yes	2.30	.60	3.44	.067
no	2.64	.62		
Utilize A S L				
yes	2.32	.63	.64	.427
no	2.42	.63		
TOTAL COMMUNICATION				
yes	2.43	.62	1.52	.220
no	2.25	.64		
ORAL				
yes	2.25	.76	.25	.615
no	2.39	.62		
ETHNICITY				
white	2.38	.64	.02	.892
non-white	2.35	.52		
SALARY				
\$0 - 9,999	2.48	.68		
\$10,000 - 19,999	2.44	.57		
\$20,000 - 29,999	2.28	.55	.86	.491
\$30,000 - 39,999	2.23	.84		
\$40,000 >	2.64	.68		
MARITAL STATUS				
single	2.42	.55	.45	.505
married	2.34	.68		
CAREER CONTINUANCE				
yes	2.40	.61	.07	.795
no	2.45	.54		

*significance at .05 level

Comparisons between the demographic category, **Degree** ($F = 3.58, p < 0.05$), and perception of co-worker Competence in PROFESSIONAL DEVELOPMENT yielded a statistically significant relationship. Primary caregivers who possessed a **GED or Diploma** (mean = 2.65) perceived co-workers as Competent in PROFESSIONAL DEVELOPMENT job activities. Individuals with post-secondary degrees; **Associate** (mean = 2.39), **B.A., B.S.** (mean = 2.27), and **M.A., M.S., Ph.D., Ed.D.** (mean = 2.19) perceived co-workers as Somewhat Competent.

Table 4.19 presents the analysis of variance results for differences in the perception of Competence of PROFESSIONAL DEVELOPMENT by the demographic characteristic **Degree**.

Table 4.19 Analysis of Variance results for the differences in the Competence of PROFESSIONAL DEVELOPMENT by demographic characteristics

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-Value
JOB RESPONSIBILITY				
teacher	2.68	.75		
counselor	2.52	.67		
supervisor	2.41	.53	.71	.589
dorm counselor/houseparent	2.23	.60		
other administrator	2.37	.62		
HOURS PROVIDING DIRECT CARE				
under 20 hours	2.53	.74		
20 - 39 hours	2.13	.45	2.67	.052
40 hours	2.49	.56		
>40 hours	2.13	.45		
YEARS IN THE FIELD				
1 - 5 years	2.50	.55		
6 - 10 years	2.21	.51	1.17	.326
11 - 19 years	2.35	.66		
20 years >	2.21	.51		
GENDER				
male	2.41	.56	.30	.586
female	2.34	.59		
AGE				
18 - 30 years	2.46	.55		
31 - 40 years	2.31	.59	.69	.562
41 - 50 years	2.24	.60		
>50 years	2.24	.60		
HEARING STATUS				
hearing	2.40	.60	1.28	.259
deaf/hard of hearing	2.24	.51		
DEGREE				
GED or Diploma	2.65	.55		
Associate	2.39	.70		
B.A., B.S.	2.27	.54	3.58	.017*
M.A., M.S., Ph.D., Ed.D.	2.19	.53		

Table 4.19 (continued)

DEMOGRAPHIC VARIABLES	MEAN	SD	F-Value	p-value
DEGREE AREA				
education	2.04	.42		
counseling, psychology, social work	2.41	.48	2.41	.074
deaf education	2.08	.57		
other	2.38	.72		
SPECIALIZED TRAINING				
yes	2.31	.57	1.50	.224
no	2.53	.63		
Utilize A S L				
yes	2.30	.61	.66	.418
no	2.40	.55		
TOTAL COMMUNICATION				
yes	2.35	.58	.02	.877
no	2.37	.58		
ORAL				
yes	2.43	.39	.09	.753
no	2.35	.59		
ETHNICITY				
white	2.36	.57	.06	.803
non-white	2.41	.55		
SALARY				
\$0 - 9,999	2.51	.66		
\$10,000 - 19,999	2.46	.56		
\$20,000 - 29,999	2.31	.45	1.41	.235
\$30,000 - 39,999	2.08	.74		
\$40,000 >	2.44	.60		
MARITAL STATUS				
single	2.40	.53	.38	.539
married	2.33	.61		
CAREER CONTINUANCE				
yes	2.38	.57	.04	.834
no	2.34	.55		

*significance at .05 level

Research Question 9: Is there a significant difference between the level of Importance and the Competency level of primary caregivers across composite job skills categories?

The t-test was used to determine whether statistically significant differences exist between the perceived level of Importance of composite job skills, tasks, activities and knowledge areas and the level of co-worker Competence in the same job skills categories. Table 4.20 presents the t-test of results. Statistically significant differences were found between levels of perception in all six composite job skills, tasks, activities, and knowledge area categories.

According to the interpretation of the Importance mean rating scale outlined in Chapter III, it shows that all six job skills categories were perceived as either Very Important or Important to the projected daily job functions of primary caregivers. However, the perceived level of current co-worker competence in the same job skills categories was only either Competent or Somewhat Competent.

Figure 4.1 displays an Histogram for the Importance and Competence mean rating for the six job skills categories. From Figure 4.1 it is evident that, while SUPPORT was perceived to be the Very Important, the level of current co-worker Competency in SUPPORT was perceived to be one of the three categories they were least Competent. Table 4.20 shows these results.

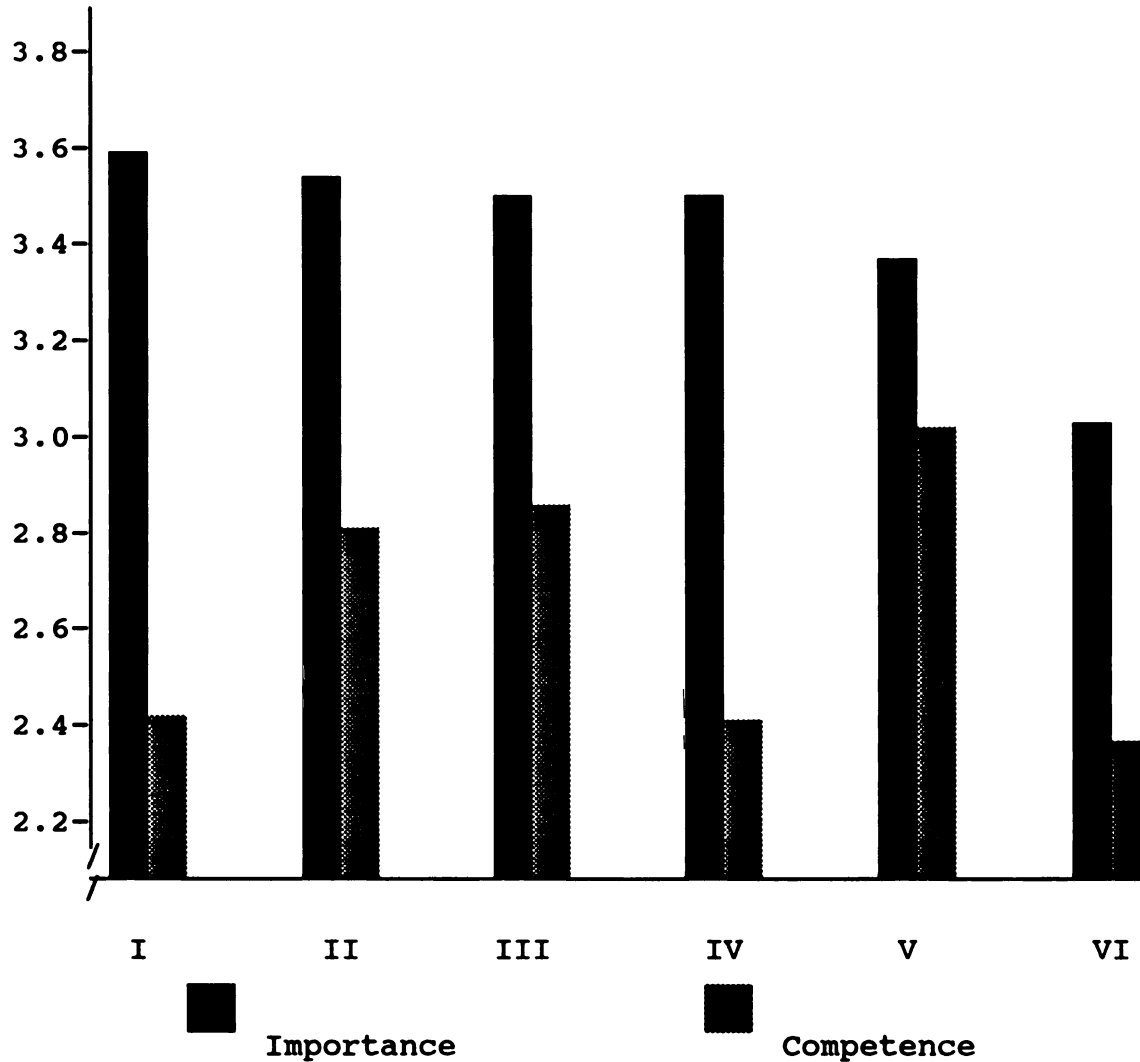
Table 4.20 Analysis of Variance results of the differences between level of perceived Importance of composite job skills categories and perception of co-worker Competence

Job Skills Category	Importance/Competence	Mean	S.D.	t-Value	p-Value
SUPPORT	Importance	3.60	0.32	20.99	0.000*
	Competence	2.42	0.51		
EDUCATION	Importance	3.54	0.35	13.93	0.000*
	Competence	2.79	0.52		
MANAGEMENT	Importance	3.50	0.39	11.20	0.000*
	Competence	2.39	0.56		
GENERAL KNOWLEDGE	Importance	3.49	0.44	17.06	0.000*
	Competence	2.39	0.62		
PRIMARY CARE	Importance	3.40	0.44	6.37	0.000*
	Competence	3.03	0.49		
PROFESSIONAL DEVELOPMENT	Importance	3.08	0.62	10.05	0.000*
	Competence	2.36	0.58		

*significance at .05 level

Figure 4.1 Level of perceived Importance compared to level of perceived co-worker Competence in composite job skills, tasks, activities and knowledge areas

Mean rating



I: SUPPORT
 II: EDUCATION
 III: MANAGEMENT

IV: GENERAL KNOWLEDGE
 V: PRIMARY CARE
 VI: PROFESSIONAL DEVELOPMENT

CHAPTER V

SUMMARY OF FINDINGS AND CONCLUSIONS

The major purposes of the present study were to assess the degree to which Primary Caregivers perceived job skills, tasks, activities and knowledge areas relevant in Importance to expected job performance needs of Primary Caregivers in community-based group homes, the degree to which Competence in the current job performance by co-workers is perceived, and the degree to which the perceived level of Competence in job skills, tasks, activities and knowledge areas compares to perceived level of Importance.

Findings and Discussions

Research Question 1

Is there a statistically significant difference in perceived level of Importance among the six composite job skills categories?

Statistically significant differences were found in perceived level of Importance on all six composite job skills, tasks, activities, knowledge area categories, to projected job function needs of primary caregivers in community-based group homes, for deaf/hard of hearing youth with behavioral deficits.

According to the mean rating scale presented in Chapter III, Primary Caregivers perceived all job skills categories as Important, however SUPPORT, EDUCATION and MANAGEMENT ranked slightly more important than GENERAL KNOWLEDGE and PRIMARY CARE. PROFESSIONAL DEVELOPMENT had the lowest mean rating priority in terms of being Important.

Research Question 2

What are the most Important specific job skills, tasks, activities, and knowledge areas perceived to be needed by primary caregivers who would work with behaviorally disordered deaf/hard of hearing youth in community based group homes?

Sixteen specific job skills, tasks, activities and knowledge areas were perceived to be Very Important to projected job functions of primary caregivers in community-based group homes for deaf/hard of hearing youth with behavioral deficits.

SUPPORT contained five Very Important specific items out of a total of six category items. The job skill exception to this mean rating level was conducting therapy, which was only perceived to be important. Also within this category was the single item; helping the child to manage their own behavior by controlling aggression. This particular item had the highest mean of all 36 specific job skills, tasks, activities and knowledge areas.

In the category of EDUCATION, which had the second highest mean rating on Importance; promoting learning opportunities, responsibility and decision making; teaching

the child basic daily living skills; and teaching social skills were considered Very Important. Primary Caregivers perceived the remaining category items; presenting drug and alcohol information and stimulating the child to seek knowledge, Important. They considered assisting with homework the least important of the three.

Within the job skills category of GENERAL KNOWLEDGE; being able to communicate utilizing ASL, knowledge about behavior disorders in deaf children, knowledge about deaf child and adolescent development, and knowledge about deaf people, their culture and community were perceived as Very Important. Important job skills in this category were; etiology, and knowing about laws affecting the hearing impaired.

Three Very Important job skills in the category of MANAGEMENT were communicating with parents, school teachers, psychologists, social workers, and others involved with child; keeping informed of child's progress or difficulties; and communicating with group home staff. Job skills related to planning goals, record keeping and planning activities were merely considered Important.

In the composite job skills category of PRIMARY CARE only one specific item was considered Very Important, that of disciplining children.

None of the specific job skills, knowledge areas in PROFESSIONAL DEVELOPMENT were perceived Very Important, although all items were considered Important.

Research Question 3

Is there a statistically significant difference in primary caregivers' perceptions of the level of Competency of co-workers among the six composite job skills categories?

Primary caregivers currently employed in residential schools for deaf/hard of hearing youth perceived their co-workers to be generally performing at levels between Competent and Somewhat Competent among the six composite job skills categories.

PRIMARY CARE, MANAGEMENT and EDUCATION were the three composite job skill categories where co-workers were perceived as Competent in the performance of their job responsibilities. Co-workers were only perceived as Somewhat Competent in the performance of their job responsibilities in the composite job skill, tasks, activities and knowledge areas of SUPPORT, GENERAL KNOWLEDGE and PROFESSIONAL DEVELOPMENT.

Research Question 4

What are the perceived competency levels in specific job skills, tasks, activities and knowledge areas of co-workers?

Co-workers were perceived to have job performance levels in specific job skills, tasks, activities and knowledge areas that were either Competent or Somewhat Competent. A noticeable exception was the specific item, conducting therapy, which had a mean rating level indicating

that primary caregivers clearly perceived co-workers as Not Competent in that particular activity out of all 36 items.

Primary Caregivers were perceived Competent in all specific job skills within the category of PRIMARY CARE: supervising daily routines, general maintenance, planning and participating in recreational activity, monitoring health needs, disciplining, and applying first-aid. All items within MANAGEMENT: keeping informed of the child's progress, communicating with group home staff, communicating with other professionals involved in the care of the child, planning activities, record keeping, and planning goals, were identified as specific job skills, tasks, activities, and knowledge areas where Primary Caregivers are perceived Competent.

Perception of co-worker Competency in: teaching daily living skills, assisting with homework, teaching social skills, promoting learning opportunities, and providing information on alcohol and drugs, were specific job skills in EDUCATION where Primary Caregivers were considered Competent. The only job activity in this category where Primary Caregivers were perceived Somewhat Competent, was the activity of stimulating the child to seek knowledge.

Co-workers were perceived Competent in the following individual SUPPORT job activities: creating a positive emotional climate for the child, and helping the child to manage their own behavior. Primary Caregivers were only Somewhat Competent in helping youth cope with anxiety,

teaching problem solving techniques, and helping parent(s)/guardian(s) maintain positive behavior changes of child when at their own home.

Primary Caregivers were perceived Competent in communicating in ASL and knowing about deaf people, their culture and community under GENERAL KNOWLEDGE job skills. Interestingly, co-workers perceived each other only Somewhat Competent in knowledge about child and adolescent development of deaf/hard of hearing youth, behavior deficits, etiology, and current legislation affecting the deaf population.

The level of perceived Competence of Primary Caregivers was only Somewhat Competent for five out of six specific job skills items in PROFESSIONAL DEVELOPMENT. Participating in seminars, workshops and other professional development activities was the only activity where Primary Caregivers were perceived Competent.

Research Question 5

Is there a statistically significant difference in the perception of Importance of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

No statistically significant differences were found between hearing and deaf/hard of hearing primary caregivers on their perceptions of Importance of composite job skills categories.

Research Question 6

Is there a statistically significant difference in the perception of Competence of composite job skills between hearing caregivers and deaf/hard of hearing caregivers?

Multivariate tests for between category differences were not significant. The results of the univariate F-tests for within category differences in perception of competence of co-workers was statistically significant for PRIMARY CARE. These results suggest that deaf/hard of hearing respondent's perceptions of Competence was different than hearing respondents for the category PRIMARY CARE.

Research Question 7

Is there a statistically significant relationship between perception of Importance of job skills and the respondents' demographic characteristics?

Statistically significant findings on Importance were observed between the following general job skills categories and individual demographic dimensions:

SUPPORT: primary job responsibility; specialized training

EDUCATION: age; salary

PRIMARY CARE: utilize American Sign Language (ASL)

GENERAL KNOWLEDGE: age; utilize American Sign Language

PROFESSIONAL DEVELOPMENT: number of hours providing direct care

No statistically significant results were found in the job skills category MANAGEMENT.

Research Question 8

Is there a statistically significant relationship between perception of Competence of composite job skills categories and the respondents' demographic characteristics?

Statistically significant findings were observed on the following job skills dimensions and demographic characteristics:

SUPPORT: primary job responsibility
 degree held
 specialized training

EDUCATION: age

PRIMARY CARE: hearing status

MANAGEMENT: primary job responsibility

PROFESSIONAL
DEVELOPMENT: degree held

No statistically significant findings were found in the job category of GENERAL KNOWLEDGE.

Research Question 9

Is there a significant difference between the level of Importance and the level of Competency of primary caregivers across composite job skills categories?

Statistically significant differences were found between the perceived level of Importance and level of Competence of composite in all six job skills, tasks, activities and knowledge area categories: EDUCATION; PRIMARY CARE; MANAGEMENT; GENERAL KNOWLEDGE; PROFESSIONAL DEVELOPMENT.

CONCLUSIONS

The following conclusions were drawn from the findings of this study:

Importance of job skills, tasks, activities and knowledge areas

Respondents generally perceived that all job skills, tasks, activities and knowledge areas are Very Important or Important, in order to perform efficiently as Primary Caregivers in community-based group homes for deaf/hard of hearing youth with behavioral deficits.

When composite categories of job skills, tasks, activities and knowledge areas were prioritized, according to a mean rating scale, the following ordering occurred: SUPPORT; EDUCATION; MANAGEMENT; GENERAL KNOWLEDGE; PRIMARY CARE; PROFESSIONAL DEVELOPMENT.

An interesting observation of the importance of specific job skills characteristics was shown in the category of SUPPORT, in that, all items except the activity of conducting therapy were perceived Very Important. The activities within this area are focused on encouraging and assisting youth in the examination of their inner thoughts and feelings. Through this supportive self-examination process deaf/hard of hearing youth are guided toward the identification and interpretation of their feelings. The involvement of primary caregivers within the particular activity of conducting therapy is directed toward the development of youth at an introspective level, and could

incorporate the use of therapeutic techniques and intervention. Primary caregivers usually have job descriptions that do not include the expectation that they will need to assume the responsibilities of counselors or mental health therapists. However, supportive counseling would be an expected job function of primary caregivers in group home settings. In the final analysis, the intervention and involvement of primary caregivers should prepare deaf/hard of hearing youth to assume more responsibility for their behavior, and to demonstrate more appropriate ways of responding to stress or conflict.

Another interesting observation was made in PROFESSIONAL DEVELOPMENT. Although specific skills in the category were perceived to be Important, it had the lowest priority when compared to other job skills categories, and the lowest mean ratings on the Importance of specific job characteristics. It is possible, taking into consideration the daily role responsibilities of primary caregivers, that sufficient opportunity to participate in activities in this area of importance could have been limited. Another observation is linked to the issue of professional recognition of primary caregivers. If PROFESSIONAL DEVELOPMENT is not accepted as a viable activity with proactive encouragement, participation and support from key administrators, primary caregivers may be reserved in showing interest in this area.

Communicating with primary caregivers in other group homes had the lowest mean rating of all 36 job skills, tasks, activities and knowledge areas. Primary caregivers may have perceived that group home primary caregivers would not be willing or encouraged by administrators to avail themselves of the advice or scrutiny of other caregivers outside of their particular work settings. This could reflect underlying issues of territorial protectiveness in managing responsibilities by staff and/or administrators. Additionally, the job tasks may be thought by primary caregivers to be so routine and/or uniquely tailored to their setting, that they would not require external audit. Or, it could simply be that, there may not be other primary caregivers or persons with similar job responsibilities with whom to communicate. The residential school could be the only facility to employ primary caregivers for deaf/hard of hearing youth, who would have any useful information to share about professional development concerns, and it may not be within close proximity to the group home.

Competence in job skills, tasks, activities and knowledge areas

Primary Caregivers were perceived Competent in PRIMARY CARE, MANAGEMENT, and EDUCATION, and only Somewhat Competent in SUPPORT, GENERAL KNOWLEDGE and PROFESSIONAL DEVELOPMENT, in this order. It was not surprising that PROFESSIONAL

DEVELOPMENT had the lowest mean rating for Competence, since it also had the lowest mean rating for Importance.

Conducting therapy was clearly a specific activity where Primary Caregivers perceived co-workers' performance Not Competent. This is a reasonable outcome since therapy is not an expected job performance area for Primary Caregivers in residential school settings. Few Primary Caregivers have within the framework of their job descriptions, the expectation that they will be responsible for therapeutic intervention and support. Job responsibilities have typically been defined for Primary Caregivers where basic custodial care is the primary function.

It was not expected that Primary Caregivers would be only Somewhat Competent in helping youth cope with anxiety, or in helping them to develop problem solving techniques. In fact, the Social Constructivist theory would predict problems, which are borne out in the literature. The literature reveals a moderate percentage of deaf/hard of hearing youth who are predisposed to an increased probability for developing emotional and behavioral disturbances. Primary Caregivers who are perceived only Somewhat Competent in knowledge about the development of deaf/hard of hearing youth, behavior deficits, and the etiology of deafness, could cause confusion in the transmittal of information. Inadequacies in communication skills and general knowledge of deafness in Primary

Caregivers interfere with the cognitive development process of deaf/hard of hearing children. These points provide some explanation for the findings listed above.

Co-workers were perceived to be Competent, in those specific job functions that appeared to demand less in the way of formal training or educational preparation. The skills were less complex, and appeared to be closely related to those tasks primary caregivers might ordinarily perform in the course of their own personal lives.

The job tasks in which co-workers were perceived as Somewhat Competent suggests that primary caregivers may need professional development, training, and education in understanding the needs of the populations they are serving. Primary caregivers appear Competent in routine custodial care activities, but somewhat ineffectual in making applications between theory and practice, to achieve the desired result of helping deaf/hard of hearing youth experiencing behavioral deficits to function at more appropriate levels in the larger society.

Hearing status and perception of Importance of job skills, tasks, activities and knowledge areas

Hearing Primary Caregivers and deaf/hard of hearing caregivers perceived composite job skills categories to be Important to the projected job performance of primary caregivers in community-based group home settings.

However, when categories were casually observed based on the mean ranking of level of Importance, the two groups prioritized composite categories somewhat differently.

EDUCATION and GENERAL KNOWLEDGE shared rank 1 for deaf/hard of hearing caregivers, whereas hearing caregivers ranked SUPPORT at 1. The job skills items listed under EDUCATION, focus the attention of the primary caregiver on the development of deaf/hard of hearing youth, in those areas where he or she will be able to independently function with minimal supervision and to manage their own lives. The job skills, tasks, activities and knowledge areas under GENERAL KNOWLEDGE require the primary caregiver to be knowledgeable about issues and conditions associated with deafness, child development, behavior deficits, and to have adequate sign language skills for communication with residents and deaf/hard of hearing co-workers.

It is particularly critical, especially within a mainstream educational program, that deaf/hard of hearing youth receive adequate training and education. If the primary caregiver or teacher is not knowledgeable in A.S.L., causes of deafness, behavior disorders, deaf culture, etc., the learning process for deaf/hard of hearing youth is even further impeded. Responsive educators and primary caregivers should recognize that additional efforts are required to address deficiencies caused by language deprivation.

A deaf person's access to general knowledge is severely limited by an inability to adequately perceive sound signals, which can be detected from the moment in embryonic development when the ears are formed and are properly functioning, throughout the course of life. The mother's heartbeat, digestive noises, and some external sounds are purportedly heard by the developing fetus. Young children are able to make associations between sounds and corresponding activities, prior to having command of the language. Eventually individuals are able to simultaneously decipher a complex array of sounds, attending only to those interpretations of sound which require response.

Accumulated sounds from a hearing individual's environment can be effortlessly translated into meaningful experiences. These experiences provide a basis for building vocabulary, adding knowledge, and increasing understanding. To achieve a comparable level of knowledge, deaf/hard of hearing persons must be assisted in the beginning stages of formative development, to stimulate the learning process that will provide information about many aspects of their environment.

Nothing should be taken for granted or left for chance in the language acquisition and word meaning development of deaf/hard of hearing persons. The findings suggest that deaf primary caregivers may be more cognizant of this feature than their hearing counterparts. It is understandable then, that deaf/hard of hearing caregivers

ranked GENERAL KNOWLEDGE at the same level as EDUCATION in Importance. These two areas in combination encourage practical applications of information in support of the fundamental growth and development of deaf/hard of hearing youth.

Hearing primary caregivers ranked SUPPORT first in Importance. Hearing primary caregivers, because of educational training or acceptance of socially supported trends, may be more prone to choose psychological models for identifying and remediating dysfunctions. Their energies could be directed toward the acquisition of more intrinsically complex levels of understanding and functioning, because it could have been an acceptable way to address difficulties in their own lives. Unfortunately the acquisition of intrinsically complex levels of functioning, from a therapeutic position, requires a broad vocabulary and an ability to conceptualize subtle discrepancies in word meanings and utilization of terminology. This could be a difficult skill for deaf/hard of hearing children to acquire since, "talking" problems through, to increased understanding often requires a language base that may exceed the boundaries of deaf/hard of hearing youth who struggle to adequately express complex emotions with overwhelming language deficits.

Deaf/hard of hearing children are not born with language deficits. They usually fall behind because no one can communicate adequately with them. A large majority of

deaf children are usually born to parents who are not skillful in sign language, are unfamiliar with deafness, or who are not able to detect the handicapping condition early in the child's development. Language deficits are not the fault of deaf/hard of hearing children. They are the result of inaccessibility of environmental stimuli, including prior engagement in conversation with parents or others.

The priority ranking for EDUCATION and GENERAL KNOWLEDGE by deaf/hard of hearing primary caregivers, compared to SUPPORT for hearing primary caregivers, could denote differences in the process of acquiring information by hearing primary caregivers and deaf/hard of hearing caregivers. It may also reflect the process of life development between the two groups.

SUPPORT and MANAGEMENT shared 2nd place for deaf/hard of hearing caregivers whereas, EDUCATION was 2nd for hearing caregivers. SUPPORT category items focus on the child's emotional, behavioral, and psychological well-being. Activities under MANAGEMENT provide communication linkages between the primary caregiver and other individuals, groups or agencies that are involved in the care and development of deaf/hard of hearing youth.

For deaf/hard of hearing primary caregivers, SUPPORT and MANAGEMENT could be equally Important because of an interdependence between the two category of items. Deaf/hard of hearing caregivers may have an increased need to have frequently updated information about what is going

on around them. Their environment is constantly changing and much of what may be learned about those changes is communicated verbally, or transmitted by a generally understood sound, i.e., fire alarm, crash, yell, etc. This joint priority ranking could be indicative of their efforts to more efficiently manage the lives of deaf/hard of hearing residents and to reduce possible anxiety about occurrences in their environment.

A reasonable response by deaf/hard of hearing primary caregivers working with behaviorally disordered deaf/hard of hearing youth is, to keep in frequent contact with teachers, school officials, and others to establish and maintain structure and consistency for the youth. In turn, primary caregivers are possibly better prepared to assist their charges by increasing the conditions for a positive emotional climate and increased self management of behavior.

EDUCATION was in second place in Importance for hearing primary caregivers. Under this heading primary caregivers are expected to stimulate children to seek knowledge about themselves and about the world around them. These activities range from instructing in basic living skills to training in independent search for knowledge. Recalling that SUPPORT was first, it could be assumed, from the perspective of hearing primary caregivers that, after deaf/hard of hearing youth are able to bring their behavior under control with restructured problem solving techniques (SUPPORT), they would be able to take advantage of

structured learning activities. In general, the subtle and not so subtle message that hearing primary caregivers may have incorporated into their perceptions of job role functions from their own life experiences, is that education is a foundation for improving oneself. This message is believed to be the same, and valued with equally high regard by deaf/hard of hearing primary caregivers. However, the myriad of complexities that may be associated with deafness; the inability to hear repetitive verbal cues; the uncertainty of family support; difficulty in communication because of the overwhelming hearing (speech) model; the inconvenience of educational access, or the presence of any number of additional factors could have had an effect on caregivers' perceptions which affected ranking between the two groups.

The mean rating attributed by hearing Primary Caregivers to MANAGEMENT and GENERAL KNOWLEDGE resulted in a tie for third position. Caregiver management activities provide an organized and systematic structure of home operation and resident care. More often than not, this category of job skills contains the "paper work" activities; record keeping and documentation. GENERAL KNOWLEDGE requires more of hearing primary caregivers in the way of proficiency in A.S.L., expertise in issues related to deafness, behavioral disorders, child development and legislation affecting deaf citizens. These activities could be used to serve as a measure of accountability, and

contribute to the assessment of the professionals' performance in job responsibilities that impact on the deaf/hard of hearing population. This association makes it seem likely that hearing Primary Caregivers would rate them at the same level of Importance.

PRIMARY CARE was ranked next to last in prioritized Importance for both deaf/hard of hearing caregivers and hearing caregivers. PRIMARY CARE job tasks could almost be described by changing the category name to "parental care". The job tasks of primary caregivers are similar to the kind of responsibilities that are typically performed by parents or guardians within a family living environment: children are disciplined, their health needs are monitored, they participate in recreational activities, and they are involved in routine household chores.

Deaf/hard of hearing primary caregivers and hearing primary caregivers perceived that PRIMARY CARE is an area that is Important, however, the order of priority and the similarity of job skills to those ordinarily performed in the course of daily living seems to suggest that deaf/hard of hearing primary caregivers, as well as hearing primary caregivers, consider other issues previously mentioned more Important.

PROFESSIONAL DEVELOPMENT was observed to have the lowest priority on Importance by both groups of caregivers and was ranked last based on the mean rating scale for hearing and deaf/hard of hearing primary caregivers. In a

prior discussion, it was suggested that PROFESSIONAL DEVELOPMENT activities may not be perceived as Important if conditions are not conducive for their advancement.

Hearing status and perception of Competence in composite job skills, tasks, activities and knowledge areas

Statistically significant differences in perceptions of co-worker Competence between deaf/hard of hearing and hearing primary caregivers could be related to an enhanced personal understanding of deafness, and its impact on the lives of deaf/hard of hearing individuals. Deaf primary caregiver responses, and hearing primary caregiver responses to deafness, may have been shaped by a perspective of the hearing world that reflects an historical relationship to individuals with handicapping conditions. Differences could also be related to limited signing skills on the part of hearing caregivers to communicate requests and information in a mode that is clear. Other factors for consideration include fear and uncertainty about deafness, misinformation, misinterpretation of behavioral responses and inappropriate or low expectations of deaf individuals.

Deaf persons are capable of handling their own affairs, and functioning in a hearing world. However, attitudes by hearing individuals in decision making positions have historically prevented opportunities for this population of people to demonstrate their skills. A major obstacle, which has largely remained intact, is the communication barrier.

Demographic characteristics and perception of Importance of specific job skills, tasks, activities and knowledge areas

Given the general activities within SUPPORT, the significance of Job Responsibility significant results appear to be consistent when compared to the fundamental responsibilities of individuals (counselors, teachers, supervisors and dorm counselor/house parents) involved in direct interactions with deaf/hard of hearing youth, i.e., to be supportive, and to foster the overall development and psychological functioning of the individual.

Additionally, it did not matter whether primary caregivers had specialized training or not, since each specific group perceived SUPPORT to be Very Important according to the mean rating scale. It could suggest that on-the-job training, or observation of the needs of deaf youth was sufficient enough to motivate those individuals within the Specialized Training demographic group to perceive SUPPORT Important.

Under EDUCATION, younger individuals 18 - 30, and those with salaries in lower income brackets which ranged from \$0 to \$9.999.00, are probably more cognizant of the significance of preparing deaf/hard of hearing youth with the tools necessary to survive. They may be more apt to believe a common assumption that, the better prepared one is academically, the greater ones' opportunities for employment and financial security.

It makes sense that the demographic characteristic utilizing ASL was perceived Important to Primary Care, since this category of job skills, tasks, activities and knowledge areas requires a great deal of casual, although direct communication with deaf/hard of hearing behaviorally disordered youth in the course of daily living activities.

The category of GENERAL KNOWLEDGE focused the energies of caregivers around an understanding of the interconnecting issues surrounding the development of deaf/hard of hearing children, as well as the impact of social and political factors upon their lives. The demographic characteristics Age and ASL were significant to GENERAL KNOWLEDGE. Very likely some of the same reasons that age and ASL may have been speculated to be significant to other composite categories holds true for GENERAL KNOWLEDGE as well. One suggestion that has not been explored is the relationship between the influence of life stage/age issues of primary caregivers and their projection of life stage/age needs of deaf youth. For example, younger caregivers, 18 - 30 had the highest mean rating on perceived Importance, while 31 - 40 year old caregivers had the lowest mean rating. One speculation is that younger caregivers are still learning, and in the process of building their expertise within the career, while 31 - 40 year old caregivers may have been in the field longer, or considering career advancements within or outside of the field.

Primary caregivers providing at least 40 hours or more in direct care perceived PROFESSIONAL DEVELOPMENT as Important. This relationship might be significant because, individuals providing 40 hours or more to a job are more than likely full-time employees with a vested interest in their professional performance and career advancement potential. These individuals could also have more supervisory or administrative responsibilities.

Demographic characteristics and perception of Competence in specific job skills, tasks, activities and knowledge areas

Counselors and teachers perceived co-workers at Competent levels of job performance, while supervisors, other administrators, and dorm counselors rated co-workers at levels that were Somewhat Competent in SUPPORT. This result should be interpreted with the understanding that evaluations of competency possibly excluded co-workers from other job function areas. If so, those individuals with job responsibilities in direct care and management of residents, have findings which suggest that, support personnel may need to pay more attention to improving professional effectiveness with deaf/hard of hearing youth.

Respondents with a GED or high school Diploma perceived co-workers' performance to be Competent, while those individuals with post-secondary degrees perceived co-workers performing at levels that were only Somewhat Competent. Perhaps this last group of primary caregivers, as a result

of formal academic training, possessed an understanding of what could be considered acceptable levels of expertise to perform within the job skills category of SUPPORT. They may not have considered others sufficiently prepared to become involved in therapeutic intervention, as suggested by the specific job skills item, conducting therapy. individuals with post-secondary degrees may have been aware of the educational training one must satisfy before conducting therapy.

Relationship between Importance and Competence of job skills, tasks, activities and knowledge areas

There appear to be clear indicators which strongly suggest that close attention needs to be paid to examining the reasons for the gaps between those job skills, tasks, activities and knowledge areas that are perceived to be Important to the role functions of primary caregivers, that are not being performed at satisfactory degrees of competence. The assumption is that primary caregivers should perform well in those areas they consider Important, however the data analysis shows that respondents perceive the situation to be just the opposite. Could it be that too many assumptions are made about the "routineness" of the responsibilities of primary caregivers or that, just using ones' common sense to carry out job tasks is enough?

Linkages can be made to previous results for PROFESSIONAL DEVELOPMENT to provide additional insight into

this problem. It is clear that primary caregivers do not perceive the five composite job skills to be Important; neither are they Competent in them. This may suggest a need for education and in-service training to elevate the performance levels of primary caregivers, and to modify their perceptions of their professional role and responsibility.

Preceding discussions in this research study have examined issues about primary caregivers and their potential for affecting the development of deaf/hard of hearing youth with behavioral deficits from a social constructivist theoretical point of view. In Chapter I, Introduction, the theoretical importance of social constructivism was used to structure the problem of identifying job functions which are germane to the performance of primary caregivers. Chapter II, Literature Review, included information from the current body of knowledge about deafness, behavioral disorders, and primary caregivers. The research design, instrumentation, procedure for conducting the research and method for analyzing the data were outlined in Chapter III. The results of the statistical analyses were presented in Chapter IV. The summary of the findings and conclusions were presented in Chapter V. Chapter VI utilizes information from previous chapters to lay out the implications and recommendations of the study to formulate a general structure and design of a model group home for deaf/hard of hearing youth with behavioral deficits.

CHAPTER VI

RECOMMENDATIONS AND IMPLICATIONS

Summary

This research examined the importance of role responsibilities and competencies in job functions of primary caregivers. It allowed the researcher an opportunity to make projections about the application of skills, which are acquired and utilized in larger residential schools, to skills which could be performed in community-based group homes for deaf/hard of hearing youth experiencing behavioral deficits. It also allowed the researcher an opportunity to speculate on the value of interactive relationships between deaf/hard of hearing children and primary caregivers which are important to the process of comprehensive life development.

The purpose for conducting this research was to examine the perceptions of primary caregivers, currently employed in residential school settings for deaf youth, on the job skills they considered most important for the effective functioning of individuals who would work in community-based group homes, for deaf/hard of hearing behaviorally disordered youth. The study also examined caregiver

perceptions of co-worker competency in current job functions.

The results, presented from the statistical analyses and reported on at length in this research study, suggest that SUPPORT, PRIMARY CARE, EDUCATION, MANAGEMENT, GENERAL KNOWLEDGE and PROFESSIONAL DEVELOPMENT are composed of job functions which are Important to the projected job performance of primary caregivers in group home settings for deaf/hard of hearing youth. The findings also suggest that Primary Caregivers perceive each other to be currently performing at levels that are generally Competent to Somewhat Competent.

This research effort is not intended to argue the merits of residential care verses group home care, rather; it addresses the ultimate need to adequately prepare primary caregivers in the professional care of deaf/hard of hearing youth, with behavioral deficits in congregate care facilities whether they are large or small.

Recommendations

1. Group home developers. Professionals, individuals with special needs, human resource/service agencies, and others interested in establishing group homes for deaf/hard of hearing youth should consider utilizing a comprehensive personnel hiring process. Ideally, it should focus on qualifications of the applicant in those areas which the findings in this study suggest are Important to the

projected job functions of primary caregivers, i.e.:
SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, GENERAL
KNOWLEDGE, and PROFESSIONAL DEVELOPMENT.

In addition, the philosophy of prospective primary caregivers should be examined for compatibility with the operational philosophy of the group home. Primary caregivers also need to be prepared to execute steps which direct residents toward better management of their behavior, and the acquisition of independent living skills.

The development of a community-based group home would also require input from various interest groups and community representatives to ensure balance in planning the inclusion of a group home within the structure of established neighborhoods. A key element in fostering the acceptance of a specialized care facility within a neighborhood demands that extensive groundwork be laid to help allay fears and misunderstandings about residents and the potential for harm. All issues must be confronted and dealt with honestly and realistically through public information forums, public relations efforts and awareness building activities. Much of what transpires in the initial steps to establish a community-based group home, sets the stage for community acceptance of the group home, and affects daily operations. Mangled communication promotes alienation and suspicion by those parties who perceive they are not given information about events that will affect their lives. The literature resoundingly asserts this fact

for deaf/hard of hearing persons, and it also applies to individuals who are hearing.

2. Residential school administrators interested in increasing competency levels of residential program staff.

Residential school administrators are responsible for maintaining a quality educational program for deaf residents and providing an administrative structure that supports professional development and total involvement. If the attitude and expectation of an administrator is incongruent with staff, teachers, caregivers and other personnel, morale may suffer. This situation could be managed by recognizing the value of primary caregivers and advocating for their professional development.

Primary caregivers are considered prime facilitators of the growth and development of deaf youth. Their attitudes and expectations of themselves, and perceptions by administrators, seem to set the stage for work morale and competent job performance. Residential school administrators addressing the need for primary caregivers to increase their competencies could encourage participation in professional development activities. This would potentially improve the work performance of staff and capitalize on the benefits of their commitment and investment in their role responsibilities.

Involvement in regularly scheduled in-service workshops and training/re-training sessions would keep caregivers

current on how to perform more competently in their role functions from many perspectives. Information sessions could expose them to the latest developments in the field of deafness, provide data about research studies, or give them an opportunity to improve in a skill area. The goal of these activities should be designed to set the criteria for defining efficient job performance. This will help establish standards for competency and eliminate individual interpretations of what are acceptable levels of job performance. More importantly, attention should always be focused on bringing an awareness to the primary caregiver of their important function in the total life development of deaf/hard of hearing youth.

3. Primary caregivers need to be involved in professional development activities.

This study revealed that although PROFESSIONAL DEVELOPMENT was considered Important, it had the lowest priority rating and it was not an area where primary caregivers were perceived to be Competent. Primary caregivers need to recognize how important their total involvement is in the lives of deaf youth, and that they are significant contributors to cognitive development and life skills training. Several major contributing factors were identified which undergird the professional role development of primary caregivers, and were considered essential to the practitioners' involvement with deaf/hard of hearing youth.

Participating in national efforts, in addition to organizing at local and district levels, would establish child care work as a viable profession and contribute toward structuring of the career. Networking with other caregiving professionals would create opportunities to design forums, workshops, and conferences within which practitioners could exchange relevant information about themselves, their profession, and the persons they are directly responsible for. Lobbying to affect legislative and policy decisions would ensure financial stability, and confirm the validity of the profession. Professional development activities would not be complete if on-going, required instructional components in sign language were not included.

4. In-service for primary caregivers is important.

Residential school administrators need to recognize the critical importance of the relationship between primary caregivers and residents and the impact of that relationship on cognitive development. Education and training need to be incorporated in the job activities of primary caregivers in an effort to bridge the gap between job skill potential and job skill proficiency.

A perpetual goal of a residential program should be to increase knowledge and understanding. Researchers and practitioners can contribute important information to the field of deafness by collaborating on the effective utilization of various teaching and learning modalities in

working with deaf/hard of hearing youth, especially those with behavioral deficits.

5. All employees need to utilize modes of communication appropriate for deaf/hard of hearing residents.

Throughout the literature, a recurring observation has been pointed out; barriers in communication significantly impact on acquisition of knowledge. Communication barriers affect the ability of deaf individuals to receive, interpret and transmit information. It is extremely difficult to formulate an understanding of the meaning and consequences of what is being communicated, if the communication process is impeded by an inability of the communicators to express themselves in modes that are mutually understood by each participant.

The theoretical perspective of social constructivism supports the idea that individuals are able to develop cognitively and socially by participating in exchanges with other more knowledgeable persons in the environment. Ineffective interactions in communication can cause misinterpretations of expectations, and place obstacles in the process of cognitive development. Acquiring and developing skill in American Sign Language, and other communication modes for use with deaf persons is crucial in creating or broadening access to information.

Recommendations for Further Research

This study was undertaken to assess the importance and competency of job skills, tasks, activities, and knowledge areas to job performance needs of primary caregivers. Identifying a unique category of individuals with job titles and functions directed exclusively toward caregiving responsibilities made this task more difficult.

An examination of the literature revealed an inherent problem in succinctly defining caregivers, and in isolating duties specific to their role functions. Some basic work assignments have been identified for primary caregivers, however, work settings, clientele, staffing, program structure, management priorities, and a host of other contributing factors make delineation of the field a complex procedure.

For a more comprehensive evaluation, it is recommended that further research be conducted to assess the importance of job skills to projected job function requirements of primary caregivers in group homes for deaf/hard of hearing youth with behavior deficits. It is further recommended that research be undertaken to evaluate current competency levels of job performance of primary caregivers.

Implications

The focus of this study was concentrated on identifying job skills, tasks, activities and knowledge areas along with assessing current levels of expertise in the work

performance of primary caregivers. The findings suggest that primary caregivers are cognizant of the importance of particular task components to the purpose of work activities. The results of the research also indicate that overall levels of expertise are marginal.

The implications of these research findings have profound relevancy for counselors. Counselors can play a significant role in the provision of service to deaf clients and their families, educators, social workers and other professionals involved in the care or provision of other supportive services to deaf clients. These activities could range from genetic counseling or helping families cope with the initial diagnosis of deafness, to providing information which increases awareness and sensitivity by the general public, to addressing the issues of elderly deaf people. Counselors could be instrumental throughout each stage in the process of life development.

It has been substantiated that approximately 90 percent of deaf/hard of hearing children are born to hearing parents who are generally unaware of how to cope with deafness. This could introduce traumatic problems of adjustment in ensuing years, if, in the formative stages of development, deaf children become confused, learn to mistrust, or have an increased potential for emotional difficulties, due to the absence of an effective communication mode with significant others. Counseling intervention with parents and families at critical beginning stages of the deaf child's life,

provides support through the process of acceptance of their handicapped child or family member. More importantly, immediate attention can be paid to stimulating communication by using a constructive language acquisition process. This can be accomplished by having everyone in the family learn sign language, or an effective communication mode for use with deaf individuals. The ease with which parents, families and deaf family members are able to cope with deafness depends heavily on early identification and intervention.

It is generally understood that each citizen, regardless of a handicapping condition, has the right, and an obligation, to participate in the educational system. Since the early 1800's, deaf children have been able to attend public and private residential schools and day schools and classes. However, with the advent of the legislative initiative PL 94-142, deaf children, in fact all handicapped children, have the right to participate in schools and classes within their neighborhood districts. Theoretically, this makes good sense. Operationally, it has been problematic. An implication for the services of counselors suggests that, they would work with educators to increase their understanding of the ramifications of hearing impairment and its effect on the learning style needs of deaf/hard of hearing learners. Psychological testing and evaluation, academic achievement testing, career counseling and evaluations could be monitored and/or conducted by

counselors skilled in effective communication modes and who are knowledgeable about deafness.

At some point, deaf individuals and their families may need the assistance of a social services agency to secure referral information for additional services, qualification for financial or medical benefits, or help with any number of concerns. The involvement of qualified counselors can facilitate the understanding, and sometimes patience, of deaf clients going through a sometimes confusing, complicated bureaucratic process.

Counselors skilled in sign language, and knowledgeable in deafness can be invaluable facilitators of positive psychological growth, throughout the comprehensive life development process of deaf persons. In general, they can support the growth of deaf individuals toward accepting themselves, as well as increase more appropriate responses and acceptance by hearing persons.

Group Home Model

This group home model is designed around a social constructivist theory which supports the researcher's belief that deaf/hard of hearing youth are capable of learning and growing to their full potential, in collaboration with primary caregivers--significant facilitators in cognitive, social, language, and general development. This group home model is also built around the assumption that primary caregivers can provide supportive therapeutic interactions with deaf/hard of hearing youth diagnosed with behavioral deficits, in small community-based group home facilities.

Job functions and responsibilities of primary caregivers in the group home will be discussed, to include a general demographic profile of job qualifications, based on summary data from responses to open-ended questions on the research instrument and reference to the literature review. This discussion is framed within a social constructivist perspective of caregiver roles.

The group home model will be broadly outlined, identifying residents, community setting, and physical structure, providing a structural overview of these areas.

Primary Caregivers

Primary caregivers are allowed to expand their function as therapeutic change agents in the care of residents in group home settings. Emphasis on the formative and developmental nature of their work and involvement with

deaf/hard of hearing youth shapes their professional role and responsibility in the group home. Primary caregivers operate within a broad spectrum of job functions which occur within the composite job skills categories of; SUPPORT, EDUCATION, PRIMARY CARE, MANAGEMENT, GENERAL KNOWLEDGE, and PROFESSIONAL DEVELOPMENT. Throughout each of these areas, a consistent philosophy of nurturing the development and therapeutic progress of deaf/hard of hearing residents with behavior deficits, is actively reinforced in enhancing language acquisition through communication.

The success of the group home is dependent upon the skills, qualifications and professionalism of the staff. In order to contribute to this success, it is recommended, from the researcher's exploration of information found throughout the literature, that primary caregivers meet certain minimum qualifications (Small & Dodge, 1988; VanderVen & Tittnick, 1986).

Establishing a set of qualifications for primary caregivers is one part of the task in hiring well-prepared individuals. Responses on the research instrument, along with information reviewed in the literature, were utilized to compile recommended qualifications. In job function areas where skills are not yet developed, applicants should be evaluated on their willingness and potential to acquire new skills. Participation in in-service training courses or sessions, should be scheduled to give primary caregivers opportunities to develop proficiencies in job tasks.

Primary Caregiver Job Qualifications Profile

In order to qualify for a primary caregiver position, applicants must be proficient in sign language, and possess a thorough understanding of deafness and related issues. Working with youth who are experiencing behavioral deficits can present unique challenges to caregivers who will need to demonstrate an ability to function in stressful situations while remaining focused and flexible. Having a sense of humor, while not a qualifications criteria, could help primary caregivers alleviate a potentially negative episode, and demonstrate to youth alternative ways of resolving problems to avoid unnecessary confrontations.

Applicants should have at least 2 years of college or an associate degree in psychology, deaf education, counseling, education, sociology, social work, rehabilitation, child development, behavior deficits, exceptional children, or related area(s). Two years of paraprofessional mental health training would also be acceptable.

Caregivers are primarily responsible for the management and daily operation of the group home. In order to carry out these functions, primary caregivers should have adequate administrative, management and organizational skills to support the smooth operation of the home. Skills in record keeping, budgeting, and accounting are required to keep the program financially sound.

In addition to business management proficiencies, caregivers must be adept at managing the comprehensive life development of residents. These activities include contributing to resident policy formation, planning activities, coordinating the involvement of professionals and contributions of other concerned persons who are involved in the lives of deaf children and youth.

Primary caregivers are key factors in the success of residents in the group home. They have increased opportunities to interact and spend quality time with residents. Because the size of the group home is much smaller than a residential school, primary caregivers have the authority to exercise greater professional autonomy and independence in the management of daily operations of the group home.

Primary caregivers are involved as general managers in completing routine daily activities of the group home. With the assistance of a cook, housekeeper, maintenance/gardener, and assistance of other support individuals when needed, caregivers can capitalize on their skills in management and decision making to make the group home run smoothly and efficiently, allowing more latitude to focus attention on residents.

Primary caregivers have a unique and important relationship to the development of deaf/hard of hearing youth who are experiencing deficits in behavior. The most important aspect of this relationship involves

communication. The effort that primary caregivers put toward therapeutic intervention in behavior adjustment takes place in the activity of communication with deaf/hard of hearing residents. Through contact with residents in signed or oral conversations, primary caregivers impart information. In the process, they assist residents in vocabulary expansion, improved understanding of word meanings and increased conceptual understanding. When deaf/hard of hearing residents improve their communication capabilities, they are given tools with which to shape their thoughts and monitor their behavior. Since communication is vital to treatment and facilitating understanding, the development of communications skills will be mandatory for all residents and staff. All communication systems utilized by deaf persons will be explored with select methods practiced for optimal vocabulary expansion and conceptual understanding.

According to social constructivism, individuals learn about their environment and themselves from involvement in social interactions with others. Individuals internalize the interactions later to formulate perceptions by which they govern themselves, and they are based on their understanding of cultural expectations of behavior. Suppose S. is referred for participation in this therapeutic group home environment with complaints from her parents that she is willful, non-compliant and that she ignores authority. Primary caregivers would utilize a pro-active approach,

providing S. with activities and demonstrations intensely structured around word/concept meaning related to the issues surrounding her behavior. They would also make sure that S. is given every advantage to learn how to communicate in a mode that effectively allows her to grow in her capacity to understand herself as well as others.

Because the group home is designed as a therapeutic home environment, formal therapy sessions for S. would be conducted by mental health specialists proficient in sign language and issues regarding deafness. Primary caregivers and mental health practitioners would work collaboratively with S. and her family in addressing and alleviating problematic issues in the situation. For this particular child, part of the problem was related to an inability of the family to communicate effectively; therefore, part of the treatment plan would include arrangements to assist the family in acquiring those skills. Therapeutic intervention that incorporates involvement with parents and family members, especially mothers, increases the chances for the successful outcome of therapeutic intervention.

The primary caregiver strives to promote the comprehensive development of deaf/hard of hearing youth with behavior deficits. Each interaction, each activity, each accomplishment that helps a resident achieve short-term goals, moves deaf/hard of hearing youth with behavioral deficits toward the long-range goal of establishing independent living skills, and more appropriate ways of

responding to stress and conflict. The better prepared the primary caregiver is at a professional level, the more efficient the interaction between primary caregivers and residents. The caregiver professional incorporates the components of education, training, and other experiences into a pattern of positive development that advances deaf/hard of hearing residents toward independent living and self-sufficiency. This effort is accomplished through regular consultations with other primary caregivers in the group home, with participants on the advisory board, school instructors, the referring agent, residents and parents/sponsors.

Community Setting

The procedure for selection, purchase and establishment of the group home should include input from a comprehensive body of representatives to include; the funding source(s), group home administrators, delegates from the community at large and from the deaf community. This body of concerned citizens would form an advisory board, whose mission would be to provide input regarding the operation of the home and guidance or assistance to primary caregivers. Every effort should be exercised to meet with neighborhood association groups, city government officials and individuals who may be interested in the establishment of the home in the neighborhood. Care should be taken to raise diplomatically the level of awareness and sensitivity to the issues related

to deafness, behavioral deficits and to dispel any preconceived myths about deaf individuals. Informative pamphlets and other accurate documentation could be used to accomplish this. The community and neighborhood which are selected to accommodate the group home should be investigated and observed in the several areas.

Ideally, the group home should be located in a neighborhood with a diverse demographic profile, particularly since group home residents may have diverse demographic characteristics. This accomplishment would purportedly ease the transition of residents into the fabric of the community. The neighborhood and surrounding structure of the general community at-large, should provide those services, activities and establishments that support the recreational, financial, health, and general human needs of individuals. More specifically, the community should have programs, services, and activities that are accessible to deaf/hard of hearing persons.

Renovations, landscaping or other major structural work should be contracted, work schedules correlated and arrangements made to guarantee completion of all work orders in a timely manner, not to exceed the first day of operation of the group home. The group home should meet or exceed required safety, fire, and building codes to the degree that zoning laws or local ordinances are not violated. Operational licenses should be properly secured and maintained.

Group Home Physical Structure

The following brief description of a group home structure is formulated from responses to open-ended questions on the Primary Caregivers Group Home Questionnaire, Superintendents' Questionnaire, and findings from the research study. Based on those responses, community-based group homes are considered appropriate places to serve deaf/hard of hearing youth who require involvement in behavior management treatment modalities.

The size of the home should be spacious enough to accommodate private living quarters for full-time primary caregivers, with guest quarters for part-time, temporary, or relief caregivers. Adequate numbers of rooms for residents should be based on double occupancy. Special rooms or areas should be available for study and guided learning, recreation, group discussion, and other activities where necessary. Furnishings should be selected for durability and complemented by decorations and accessories that help convey the group home as an environment of warmth, safety, comfort and support.

Special attention should be paid to equipping the home with communication assist devices. Telecommunications Devices for the Deaf, and closed captioning devices should be standard equipment for the home. Group home developers should ensure the safety of occupants by installing an emergency system with automatic alert to police, fire and

medical emergency units. Additionally, the home should have signaling devices, with accompanying light signals, for the telephone, fire alarm, doorbell, and for other equipment, machinery or situations that might require attention.

Personal computers in the group home will increase opportunities for deaf/hard of hearing youth to utilize educational software programs to increase academic abilities, and provide avenues for self-paced interactive learning. Equipping the group home with these considerations will create an environment that provides safety, accessibility and comfort.

Residents

Applicants who are referred for admission to the group home should be enrolled/mainstreamed in area schools or vocational education/preparation programs. Participation in the group home should provide a reasonable treatment alternative for the applicant who is perceived to be capable of benefiting from a therapeutically structured milieu. Referral to the group home is appropriate when: a child's behavior is problematic at home and school; all efforts to moderate the behavior have been exhausted; remediation requires more than weekly outpatient intervention.

Residents may be referred by any individual, agency or institution. Children served in these settings could vary in age from less than 10 years to greater than 18 years, and number no more than three residents for each primary

caregiver. Admission decisions by gender would depend on the age of the youth and the composition of the group home at the time of the referral.

Deaf/hard of hearing youth with severe behavior deficits, i.e., self-injurious behavior, suicidal ideation or attempts, physical violence, fire setting, cruelty to animals, substance abuse, autism, pervasive developmental disorders, assault, sexual deviancy, etc. may require services more extensive than that for which this particular model is designed. For these children, referrals should be made in collaboration with mental health consultants and professionals in the field of deafness.

In an effort to blend into the fabric of the neighborhood, to allow for a smooth transition for residents and caregivers occupying the group home, and to minimize community resistance, the initial group of residents will be introduced into the group home, one at a time, with at least one week between admissions, until the desired ratio of no more than three residents to one Primary Caregiver is achieved.

In the initial stage of the application process primary caregivers will be responsible for providing the referral source with a screening application and materials describing the function and purpose of the home. The purpose of the screening application is to assess the appropriateness of the referral and to obtain a brief, concise statement of the need for group home placement. Each community group home

will accept residents based on a set of criteria established by caregivers, in consultation with sponsoring representatives, and members of the advisory board. Members on the advisory board should represent all operational aspects of the group home, i.e., educational; mental health services; health and nutrition; legal services; engineering; public assistance; banking and accounting, local government etc.

Caregivers will actively participate in admissions procedures from the point of initial referral to actual acceptance of the resident into the group home. A general outline of each responsibility in a six stage admissions process for residents is suggested as follows:

Six-Stage Application and Admissions Process

Stage I. Referral

- A. Initial screening application forwarded for completion
- B. Preliminary case file started
- C. Appropriateness of referral determined
- D. Referral assistance provided where necessary

Stage II. Documentation

- A. Initiate case file
- B. Obtain supporting documents
 - 1. psychological
 - 2. behavioral assessments
 - 3. family/social history
 - 4. detailed medical history
 - 5. educational/school records
 - 6. audiological results
 - 7. other supportive documentation

Stage III. Interview

- A. Interview/observe applicant
- B. Interview significant others

responsible for the care or education of applicant

B. Schedule comprehensive evaluations

Stage IV. Case Review and Presentation

- A. Prepare file for admissions consultation
- B. Formal acceptance decision
- C. Recommendations of goals outlined
- D. Referral assistance and advocacy provided to non-admitted applicants
- E. Transition schedule arranged

Stage V. Transition Weekend

- A. Weekend visit scheduled for new resident
- B. Familiarize applicant with rules and regulations
- C. Review policies
- D. Discuss behavioral and general goals
- E. Observe interactions with other residents
- F. Note observations by current residents
- G. Allow one week cooling-off period prior to actual establishment of residency

Stage VI. Finalize Admission

- A. Establish medical, financial coverage
- B. Arrange supportive services
- C. Conduct final admission interview; include resident, parent(s), referral source, primary caregivers
 - 1. establish short-term and long-term goals
 - 2. review regulations and group home policies
 - 3. review client rights and group home rights
 - 4. negotiate a contract for participation in the group home
- D. Arrange a welcoming activity

This six step admissions process for residents will be implemented to ensure that current residents and staff will be prepared to interact in a positive, supportive way with the new resident. It also provides a mechanism for conducting comprehensive evaluations to ensure an appropriate admission or referral.

The model presented here only provides a sketch of general considerations for the development of a group home that serves deaf/hard of hearing youth with behavioral deficits. A more comprehensive description would involve further research which delves extensively into group home development. Based on this research study, the most important feature of the group home design requires the involvement of competent, motivated primary caregivers, who are skilled in maximizing the potential of deaf/hard of hearing youth. Focusing on this establishing this prerequisite would satisfy the minimal criteria for initiating group home development. Properly prepared primary caregivers will contribute significantly toward the total life development and personal empowerment of deaf persons.

Concluding Comments

Flynn and Nitsch (1980) made a statement regarding deviant behavior that initially grounded the efforts surrounding this research. In brief, they asserted that deviancy is not within the person; rather, it is an interpretation shaped by society that varies across cultures and time. Coupled with this perspective was the notion by Vygotsky (1978), that individuals within one's environment can significantly impact on development. Together, these two ideas fueled the motivation to conduct research on the relationship of primary caregivers to deaf/hard of hearing

youth with behavior deficits, according to perceptions of importance and competence in job skills.

Positive changes are gradually occurring within our society which affect how we perceive ourselves, and how we perceive others who possess characteristics that may be different from our own. These changes are being attributed to activities which increase awareness of differences by presentations which are informative and positive. They are also attributed to examples of more aggressive challenges to systems and mind sets, which have historically prevented accessibility to those who have been disenfranchised.

During the course of this research, Gallaudet University made front page headline news when students protested the candidacy of a hearing individual, over an extremely well qualified deaf individual, for selection to the presidency of the university. The ability to hear seemed to have been a major discriminating factor for some who argued that, deafness would interfere with an individual's ability to direct the administrative process of the university, and impair leadership. Others countered this argument suggesting that, the leadership of a university specifically established for the educational needs of deaf persons, would be more appropriately served by an individual who could relate to the needs of the students, and who was acutely aware and attentive to the complexities of deafness. After great debate, Gallaudet University

achieved an historical milestone and celebrated the inauguration of its first deaf president.

The effects of deafness are exacerbated by attitudes of paternalism and reluctance on the part of others who are hearing, to make information easily accessible to deaf persons through compatible modes of communication, i.e., A.S.L., closed captioned T.V., T.D.D's or interpreters. An unwillingness to adjust ones' attitude or perception regarding the potential for achievement in deaf individuals, could decrease their participation in the mainstream of society and diminish their opportunities for making contributions to humanity. Perceptions of deviancy formulated on misinformation and inappropriate standards of relevancy constitute a social injustice.

We must be willing to broaden our perspectives, explore alternative options for realistic interventions and collaboratively assist deaf/hard of hearing persons toward achieving personal empowerment and autonomy over their own lives.

APPENDICES

APPENDIX A:
LIST OF RESIDENTIAL SCHOOLS

RESIDENTIAL SCHOOL LISTING

Alabama Institute for Deaf and Blind
205 South Street
Talladega, Alabama 35160

George C. Wallace Speech & Hearing Center
Station 6720
Montevello, Alabama

Parlow State School & Hospital Program for the
Sensory Impaired
P.O. Box 1730
Tuscaloosa, Alabama 35403

Alaska State School for the Deaf
2220 Nicholas Street
Anchorage, Alaska 99507

Arizona State School For The Deaf And Blind
1200 W. Speedway Boulevard
Tucson, Arizona 85703

Arkansas School For The Deaf
2400 W. Markham
Little Rock, Arkansas 72205

Arkansas School For the Blind: Deaf-Blind Unit
2600 W. Markham
Little Rock, Arkansas 72203

California School For The Deaf, Fremont
39350 Gallaudet Drive
Fremont, California 94538

California School For The Deaf, Riverside
3044 Horace Street
Riverside, California 92506

Colorado School For the Deaf and Blind
33 North Institute Street
Colorado Springs, Colorado 80903-3599

American School For The Deaf
139 North Main Street
West Hartford, Connecticut 06107

Margaret S. Steerck School For The Hearing Impaired
620 East Chestnut Hill Road
Newark, Delaware 19713

Providence Christian School for the Deaf
5416 Providence Road
Riverview, Florida 33569

Model Secondary School For The Deaf
800 Florida Ave., N.E.
Washington, D.C. 20002

Florida School For The Deaf and the Blind
207 N. San Marco Avenue
St. Augustine, Florida 32084

Georgia School For The Deaf
P.O. Box 99
Cave Spring, Georgia 30124

Houston Speech School
100 Pine Valley Drive
Warner Robins, Georgia 31093

Hawaii School For The Deaf And Blind
3440 Leahi Avenue
Honolulu, Hawaii 96815

Idaho School for the Deaf and Blind
1450 Main Street
Gooding, Idaho 83330

Centerview Therapeutic School
10100 Dee Road
Des Plaines, Illinois 60016

Illinois School for the Deaf
125 Webster
Jacksonville, Illinois 62650

Jack Mabley Developmental Center
1120 Washington Avenue
Dixon, Illinois 61021

Philip Rock Center & School
818 DuPage Boulevard
Glen Ellyn, Illinois 60137

Indiana School for the Deaf
1200 E. 42nd Street
Indianapolis, Indiana 46205

Iowa School for the Deaf
1600 South Highway 275
Council Bluffs, Iowa 51503

Kansas School For The Deaf
450 East Park
Olathe, Kansas 66061

Kentucky School For The Deaf
P.O. Box 27
Danville, Kentucky 40422-5132

Louisiana School For The Deaf
P.O. Box 3074
Baton Rouge, Louisiana 70821

Special School District #1
P.O. Box 191
Pineville, Louisiana 71360

Belle Chase State School:
Metropolitan Developmental Center
Box 7070
Belle Chase, Louisiana 70037

Governor Baxter School For The Deaf
Mackworth Island
P.O. Box 799
Portland, Maine 04104-0799

Northwest Louisiana State School &
Special School District #1
5401 Shed Road
Bossier, Louisiana 71111

Maryland School For The Deaf
P.O. Box 250
Frederick, Maryland 21701

Maryland School For The Deaf
P.O. Box 894
Columbia, Maryland 21044

Boston School For The Deaf
800 North Main Street
Randolph, Massachusetts 02368

Beverly School For The Deaf
6 Echo Avenue
Beverly, Massachusetts 01915

The Clarke School For The Deaf
Round Hill Road
Northampton, Massachusetts 01060

The Learning Center for Deaf Children
48 Central Street
Framingham, Massachusetts 01701-4815

Michigan School For The Deaf
West Court and Miller Road
Flint, Michigan 48502

Michigan School For The Blind/Deaf-Blind Department
715 W. Willow
Lansing, Michigan 48912

Minnesota State Academy For The Deaf
P.O. Box 308
Faribault, Minnesota 55021

Magnolia Speech School, Inc.
733 Chapel Road
Jackson, Mississippi 39209

Mississippi School For The Deaf
1253 Eastover Drive
Jackson, Mississippi 39211

Ellisville State School
Mississippi Deaf-Blind Services
Ellisville, Mississippi 39437

Central Institute for the Deaf
818 S. Euclid
St. Louis, Missouri 63110

Missouri School For The Deaf
505 East 5th Street
Fulton, Missouri 65251-1799

St. Joseph Institute for the Deaf
1483 82nd Boulevard
St. Louis, Missouri 63132

Missouri School For The Blind
Deaf-Blind Department
3815 Magnolia Avenue
St. Louis, Missouri 63110

Montana School For The Deaf & Blind
3911 Central Ave.
Great Falls, Montana 59401

Nebraska School For The Deaf
3223 North 45th Street
Omaha, Nebraska 68104

Marie H. Katzenbach School For The Deaf
320 Sullivan Way, CN535
West Trenton, New Jersey 08625-0535

New Mexico School For the Deaf
1060 Cerrillos Road
Santa Fe, New Mexico 87503

Lake Grove School
P.O. Box 442
Lake Grove, New York 11755

Lexington School For The Deaf
75th Street & 30th Avenue
Jackson Heights, New York 11370

New York School For The Deaf
555 Knollwood Road
White Plains, New York 01603

Rochester School For The Deaf
1545 St. Paul Street
Rochester, New York 14621

St. Mary's School For The Deaf
2253 Main Street
Buffalo, New York 14214

Central North Carolina School For The Deaf
P.O. Box 14670
Greensboro, North Carolina 27415

Eastern North Carolina School For the Deaf
Post Office Drawer 2764
Wilson, North Carolina 27894-2450

The North Carolina School For The Deaf
Highway 64 South
Morganton, North Carolina 28025

North Dakota School For The Deaf
13th Street & College Drive
Devils Lake, North Dakota 58301

Ohio School For The Deaf
500 Morse Road
Columbus, Ohio 43214

St. Rita School for the Deaf
1720 Glendale-Milford Road
Cincinnati, Ohio 45215

Oklahoma School for the Deaf
East Tenth & Tahlequah Streets
Sulphur, Oklahoma 73086

Oregon State School For The Deaf
999 Locust Street, N.E.
Salem, Oregon 97303

American Christian Academy for the Deaf
7564 Brown's Mill Road, Kauffman Station
Chambersburg, Pennsylvania 17201

The Pennsylvania School For The Deaf
100 W. School House Lane
Philadelphia, Pennsylvania 19144

Scranton State School for the Deaf
1800 North Washington Avenue
Scranton, Pennsylvania 18509

Western Pennsylvania School For The Deaf/Center on Deafness
300 East Swissvale Avenue
Pittsburgh, Pennsylvania 15218

The Devereux Foundation Hearing Impaired Program
Road 1
Glenmoore, Pennsylvania 19343

Western Pennsylvania School for Blind Children
Multi-handicapped/Deaf-Blind Program
201 North Bellefield
Pittsburgh, Pennsylvania 15213

Evangelical School for the Deaf, Inc.
Box 7111
Luquillo, Puerto Rico 00673-9602

South Carolina School For The Deaf and Blind
Cedar Spring Station
Spartanburg, South Carolina 29302

South Dakota School For The Deaf
1800 E. 10th Street
Sioux Falls, South Dakota 57103

Tennessee School For The Deaf
2725 Island Home Boulevard
Knoxville, Tennessee 37920

Texas School For The Deaf
P.O. Box 3538
Austin, Texas 78764

Lubbock State School for the Deaf and Blind
P.O. Box 5396, North University
Lubbock, Texas 79417

Utah Schools for the Deaf and Blind
846 20th Street
Ogden, Utah 84401

The Austin School For The Deaf
120 Maple Street
Brattleboro, Vermont 05301

Virginia School For The Deaf and Blind at Hampton
700 Shell Road
Hampton, Virginia 23661

Virginia School For The Deaf and Blind at Staunton
P.O. Box 2069
Staunton, Virginia 24401-0943

Washington State School For The Deaf
611 Grand Boulevard
Vancouver, Washington 98661

West Virginia School For The Deaf and the Blind
301 East Main Street
Romney, West Virginia 26757

Wisconsin School For The Deaf
Educational Service Center for the Hearing Impaired
309 West Walworth Avenue
Delavan, Wisconsin 53115

White River School District #416
Ranier School
P.O. Box G
Buckley, Washington 98321

APPENDIX B:
COVER LETTER FOR STUDY TO SUPERINTENDENTS

Date

Name

School Name

Street Address

City, State Zip Code

Dear Superintendent;

I am in the process of conducting a research project in cooperation with the Department of Counseling Psychology at Michigan State University. The first of its kind, this study seeks to identify the types of job skills, knowledge areas and activities necessary for primary caregivers to best serve behaviorally disordered hearing impaired youth in community-based group homes. Group homes typically are those residences which are established within community neighborhoods, and are designed to provide residents with a "family-like" atmosphere which is therapeutically structured.

While information exists on the job responsibilities and functions of primary caregivers within large residential institutions, very little is known about these workers in **community-based group homes**. Even less information is known about primary caregivers in community-based group homes **specifically** designed for behaviorally disordered hearing impaired youth. For example, how many homes of this type exist? How many residents are served? What is the need for this kind of facility?

This survey is an attempt to answer the above and other questions. I realize that completing this questionnaire is an added strain to your already demanding work load. However I am asking you to complete the superintendents' questionnaire and to strongly encourage deaf and hearing volunteers from your primary caregivers staff to complete the Group Home Primary Caregiver questionnaire. You and your staff are the experts in the field of residential living, and you are the only persons who can provide this valuable information.

The results of this survey will be used to facilitate the development of guidelines for primary caregivers in community-based group homes. Additionally, the information

will be used to make suggestions about the design of a model community-based group home facility for behaviorally disordered hearing impaired youth.

Without your help I could not develop a complete picture of the perceived guidelines for primary caregivers, nor could I make suggestions about the design of a model community-based group home for behaviorally disordered hearing impaired youth. Therefore I ask that you, and the other research volunteers, complete the questionnaires **by June 20, 1989 or as soon as possible**, and return them in the pre-addressed stamped envelopes.

If you have questions about the questionnaire, you may call me at (517) 355-8310, Monday-Friday, 8:00 a.m. to 5:00 p.m. E.S.T., or at (517) 355-7921 after 6:00 p.m. E.S.T.

Thank you for your support and participation in this study.

Sincerely,

Aurles U. Wiggins
Project Director

c.c. Tane Akamatsu, Ph.D., Faculty Advisor
Counseling and Educational Psychology and Special
Education

APPENDIX C:
COVER LETTER FOR STUDY TO CAREGIVERS

Date

Dear Primary Caregiver;

I am in the process of conducting a research project in cooperation with the Department of Counseling Psychology at Michigan State University. The first of its kind, this study seeks to identify the types of job skills, knowledge areas and activities necessary for primary caregivers to best serve behaviorally disordered hearing impaired youth in community-based group homes.

Behaviorally disordered refers to those hearing impaired individuals whose behaviors consistently create difficulties in learning situations as well as in social situations. Since you are the expert, your responses will provide a significant contribution to the field of deafness, specifically to the development of primary caregiver guidelines.

Please know that your participation in this study is strictly voluntary. You can be assured that your responses will remain anonymous.

Your assistance in responding to the survey is **crucial** to the success of this study. In the interest of time, please return your questionnaire by **June 20th**. For your convenience, a stamped, self-addressed envelope has been provided for the return of your questionnaire.

If you have questions about the questionnaire, you may call me at (517) 355-8310, Monday-Friday, 8:00 a.m. to 5:00 p.m. E.S.T., or at (517) 355-7921 after 6:00 p.m. E.S.T.

Thank you for your support and participation in this study.

Sincerely,

Aurles U. Wiggins
Project Director

APPENDIX D:
SUPPORT LETTER



RONALD L. BEMIS
Superintendent
Public Instruction

DEPARTMENT OF EDUCATION

MICHIGAN REHABILITATION SERVICES
P.O. Box 30010, Lansing, Michigan 48909
187

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Ex Officio

June 5, 1989

Dear Residential School Service Provider;

The field of deafness is continually growing by leaps and bounds. Each effort toward conducting research in this field makes a significant contribution toward an increased understanding of the issues that affect the deaf community. As you are aware, community-based residential care for the hearing impaired is a new area of interest. This research should prove invaluable in providing information to enhance the services currently available to hearing impaired youth. Moreover, this is the first national study to address this issue, so your cooperation in completing the enclosed questionnaire is most important.

As the State Consultant for Deaf Services and Program Development to the deaf community in the state of Michigan, I endorse this research effort and look forward to its findings.

Continued success in your career.

Sincerely,

Gail Faulkner

cc: Dr. Tane Akamatsu, Faculty Advisor
Department of Counseling and Educational Psychology and
Special Education
Michigan State University



RECYCLED
PAPER

APPENDIX E:
GROUP HOME PRIMARY CAREGIVER QUESTIONNAIRE

GROUP HOME PRIMARY CAREGIVER QUESTIONNAIRE

INSTRUCTIONS:

The Group Home Primary Caregiver Questionnaire (GHPCQ) seeks to determine what job skills, knowledge areas, and activities you feel would be necessary for caregivers to best serve behaviorally disordered hearing impaired youth in community-based group homes.

Group homes typically are those residences which are established within community neighborhoods, and are designed to provide residents with a "family-like" atmosphere which is therapeutically structured. Behaviorally disordered hearing impaired youth are sometimes described as individuals whose behavior gets in the way of their education. Very often they create problems in the classroom making it difficult for other children, and themselves, to concentrate on learning. They also experience problems getting along in other settings.

Because your responses are so important to this new area of research, please answer all questions. You should provide two responses to each of the 36 items in Part I of the questionnaire as follows:

* **FIRST**, using the "Importance Scale" indicate how important you feel the item would be if you were a primary caregiver working in a group home for behaviorally disordered hearing impaired youth. Place the most appropriate response in the blank space before each item.

* **SECOND**, indicate in the column marked "Competency-Others" following each item how competent you feel the average worker is in your residential facility.

IMPORTANCE SCALE

4 = Very Important
3 = Important
2 = Somewhat Important
1 = Not Important

COMPETENCY SCALE

4 = Very Competent
3 = Competent
2 = Somewhat Competent
1 = Not Competent

As time is very important, it would be greatly appreciated if you would return the questionnaire by June 20, 1989. Thank you very much for your support and participation in this study.

EXAMPLE: Following is an example of responses if you feel
1) the item is "very important" for caregivers and;
2) the skills of other caregivers at your place of employment are "somewhat competent".

IMPORTANT		COMPETENCY OTHERS
<u>4</u>	1. Provides standards and structures for daily behavior.	<u>2</u>

GROUP HOME PRIMARY CAREGIVER QUESTIONNAIRE

IMPORTANCE SCALE

- 4 = Very Important
 3 = Important
 2 = Somewhat Important
 1 = Not Important

COMPETENCY SCALE

- 4 = Very Competent
 3 = Competent
 2 = Somewhat Competent
 1 = Not Competent

- ___ 1. Helping child manage own behavior; controlling aggression. _____
- ___ 2. Providing learning opportunities; responsibility and decision making. _____
- ___ 3. Supervising daily routines. _____
- ___ 4. Participating in planning goals for each child. _____
- ___ 5. Knowing about behavior disorders in deaf children. _____
- ___ 6. Communicating with primary caregivers in other group homes. _____
- ___ 7. Conducting group/individual therapy. _____
- ___ 8. Stimulating child to seek knowledge. _____
- ___ 9. Disciplining children. _____
- ___ 10. Communicating with parents, school teachers, psychologists, social workers, and others involved with child. _____
- ___ 11. Knowing about deaf child/adolescent development. _____
- ___ 12. Being aware of current child care issues. _____
- ___ 13. Teaching the child problem solving techniques. _____
- ___ 14. Teaching the child basic daily living skills. _____
- ___ 15. Planning and participating in recreational activities. _____
- ___ 16. Communicating with group home staff. _____
- ___ 17. Knowing about deaf people, their culture and community. _____

GROUP HOME PRIMARY CAREGIVER QUESTIONNAIRE

IMPORTANCE SCALE

- 4 = Very Important
 3 = Important
 2 = Somewhat Important
 1 = Not Important

COMPETENCY SCALE

- 4 = Very Competent
 3 = Competent
 2 = Somewhat Competent
 1 = Not Competent

- ____18. Participating in seminars, workshops and other professional development activities. _____
- ____19. Helping children cope with anxiety. _____
- ____20. Providing information on alcohol and drugs, sexuality, etc. _____
- ____21. Monitoring health needs. _____
- ____22. Participating in group home planning activities. _____
- ____23. Knowing about laws affecting the hearing impaired. _____
- ____24. Engaging in supervision of trainees in child care. _____
- ____25. Helping parent(s)/guardian(s) maintain positive behavior changes of child when at their own home. _____
- ____26. Teaching social skills. _____
- ____27. Supervising/engaging in routine maintenance and clean-up of living environment. _____
- ____28. Participating in record keeping/ recording observations. _____
- ____29. Knowing about related medical problems. _____
- ____30. Achieving professional certification (e.g. diploma or license). _____
- ____31. Creating positive emotional climate for child. _____
- ____32. Supervising and assisting with homework. _____
- ____33. Having first-aid skills. _____
- ____34. Keeping informed of child's progress and/or difficulties. _____
- ____35. Being able to communicate using ASL (American Sign Language). _____
- ____36. Working for fair child care personnel practices. _____

The following section concerns recommendations you might consider to best meet the needs of behaviorally disordered hearing impaired youth in community-based group homes. Please respond to each area as though you were responsible for the development of an ideal model community-based group home.

* Is a community-based group home an appropriate place to serve behaviorally disordered hearing impaired youth?

☐ Yes ☐ No

* Ideally, how many behaviorally disordered hearing impaired youth should live in a community-based group home?

☐ less than 4 ☐ 8 - 9 ☐ 14 or more
☐ 4 - 5 ☐ 10 - 11
☐ 6 - 7 ☐ 12 - 13

* Do you think it is appropriate for a community-based group home to house behaviorally disordered hearing impaired children of different age groups?

☐ Yes ☐ No

* For what ages are community-based group homes appropriate for behaviorally disordered hearing impaired youth? Check all that apply.

☐ less than 10 years ☐ 15 - 16
☐ 11 - 12 ☐ 17 - 18
☐ 13 - 14 ☐ greater than 18

* What are your feelings about behaviorally disordered hearing impaired children who live in a community-based group home?

☐ they should all be of the same sex
☐ they should have both sexes
☐ it does not matter
☐ it depends on the age

* Ideally, what is the maximum number of behaviorally disordered hearing impaired youth that one primary caregiver should be responsible for?

☐ 1 youth ☐ 4 youths ☐ 7 or more youth
☐ 2 youths ☐ 5 youths
☐ 3 youths ☐ 6 youths

* Do you favor state certification of primary caregivers in community-based group homes?

☐ Yes ☐ No

* Should primary caregivers in a community-based group home be a married couple?

☐ Yes ☐ No

* Check how acceptable it would be for each of the following to be primary caregivers in community-based group homes for behaviorally disordered hearing impaired youth.

	HIGHLY ACCEPTABLE	ACCEPTABLE	UNACCEPTABLE
married couple <u>with</u> children	_____	_____	_____
married couple <u>without</u> children	_____	_____	_____
unrelated male and female	_____	_____	_____
2 unrelated males	_____	_____	_____
2 unrelated females	_____	_____	_____

Part II: INDIVIDUAL INFORMATION

Note: In this section please provide the requested information about yourself. Check the correct response where appropriate.

1. What is your primary job responsibility? _____

2. Number of hours worked per week providing direct care. _____
3. Number of years in the field. _____
4. Sex _____Female _____Male
5. Age range _____less than 21 years
_____21 - 30 years
_____31 - 40 years
_____41 - 50 years
_____Over 50 years
6. Are you deaf/hearing impaired? _____Yes _____No
7. What is the highest level of education you have finished?
_____less than high school _____B.A., B.S.
_____GED or Diploma _____M.A., M.S.
_____Associate _____Ph.D., Ed.D.
8. If degree, indicate area(s) of study. _____
9. Have you had any specialized training (CPR, deafness...)?
_____Yes _____No If yes, area of study _____
10. What preferred method do you use to communicate with hearing impaired individuals?
_____ASL (American Sign Language, _____Cued Speech
_____Real Deaf Sign, Sign Language) _____Oral
_____Total Communication
11. What is your ethnic background?
_____African American (Black) _____Hispanic
_____Asian and Pacific Islander _____Native American
_____White _____Other _____
14. Indicate your yearly salary range.
_____ \$0 - 9,999 _____ \$30,000 - 39,999
_____ \$10,000 - 19,999 _____ \$40,000 - 49,999
_____ \$20,000 - 29,999 _____ \$50,000 and over
15. Please check your marital status.
_____Single _____Married
16. Do you plan to continue your career as a primary caregiver to the hearing impaired? _____Yes _____No

APPENDIX F:
SUPERINTENDENT/DIRECTOR QUESTIONNAIRE

SUPERINTENDENT/DIRECTOR QUESTIONNAIRE

The following questions are intended to elicit information about your residential facility. Please record your answers in the space provided or on additional sheets if you need more room.

Please provide information in the following areas:

Part I: Institutional

1. Year established_____
2. Number of employees_____
3. Number of primary caregivers_____

Part II: Students

4. Total number of students_____
residential_____ respite_____
day_____ other_____
5. Distribution of student disability categories (give numbers):
physically handicapped_____ cerebral palsy_____
mentally retarded_____ blind_____
behaviorally disordered_____
other_____ (specify)_____
6. Ethnicity (give numbers):
African American/Black_____
Asian/Pacific Islander_____
Hispanic_____
Native American_____
White_____
7. Average length of stay (in years)_____

Part III: General

8. Do you feel that a community-based group home could appropriately serve behaviorally disordered hearing impaired youth? _____ Yes _____ No

(Please explain) _____

9. What do you feel will be a future direction of residential care for behaviorally disordered hearing impaired youth?

_____ State or private _____ Community-based
residential schools residential programs

(Please explain) _____

10. What training or skills should primary caregivers possess in order to work with behaviorally disordered hearing impaired youth?

(Please explain) _____

11. Please provide information below about group homes for the hearing impaired in your area.

Group Home Director/Contact Person

Name of Group Home _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone Number _____

Group Home Director/Contact Person

Name of Group Home _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone Number _____

[illegible]

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