Deconstructing Bias: The Impact of Privilege on EHDI Services & Outcomes

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Introduction

Based on mass movements of people from marginalized groups organizing for things like #BlackLivesMatter and #SayHerName, it is appropriate to assess how implicit and explicit biases, in the form of privilege, of Early Intervention providers may have impacts which counteract their intentions. Introduction of social justice theories and multicultural competence provide a framework for this analysis. Because Early Hearing Detection and Intervention (EHDI) professionals often work across areas of difference (i.e. being a hearing/able-bodied provider working with a deaf, hard of hearing, deaf-blind, or deaf-disabled [DHHDBD] child), allyship is also considered.

Definitions

Privilege: Personal, societal, and institutional advantages, entitlements, benefits, responsibilities, assumptions, choices and positive expectations granted to a person based on one’s membership in a dominant group. These benefits are often bestowed unintentionally, unconsciously, and are often invisible to the receiver.

Power: Access to resources and institutions; the ability to exercise control, influence others, and gain access to decision-makers to get what you want done.

Oppression: The systematic subjugation of a social group by another social group with access to institutional or systemic power. Power + Prejudice = Oppression

Diversity: Having multiple people represent various backgrounds, identities, and experiences.

Accessibility: Having accommodations in place so that people in marginalized groups have access to places of power and privilege. Access usually requires requests for accommodations.

Inclusion: The pre-existing accessibility of a space or group. Intentionally making accommodations available prior to requests. Members of marginalized identities have full access to their environment and are not the only person of their gender or background.

Intersectionality: The intersection where multiple forms of identities come together. The experience of holding multiple oppressed or multiple dominant identities at the same time.

Bias (implicit and explicit): Prejudice in favor of or against one thing, person, or group compared with another. Unconscious (implicit) or conscious (explicit) preference which is usually left unchallenged, and unquestioned.

Prejudice: Pre-judging or making a decision about a person or group of people without sufficient knowledge. Prejudice is often based on stereotypes.

Discrimination: Denial of opportunities, justice, and fair treatment. Granting advantages to one group while denying opportunities to another.

Ally: A member of a dominant group who works to dismantle the oppression from which he/she benefits.

Myths about Allyship

Knowing, working with, or loving a person of color does not preclude you from racism.

Knowing, working with, or loving a LGBTQIA+ person does not preclude you from homophobia, heterosexism, or transphobia.

Knowing, working with, or loving a woman does not preclude you from sexism or misogyny.

Knowing, working with, or loving a person with a disability does not preclude you from ableism.

Knowing, working with, or loving a person from a different socioeconomic or educational background does not preclude you from classism.

Knowing, working with, or loving a Deaf or hard of hearing person does not preclude you from audism.

The Four I’s of Oppression

Institutional

Media systems, legal system, early intervention system, education system, healthcare, religion, academia and research, textbooks

Ideological

Racial, ethnic, cultural norms, cultural stereotypes, assumptions, fears, and logic

Interpersonal

Personalized narrative, harassment, bullying, power to impose violations, double-standards, expectations, condescension, pathological views, alius, helper/savior mentality

Internalized

Impaired self-sufficiency, self-harm, self-hate, social anxiety, mental health struggles, isolation, victimization, crimes, learned helplessness, self-hate, behavioral problems

Discussion

Like most medically informed social service organizations, EHDI providers value the "Hippocratic Oath" to keep the secrets of patients who trust them the desire to be helpful and supportive. So, what happens when we find out that our impact was different than our intentions? How do we integrate information from our clients when they say, "That didn’t work for me" and "That wasn’t for me"?

In a profession dominated by hearing individuals with multiple other intersections of privileged identities (i.e. education level, employment, class), we must be especially mindful of the fact that we are working across areas of difference. An inherent power dynamic exists when hearing practitioners work with DHHDBD clients. The privilege of a provider may cross intersections of class, race, ethnicity, gender, socioeconomic status, education, first language, age, sexuality, or religion. For that reason, the practices of allyship (see Table A) and intercultural sensitivity (see Table B) are of crucial importance for EHDI outcomes.

EHDI outcomes include hard skills (i.e. language development) and soft skills (i.e. emotional resilience). An increasing body of research and anecdotes indicate that soft skills influence the development of hard skills. Fields of interpersonal neurobiology, epigenetics of trauma and oppression, and neuroscience explore this interplay in more depth. For example, social and emotional development is subtly influenced in young children by cues of power, privilege, and oppression. The Clark Doll Test is a primary example of the rapid internalized oppression that children acquire from social interactions and media representations, omissions, and misrepresentations of members of their group. In this experiment, after playing with a white doll and a black doll, both white children and black children would identify the white doll as “good” and the black doll as “bad.” As EHDI providers, we must do all we can to counteract institutional, ideological, interpersonal, and internalized messages that associate hearing with “good” and non-hearing with “bad.”

At this pivotal moment in history, dominant society is receiving ample feedback from marginalized populations that implicit and explicit bias of people with privileged status is impeding the development of soft skills in people of disadvantaged identities. In EHDI services, that information is coming from DHHDBD children, adolescents, and adults.

Conclusion

First and foremost, it is ideal for EHDI providers striving for allyship and intercultural sensitivity to recognize that privileged identities sometimes cause unintentional harm. It is important to remember that "privilege is not having to think about it," many competent providers can still omit important details which support the inclusivity of people with diverse identities and experiences. Accepting the reality that we can cause unintentional harm does not mean we are bad people. We are just incompetent providers. It simply means that there is space for an apology, learning something new, and making appropriate changes to prevent similar harm in the future.

As we move towards a model of allyship, it is important to remember that diversity is different than difference. Furthermore, accessibility does not guarantee inclusion. Inclusion includes the valuing of clients’ autonomy, choice, and wisdom about what works for them. The Deaf community has joined the Disability movement in emphasizing important things: "Respect Me,” "I’m Not Crazy,” "Abuse Us,” “Just like no decisions about women should be made without women’s involvement and leadership, no decisions should be made about Deaf people without Deaf people’s involvement and leadership.”

When considering the impacts of privilege on EHDI services and outcomes, we see that implicit bias impacts social and emotional development. When social and emotional development is impacted, and development is cognitive and academic development. We have learned this from extensive anecdotes of children who grew up without sign language finding full linguistic accessibility in the Deaf community, learning to sign, and wishing they had grown up with access to the sign language they now see as extending the intersections of additional marginalized identities, as identified in the Discussion section.

Due to the long history of the medical system being run by people with extensive intersectional privilege, classism, racism, heterosexism, and ableism are inherently embedded in the way we work with Deaf children. The question ultimately is not about whether the system is biased but whether people are willing to transform this reality. How might EHDI providers further demonstrate allyship and engage with Deaf people to support and ground them in their work with Deaf children. The question is how we go from here. How do we acknowledge our judgments and interrupt them before they cause harm? When we learn that we unintentionally caused harm, why do we apologize and repair that relationship?

The authors collaboratively suggest investing in allyship trainings which support the development of intercultural sensitivity. As we engage in these types of trainings, we learn how to present the pain and confusion from multiple perspectives across differences. We learn to take ownership for the historical, institutional, and interpersonal impacts of privilege and power. We learn to say “I believe you.” Instead of “That can’t be true.”

Ultimately, privilege is not inherently a negative thing. Sometimes it cannot be avoided, nor given up considering our abilities. As allies, people can do much to actively minimize harm, as well as counteract systemic biases. Unquestioned privilege, however, can bulldoze through the sense of self-worth of people with marginalized experiences and identities. It is critical for EHDI providers to be competent in issues of power, privilege, and oppression in order to optimize EHDI services and outcomes.

References


Authors’ Backgrounds

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