Mental Health and Deafness

by

Sherry Thow
A practicum report
presented to the University of Manitoba
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ABSTRACT

This practicum report describes the writer's experiences in counseling with deaf persons who have mental health problems. A comprehensive literature review on mental health and deafness is presented. A number of practical methods of intervention with deaf persons are referred to. Particular emphasis was placed on the application of reality therapy. Most effective was concrete, behavioral, reality-oriented approaches. The evaluation tool of goal attainment scaling is also examined, and applied to several cases.

The setting of the practicum is described as well as some of the cases carried out by the writer. Finally, there is a discussion of some of the common issues that arose in counseling with deaf persons. The practicum, in its entirety, is evaluated and areas in which the writer gained new skills and knowledge are identified.

ACKNOWLEDGEMENTS

Ours is not the silence that soothes the weary senses. It is an inhumane silence which isolates, cruelly and completely. Hearing is the deepest, most philosophizing sense man possesses... the sound of the voice that brings language, sets thoughts astir and helps us in the intellectual company of man.

Helen Keller

INTRODUCTION

The practicum described in this report was conducted from January, 1982 to July, 1982. The chosen area of specialization was counseling with deaf persons who are experiencing mental health problems.

1. OBJECTIVES OF THE PRACTICUM

The aim of the practicum was to develop a form of intervention which will assist deaf persons who are experiencing mental health problems to become independent, mature decision-makers, able to deal competently with everyday problems.

The expected educational benefits were as follows:

1. To develop specialized expertise in dealing with a specific client population, namely deaf adults.

2. To further improve my counseling and practice skills in working with this client group.

3. To develop my ability to evaluate the outcomes of this type of intervention.

2. THE PRACTICUM REPORT

The practicum report will discuss the writer's experience in the areas outlined above. In the first chapter this report will consider the literature on deafness and mental health with a focus on the effects of deafness on developmental and family processes and its impact on education and language acquisition. The literature review will also discuss the incidence of mental health problems among deaf persons and the lack of existing services to deal with these problems. Methods of interventions that have been found to be useful with deaf persons will be examined, with a focus on the application of reality therapy, as used in the practicum. Finally, the use of goal attainment scaling as a method of evaluation will be discussed.

The second chapter of the report will describe the setting of the practicum and will discuss some of the cases that were carried out by the writer. In this chapter, the outcome of the evaluations will be presented as it applies to the cases.

The third and concluding chapter will be in two parts. Firstly, there will be a discussion of the common issues that arose in working with the clients. These issues pose therapeutic challenges for any professional who works with deaf individuals. The second part of the chapter will involve a discussion of the practicum in its entirety and the areas in which the student gained further skills and knowledge.

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Chapter I

REVIEW OF THE LITERATURE

1.1   FACTORS ASSOCIATED WITH AUDITORY IMPAIRMENT

Hearing impairment is rarely an all or none affair (Furth,
1973).   Two factors associated with hearing impairment are
the degree of hearing loss and its age of onset.   These
variables possess major implications for the future develop-
ment of the inflicted infividual.

1.1.1   Degree of Hearing Loss

Hearing loss refers to the increase in the intensity of
sound above the normal level which is required to reach
threshold (Katz, 1978).

Audiologists measure hearing loss in decibels (dB), a
scale of intensity of loudness.   An audiogram provides a
graphic display of the results of testing and determines the
range, nature and degree of hearing loss (Streng, Kretsch-
mer, and Kretschmer, 1978).   The degree of hearing loss can
be divided into six classifications:

1. Slight (15-26 dB) - An individual with a slight loss
     will not function as well as he/she could as speech
     discrimination and verbal ability is impaired.

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2. Mild (26-41 dB) - A hearing loss in this category creates language problems, affects reading comprehension and verbal ability.

3. Moderate (41-56 dB) - This range of hearing loss has severe implications for education, manifested in problems with language development, reading, vocabulary and spelling.

4. Moderate-Severe (56-71 dB) - Emotional and social problems are frequent in individuals whose hearing loss falls into this category as well as increased difficulties in the educational setting.

5. Severe (71-90 dB) - Congenitally and pre-linguistically deaf children usually show marked educational retardation. As well, emotional and social problems are usually present in children and adults.

6. Profound (91 dB and up) - Emotional and social problems are sometimes present in children and adults. These persons would generally not possess any understanding of speech. In addition, educational and emotional problems present in the "severe" category are exacerbated.

The writer would like to clarify that the above statements are based on generalizations. In fact, many profoundly deaf people function independently. Conversely, some people with slight or mild losses may demonstrate emotional problems and/or educational deficits.

Hearing impaired persons can be divided into two separate groups (Jacobs, 1974):

1. The <u>deaf</u> are those in whom the sense of hearing is nonfunctional for the ordinary purposes of life. This general group is made up of two distinct classes based entirely on the time of the loss of hearing: (a) the congenitally deaf - those who were born deaf; (b) the adventitiously deaf - those who were born with normal hearing, but in whom the sense of hearing is non-functional later through illness or accident.

2. The <u>hard</u> <u>of</u> <u>hearing</u> are those in whom the sense of hearing, although defective, is functional with or without a hearing aid.

In addition, to these clinical-pathological definitions of hearing impairment, a cultural one also exists. According to Baker and Cokely (1980), a cultural definition of deafness exists when a group of persons share a common means of communication (signs) which provides the basis for group cohesion and identity or when a group of persons share a common language (ASL) and culture. As well, attitudinal deafness occurs when a person identifies him or herself as a member of the deaf community and other members accept this person as part of the deaf community (Baker and Cokely, 1980).

1.1.2 <u>Age</u> <u>of</u> <u>Onset</u> <u>of</u> <u>Hearing</u> <u>Impairment</u>

The age at which hearing impairment occurs is important to subsequent language development. Children who suffer hearing loss after the acquisition of spoken language have a definite educational advantage over those with congenital deafness. As well, postlingual hearing loss does not substantially affect a person's knowledge of his first language, whereas prelingual severe hearing loss makes the acquisition of this knowledge a severe problem.

Thus, the degree of hearing loss and the age of onset of hearing impairment is related to hearing handicap. For the purpose of this practicum, deafness should be perceived not as a problem belonging to the ears but as a problem belonging to and affecting the whole person.

1.2 <u>DISCOVERY</u> <u>AND</u> <u>DIAGNOSIS</u> <u>OF</u> <u>DEAFNESS</u>

Children whose deafness is hereditary are more likely than other deaf children to have deaf parents. However, the combination of a deaf child with deaf parents is rare: Only about 10% of deaf children have deaf parents (Rainer, Altshuler and Kallman, 1969). More commonly, then, the deaf child is born into a hearing family, that, prior to the discovery of the child's deafness, had little or no knowledge about hearing loss.

When parents are confronted with the discovery of their child's deafness and finally realize that he/she is not responding to environmental sounds, psychological operations come into play, which have crisis implications for the entire family. Firstly, the stressful event poses a problem which is insoluble and obviously beyond the control of the family.

Secondly, the problem overtaxes the psychological resources of the family, since it is beyond their traditional problem-solving methods. Rarely is either parent experienced in rearing a deaf youngster; nor do they know other parents of deaf children (Mindel and Vernon, 1971). Thus, they are consumed with feelings of helplessness. Solnit and Stark (1961) add "the irretrievable nature of the deafness adds to the mother's trapped feeling - she has failed to achieve what she has so laborously prepared herself to create or produce. Fathers, too, have similar or related reactions."

Thirdly, Parad (1965) states that the situation is perceived as a threat to the life goals of the family members. The discovery of the deafness alters the concept that the couple had of their family. Finally, this period often awakens unresolved key problems from both near and distant past.

During pregnancy, the development of an image of a hoped-for child is an important process in the preparation for parenthood; in turn, the image allows for the beginning of the bonding process and provides the foundation for later secure attachment between partners (Waechter, 1977). When the infant is born with a defect, the discrepancy between the fantasy and the reality perception precipitates a tremendous sense of loss - loss of a desired goal, of the visualized perfect child, of important elements of self-esteem, and of satisfaction in the birth process.

In the case of a deaf child and his parents, this crisis is often delayed, for deafness is an invisible handicap and is often not detected at birth. In fact, if the newborn shows no obvious physical abnormalities, the infant and his or her parent enter into a relationship in which expectations and feelings for the infant blend with his/her infant personality (Webster, 1977). As the infant's initial repertory of actions is mostly instinctual and not greatly different from other infants, the parents' reactions and interpretations of his/her behavior are based on their own personalities (Mindel and Vernon, 1971). Thus, the parents may ignore their own observations that the child fails to respond to their voices. They see the child turn as they approach him while speaking and interpret this as a response to their voice.

It is generally not until the second half of the first year when parents begin to be concerned and recognize that something is wrong (Altshuler, 1974). The usual signs are that infant babbling decreases and the child ceases to be responsive in the expected way. Research conducted by Becker (1976) indicates that delays in consulting the doctor vary from 0 to 2 years while the average delay is 8 1/2 months between suspicion and confirmation (Freeman, 1975).

Becker (1976) proposes that in addition to being desirable for the child's development, early detection of the impairment also helps the parents to adjust more realistically to the hearing loss and the implications for the functioning of the family. The parents who detect their child's hearing impairment during the first year are recognizing an impairment that changes but need not define their interaction with their child.

When parents interact for over a year with the child on the basis of limited communication, a pattern of denial has been established whereby the child is considered "normal" even if he doesn't act normally. The later detecting parent has to completely reestablish his perception of the child and of himself, whereas the earlier detector only has to readjust his perceptions and patterns of communication with the child, based on a realistic awareness of the child's impairment. The earlier detector has a "normal" child only

for a limited time, whereas the later detector has a "normal" child long enough for a whole pattern of interpersonal attitudes and interactions to have developed that are based on denial.

There are indications that the recent establishment of high risk registries in some major cities may have positive effects on the detection of congenital deafness. Many childrens' impairments are being detected at birth which permits parents the opportunity to deal with the effects of deafness at an earlier age.

Mindel and Vernon (1971) stress that the discovery of the child's deafness is not an event that happens instantly. It feels as if it happens all at once because the emotional reaction becomes so intense when the parent is finally confronted with reality. The discovery, however, is a gradual unfolding of knowledge about the child. When parents are confronted with the diagnosis that their child is not responding to environmental sounds, they experience blends of emotion that interfere with their sense of well-being (Robinson, 1978).

Mindel and Vernon (1971) suggest that at this time, two psychological mechanisms occur - namely denial and rationalization. A mother or father may be able to perceive the true nature of a situation. However, in interpreting what he/she has perceived, he/she will exclude certain essential

elements that would give the true picture of the child's hearing capacity. The authors state that "as the mother's or father's intellect leads them towards a painful realization, their feelings, stimulated by anticipated psychic pain cause them to abandon or alter the nature of certain important perceptions so that the picture remains incomplete."

Another important psychological operation is rationalization. Rationalization creates fictionalized alternatives that replace the more realistic and pain-inducing explanations of the facts observed. Deafness may not immediately be seen as the reason for the child's unresponsiveness to sound. Instead, he/she is seen as "just being stubborn" or "hearing what he/she wants to hear". Other reasons may be invoked such as a family history of "late talkers". In essence, where lack of hearing is the plausible explanation, the mother or father, as illustrated, may use other factors concurrent in the environment to create an explanation other than deafness for the child's failure to hear (Mindel and Vernon, 1971).

Mindel and Vernon (1971) maintain that parents will not obtain a more realistic understanding of their child until they bring him to a competent professional for definitive diagnosis. However, other authors disagree. Although a professional diagnosis may be important in assisting the parents to acknowledge the deafness, in some situations, this can create more uncertainty.

In a study conducted by Freeman, Malkin and Hastings (1975), 54 % of the family physicians consulted rejected the idea of deafness with or without some sort of test. The physician, misled by his wish to help, often ignorant of what deafness entails, and uncomfortable in the face of his own uncertainty, may offer reassurance that is more wishful than accurate. It has been reported by some families that pediatricians minimized their concerns, delaying definitive diagnosis to unspecified future times (Mindel and Vernon, 1971). Occasionally, such pediatric cliches such as "its a phase" or "he will outgrow it" are heard. These kinds of suggestions and remarks are unfortunate and costly mistakes. They lead parents to procrastinate further over something that has already given them many months of anxiety. Recollections of such experiences often form the core for many of the angry indictments later hurled at the medical profession.

As well, there have been situations where a physician has not detected a child's hearing loss as his/her failure to respond. Instead, misdiagnoses, such as mental retardation have been applied. This is damaging to both the child and his/her family.

Often, parents must take their child to a second physician in order to obtain an affirmative diagnosis. In addition, it is not uncommon for the busy physician or audiolo-

gist to feel that his or her responsibility has been fulfilled once he or she established the diagnosis of irreversible deafness (Mindel and Vernon, 1971). This is only the beginning of the time of parents' greatest need.

The four stages of the reaction to crisis postulated by Shontz (1965) can be related to the parents of a deaf child. On learning of a child's deafness, the parents experience shock. This period can be brief or it can last for a prolonged period. Shock can bring numbness, a sense of unreality or disbelief. The question "Why did it happen to me?" is often asked. Some parents consciously regard the child's deafness as punishment for remembered transgressions (Mindel and Vernon, 1971).

Shock is followed by realization or an awareness of the reality of the situation. Realization can be accompanied by acute anxiety which prevents the parents from accurately perceiving the situation. Parents may seem fearful, easily upset or annoyed, or give some indication that their anxiety level is very high. They often become overwhelmed and disturbed by their ignorance of what deafness involves and feel inadequate to meet the developmental needs of a deaf child. They may feel that "the child is not whole" (Altshuler, 1976). Parents may also feel anger and guilt towards the child, compounded by their inability to communicate.

In the stage of <u>defensive</u> <u>retreat</u> the parent attempts to avoid coping with the anxiety-producing situation by retreating. In this stage, the parent may look to others - an institution, a professional, or a clinic for the child.

The fourth stage is one of <u>acknowledgement</u> and in spite of anxiety and disappointment, the parent can now mobilize inner forces to cope with the situation. Webster (1977) states that only now can a parent become an active participant in the various services provided for the child.

Note that the definition of acknowledgement does not include acceptance. There are many aspects of life that a person cannot accept but can learn to adjust to and cope with. Mindel and Vernon (1971) state that as the years go by, most parents gradually accept the limits imposed by deafness. They sink into a state of bitter resignation. Eventually, some are able to assume a more realistic attitude. However, others are unable to relinquish fantasies of normality and perfection. Perhaps the greatest temptations come from the deaf child's visible similarities to his hearing peers.

Among these similarities are vocal utterances similar to the sounds of young hearing children up to the age of 18 months, early play patterns that closely duplicate those of hearing children and normal achievement of certain growth milestones such as creeping, walking and running. The in-

tense psychological need for a "normal" child leads the parents to interpret the failure to develop communication not as the failure it is but as a promise of things to come (Mindel and Vernon, 1971). With the acquisition of the first word or the reestablishment of rudimentary gestural communication, there will be temporary relief of their feelings. As the child matures, however, and needs for complex communication skills increase, differences between the deaf child and his hearing peers become more noticeable and the parents' anxieties will be reactivated (Mindel and Vernon, 1971).

Other authors have reported similar reactions to the crisis of a deaf child. Mindel and Vernon (1971) and Schlesinger and Meadow (1972a) have described a common reaction of parents to the diagnosis: "shock and a tragic crisis and long-term implications for family life". Becker (1976) found that the ten couples studied in her research reported similar stages in the identification of their child's hearing impairment: concern, denial and rationalization, followed by a professional diagnosis. Shock, disbelief, grief, helplessness, anger and guilt were elements of all the parents' reactions to the diagnosis.

Altshuler (1974) proposes that parental reaction to the discovery is inevitably a depression. He states that "the creative scope of giving life is imbued with all the unre-

solved fantasies and wishes of one's own early development. Both mother and father possess feelings of fulfillment and increased self-esteem. The presence of a defect is a blow to such aspirations and is reacted to with intensity. Thus, a depression is inevitable and is reacted to with wishes of denial. All advice received is filtered and refracted through these hopes for normalcy. But wishful denial cannot work: the child is deaf and will be always. His or her presence is an unavoidable reminder of personal failure and disappointed aspirations. The parental dilemna is how to love a child who represents such a reminder.

Webster (1977) indicates that guilt is closely related to parental aspirations for themselves. She writes that guilt feelings are normal reactions experienced by all people. Parents of a deaf child may feel guilty when they show anger towards him/her or when they feel discouraged and wish to be away for a time. The feeling that they are not providing adequately for other family mambers stirs guilt. Parents who must perform tasks in their children's treatment or education may feel guilty when they feel tired of doing this.

Anger also stems from the helplessness and confusion that comes from not having anticipated a deaf child. The parents know little of what to expect or do (Mindel and Vernon, 1971) and have rarely had contact with successful deaf adults. When they gradually realize the limitations imposed

by deafness, they feel helpless because they cannot change it. As the child moves into his or her formative years for speech and language the parent feels helpless in conveying basic information and needs. They feel even more helpless when the child is fretting and can communicate only as much as squeals, gestures and tears will convey.

Mindel and Vernon (1971) suggest that grief, anger, guilt and helplessness, stimulated by the discovery of a child's deafness, seldom disappear in any parent. Although most achieve various partial resolutions of these painful emotions, the mildest emphathic probing of parents' feelings will inevitably reactivate an intense but transient grief. Each new frustration in understanding and meeting the child's needs serve as a new stimulus. This has been observed in parents of young children as well as in parents of deaf offspring now in their forties (Mindel and Vernon, 1971).

Deaf parents of deaf children appear to expect the diagnosis and to accept it at a much earlier age. There is also some experimental and clinical evidence that indicates that deaf parents of deaf children cope with the crisis of diagnosis easily and quickly, while their hearing counterparts prolong and intensify it. Once the initial diagnosis is made, deaf parents are less likely to seek confirmatory diagnosis or a miraculous cure (Schlesinger and Meadow, 1972a).

The deaf child directly challenges his parents' capacity to cope with novel parental experiences. Most parents are themselves understandably handicapped in learning to cope realistically with their child's deafness. Ninety percent of deaf children have hearing parents, many of whom have had no prior experience with deafness and no reason to expect deafness in their child (Robinson, 1978). According to Mindel and Vernon (1971), factors that affect the ability of the parents to cope are tha nature of the parents' personalities, the state of the marriage, the parents' relationship to members of the extended family, the ordinal position of the deaf child and the importance of verbal language to the family.

The psychological ambivalence which some parents feel after giving birth to a deaf child, together with their confusion over how best to help the child, are not insurmountable problems; many parents, both deaf and hearing, have great success in providing the environments which allow their children to develop normally (Robinson, 1978).

However, many authors agree that if the parents fail to resolve their feelings of grief, anger and helplessness, they will be forced to remain arrested in the earliest stages of their psychological reactions to their child's deafness (Mindel and Vernon, 1971; Robinson, 1978). This is the stage wherein the primitive psychological processes of deni-

al and rationalization form the chief mode of handling psychic pain caused by the child's deafness. It is these authors' beliefs that the parents' early reactions related to the discovery of deafness and their resolution of these feelings toward the child influence all major decisions.

Literature on the birth of defective children (Shontz, 1965; Becker, 1976; Solnit and Stark, 1961) reveals that the majority of these normal parents do not receive adequate support from the professionals they have sought out for diagnostic certainty, therapeutic guidance, and prognostic formulations. Finding helpful experts, meeting other parents, working out varieties of compensatory solutions for the deficit - all these partial resolutions free the parent to be more effective (Robinson, 1978).

1.3 <u>EARLY</u> <u>HOME</u> <u>LIFE</u> <u>OF</u> <u>A</u> <u>DEAF</u> <u>CHILD</u>

In their book <u>Sound</u> <u>and</u> <u>Sign</u>, Schlesinger and Meadow (1972a) discuss the impact of auditory deficit on the development of deaf persons using an Eriksonian framework. The writer found that by examining the effects of deafness on childhood development using this model, she was able to acquire a fairly comprehensive understanding of the deviant developmental processes that deaf children experience. Therefore, she has also chosen to describe the patterns of development by referring to the stages of humans identified by Erikson.

Erikson maintains that the whole life cycle, the eight stages of humans can be seen as an integrated psychosocial development in a sequence of critical phases (Erikson, 1968). Each phase is characterized by age-specific developments that must be solved; the foundation for the solution is prepared in the previous stages and is worked out further in the subsequent ones (Schlesinger, 1978).

Each critical phase can be described in terms of extremes of successful and unsuccessful solutions, although the usual outcome is a balance between these two extremes:

1. Basic Trust versus Mistrust;

2. Autonomy versus Shame and Doubt;

3. Initiative versus Guilt;

4. Industry versus Inferiority;

5. Identity versus Identity Diffusion;

6. Intimacy versus Isolation;

7. Generativity versus Stagnation;

8. Integrity versus Despair.

The resolution of each critical phase by the deaf child depends on the difficulty of the crisis as influenced by the degree, onset, and shape of his hearing loss, and the individual, parental, and societal resources that are immediately available to him.

For the purpose of this report, the first three critical stages of development will be examined in relation to prel-

ingual deafness. Schlesinger (1978) suggests that the child must have meaningful, reciprocal, and largely positive interactions with his environment in order to resolve the first three critical stages successfully.

1.3.1 Infancy: Basic Trust versus Mistrust

According to Erikson (1968), the basic task of infancy, the period from birth to 18 months, is to establish a sense of trust in the world that will later become a feeling of hope about oneself and the world (Schlesinger, 1978). To survive, all infants need to have their most urgent physiological and cognitive needs met.

The infant is not born with the expectation that particular individuals will respond to his distress (Mindel and Vernon, 1971). His/her limited responses to outside influences are essentially reflexive and instinctual. Optimally, early physiological needs must be met in consistent, positive, and predictable ways through mutual regulation with a human being. This is a time when ideally the infant finds that the physical environment and the people that inhabit it are trustworthy, that they respond to his/her needs in largely positive and predictable ways (Schlesinger and Meadow, 1972a).

Distinctive characteristics develop early in the unfolding relationship between the deaf infant and his/her parent

which distinguish the relationship between a parent and his/her nondeaf infant. One reason for these differences is that communication patterns between the mother/father and deaf infant are not established in the conventional way. Of crucial importance is how the differences create a sense of distance between the parents and the infant which, in turn, causes later alterations in the personality development of the deaf individual (Mindel and Vernon, 1971).

Schlesinger and Meadow (1972a) state that data from their research suggests that deaf infants may be "more quiet" and slightly more passive. This may occur because they do not actively seek out the environment, and their parents, in turn, permit them to rest more quietly without providing the variety of stimuli necessary for ongoing development.

However, Schlesinger (1978) notes that depending on the pattern and severity of the hearing loss, some youngsters will learn to appreciate environmental sounds; to discriminate between speech and environmental sounds and some will be able to eventually repeat words with good approximation. Even if the auditory route remains blocked, the deaf child may benefit from compensatory visual and tactile contact.

During the attachment phase of infancy, communication between parent and child occurs primarily through such nonverbal means as voice quality, touch and smile. As well, it is clear that sound has important implications for the quanti-

ty, quality, and effectiveness of the child's experience with objects (Liben, 1978). With the absence of severe attenuation of sound, the deaf child is deprived of knowledge about the sound-making qualities of objects and actions. Furthermore, insofar as noises made by objects and actions excite the child toward exploration, the absence of an auditory channel might be expected to limit the motivation for exploration and hence, retard cognitive growth. Many of the observations made by Piaget suggest that sounds are important for the child's sensorimotor exploration.

The early sensory deprivation of deafness may lead to indirect restrictions in the child's environment because of reduced organismic exploration. Specifically, since the visual system is bound to the immediate environment, the absence of audition prevents the individual from receiving information from removed sources, such as the next room.

1.3.2 Early Childhood: Autonomy versus Shame and Doubt

The basic task of early childhood, the period from 18 months to 3 years, is to develop a sense of autonomy, the sense of being a separate human being who has control over his/her body and who can influence the environment increasingly more maturely (Erikson, 1968). As well, in this stage of development, symbolic linguistic communication assumes a more important role.

Deaf youngsters show delayed resolutions of the crisis of autonomy in many areas other than verbal. Accounts of delayed toilet training, feeding problems, impositions of stringent safety measures abound in the literature (Schlesinger and Meadow, 1972a). It appears clear that an optimal imposition of restraints on the young child is hampered by the lack of meaningful recipricol communication at this age.

The important role of language has been recognized by people in a variety of disciplines. Psychiatrists have focused on substituting or supplementing behavior with words (Gambrill, 1977) and on transmitting, clearly or ambigiously, the communicative techniques of the culture to the child (Schlesinger, 1978). Some cognitive theorists have suggested that language does shape thought (Vygotsky, 1962); others have suggested that although thought precedes language, language does provide freedom from immediacy (Furth, 1973). Others have noted that cognitive structuring, clear statements of parental rules, reasons for the rules and consequences for breaking them - is crucially important in teaching the child to forego, postpone, or modify strongly motivated activity (Schlesinger, 1978).

The developing deaf child, however, faces many difficulties associated with language (Schlesinger, 1978). Most deaf children are born to hearing parents who expect to socialize their child through the modality of spoken English.

This process is enormously difficult, especially for young-sters whose auditory contact with the environment is inade-quate for speech discrimination. Linguistic input for many deaf children is limited to what can be lipread. Lipreading is difficult, even for persons with well developed English skills, because only about 20-40 % of spoken English is vis-ible on the lips (Furth, 1973). Consequently, there are de-lays in language acquisition and deficits in age-appropriate linguistic competence and performance, with these problems leading to cumulative deficits as the child matures.

In addition to organismic and physical restrictions, the environment may be reduced for the deaf child as a result of caretaking practices. Within the family setting, parents are likely to overprotect their deaf child, thus reducing the range of experiences and objects available for manipula-tion.

Schlesinger and Meadow (1972b), for example, have noted that parents of deaf children tend to restrict their child's intrusions into the outside world by innumerable safety lim-its. In questionnaires concerning socialization for safety, Schlesinger and Meadow (1972a) found that in an effort to avoid street accidents, parents with deaf children were more likely to control the environment by setting physical re-strictions on movement than were parents with hearing chil-dren. As Schlesinger and Meadow note, greater restrictions

are often justified, but restrictions are often unnecessarily excessive.

The hearing parents of a deaf child, frustrated by limitations in communication, frequently resort to restrictive, imperative, positional linguistic codes (Schlesinger, 1978). It is easier to say "no" to a deaf child than to patiently help the child understand by qualifying the "no" with the rationale underlying it. In comparing the interactions between deaf and hearing children and their mothers, it has been noted that as a group, the mothers of the hearing children were more flexible, permissive, encouraging and creative; they were less frequently didactic and intrusive.

1.3.3   Later Childhood: Initiative versus Guilt

The task of childood from three to six years is to develop a sense of initiative with a feeling of the purpose of life and of one's own self (Erikson, 1968). Children at this stage frequently attach themselves to people with occupations they can grasp: firemen and policemen, gardeners and plumbers (Schlesinger and Meadow, 1972a).

The normal child moves intrusively into a larger society; he/she does so by vigorous locomotion, occasional aggessiveness, expression of so-called infantile sexuality and insatiable curiosity manifested by unceasing questions. As in all stages of development, the environment must present cer-

tain minimum nurtiments to further the growth of the child

(Schlesinger and Meadow, 1972b).   Earlier, a variety and

abundance of meaningful sensory input were of primary impor-

tance; now responsiveness of the environment to the child's

activities assumes prime importance.

The childhood stage is characterized in the normal child

by marked motor exuberance. In the deaf child, this exuber-

ance is doubly inhibited - the verbal exuberance is almost

invariably diminished by a paucity of symbols, but the feel-

ings remain exuberant and it is not suprising that young-

sters "deprived of the ability or opportunity to express

powerful feelings in words.....usually erupt in actions"

(Katan, 1961).

The environment places an additional deprivation on the

development of the deaf youngster (Schlesinger and Meadow,

1972).   Although identifications at this age still remain

primarily familial, there is increasing evidence that self-

esteem is already developing.   The growth of self-esteem is

accompanied by early awareness of human differences, which

ideally can be accepted either joyfully or neutrally.

It has been noted that many parents attempt to force

their youngsters into a normalcy not available to them

(Schlesinger, 1978). Some parents abhor any vestige of dif-

ference and forgo the hearing aid, inhibit gestures and

voice.   Their children learn easily that their deficiencies

- hearing aids, voice quality, use of gestures - are devalued by the overall society. As well, the deaf child of hearing parents is characteristically deprived of contact with successful deaf adults, a fact that may deeply influence his/her self-concept. For if he/she sees only deaf children and never meets deaf adults, he/she may develop distorted expectations of what happens to deaf children grown up. He/she may wonder whether deaf children suddenly become hearing or whether they die. The deaf child of deaf parents clearly has higher self-esteem at the earlier ages (Meadow, 1969).

1.3.4 Conclusion

The patterns of development described suggest that the typical deaf child of hearing parents suffers in the resolution of each of the three early phases identified by Erikson. The way in which the deaf child and his/her parents resolve these critical stages has life-long implications for the future development of that individual.

The psychological ambivalence which some parents feel after giving birth to a deaf child together with their confusion over how best to help the child, are not insurmountable problems; many parents, both deaf and hearing, have great success in providing the environments which allow their children to develop normally. There is little doubt, however, that others are in need of guidance and counsel and that

lack of such direction may seriously retard the child's sub-
sequent socialization.

1.4   EDUCATIONAL IMPLICATIONS OF DEAFNESS

The period when a child is about to enter first grade has
been identified as one of potential stress (Moores, 1978).
The life cycle of a family involves changes in family rela-
tions and in individual roles over a long period of time.
Although the deaf child has probably received some preschool
training, parents perceive entrance into the formal elemen-
tary school years as a critical point.

If the parents are able to work through their grief real-
istically, and turn to the healthy development of the child,
they are often at a loss to discover the best means of edu-
cating their child in the early years (Streng, Kretschmer
and Kretschmer, 1978). They learn that there has long been
a dispute between educators of the deaf over oral versus
manual techniques of communication and language learning.
They also hear that the choice of educational program that
they make for their child is critical for his/her future de-
velopment. This puts added stress on the parents to make
the "right" choice.

It is difficult to convey adequately the issues that are
implied by the phrase the oral-manual controversy (Furth,
1973). This controversy, which is as old as deaf education,

colors all educational considerations; any major decision or change concerning educational practices implies some stand on the controversy. It is much more than a difference in teaching methods; it touches the very core of deaf people's existence. Proponents of the different methods can cite evidence to support their favorite combination of methods (Liben 1978). Unfortunately, when parents first come into contact with the educational system, they are swayed by the personal stance of the professional that they first meet. Hearing parents of deaf children often have no idea that a reasonable alternative to oral education and joining the hearing society exists.

The aural/oral educational approach is directed towards providing hearing impaired children with speech and auditory training to promote the further development of speech and language skills. This approach involves the learning of verbal communication skills (speech), auditory training (listening), speechreading (lipreading), and amplification by hearing aids. Its major aim is to aid the deaf in integrating into the dominant hearing community (Furth, 1973).

Those espousing the oral method have had three major criticisms of using manual communication in the school (Liben, 1978). First, they suggest that its use will interfere with the individual's motivation for developing aural-oral skills, as it is easier for the deaf to master sign language

than spoken language. Second, it is suggested that the development of manual skills rather than aural-oral skills will prevent integration into the dominant hearing community as signs restrict the number of people with whom the deaf child can communicate. Third, they suggest that manual languages do not have the capacity for expressing abstract ideas, and that people using manual languages will be limited to concrete thinking.

Those supporting manual communication argue that empirical evidence refutes all three criticisms (Liben, 1978). In response to the first, several studies have shown that children who have had early exposure to manual communication do as well, or as better than children who have not had this exposure (Stuckless and Birch, 1966; Meadow, 1968). In addition, most studies have shown that deaf children of deaf parents (ie. children exposed to manual communication) performed better on tests of educational achievement, reading and writing, than deaf children of hearing parents (ie. those exposed only to spoken English). Thus, most of the literature is in agreement that the use of early manual communication need not hamper later skills, even skills specifically related to spoken language.

To respond to the issue of integration into the hearing community, those who support the use of manual communication argue that research indicates that the integration of deaf

people into the hearing world has had only limited success.
For example, many studies conclude that although deaf people
interact with the hearing community when necessary, they
tend to look toward the deaf community for their nonobliga-
tory social interactions (Liben 1978).

The third criticism, that manual languages are inherently
concrete, has been refuted by recent linguistic work.   As
Bellugi and Klima (1978) discuss, sign language may be used
for expressing abstract thought and is not a linguistically
"inferior" language.

In recent years, a third approach to communication has
emerged, called total communication.   In this approach, all
possible forms of communication are used to develop concepts
and language.   Some of the forms of communication used in-
clude hand signs and fingerspelling in English word order
(Signing Exact English), speechreading (lipreading), speech,
non-verbal communication skills (gestures and body lan-
guage), graphic aids, amplification of hearing aids and au-
ditory training (listening).

The use of total communication with very young children
appears to be gaining support, a support that may be traced
to a number of factors, including:

1. the evidence that deaf children of deaf parents
    achieve more academically than do those with hearing
    parents;

2. the growing tendency to accept the language of signs as a legitimate mode of communication;

3. the increasing militancy of deaf adults who are only beginning to make an impact on the field, the majority of whom, despite their own rigid oral training, strongly support the use of total communication (Moores, 1978).

Although one of the goals of education of the hearing impaired is to produce children proficient in speech and speechreading, the reality must be faced that rigid adherence to learning by means of speech and speech-reading is self-defeating for many deaf children. In a total population of hearing-impaired children, there will be those unable for just reason to develop real and true language, using the oral method (Harris, 1971).

Consequently, many deaf children must enter manual programs at schools for the deaf with a sense of relief; they are freed to communicate in a manner comfortable to them (Mindel and Vernon, 1971). The children placed in these programs are often regarded as dropouts from oralism. They are labelled with a variety of indecorous terms "slow learners", "aphasics", "retarded", "oral failures", "willful", "emotionally disturbed", etc. Parents who have been conditioned earlier to the "primacy" of oralism may regard placement of their child in a manual program as a signal of fail-

ure.   This   has severe   repercusions for   the deaf   child's
self-concept.

In spite of the emphasis placed on "individuality", there
has been a growing tendency to encourage uniformity in edu-
cation.   Every program for hearing-impaired children should
have available to it the possibility of pursuing through
different communication modalities - whether aural-oral, to-
tal communication, or even sign language, alone - the goal
of a healthy,   literate child (Streng,   Kretschmer and
Kretschmer, 1978).

Leo Jacobs, a deaf educator, writes that "the education
of the deaf was started by hearing people. However, instead
of developing the educational methods for greater effective-
ness toward the goal of developing happy, well-adjusted and
productive deaf citizens,   the hearing persons who have been
in the saddle of authority have placed the greater emphasis
upon molding deaf children into acceptable facsimiles of
hearing people" (Jacobs, 1974).

Deaf people,   after years of training in speechreading,
cannot speechread as well as hard-of-hearing people because
they lack the ability to utilize context and anticipate, in-
tegrate, and interpret in consistent grammatical patterns
those sounds, words,   and phrases which are difficulat to
distinguish from the lips.   As well, research studies indi-
cate that hearing persons are better speechreaders than most

deaf persons who have undergone several years of training (Bolton, 1976).

Although the oral-manual controversy has shadowed other aspects of educational programs for the deaf, there are other important variations in educational environments that affect the child's experience profoundly (Liben, 1978). One of these is whether the child lives at home or at a school residence. Most educatiors would probably agree that the optimum arrangements for young children are reflected in the situation of the child who lives at home with a loving, concerned family and attends a local school where his special needs are met (Schlesinger and Meadow, 1972a).

Unfortunately, this is frequently not possible. When a family lives in a rural area where school districts are incapable of providing for the needs of every special child, it may be a case of educational necessity for a young child to attend the nearest school for the deaf and to live in the dormitory.

Some of the disadvantages of the residential setting stem from the nature of dormitory life and the administrative hazards inherent in a large institution (Schlesinger and Meadow, 1972a). A large body of literature supports the widely held belief that institutionalization has detrimental effects on the developing child (Bolton, 1976).

A study conducted by Evans (1975) indicated that for deaf teenagers who live in residential schools, social isolation is increased because of infrequent symbolic interaction with non-deaf people such as family members, same-age hearing peers and society, in general. Life in many residential schools deprives children of normal contact with diverse segments of our society and its culture. One major consequence is insufficient exposure to, and lack of learning of, socially significant norms, roles, attitudes, values and patterns of behavior commonly induced by members of our society.

In another study that compared day students to residential students, it was found that day students were generally superior to residential students with hearing parents (Meadow and Schlesinger, 1972a). There were statistically significant differences on 10 descriptive variables (social development, communicative development and intellectual development).

One study which did not support this general conclusion compared matched samples of residential pupils and day students attending residential schools (Quigley and Fresina, 1961). This investigation failed to support the contention that living in residential schools is detrimental to the development of communication skills, educational achievement, or the social adjustment of deaf children. In regard to so-

cialization and community integration, Rainer et al. (1969) state that the data indicated that persons with early total deafness can establish adequate socialization patterns and are able to participate in and utilize general community services.

Thus, it should be noted that there are also positive aspects of institutionalization for deaf children. Children in residence settings are more likely to have contact with deaf adults, as counselors or house parents are often deaf themselves (Liben, 1978).

Moreover, in the dormitory, deaf children are surrounded by other children who share their communicative modes and have had many of the same experiences. To meet and live with other boys and girls whose activities can be much more fully accepted than hearing children must be a tremendously meaningful experience for the deaf child (Furth, 1973). Thus, most deaf children adjust remarkably well to residential school and prefer institutionalization to living at home where parents and siblings have never learned to communicate with them (Bolton, 1976). It is here that the deaf child has the experience of constructing new and meaningful ways of relating to others at the same time that he expands his skill in communication.

The discrepancies suggest that at most deaf teens are delayed in the process of socialization rather than remain al-

ien to their own society (Stephens, 1976). Without a doubt, differences exist between deaf and hearing teens. The nature and meaning of these differences are not clear, however.

Any discussion of education must include some indication of how well educational goals are being met. Research findings on the educational achievements of deaf students have not been encouraging. In fact, it has been well-established that the average deaf adult is undereducated (Mindel and Vernon, 1971). This is a clear indictment of educational systems which fail to develop the intellectual potential of the average deaf person. This lack of academic achievement also acknowledges the impediment to normal learning caused by severe or profound hearing loss.

There are a number of studies (Wrightstone, Aaranow and Moskowitz, 1962; Bolton, 1976) which document the educational failures of deaf youth. In the most extensive survey of educational achievement which included 93 % of the deaf students sixteen years or older in the United States, only five percent of the students achieved a tenth grade level or better. Most of this five percent were hard of hearing or adventitiously deafened. Sixty percent were at grade level 5.3 or below, and 30 % were functionally illiterate (McClure, 1966).

Many deaf, however, are fluent in ASL. They are able to understand English concepts when translated into their language but they have not mastered the spelling of English words. The problem lies in that their use of the English language is measured, not ASL, and consequently, they appear undereducated. This also has implications for the deaf person's self-concept for he/she goes through the school system thinking that he/she signs bad English and not recognizing that they are, in fact, using a distinct language.

Parents are traditionally led to believe that preschool oral education may correct these distressing educational deficiencies. Research on the effects of oral preschool programs fail to support such claims. One investigation on an oral preschool program showed that children with oral preschool training were not more advanced academically than the matched group with no preschool oral experience (Liben, 1978).

1.5 VOCATIONAL IMPLICATIONS OF DEAFNESS

Communication barriers erected in early life carry over into the area of vocation. A deaf person does not expect to be hired for a job that requires hearing; however, the language deficiency often begun at home and carried through the years of formal schooling becomes a serious restriction in the job market.

The demands of today's technological society limit vocational success for people saddled by deafness and their consequent undereducation (Mindel and Vernon, 1971). Even for the ambitious deaf student, self-education is difficult if not impossible when reading levels are third and fourth grade. The deaf have the same intelligence as hearing. Despite this, they are frequently forced to do manual labor rather than appropriate professional or technical work.

A study conducted in 1970 (Mindel and Vernon, 1971) indicated that 87 % of deaf people are employed in manual labor, as contrasted to less than 50 % of the general population.

Furthermore, in studies of the deaf communities in Washington, D.C. and New York, only six percent held clerical jobs and less than three percent were employers or businessmen (Schein and Delk, 1974). Thus, deaf people are overrepresented in skilled trades and grossly underrepresented in clerical, professional and managerial positions, many of which do not require hearing.

The employment prospects for deaf adults who dropped out of school, were discharged for disciplinary reasons, or who have very low levels of academic achievement are much bleaker (Robinson, 1978). In addition to confronting the usual forms of social prejudice, these individuals are likely to have minimal language deficiency and are often suffering from emotional dosorders as well.

A study conducted by Stewart (1974) concluded that the limitations of such men and women did not result primarily from deafness, but from early deprivations; lack of healthy family interaction; of preschool preparation; of opportunities for total communication and self-expression in the years of formal schooling.

It should be noted that these studies are not current. However, the student was unsuccessful in locating recent research articles regarding vocational patterns of deaf adults. It can be assumed, however, that with technological advances over the past 10 - 15 years and the current unemployment rate among the general population, that handicapped persons are experiencing increased difficulties in securing appropriate employment (Douglas and Walsh, 1980). On the other hand, there are some indications that more deaf people are entering university programs to obtain degrees, especially in the human service areas.

A large number of studies seem to agree that a significant percentage of the deaf suffer vocationally because they cannot casually obtain information about careers and work habits in the same manner as their hearing counterparts (McHugh, 1975).

Joiner et al. (1968) conducted research on the vocational aspirations versus actual participation in the chosen fields. It was found that although the vocational plans of

young deaf adults are the same as those of their hearing counterparts, less than 27 % of the deaf saw themselves as actually participating in these chosen fields. Furthermore, only 12 % of the deaf planned on entering professional and technical areas, which required advanced academic skills, and tended to make traditional and sex-stereotyped occupational choices (Moores, 1978).

A recent follow-up study of the Manitoba School for the Deaf graduates points to the generally low wages and lack of promotions afforded to deaf people in the work force (Douglas and Walsh, 1980). Philips (1975) has stated that communication problems can be a major factor in keeping a deaf employee from getting raises or promotions. Reich (1974) supports this statement with data that indicates only three percent of employed deaf people have supervisory positions.

Employer discrimination against deaf persons in hiring and job advancement policies is not uncommon (Vernon, 1967). However, the employers who give deaf workers a chance report stable tenure records; their earnings compare favorably with those of their hearing counterparts; they are not accident prone; their hearing loss does not interfere with their efficiency (Robinson, 1978). Moreover, employers view the deaf as satisfactory workers, so that whatever barriers to promotion or change might be, it can be said that the deaf individual who acquires a position will maintain it under ordinary circumstances by performing well.

Vernon (1967) identifies a rather high rate of unemployment among deaf persons (Rainer et al., 1963) which is due to a number of factors over and above the effects of automation, educational lag, undertraining, and communication problems. One of these is the tendency for the young deaf applicant to be naive about the world of work. This naivete is manifested in many ways, one of which is an unrealistically high salary expectation. Another manifestation is a lack of a feeling of responsibility to the employer. It is not uncommon for deaf youths to fail to notify their supervisor when they miss work due to illness (Vernon, 1967).

1.6 PSYCHOSOCIAL IMPLICATIONS OF DEAFNESS

The effects of impaired hearing cover the entire range of reaction and disturbance (Levine, 1960). At one extreme, defective audition raises a barrier to development that can only be scaled through the effects of a wholly unusual type of special education. At the other, it possesses the power to traumatize personality into serious disorganization. And between these extremes are the countless various repercussions of hearing loss.

This is the situation that characterizes the hearing impaired population throughout the country. This group has commonly been referred to as "deaf mutes" or "the deaf and the dumb". However, they are not mute, for there is no vocal impairment. Neither are they dumb for many are taught

to speak through special instructional techniques (Levine, 1960). The great handicap of the deaf lies in the fact that permanently impaired hearing occurs during the most vulnerable time of life - from birth through early childhood - and is so severe that it deadens the most powerful developmental stimulus of all - the sound of the human voice.

It has been hypothesized that early childhood deafness and the subsequent retarded language development would produce impairments in personality development (Bolton, 1976). It is generally recognized by child development specialists that a conception of selfhood becomes differentiated during the second or third year of life. The child's self-concept forms in the context of the socialization processes, which are inextricably correlated with language training and development. Thus, a question of importance concerns the extent to which psychological adjustment of the child may be distorted by retarded language development.

Bolton (1976) indicates that during the past 20 years, six reviews of research literature on personality and social adjustment of the deaf have been conducted. Several are summarized as follows:

Berlinsky (1952) reviewed 15 studies and concluded that deaf persons appear to reach the same overall level of adjustment as the hearing population. He then proceeded to enumerate "some slight but consistent differences." Deaf

persons have more trouble adjusting to their environment, are more introverted, less dominant, slightly more neurotic, slightly egocentric, evidence somewhat more feelings of depression and suspicion and are less mature in judgement and social competence.

Levine (1963) reviewed a wide variety of studies and concluded that "the personality patterns and traits of the deaf...suggest weakness and deficiencies for dealing effectively and knowledgably with the complex problems of life today" (Bolton, 1976).

The review of Schuldt and Schuldt (1972) considered 20 empirical personality studies of deaf children published since 1950. They concluded that deaf children manifest more abnormal personality characteristics and less adequate adjustement when compared to hearing children.

The reviewers are clearly not in agreement in the conclusions regarding the personality and adjustment of deaf persons. However, Levine (1963) states that it is agreed that many deaf adults do exhibit patterns of behavior reflecting retarted emotional development and immature social functioning as a result of growing up in a sheltered, overprotective environment and not to deafness, per se.

1.6.1 Language and Communication

The imposition a hearing loss places on communication is perhaps the most serious limitation to be incurred by this disability (Cohen, 1980). The communication problem affects every aspect of his/her life. Other problems areas exist principally because of it (Williams and Sussman, 1971). His/her degree of adjustment and achievement in all of his/ her activities is primarily dependent on aspects of his/her communication skills.

The normal nondeaf child learns the language of the society into which he/she is born by hearing it. When auditory input is greatly reduced, written and verbal language development in the child is effectively curtailed. According to Baker and Cokely (1980), language refers to "a system of relatively arbitrary symbols and grammatical signals that change across time and that members of a community share and use for several purposes: to interact with each other, to communicate their ideas, emotions and intentions, and to transmit their culture from generation to generation." Culture is transmitted through the medium of language. Language is a tool which enables humans to think abstractly. However, it is not the only basis for abstraction.

Communication refers to the various signaling systems which exist or develop among animals, including humans. Thus, communication includes a much larger range of behav-

iors than language; however, language provides one procedure for communication among people (Bolton, 1976).

The distinction between language and communication has direct relevance to the functioning of deaf persons. Most deaf persons are adequate communicators using manual sign language but are three to four years behind their hearing counterparts in their use of formal reading and writing skills. The English that deaf children encounter in their studies becomes increasingly complex as they progress up through the grades (Bornstein and Hamilton, 1978). It is the primary medium through which information is filtered in the classroom, in texts, in the larger environment, and sometimes through the student's peers, if he/she and they have achieved a really functional use of English.

Clearly, the communication problems that remain with older deaf children are very complex. There is evidence to support that as the majority of deaf children grow older, the discrepency between the level of English that they are able to master and the level of English used in the information increase with every year of life (Bornstein and Hamilton, 1978).

Hence, the ordinary communication system for adult deaf persons in our society can be summed up as follows: The deaf person lives in a society in which the most important means of communication is the oral language of that society,

both in its spoken and written form. The individual deaf person masters the elements of this language to a greater or lesser degree so that he/she can (1)lip-read, (2)speak him or herself, (3)write, and (4)read (von der Leith, 1978).

In a group of hearing persons, the deaf person will soon understand little of the conversation, when several persons speak at once. In fact, even the hard of hearing function as socially deaf in groups with more than two hearing persons. Only when one or several hearing persons of the group are fluent in sign language is there a chance for a deaf person to keep up with the conversation (von der Leith, 1978).

The manual sign language used by the deaf, is an intriguing language although considerable controversy has centered around its role in the education of the deaf (Myklebust, 1964).

As there are several variations of sign language used by the deaf, a brief discussion regarding these is appropriate. Woodward (1973) viewed these differences as occurring over a gradient. He hypothesized a continuum with American Sign Language at one pole and Signed English at the other. Between these are varieties of language called Pidgin Signed English.

1. American Sign Language (also called Ameslan or ASL) is the language used by most deaf persons to communicate with one another. Baker and Cokely (1980) de-

scribe American Sign Language as a visual-gestural language. "Gestures" can be simply defined as any movements of the body that occur for the purpose of communication. The gestures found in ASL are a special set of rule-governed behaviors which are called signs. The units of American Sign Language are composed of specific movements and shapes of the hands and arms, eyes, face, head, and body posture.

The term "visual" refers to the fact that American Sign Language, uses body movements, instead of sound, "listeners" use their eyes instead of their ears to understand what is being said. And because all linguistic information must be received through the eyes, the language is carefully structured to fit the needs and capabilities of the eyes.

ASL fulfills the requirements of a genuine language as stated by Baker and Cokely (1980), "Any symbolic language which is learned, which consists of conventional basic units and rules for their arrangement which includes a conventional set of arbitrary signs for meanings and referents." ASL also contains all the features of any language. These are semantic rules, syntactic rules, transformational rules and phonological rules.

All languages are composed of a limited number of units that are connected to each other in specific ways (Baker and Cokely, 1980). The basic building blocks of a signed language are its handshapes, its palm orientations, and the location where these occur. By combining a specific handshape, palm orientation, and movement in a particular direction, one makes a sign. Combinations of signs form sentences. In ASL, there are rules for determining how words or signs can be combined to form sentences.

Sentences are divided into three main parts and are sequenced in the order in which they visually occur. The first part is the sign that is most concrete, the second part includes the signs that describe the stimulus and the third part is the result, product or state of being.

During the past few years, several manual sign systems have been developed by educators to present English visually since their design is such that they use ASL in English word order (Katz, 1978). The new systems have as their premise that ASL, with linguistically generated variations can be the equivalent of spoken English. Furthermore, they share the idea that if this type of system is introduced to the deaf child at a very early age, the language skills, total

experiences, mental health and communicative abilities will be improved over the traditional approaches.

2. Seeing Essential English (SEE 1)

This sign system uses modifications of ASL to resemble English. SEE 1 signs represent word forms or word parts such as roots, prefixes, or suffixes. To reflect English syntax, SEE 1 emphasizes complete English word order. Verb tense is clearly indicated and irregular verb forms have signed representation. In general terms, English words are represented by the traditional American sign word plus a suffix and/or prefix.

The SEE 1 system has the largest vocabulary of any of the new systems. At present, there appears to be about 6,000 SEE 1 words (Bornstein, 1973).

3. Signing Exact English (SEE 2)

According to Bornstein (1973), the reasons leading to the development of Signing Exact English is that SEE 1 utilized too many signs that were too distant from ASL, were too radical in its use of the root word and too complex for the needs of parents and teachers. Accordingly, SEE 2 uses signs which represent words rather than roots, as well as basic affixes as needed. Signing Exact English has a vocabulary of some 2000 words.

4. Signed English (SIGLISH)

This sign system is located at the other end of the continuum. Its basic purpose is to represent English manually (Bornstein, 1973). It employs signs in English syntax and the signs represent either words, or word parts, or morphemes, etc.

The following sentence will show some of the differences and similarities between manual codes for English and ASL (Baker and Cokely, 1980).

Written English: Last week I went bowling with my friends.

SEE 1: Final week I go + ed bowl + ing with my friend + s.

SEE 2: Final week I go + ed bowling with my friend + s.

Signed English: Final week I go + (irregular past marker) bowling with my friends.

ASL: One week past me friend group from - here - group - go - to - bowling.

Other sign or communication systems employed are the Verbotonal method (emphasis on spoken rhythm of the language), Cued speech and Linguistics of Visual English (auditory methods), Rochestor method (combination of speech, lipreading and fingerspelling) and Manual English (based on SEE 2). The new sign systems are in a state of flux and transition. Incongruencies and contradictions may be seen within the systems.

One further method of communication has evolved and is used extensively in particular when deaf and hearing people are communicating with one another is Pidgin Signed English. A pidgin is a language which develops naturally when people who do not know each other's language wish to communicate with each other (Baker and Cokely, 1980). Thus, deaf people try to sign English and hearing people think they should abbreviate or simplify their signed English.

Pidgin Signed English does not have one specific set of rules. Rather, many forms exist. The forms used by deaf people tend to include more of the structures found in the grammar of ASL and less of the grammatical forms of English. Conversely, the forms of Pidgin Signed English used by hearing people tend to include more English grammatical structures and more transliterations of English idioms and little of the structures found in ASL (Bornstein, 1973).

Thus, the purpose of Pidgin Signed English - either more like ASL or more like English - is communication. For this reason, Pidgin Signed English has been generally accepted by the Deaf community as a way to interact more comfortably with hearing people. In general, hearing people have used Pidgin Signed English because they have not had the opportunity to acquire ASL.

1.6.2   Deaf Subculture

The deaf living among the hearing are in a unique situation.
On the one hand, most of them take a highly integrated part
in society in many different ways. They work with the hear-
ing; they live together with hearing friends and relatives;
they are involved in the same activities as hearing people.
On the other hand, their handicap sets them apart, communi-
cation-wise (Trevoort, 1978).

The need to nullify the communication barrier is the ma-
jor reason why the deaf have formed a subculture (Williams
and Sussman, 1971).   In the regular community associations
of hearing people, many deaf persons function marginally, on
the fringe at best.   They have to create compensations.
Thus, they are able to operate in the larger culture as nec-
essary, but they always have their own resources for satis-
fying social experiences.   Within the deaf community, there
are numerous opportunities for self-fulfillment in the so-
cial area that otherwise cannot be provided by society.   It
is within the context of the deaf community where the inter-
action of one deaf person with another is the greatest.
Deaf people hold numerous civic, social and recreational
events and have many clubs and organizations of varied in-
terests.

Unlike some other disability groups, deaf people have al-
ways taken care of their own needs.   They emphasize that

they are not the recipients of other people's charity and that the disability of deafness does not foster incompetence. They have organized and supported these clubs themselves with little help from hearing people.

1.6.3   Isolation

The impact that hearing loss places on communication also directly influences the social isolation of the deaf. With profound hearing loss, the child will be virtually excluded from information and human contact ordinarily available through hearing (Mindel and Vernon, 1971). This means the loss of that early parent-infant relationship conveyed through sound.

A more profound progressive isolation from the hearing world begins when the child starts to depend upon auditory stimulation for the development of language and general knowledge. Residual hearing insufficient to allow the child to understand speech will isolate him from conventional language development and utilization. As the deaf child matures and recognizes that oral conversation and reading are the chief modes of communication and learning, his sense of isolation increases.

Since one of the major consequences of deafness is social isolation, research studies (Rainer, Altshuler and Kallman, 1969; Schein and Delk, 1974) have been conducted to deter-

mine the influence of this isolation on emotional develop-
ment. One such study conducted on a psychiatric unit indi-
cated that the social isolation of deaf patients was far
greater than that seen in other groups of mentally ill per-
sons (Mindel and Vernon, 1971). Many of these patients were
not only unable to exchange information on rudimentary needs
with their families but also had no close friends, deaf or
hearing.

1.7 MENTAL HEALTH AND DEAFNESS

There has been considerable debate regarding the relation-
ship of deafness to mental illness. Some studies have con-
cluded that the frustrations and loneliness born of the iso-
lation lead to considerable depression in deaf persons,
especially those whose intellect and ambition are thwarted
by inappropriate educational and habilitative techniques and
by the limitations of deafness (Williams and Sussman, 1971;
Rainer, Altshuler and Kallman, 1969).

Several authors indicate that the impact deafness has on
communication has been designated as the major cause of emo-
tional disturbance and behavior disorders among the hearing
impaired. Best (1973) suggests that many theories of mental
disorder are based on the fact that frustration occurs when
an individual is unable to experience satisfying communica-
tion with others in the environment. Cohen (1980) also com-

ments on the implications of communication difficulties, suggesting that a deaf person's inability to express dissatisfaction often leads to a physical display of such feelings.

Robinson (1978) writes that deaf people experience one or more of a variety of situations which are stressful, for example, communication problems in greater or lesser degrees which affect all areas of living and usually begin in infancy; separation from family at an early age; job discrimination, prejudice, ridicule, and social isolation from the mainstream of society. There is no doubt that these factors may contribute to the development of mental illnesses.

On the other hand, Rainer et al. (1963) conducted an extensive study of psychotic illnesses among deaf people. It was found that the incidence of schizophrenia was no more greater among the deaf than in the hearing population.

There is, however, an abundance of literature on the prevalence of emotional and behavioral disturbances among deaf children, the conclusions of which seem to indicate a high degree of emotional problems.

In 1979, a survey was conducted at the Manitoba School for the Deaf, to determine the degree of emotional disturbance among school age children. Teachers were asked to complete a checklist of various types of disorders and to

indicate the primary handicapping condition for each individual. It was found that 20 % of the students displayed a significant degree of emotional disturbance. These findings were congruent with studies done in other schools for the deaf throughout North America.

Vernon's 1969 study was among one of the first attempts to identify the size of the emotionally disturbed hearing-impaired population (Cohen, 1980). In this study, teachers' ratings indicated that 20.7 % of the students had poor psychological adjustment. The proportion of students whose psychological test evaluations indicated they were emotionally disturbed was 22.5 %.

Schlesinger and Meadow (1972a) in a California survey estimated that 32.2 % of the deaf children in their large and representative sample were moderately or severely disturbed according to teachers' ratings. In a duplication of this study conducted at the Robarts school in London, Ontario, Evans and Galbraith (1981) discovered that the percentage of moderately or severely disturbed children was about 20-22 %. There are no current studies that demonstrate the degree of mental illnesses among the deaf.

1.8   EXISTING SERVICES (LOCAL, NATIONAL AND INTERNATIONAL)

Deafness can   lead to isolation   from and   frustration with,

services   which the   hearing population   takes for   granted.

Psychiatric care is one of these   services and has been neg-

lected by all but a few   mental health professionals who are

aware of the very special needs and problems of the emotion-

ally disturbed deaf adult.

The literature indicates a lack of human and physical re-

sources that   deal with the   mental health needs   of hearing

impaired   persons.   Goulder   (1977)   lists fifteen   mental

health programs for hearing-impaired persons that are locat-

ed in the United States.   Reich and Johnson (1981) identify

two mental health programs for deaf adults that are in exis-

tence   in Canada,   one in   Vancouver and   one in   Montreal.

Montreal.   None exist in the Winnipeg area.

The only   alternative is that   deaf persons   must utilize

the services   that are available   to their   hearing counter-

parts.   This solution, however, is often fraught with prob-

lems for it   means that the deaf person   must be accompanied

by an interpreter.   As noted by Bolton (1976), Bornstein et

al.   state that "the presence of an interpreter,   regardless

of his   skill and   sensitivity to the   feelings of   the deaf

client,   is essentially an   intrusion in this relationship."

In addition,   the presence   of a   third person   affects the

therapeutic process   as even   the most   skilled interpreters

face a difficult task in attempting to clarify messages be-
tween counsellor and client.

A further complication of the current situation is that
mental health professionals delivering services to deaf in-
dividuals do not possess a thorough understanding of and
sensitivity to the unique needs of their deaf clientele.
Psychiatrists, social workers, psychologists and community
mental health programs are underexposed, unsophisticated or
untrained to deal with the special problems of the deaf. In
fact, Robinson (1978) states that there is some reluctance
of mental health professionals to engage the deaf client in
therapy because of this.

The psychological and emotional needs of hearing impaired
persons are virtually ignored. There is a definite need for
more mental health professionals to firstly, be able to en-
gage in two-way communication with deaf clients and to sec-
ondly, possess knowledge of deafness and deaf people. Deaf
persons should have access to the same quality of services
as hearing persons.

In the 1981 report of Obstacle, produced by the Canada
House of Commons, it is estimated that there are over
200,000 profoundly deaf people in Canada and an additional
1,500,000 with hearing impairments.* Since it has also been

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*It should be noted that these figures may not accurately
reflect the Canadian situation. Rather, they are taken from
U.S. data and are prorated for the Canadian population.

estimated that one out of every ten people in the population require some form of psychiatric help, it may be estimated that at least 20,000 Canadians are unable to receive the quality of care afforded the hearing population.

1.9   METHODS OF INTERVENTION

In addition to a lack of available services, there is a paucity of information in the literature regarding specific interventive techniques that have been found to be success-ful with deaf clients. Scott (1978) reports that several different types of counseling have been used with deaf per-sons. These include: behavioral modification, behavioral counseling, contingency management, transactional analysis, reality therapy, relationship and skill-building groups, role-playing, psychodrama, behavioral contracts, preventive counseling, play therapy, rational-emotive psychotherapy and information- providing.

Scott also states that the more language-based types of counseling (those depending upon a wide vocabulary) do not seem to be as effective in counseling with deaf persons as they are with the general population. This appears to be due to the communication problems which are inherent in any communication with the deaf and the difficulties that many professionals experience in translating English concepts to sign language.

Successful counseling with most deaf persons and perhaps with people in general must be related to the here and now (Vernon, 1967). For example, this means the counselor goes with the client on a job interview and based on that situation, counsels in contrast to talking in his office in general terms about interview procedures. It means that counseling is best done on the job where actual behavior and specific incidents can be dealt with. It means environmental manipulation, talking to employers, getting the family to help, and giving support instead of abstractly discussing problems, and other valid but intangible therapeutic concepts. The communication limitations of many deaf clients often make abstract procedures useless (Vernon, 1967).

1.10 <u>A</u> <u>REALITY</u> <u>THERAPY</u> <u>APPROACH</u> <u>WITH</u> <u>DEAF</u> <u>PERSONS</u>

The writer has selected reality therapy as the method of intervention to be used in counseling the deaf clients. She considers it to be an appropriate method due to its focus on present behavior and acceptance of personal responsibility. Reality therapy is also effective with deaf persons as it makes use of a range of therapeutic techniques such as role-playing, modeling, limit-setting, contracts and education.

Reality therapy is a series of theoretical principles developed by Dr. William Glasser, a psychiatrist, in the 1950's. It is applicable to individuals with behavioral and

emotional problems, as well as any individual or group seeking either to gain a success identity and/or to help others toward this same goal (Glasser and Zunin, 1979). The crux of the theory is personal responsibility for one's own behavior, which is equated with mental health.

1.10.1 Theoretical Concepts

Reality therapy is a system that focuses on present behavior. The therapist functions as a teacher and a model and confronts the client in ways that help the client face reality and fulfill basic needs without harming himself or herself or others.

According to reality therapy, it is most useful to consider identity in terms of a "success identity" versus a "failure identity". In the formation of identity, each of us develops from involvements with others and with the self-image by which we feel relatively successful. Others play a significant role in helping us clarify and understand our own identities. Love and acceptance are directly related to identity formation. According to Glasser (1965), the basis of reality therapy is to help clients fulfill the basic psychological needs, which include the need to love and to be loved and the need to feel that we are worthwhile to ourselves and to others.

Reality therapy is built on the assumption that a person is ultimately self-determining. The principle implies each person's responsibility to accept the consequences for his or her behavior.

There are at least six characteristics that define reality therapy (Corey, 1977):

1. Reality therapy rejects the concept of mental illness. It assumes that specific forms of behavior disorders are the result of irresponsibility. This approach does not deal with psychiatric diagnosis. Instead, it equates mental illness with irresponsible behavior and it equates mental health with responsible behavior.

2. Reality therapy focuses on present behavior rather than on feelings and attitudes. Although it does not assert that feeling and attitudes are unimportant, all that can be changed is the present and the future. If the past is discussed in therapy, it is always related to the client's current behavior. The therapist is open to exploring all aspects of the client's present life, including his or her hopes, fears, and values.

   Therapy stresses the client's strengths, potentials, successes and positive qualities, not merely his or her misery and symptoms. Glasser (1965) urged

that the client be seen as a "person with wide poten-
tial, not just as a patient with problems". He dis-
couraged devoting therapy time to rehashing problems
and failures and suggested that the therapist look
for a client's strengths and emphasize them in the
conversations.

3. Reality therapy emphasizes value judgements.   It
places central importance on the client's role in
judging the quality of his or her behavior in order
to determine what is contributing to his or her fail-
ure in life.   It seems that change is unlikely with-
out looking at behavior and making some determination
of its constructiveness or destructiveness.

4. Reality therapy stresses the conscious, not the un-
conscious, aspects.   Reality therapy emphasizes what
clients are doing wrong,   how their present behavior
is not getting them what they want and how they might
engage in a plan for successful behavior based on re-
sponsible and realistic behavior.

5. Reality therapy eliminates punishment. Glasser main-
tains that punishment aimed at changing behavior is
ineffective and that punishment for failing to imple-
ment plans results both in reinforcing the client's
failure identity and in harming the therapeutic rela-
tionship.

Instead of using punishment, Glasser advocates allowing the client to experience the natural consequences of his or her behavior.

6. Reality therapy emphasizes the concept of responsibility, which Glasser (1965) defined as "the ability to fulfill one's needs and to do so in a way that does not deprive others of the ability to fulfill their needs." Even though all of us possess the need to love and be loved and the need to feel a sense of worthiness, we are not naturally endowed with the ability to fulfill these needs. Responsibility consists of learning how to meet these needs in reality.

Glasser (1965) contends that teaching responsibility is a core concept in reality therapy. The therapist teaches clients better ways to fulfill their needs by exploring the specifics of their daily lives and then making directive statements and suggestions of ways to solve problems more effectively. Therapy becomes a special kind of education wherein definite plans are made and realistic and responsible means of meeting personal needs are examined.

Thus, the overall goal of reality therapy is to help the individual achieve autonomy. Essentially, autonomy is the state of maturity that accounts for the person's ability to relinquish environmental support and substitute internal support. This maturity implies that people are able to take

responsibility for what they are and what they want to be-
come and to develop responsible and realistic plans to ful-
fill their goals. Reality therapy assists people in defin-
ing and clarifying their life goals. Further, it assists
them in clarifying the ways they frustrate their progress
toward their self-defined goals. The therapist helps the
client discover alternatives in reaching goals, but it is
the client who decides his or her own goals of therapy (Co-
rey, 1977).

1.10.2 Application: Therapeutic Techniques and Procedures

Reality therapy can be characterized as verbally active.
Its procedures focus on the client's strengths and poten-
tials as related to his or her current behavior as he or she
attempts to succeed in life (Corey, 1977). In assisting the
client to create a success identity, the therapist might use
a range of techniques such as the following:

1. Engage in role-playing with the client;

2. Use humor;

3. Help the client to formulate specific plans for ac-
   tion;

4. Serve as a role model and teacher;

5. Set definite limits and structure the therapy situa-
   tion;

6. Use "verbal shock therapy" or appropriate sarcasm to
   confront the client with his or her unrealistic be-
   havior; and

7. Get involved with his or her search for more effective living.

Reality therapy does not include some commonly accepted therapeutic approaches. Psychiatrists who practice reality therapy apply drugs and medications conservatively, for medication tends to remove personal responsibility for behavior. Other techniques not used are interpretation, insight, nondirective interviews, prolonged silences, free association, analysis of transference and resistance, and dream analysis.

Glasser and Zunin (1973) believe that the techniques of reality therapy are applicable to a wide range of behavior and emotional problems. They assert that the procedures of reality therapy have been successful in treating "specific individual problems, such as problems of anxiety, maladjustment, marital conflicts, perversions, and psychoses".

1.10.3   Summary and Evaluation

The advantages of this approach appear to be that it is relatively short-term therapy and it deals with conscious behavioral problems. The client is confronted with the necessity of evaluating his or her behavior and making a value judgement. A plan of action and a commitment to following through are seen as the core of the therapeutic process.

A shortcoming of reality therapy is that it does not give emphasis to the place of unconscious psychodynamics and the person's past as a determinant of present behavior. As well, Glasser's view of mental illness as "irresponsibility" is controversial. It neglects to acknowledge that many mental patients were highly responsible citizens prior to the onset of their symptoms. Further, patients may remain responsible in many areas of their lives while exhibiting psychotic or bizarre behavior (Corey, 1977).

1.11   GOAL ATTAINMENT SCALES

Goal attainment scaling involves setting a goal, implementing a program, determining subsequent goal attainment, and using this information to modify future activities (Kiresuk and Sherman, 1966).

Kiresuk and Lund (1978) state that "the core of goal attainment scaling is a goal attainment follow-up guide" (p. 345), such as the ones located in Appendix A, B, and C. A goal attainment follow-up guide is a grid-shaped form consisting of a series of discrete 5-point scales. When the follow-up guide is filled out, each scale represents a separate client or program goal area. The five levels of each scale are defined by concrete behaviors arranged along a hierarchy of possible outcomes. The nature of these outcomes range from the "most favorable outcome thought likely" to the "most unfavorable outcome thought likely" with the "expected level of success" at the middle level.

The first step in the construction of a goal attainment scale involves selecting scale headings that identify high priority goal areas. This is commonly negotiated by both client and therapist. Goals of the client or program should be described in precise and objective terms in order to facilitate measurement. Usually between three and five goal areas are identified.

For each goal specified, a scale composed of a graded series of likely treatment outcomes ranging from least to most favorable is decided upon (Kiresuk and Sherman, 1968). These points are then assigned numerical values, -2 for a least favorable outcome and +2 for a most favorable outcome with the value zero assigned to the treatment outcome considered most likely. It is important that the scale points be stated in terms of events the presence or absence of which can be easily judged by a follow-up worker who has had no contact with the clinical procedures.

The goal selector may also specify a set of weights for the goals, reflecting his/her appraisal of the relative value of each goal as an indicator of successful treatment. Following the goal selection and weighting, the treatment is administered. After a predetermined interval, the case is reviewed in regards to the client's progress towards the goals specified prior to treatment.

The advantage of goal attainment scaling is its flexible structure and ability to accomodate a wide variety of specific goals and measuring scales (Kiresuk and Lund, 1978). A presumed advantage is that the method requires each client to be measured only on dimensions that are believed to be individually relevant.

Chapter II

THE PRACTICUM EXPERIENCE

This chapter will describe the setting of the practicum and will present an overview of the cases carried by the writer. Each case will be discussed briefly with an elaboration on three clients. In this discussion, the counseling process will be summarized, including an assessment, treatment goals and plans for change. The interventive outcomes will be examined, using goal attainment scaling.

2.1   SETTING

The practicum was conducted at the Deaf Program of the Society for Crippled Children and Adults (S.C.C.A.) from January, 1982 to July, 1982. It initially occurred on a part-time basis but became a full-time effort in April, May, and June, 1982.

The S.C.C.A. provides comprehensive services to physically disabled persons from infancy to adulthood. Some of the children's services available include rehabilitation counseling, pre-school program, education, psychological services, family counseling and education, and medical assessments. Services available to adult program clients include social services and counseling, vocational assessment and training, and employment counseling and job placement.

Within the agency, the Deaf Program operates as a separate department. It provides services to both hearing-impaired children and adults such as family counseling, liaison with other oral and total communication programs, individual counseling, vocational assessment and training, upgrading and communication skills tutoring, and interpreting services. The program also acts as a liaison or complimentary service to other social service systems dealing with a deaf person.

The writer assumed a specialized caseload of hearing-impaired persons who were experiencing mental health problems and required intensive intervention. She was the primary worker in eight of the cases and worked as co-therapist with a rehabilitation worker in one situation.

All significant contacts and information were recorded in the writer's files. This mainly focused on the process of the intervention. As well, a summary of contacts was entered on the clients' files prior to termination.

Supervision was provided by the four members of the committee. The writer met semi-monthly with her principal advisor, Dr. Don Fuchs, during the academic term, and on a weekly basis in April, May and June. He provided valuable feedback and direction. Several counseling sessions were video-taped which were viewed and feedback provided on.

Ruth Rachlis and Mary Warmbrod also met with the writer for consultation, when necessary. Mike Owen, supervisor of the Deaf Program assigned the cases. The writer met with him on a semi-monthly basis for supervision.

In November, 1981, a committee meeting was held in which the writer presented a proposal that defined the specific social work activities to be undertaken. The committee accepted the plan and provided some feedback.

In April, 1982, a second committee meeting was arranged, to discuss the practicum to date, to ensure that the writer was on course and to plan for termination. The writer presented a summary of each case, goals for change, and the interventions employed.

2.2 CLIENTS

During the course of the practicum there was contact with a total of nine clients. Of these clients, two dropped out, for several reasons. One client did not feel that she required any personal counseling, other than assistance in securing a job. Another rehabilitation counselor was intervening in this area. The other client was experiencing difficulty in transferring from her previous worker, with whom she had developed a close relationship over the past several years.

Consequently, the writer worked with seven clients, who represented a range of difficulties. Of these clients, three were male and four were female. Their ages ranged from 21 years to 44 years, with the average age of 30 years. All the clients were unmarried.

Two clients were residing in mental health facilities, two were living independently, two were staying with family members and one was at the Kiwanis Center of the Deaf (K.C.D.). In addition, all clients were unemployed, although three were seeking work. Four clients used sign language to facilitate communication, one person used oral methods only, one client was relearning ASL and the other client did not know either ASL or English.

A brief discussion of four clients will be presented to give the reader an idea of the complexity and diversity of the types of cases that the writer was involved with. Following that, three cases will be examined in more detail.

2.2.1 Paul

2.2.1.1 Case Summary

Paul was a 45 year old profoundly deaf man who had attained approximately a grade three education. Reports from Paul's peers indicate that during his school years, he did not have many friends and was considered to be somewhat "strange" and a dreamer. He apparently identified strongly with Hitler and the Nazis.

Paul's father died many years ago and he had lived alone with his mother since then. They had formed a stong attachment, whereby Paul had become very dependent on her. Over the past 15-20 years, Paul would often not leave the house for weeks at a time. His activities consisted mainly of watching television. As a result of this lifestyle, Paul's sign language skills deteriorated to a point where he could not communicate with others. He and his mother had developed a home-made sign system.

In December, 1981, Paul's mother was certified under the Mental Health Act and placed in a group home. As Paul was totally dependent on her to meet all of his needs, a placement was also required for him. Subsequently, he was admitted to the psychiatric unit of a Winnipeg hospital for social reasons, where he had remained since.

2.2.1.2   Intervention

Direct counseling with Paul was not possible due to his level of functioning and the language barrier. Therefore, the writer's role consisted of linking Paul to the appropriate services that could benefit him.

The major goal that was established was to improve Paul's communication skills. The writer connected Paul with a deaf man who was employed at K.C.D. This man taught ASL to Paul for six hours a week. The writer was involved in many of these sessions. In total, she met with Paul 14 times.

The writer was also involved in assisting the K.C.D. staff to assess whether Paul was an appropriate candidate for admission to the facility. A number of meetings were held with staff from Community Services to discuss future plans and programming.

Finally, the writer referred Paul to the S.C.C.A. summer camp as it was felt that this would be a therapeutic experience.

2.2.2 Dawn

2.2.2.1 Case Summary

Dawn was a 36 year old woman who had a congenital hearing impairment in the "severe" category and subsequently, a very severe language deficit. She came from a Polish family who immigrated to Canada in the 1950's. Consequently, Dawn spoke Polish in the home and knew minimal English. Dawn lived with her parents who were resistant to any involvement on the part of social service professionals.

It was speculated that Dawn was mentally retarded. Psychological testing indicated that she functioned in the mildly to moderately retarded range of intellectual functioning. However, due to the language deficiency, it was questionable whether this score was valid. Dawn functioned at the grade two level in reading and math. She had attended a school for the retarded for approximately eight years.

Dawn did not know any sign language and communicated by writing, using simple words. Dawn was attending the Employment Preparation Center daily where she was involved in assembly work.

2.2.2.2   Intervention

As Dawn did not know ASL or English, it was difficult to communicate with her. The writer was thus involved in connecting her to other appropriate resources.

The primary treatment goal was that Dawn needed to learn ASL in order to develop communication skills with other deaf people. The writer arranged for a tutor to work on developing her language skills. However, a mental health worker was responsible for obtaining the funding, which was not approved during the writer's practicum.

The writer, however, facilitated arrangements for a Polish interpreter to assist the Deaf Program's tutor in completing a language assessment. This was vital to gain an understanding of whether Dawn did, in fact, have a grasp of the Polish language or whether she had no language skills.

2.2.3   Ian

2.2.3.1   Case Summary

Ian was a 21 year old native man who had a profound to severe hearing loss, which was progressive in nature. Ian's

parents were separated and their whereabouts unknown. He had been raised on reserves and was reportedly abused. Ian had reached a grade three level of education in an oral school.

It was suspected that Ian suffered from fetal alcohol syndrome, characterized by an abnormal growth pattern; indented, droopy eyes; hyperactivity; poor coordination; a short attention span; behavioral problems; and possibly mental deficiency. As well, Ian, himself, was an alcoholic, who appeared to have little control over his drinking patterns.

Ian had an attendence problem. He consistently failed to appear for appointments. As a result, he had a poor work history and had been fired from numerous jobs. As well, Ian had attended programs at Red River College and the Employment Preparation Center, but was dismissed from both programs due to his lack of commitment. He was currently unemployed and receiving welfare.

2.2.3.2   Intervention

The writer attempted to contract with Ian to provide counseling that focused on maintaining a job and working on his alcoholism problem. However, Ian refused to admit that he had any problems and blamed the loss of his previous jobs on the employers. He denied that he had a drinking problem and tended to avoid the issue by changing the subject.

Ian consistently missed appointments with the writer. He would call at a later time to arrange another appointment but often would not appear. When confronted with this behavior, he would apologize and say that it wouldn't happen again. However, he would not keep his agreement.

As Ian wanted help finding a job, the writer contracted with him that if he kept three appointments and provided proof that he had applied for three jobs, she would become more involved in assisting him. This was done to encourage Ian to accept responsibility for his behavior, which Glasser (1965) contends is the key concept in reality therapy. However, he missed the next appointment and the intervention did not reach that stage.

2.2.4   Pat

2.2.4.1   Case Summary

Pat was a 23 year old unmarried hard-of-hearing woman. She communicated using both voice and sign language. Pat had attained a grade 4-5 level of education at the Manitoba School for the Deaf.

In October, 1979, Pat had an illigitimate son, from a relationship with another deaf man. At that time, Pat became involved with Children's Aid to relinquish custody of the child. However, she changed her mind and decided to keep him. She was not currently involved with the father although he continued to pay child support.

Pat displayed numerous personal and emotional problems. She was extremely unreliable and had a tendency to miss appointments. This had resulted in her dismissal from several jobs. Pat was currently seeking employment at the time of the writer's involvement. It was questioned whether Pat was able to provide a positive, supportive environment for the growth of her son.

2.2.4.2   Intervention

Pat missed six appointments before she met with the writer. She identified her problem areas as 1) needing a job, and 2) arranging day care for her son. In total, the writer met with Pat six times.

The writer initially contracted with Pat to assist her in finding a job. In doing so, Pat requested the writer to accompany her to the Canada Employment Center. However, Pat did not appear to meet the writer.

Four sessions were spent with Pat providing counseling regarding appropriate work. However, she was unsuccessful in securing employment, which was partly due to the current job market and her poor work history.

The writer referred Pat to an employment counselor at S.C.C.A. However, Pat failed to show for the appointment.

2.2.5   David

2.2.5.1   Case Summary

David was a 42 year old profoundly deaf man.   He had no
speech and communicated using the SEE method.   David was of
average intelligence and had attained a grade four level of
education (when compared to hearing norms) at the Saskatche-
wan School for the Deaf.

David's parents were divorced about ten years ago. Since
that time he had lived with his father. He had one sister,
who lived in Winnipeg and one brother, who resided in Cal-
gary.   His mother also lived in the city.   She had regular
contact with David and often prepared his meals for him or
cleaned his house.   She did not know sign language and com-
municated to David by writing and sometimes speaking to him
as if he could hear.

David had a lengthy history of psychiatric problems and
had had three admissions to mental health facilities since
1968.   However, his depression appeared to have stabilized
over the past five years.   He had been working fairly stead-
ily at a manual laboring job for several years.   Reports
from his employer indicated that he was a consistent and re-
liable worker.

In December, 1981, David's father passed away.   Immedi-
ately following, David was readmitted to hospital, suffering
from acute depression. He was prescribed antidepressant me-

dication, which seemed to stabilize the depression and was discharged after one month.

Since this time, David had lost interest in all activities. He continued to live alone in his father's house, which he inherited.

2.2.5.2 Assessment

David was a man who had led a fairly lonely life. He lived with his father until his death last winter. David was unable to cope with this event and had been admitted twice to mental health facilities with the diagnosis of depression. Mindel and Vernon (1971) state that the frustrations and loneliness born of the isolation lead to considerable depression in deaf persons.

However, the writer did not consider David to be clinically depressed and preferred not to use this diagnosis. Instead, David possessed numerous misunderstandings and lacked much information. He felt guilty over his father's death as he regretted the arguing they had done. David possessed anxieties that were normal for a person who had lost a close family member. However, David considered these feelings to be weird and abnormal. As a result, he worried more, which increased his anxieties.

At times, David worked himself into a state where he was severely agitated. He would express ideas such as "my heart

and soul are upside down" and "my feelings are tingling". This was David's way of expressing his anxieties.

A complicating factor was that David's mother (Mrs. T), who had little contact with him until his father's death, reentered the picture. At times, she treated David as if he could hear and communicated to him by speaking, using gestures, and writing. Communication with her was not a satisfying experience for David.

Mrs. T. possessed poor problem-solving skills. She would frequently exaggerate a situation into a crisis- producing one. She would phone the writer and talk at length, about nothing, in particular.

David's home situation was contributing to his feelings of sadness. He was not working and sat at home all day with little stimulation and nobody to communicate with. It was possible that he was content to play the "sick role" as he received alot of attention.

He became somewhat of a recluse and would seldom leave the house. He had not returned to his job which had remained open to him. David spent most of his days watching television. He reported a decrease in appetite and usually went to his mother's house for meals when he ate. David indicated that he spent most of his time thinking about his father and worrying about his anxieties and depression. His

anxiety sometimes became so acute that he feared that he was experiencing a heart attack and was going to die. David had little insight into his problems. He continued to see a mental health worker weekly to monitor his depression.

2.2.5.3 Goals

It was agreed that the goal of counseling would be to assist David to become independent and in his words, "to be the same as I was before". This is congruent with the overall goal of reality therapy which Glasser (1965) states is "to help the individual achieve autonomy". This implies that people are able to accept responsibility for what they are and what they want to become and to develop responsible and realistic plans to fulfill their goals.

David was unable to articulate more specific goals for change so the writer, after much probing, helped him further identify four areas. These were:

1. To organize his living situation so as to minimize his loneliness and dependency on his mother;

2. To stabilize his depression;

3. To alleviate his anxiety attacks; and

4. To resolve his feelings regarding his father's death.

2.2.5.4 Intervention with David

David's case was referred to the writer in late January, shortly after he had been discharged from the hospital. The

previous worker sent a letter requesting him to come to the office in order to meet the writer. However, David did not appear.

The worker and the writer then went to David's house to speak with him. David was at home and the writer was introduced to him. At that time, he appeared depressed and unhappy, and communication with him using sign language was slow. David agreed to come to the office for an appointment. However, again, he did not show up.

For the second time, the worker and the writer went to David's home. However, he was not there so a note was left with another appointment time. David did not appear for this appointment, either.

Finally, the writer visited David's home alone. She found him to be in an extremely agitated state and as expressing such thoughts as "my heart and my soul are upside down" and "my feelings are tingling". The writer interpreted these remarks as David's way of expressing his anxieties. David's mother was present but she was distressed and did not know how to handle the situation.

The writer spent this time exploring the situation with both David and his mother. David was very insistent that only "shock treatment" could help him and wanted to return to the hospital. At David's request, the writer accompanied

him and his mother to the Emergency Department and acted as interpreter. The doctor did not admit him as he felt that David was suffering an anxiety attack.

The writer felt that this incident was a turning point. David began to see her as a supportive person who was willing to accept him. At this point, the writer was able to contract with David to see her on a weekly basis.

The next several sessions focused on developing a relationship with David and further engaging him into treatment. On three occasions, the writer accompanied David and his mother to his weekly appointments with his mental health worker and acted, not as an interpreter, but as his social worker, who could provide valuable feedback on his progress. The writer also helped to facilitate communication between David and the mental health worker.

In the initial sessions with David, one of the main tasks of the writer was to provide support and reassurance that his feelings of anxiety were normal for a person who had experienced the loss of a family member. He often appeared genuinely surprised to hear that other people also had anxieties. Consistent with reality therapy, one of the roles undertaken by the writer was that of a teacher, to educate David regarding his numerous misconceptions (ie. that this descriptions of his heart and soul turning upside down was his way of explaining his anxieties).

It was the writer's impression that David's living situation was contributing to his feelings of unhappiness. He was living alone, had nobody to communicate with and spent most of his time watching television and dwelling on his problems. David had been presented with the idea of moving into the Kiwanis Center of the Deaf (K.C.D.) several months prior but had not yet made a decision.

The Kiwanis Center of the Deaf is a multi-purpose facility for the deaf, hearing impaired, multiple-handicapped, and senior citizens. Its main purpose is to provide a place of comfort and residence for the deaf/hearing impaired and to provide for the deaf community a center that may be used for meetings, religious services, recreation and theatre.

The writer helped David to further explore this alternative. She arranged for him to visit K.C.D. for a day. Following this, David still could not make a decision so he was encouraged to move in for a one month trial. These techniques are congruent with those used in reality therapy, as "the therapist should help the client to formulate specific plans for action, set definite limits and structure the therapy situation" (Corey, 1977).

2.2.5.5   Intervention with Mrs. T.

The writer also dealt extensively with Mrs. T, who up until David's father died, had been totally uninvolved with him.

Mrs. T. appeared to feel guilty about her previous lack of involvement and as a result, had become overinvolved with him. She did not know sign language and communicated with him by writing and speaking to him as if he could hear. The writer wondered if Mrs. T. had ever resolved her feelings around his deafness. Mindel and Vernon (1971) maintain that grief, anger and helplessness, stimulated by the discovery of deafness, seldom disappear in any parent.

Mrs. T. would sabotage the treatment plans in subtle ways. Overtly, she would agree with the writer that David needed to improve his social adjustment by moving into K.C.D. where he could communicate with other deaf people. However, Mrs.T. would then state that she didn't want to push David out of his home and that she could care for him. She consistently gave David "double messages".

Four sessions involving Mrs. T. and David took place. The purpose was to explore her feelings regarding David's mental health problems and his future plans. Mrs. T. required a great deal of support and reassurance that she was not neglecting her responsibilities as a parent and that David would probably be happier if he were living in a residential situation where he could communicate with other deaf people. After several months of ongoing involvement with Mrs. T., she began to be more supportive of David's future plans and the subsequent move to K.C.D.

2.2.5.6 Evaluation

Evaluation of David's progress, as with all the clients, was conducted using goal attainment scaling as described in Chapter I. The overall goal that David identified was to "be as healthy as I was before". The writer helped him to further divide this into concrete goals that could easily be measured (see Appendix A).

Thus, four goals were identified:

1. To stabilize his depression (Scale 1);

2. To improve his social adjustment (Scale 2);

3. To alleviate his anxiety attacks (Scale 3);

4. To resolve his feelings regarding his father's death (Scale 4).

These goals were established in early February and evaluated in mid-June, prior to the termination of the practicum. A set of weights for the goals was specified, which reflected the writer's appraisal of the relative value of each goal as an indicator of successful treatment. Scale 1 was considered to be a priority as it was the problem area that was interfering most with his functioning. However, all of the problem areas were interrelated and an improvement in on would most likely have an effect on the others. Thus, scale 1 was administered a weight of 50, scale 2 and 3 both received a weight of 40, and scale 4 was given a weight of 30.

David attained "more than expected success" on scale 1 (depression). At the time of evaluation, his mood had stabilized, he had accepted that he must take medications regularly and was doing so. He continued to be monitored by the mental health worker every two weeks.

On scale 2 (social adjustment), David reached the "most favorable outcome thought likely". He had moved into K.C.D., had passed the one-month trial period, and wanted to stay. In late-May, David requested the writer to contact his previous employer regarding his return to work. He subsequently started work in early-June but continued to express some anxieties. His mother was allowing him more independence and rarely called the writer to ventilate her feelings. David was socializing with other deaf people at K.C.D. and making new friends.

David's anxiety attacks (scale 3) had stopped. He occasionally had worries that he wanted to discuss with the writer but was easily reassured and did not allow them to affect his functioning. David achieved "more than expected success" on this scale.

In regards to scale 4 (grieving process), David had resolved most of his feelings around his father's death but continued to think about him, at times. Hence, he reached the "expected level of success".

In conclusion, the writer was satisfied with the progress that David made. He viewed her as a person who had helped him to organize his life and thus, become more independent. However, as no control group was used, it cannot be concluded that he improved as a result of the writer's intervention, but rather, that changes occurred during it. The writer anticipates that David will continue to experience flucuations in his level of functioning.

2.2.6   Kelli

2.2.6.1   Case Summary

Kelli was a 24 year old unmarried female who had an extensive history of emotional and behavioral problems. Kelli was born with congenital anomalies secondary to maternal rubella. Consequently, she had poor vision resulting from a cateract and a moderate to severe bilateral hearing loss. She communicated using both speech and sign language. Kelli had been a patient in the Selkirk Mental Health Center since August, 1974. She was originally admitted as her parents could not deal with her behavioral and emotional problems and there were no other resources available.

Kelli was the oldest child of four children. As a child, her family moved around numerous times to live in different communities throughout Manitoba and Saskatchewan.

Reports on file indicated that Kelli came from an unsupportive, unhealthy family situation. Kelli's parents divorced many years ago and she had a poor relationship with her mother. She occasionally visited her mother from the Selkirk hospital.

Kelli attended the Saskatchewan School for the Deaf during grades one, two, and three. As her family moved to Manitoba, she then transferred to the Manitoba School for the Deaf to attend grade four. During her school years, Kelli presented major management problems. Although she had also received tutoring since then, she functioned at about a grade three level.

Overall, reports from Selkirk indicated that Kelli's behavior flucuated. She would go for long periods without an aggressive outburst. However, these periods still occurred during which time she was placed into seclusion. As a result of these violent episodes and the fact that no appropriate resources existed in the community, the Selkirk staff had no plans for Kelli's discharge.

In fact, her treatment plans consisted of (1) heavy dosages of medications to control her aggressive behavior, (2) occupational therapy 1/2 hour daily, and (3) janitorial work on the hospital ward.

2.2.6.2   Assessment

Since an early age, Kelli was raised in a competitive, at times, hostile, rejecting environment. Consequently, Kelli developed deep-seated feelings of insecurity and inferiority with a poor self-image and a low frustration tolerance. Her consequent attempts at adjustment had been characterized by an attention-seeking, frequently hostile, and at times, impulsive, aggressive behavior.

Kelli was inappropriately admitted to Selkirk eight years ago. She had never presented any symptoms of mental illness and was prescribed heavy dosages of medication solely to control her acting- out behaviors. Because no discharge plans were formulated, it did not provide any incentive for Kelli to improve her behavior to leave hospital. She perceived herself as a "mental patient" who had no self-worth and no future outside of the hospital.

In the Selkirk Mental Health Center, Kelli's days were not filled with rewarding activities. She attended occupational therapy for 1/2 hour daily, participated in recreational activities and was permitted to do some ward work. Kelli did not consider this to be meaningful work, which reinforced her feelings of low self-esteem.

A further difficulty was that of communication. Although Kelli had some speech and frequently used that method to communicate, her speech was difficult to understand. Howev-

er, as there were no staff who knew sign language, Kelli communicated to them mostly by writing and using her minimal speech. These means were inadequate and often resulted in frustration and behavioral outbursts.

2.2.6.3   Goals

The ultimate goal for Kelli was discharge. However, this was a sensitive issue, due to the length of time that she had been a patient at Selkirk. Ideally, this would involve two separate, but interrelated plans, over a period of several years.

1. Full-time attendence at a community-based work training or activity program for at least a six month period demonstrating positive work performance.
2. Integration into a community-based mental health residence. This would mean that this residence would be involved intensively with Kelli in assisting her to integrate back into the community.

As the writer had no control over the hospital activities, she was thus unable to promise Kelli to help her achieve the above goals. Therefore, short-term goals were established that could be connected to the intervention. Hence, the major goal of counseling was to provide an outlet for Kelli to express her feelings and to teach her more appropriate ways of dealing with her anger. It was hoped that Kelli would perceive an improvement in her behavior as a po-

sitive step toward developing a "success identity" as opposed to the "failure identity" that she had acquired.

2.2.6.4 Intervention

Due to the short-term nature of the practicum, it was decided to work with Kelli on a co-therapy basis. Thus, her rehabilitation worker continued to be involved. In mid-March, the rehabilitation worker and the writer met with the attending psychiatrist and social worker at Selkirk to discuss whether future plans had been established for Kelli. The staff appeared to be resigned to the fact that Kelli was a long-term patient and did not forsee any future plans for discharge.

The worker and the writer then met with Kelli to discuss potential involvement. It was presented to Kelli that counseling sessions could occur every 2 weeks where she could discuss any problems or concerns. Kelli was amenable to the idea and stated that her goal was to improve her behavior so that she could leave the hospital. In total, Kelli was seen six times, with each session lasting approximately 2 hours.

The first session was spent exploring Kelli's future plans and the role of the counselors. Kelli was given the homework assignment of preparing a list of her goals in relation to future work and living arrangements.

During the second appointment, Kelli explained in detail the goals that she had listed. A problem-solving approach was used to help Kelli further define the goals and to consider the steps that needed to be undertaken to achieve them. Reality therapy assists people in defining and clarifying their life goals (Glasser, 1965). As Kelli's signs and fingerspelling were often difficult to read, several role-plays were used to further express herself and/or clarify the situation.

At the third session, it was revealed by Kelli that she had lost her job of cleaning the floors on the ward. According to Kelli, this was precipitated by an argument she had with a nurse. As this was being discussed, Kelli provided the information that an argument with her boyfriend had led to the fight with the nurse. The session focused on ways that Kelli could deal with her negative feelings and how she could improve her behavior to regain her job. A problem-solving approach was also used to involve Kelli in understanding the connection between her behavior and the resulting consequences. She was then asked to identify and list alternate methods of dealing with her anger.

The writer and worker arrived one hour late for the fourth session but had left a message with the staff to inform Kelli. Kelli was extremely angry as she had been waiting patiently. Subsequently, the session focused on more

appropriate ways to deal with her anger and other negative feelings. The writer and worker together did a role-play to demonstrate alternate ways of achieving this. Kelli was then requested to imitate the role-play.

In the fifth session, Kelli was sullen and angry and refused to communicate. When this was explored, Kelli revealed that she wanted the writer and worker to visit her weekly. This led to a confrontation where Kelli was told to start accepting responsibility for her behavior and to start expressing her feelings instead of becoming angry and uncommunicative. Glasser (1965) uses this technique, which he calls "verbal shock therapy" to confront the client with his or her unrealistic behavior.

Prior to the sixth session, the writer and the rehabilitation worker met with the Selkirk social worker to discuss possible future plans. It was agreed that with the rehabilitation worker's involvement, discharge plans could be formulated and implemented. A future meeting with the attending psychiatrist was planned to further discuss this.

During the sixth session, the focus continued to be on helping Kelli to identify alternate ways of dealing with her feelings. She was requested to become involved in an exercise where she would specify whether certain events elicited positive or negative feelings. For example, she was asked how she felt when her father promised to visit her and

failed to appear. Conversely, she was asked how she felt when he kept his promise and did show up. The purpose of this exercise was to demonstrate that she reacts with different emotions, depending on the situation.

In this session, Kelli was asked to consider goals for subsequent counseling sessions, which the rehabilitation worker would be involved in conducting.

2.2.6.5   Evaluation

As discussed under the previous subheading Goals, Kelli's problem areas and subsequent goals were divided into long-term and short-term categories (Appendix B). As the long-term goals were not connected to the intervention or practicum, the results of these will not be examined.

In retrospect, the goal of counseling was to provide an outlet for Kelli to express her feelings and to learn more appropriate ways of dealing with her anger. This was further divided into the quantifiable goals of:

1. Involvement in ongoing counseling sessions and an increase in her participation (scale 1); and

2. No aggressive outbursts indicating an improvement in her behavior (scale 2).

It was assumed that the attainment of these goals would lead to a movement towards the ultimate goal - discharge. These goals were established in mid-March and evaluated in mid-June.

Scale 1 was assigned a higher weight of 40 as it was felt that it was most important for Kelli to perceive some value in the sessions and to make a commitment before significant changes would be made. Scale 2 received a weight of 30. Scale 3 and 4 were considered to be long-term goals and were assigned lower values.

On scale 1 (counseling sessions), Kelli attained "more than expected success". After five sessions, she was starting to express her feelings with minimal prompting and was beginning to connect her feelings and thoughts to her behavior. She also saw value in the intervention in that she waited eagerly for each session and had requested weekly involvement. She was beginning to understand the role of the writer and rehabilitation worker.

Scale 2 (behavior) was difficult to evaluate due to the lack of information received on her daily behavior. The writer and worker had to depend on Kelli's accounts of her behavior, which were not always reliable. However, to the best of the writer's knowledge, Kelli's behavior did not significantly improve. She continued to have aggressive outbursts and as a result, had remained on the locked unit. She maintained "the expected level of success".

In conclusion, Kelli made only minimal gains during the course of the practicum, which for her, were very significant. This had been expected due to the length of time that

she had been institutionalized.   In spite of this, however,
there was a glimmer of hope that with long-term intervention
and a comprehensive, consistent master plan,   Kelli could
learn to accept responsibility for the consequences of her
behavior, face reality, and fulfill her own needs, without
harming herself or others.

Consequently, the rehabilitation worker and the writer
developed such a master plan to present to the staff at the
Selkirk Mental Health Center in an effort to move Kelli to-
wards reintegration into the community. The worker intended
to remain involved to monitor the plan, with Selkirk's sup-
port, after the practicum ended.

2.2.7   Claire

2.2.7.1   Case Summary

Claire was a 25 year old profoundly deaf woman. She was the
fifth of seven children, none of whom have hearing losses.
Claire attended the Manitoba School for the Deaf until age
20 but had only attained a grade three level of education,
when compared to regular hearing schools.   Psychological
testing indicated that she functioned in the dull normal
range of intellengence.

Claire had always demonstrated poor coping skills which
seemed to create a series of crises in her life.   Within a
five month period, she had experienced two abortions.

Claire was known to select friends who were trouble makers and a bad influence on her. She was easily led and had little insight into her difficulties. At the time of her engagement with the writer, she had been fired from her job as she was experiencing conflicts with her employer. She was collecting welfare but was seeking employment. She had a poor work history as she had frequently been involved in interpersonal conflicts with her bosses, usually leading to dismissal.

2.2.7.2 Assessment

Claire demonstrated poor frustration tolerance and coping skills. She easily became upset when she could not handle the situation. Claire had little life experience and had attained a low level of education. Consequently, she misunderstood much information, which sometimes led to anger and aggressive behavior. She also experienced difficulties in developing positive relationships with others.

Claire had no future plans and saw nothing positive in her future. She possessed little ability to organize herself.

2.2.7.3 Goals

Claire identified her goals as (1) obtaining a job and (2) finding an apartment. The writer further established the goals of:

1. regular attendance for appointments with the writer and;

2. the ability to solve future crises.

2.2.7.4 Intervention

Claire was seen for a total of ten sessions and she missed five more appointments. The purpose of the first two sessions was to get to know Claire and to gather information on her problem areas. Initially, Claire had a difficult time understanding the writer's role, so it was explained that she would receive help with the problem areas that she identified.

The next two sessions were spent counseling Claire in the office about types of jobs that she was interested in. Claire would buy a newspaper which was carefully scrutinized. The writer helped her to organize a plan to proceed with. It appeared to be difficult for Claire to discuss abstract ideas such as the proper procedures of seeking work. Instead, she responded well to writing her plans on paper, role-playing and actually filling out job applications. This technique was used to help Claire accept personal responsibility for solving her problems and to learn better ways of doing this.

Claire did not appear for the next two appointments so the writer went to her home. As the writer did not feel

that any progress was being made in the office she decided to change the setting of the counseling. Therefore, from this point onward, the writer assisted Claire in developing a plan to search for both a place to live and a job. The writer would accompany Claire to the various places she wished to apply and provided counseling, when appropriate.

A second technique used in counseling was education. Claire lacked a lot of basic information such as how to fill out an application form properly and she was not familiar with many English words. For example, "previous employment history" had to be explained as meaning "past work". She required a great deal of assistance in changing her ASL into proper English. Consistent with reality therapy, therapy becomes a special kind of education where definite plans are made (Glasser, 1965).

A third technique employed was that the writer served as a role model. For example, she would demonstrate to Claire the appropriate way to approach a person to request a job application. Claire would then be requested to imitate the behavior or to role-play the identical situation.

Lastly, contracting was also used. The writer requested Claire to independently conduct a job search and look for an apartment between appointments and to report on her activities. Six full-day sessions were held with Claire similar to what has been described above.

2.2.7.5   Evaluation

Two goals were identified by Claire (see Appendix C).   These
were:

1.   locating an apartment (scale 2); and

2.   securing full-time employment (scale 4).

The writer further identified the goals of:

1.   regular attendance at counseling sessions (scale 1);

2.   improved ability to deal with future crises (scale
     3).

Scale 1 (attendance) was administered the highest weight
of 50 as it was felt that attendance was important in order
to engage Claire into treatment.   On this   scale,   Claire
reached the category of "more than expected success".   Ini-
tially, she had missed numerous appointments but towards the
conclusion of the practicum, was attending regularly.   She
would occasionally have her landlord phone in advance to
cancel and would reschedule for another time.

Scale 2 (apartment search) was given the weight of 40 as
it was critical that she find a place to live. Claire inde-
pendently found a place to live with little assistance from
the student.   Thus, she attained the "most favorable outcome
thought likely".   However, three months later, her landlord
decided to sell the house and she was again faced with the
task of searching for another place to live.

Scale 3 (crises) was the next priority with a weight of 30 as it was the writer's opinion that the crises in Claire's life affected other activities such as maintaining jobs. Scale 3 could not be evaluated. During the student's involvement, there were no crisis situations (other than looking for another place to live) that were brought to her attention. However, Claire gave no indication that she wanted to change her lifestyle so it was probably a matter of time before one occurred.

Scale 4 (job search) was given the weight of 40 as it was felt that Claire needed to deal with her other problems before she would be able to sustain a job. On this scale, Claire met the criteria for "less than expected success". She would actively search for work with the student's assistance but did not look between sessions. This probably indicated her lack of motivation to change her lifestyle as she was content to collect welfare. In addition, the combination of hearing impairment, lack of training, poor work history, and the current job market made it difficult for her to secure a suitable job.

In conclusion, Claire made little progress. She was unmotivated to change her lifestyle. She refused to accept responsibility for her behavior and failed to follow-through on making any changes.

2.3   COMMENTS AND CONCLUSIONS

The clients discussed in this chapter represented a continuum of cases.   They were not a homogenous group and could be conceptualized as falling into three distinct, yet not mutually exclusive categories.

In the first category, Paul, Ian, and Dawn demonstrated varying degrees of language deficits which contributed to communication difficulties and mental health problems. Subsequently, developmental delays were also present.   Direct counseling was not possible with this group.   Instead, structured programs were more effective.   The writer was involved in working with the larger social service system in connecting them to approprite resources.

In the second category, David and Paul presented more classical types of mental illnesses, resulting from lack of education and stimulation and made worse by the loss of a family member.   They required a supportive, education-based counseling approach that assisted them in achieving a higher level of independence.

Kelli, Claire and Pat fell into a third category characterized by behavior problems and personality disorders. They experienced communication problems with hearing people and poor frustration tolerance which often resulted in emotional and/or behavioral outbursts.   These clients responded to a task-oriented treatment approach that encouraged them

to learn better ways of dealing with their problems and anger.

The practicum represented a continuum of cases, ranging from language deficits and communication problems to more common psychiatric disorders. As a result, these clients required different treatment approaches to deal with their diverse problems and needs. Several individuals needed basic education and language training while others benefitted from a task-oriented casework approach.

In all of the cases, the writer was struck by the lack of education and knowledge that the clients possessed. They were also self-centered and had little awareness of the larger society. This had implications for determining the goals and intervention to be used.

The writer would like to emphasize that these clients are not reflective of the general deaf population. In fact, most deaf persons are well-adjusted, self-sufficient human beings who contribute to the Deaf Community and the larger society.

It is the writer's opinion that the hearing-impaired clients she worked with, as well as others, could benefit from long-term intervention, similar to what was provided in this practicum. There is a definite need for mental health services for hearing-impaired persons. At the present time,

there are insufficient numbers of fully qualified mental health professionals to work with deaf persons. Training can take two directions: the first involves teaching competent mental health professionals about the special developmental and psychosocial aspects of deafness and the requisite sign language skills. The second approach is to teach people with knowledge of and experience with deafness the principles and practices of the mental health field. Only when this happens, will mental health services for the deaf be established.

Chapter III

CONCLUSIONS

This chapter is divided into two parts. The first part will describe some of the common issues that arose in all of the clients. The second part of the chapter will discuss the practicum in its entirety and the areas in which the writer learned skills and gained knowledge.

3.1 ISSUES THAT AROSE WHEN COUNSELING WITH DEAF PERSONS

The writer found counseling with deaf persons to be difficult yet stimulating work. Several issues that presented challenges for the writer consistently arose.

The first issue was that of communication. It is consistently stated by professionals in the field of deafness that communication is a serious problem which creates barriers to social interaction and to adequate socialization (Evans, 1975). The writer was faced with the task of improving her communication skills as she had not used them for a period of time. As well, as the writer had moved from another province, it became clear that regional sign variations existed. Thus, it was necessary to discard some signs and learn some new ones.

Many of the clients also used different signs and the writer had to learn to use signs that each client was familiar with. Some clients had good communication skills while others had low verbal skills. The writer had to adjust her level of communication accordingly. With several clients, it was helpful to use visual aids, such as writing, to facilitate communication.

During the initial sessions, until the writer became familiar with each client's method and level of communication, there was a need for constant clarification as misunderstandings often arose. However, as counseling progressed, the need for clarification lessened and communication improved.

A further point was that the writer found counseling with hearing-impaired persons to be an exhausting experience, at times. As the writer was using a language other than her native one, it required a great deal of concentration and energy.

The second issue was that all of the clients consistently missed appointments. This made it extremely difficult to develop a relationship with them and to engage them in treatment. One client missed six appointments before she appeared to meet the writer. Four clients would sporadically not appear for appointments without contacting the writer to inform her. None of the clients owned telephone devices

for the deaf. Therefore, the writer was unable to contact them. On several occasions, a trip was made to the client's homes to arrange for another appointment but frequently, nobody was home.

The writer interpreted the failure to appear for appointments as indicating firstly, that the clients lacked responsibility and secondly, that they did not perceive her potential involvement as meaningful. Therefore, the role of the writer and the value of the intervention had to be demonstrated to them. For example, instead of making office appointments, the writer made arrangements to see them in their home, or to accompany them to job interviews, doctor's appointments, etc. Following the change in counseling setting, there appeared to be some improvements. The clients appeared more relaxed and would disclose more information. It became easier to engage them into treatment and they began to accept the student's role.

One method of dealing with deaf clients who consistently miss appointments is to (1) establish mutual goals; (2) contract to ensure that both parties understand each other's role and expectations; and (3) develop a task-oriented treatment plan that requires the client to follow through with certain tasks.

An attempt was also made to intervene in the problems that he/she identified, rather than what significant others

or the file stated. For example, it was common knowledge that several clients had personal/emotional problems. However, the clients often identified the problem as needing a job and did not understand how their past behavior was connected to their dismissals from jobs. The writer would use the client's goal of "getting a job" to intervene and counsel in other areas (ie. emotional problems).

A third issue that the writer encountered was that of dependency versus independency. All of the clients at one time or another attempted to get the writer to perform activities for them that they could have done themselves. The writer encouraged the clients to accept responsibility for their behavior by giving them tasks that gradually increased their level of responsibility. The place on the continuum where each individual client fell determined the type of intervention, level of responsibility and ultimately, the amount of independence expected.

These three issues presented many challenges to the writer throughout the practicum and will present similar challenges to any professional working with hearing-impaired persons.

3.1.1 Basic Qualities of the Therapist

Successful counseling with deaf person requires the social worker to possess a number of unique qualities. Firstly, the therapist needs to have a comprehensive knowledge base of the vast field of deafness. He/she should be aware of the different types of hearing loss, how each client relates to the deaf subculture, his/her level of communication skills, family factors, etc. In addition, the therapist should be skilled in the use of ASL.

Secondly, the therapist should possess skills in developing and utilizing a theoretical framework to guide his/her clients towards effective changes. This involves contracting with the client, establishing goals and implementing a plan to achieve them. The clients should be active participants in the counseling process. The therapist should also be flexible in implementing treatment plans to meet the diverse needs of all the clients.

Thirdly, certain personal attributes are vital. The counselor should be able to relate to deaf persons as individuals who are attempting to maintain their independence despite the numerous obstacles that are encountered. One should be able to see, an individual, first, and deafness, second

The counselor should be able to treat his or her clients with respect and work with them to achieve greater autonomy.

3.2   CONCLUSIONS OF THE PRACTICUM

There is no doubt that the objectives of the practicum were met. Firstly, the writer developed specialized expertise in counseling deaf adults who were experiencing mental health problems. The vast amount of literature that was reviewed throughout the year helped the writer to broaden her knowledge of the comprehensive field of deafness. She was able to integrate her previous experience in the mental health field with her newly acquired knowledge of deafness. Specifically, the writer's knowledge of mental illness, medications and how to deal with the mental health system contributed to her ability to work effectively with her clients.

However, the writer was aware that the area of deafness is a difficult and sensitive one, and that acquiring new knowledge and skills is an ongoing process, to be extended past the experience of a practicum.

Secondly, the writer's counseling and practice skills were further improved. She was able to experiment with various techniques advocated by reality therapy such as role-playing, contracts, limit-setting and visual aids. The use of video-tape provided the writer with important feedback regarding her counseling skills.

The use of reality therapy with deaf persons was a useful interventive tool. It provided a framework for the writer to engage the clients in goal-directed, task-oriented coun-

seling and thus, move them towards improved social skills and greater independence.

Finally, the writer's ability to evaluate the effectiveness of the intervention was further developed. Using goal attainment scaling jointly with the client, when feasible, helped both the client and writer to determine whether the goals were being met or whether revisions needed to be made.

In reflecting upon the total practicum experience, the writer would like to identify some of the difficulties encountered in entering the field of deafness. The extent of the knowledge and the number of involved disciplines in the area (ie. audiologists, teachers, psychologists, social workers, etc.) complicated the process of acquiring all of the necessary information.

As well, it takes considerable time to develop a relationship with the clients and with other deaf people who are involved in the deaf community. As a student, who was organizing a time-limited practicum, the deaf clientele were unaware of who she was or what her role consisted of. As a result, they were possibly, slightly mistrustful and apprehensive.

To alleviate some of these difficulties, in future student practicums, the writer would recommend:

1. that any student be assigned to an individual worker for participation in co-therapy. This would alleviate problems in engaging the client,establishing a role for the student and referring them on, following the termination of the practicum. As well, both the student and the worker could gain new skills and knowledge from one another.

2. that a student participate in a comprehensive orientation that involves acquiring both theoretical and technical information concerning deafness.

Overall, it must be concluded that the objectives of the practicum were attained. The knowledge and skills acquired throughout the year have advanced both the writer's professional and personal growth and have furthered her ability to contribute to the field of social work.

Appendix A

GOAL ATTAINMENT SCALING – DAVID

LEVELS OF PREDICTED ATTAINMENTS	SCALE HEADINGS AND SCALE WEIGHTS			
	SCALE 1: 50 DEPRESSION	**SCALE 2:** 40 SOCIAL ADJUSTMENT	**SCALE 3:** 40 ANXIETY	**SCALE 4:** 30 GRIEVING PROCESS
MOST UNFAVORABLE OUTCOME THOUGHT LIKELY	Readmitted to Hospital with Acute Depression	Stays at home, refuses to leave house, complains of lonliness, refuses to go to work.	Continues to have anxiety attacks.	Continues to feel guilty and depressed over father's death.
LESS THAN EXPECTED SUCCESS	Depression fluctuates, requires mental health involvement on and off.	Mother visits him everyday. Remains dependent on her.		
EXPECTED LEVEL OF SUCCESS	Mood stabilizes, takes medications and sees doctor weekly	Goes out occasionally, sometimes lonely.	Occasionally becomes anxious	Sometimes thinks about his father's death but does not * become overly anxious.
MORE THAN EXPECTED SUCCESS	Mood stabilizes, sees Mental Health Worker, every two weeks takes ' * medications.		Occasionally worries but does not become anxious. *	
MOST FAVORABLE OUTCOME THOUGHT LIKELY	No depression no need for medications and mental health involvement.	Returns to * work daily, lives with other people mother allows independence.	No sign of anxiety attacks.	Accepts his father's death and does not dwell on it.

Appendix B

GOAL ATTAINMENT SCALING - KELLI

LEVELS OF PREDICTED ATTAINMENTS	SCALE HEADINGS AND SCALE WEIGHTS			
	SCALE 1: 40 COUNSELLING SESSIONS	SCALE 2: 30 BEHAVIOUR	SCALE 3: 20 WORK TRAINING	SCALE 4: 10 DISCHARGE
MOST UNFAVORABLE OUTCOME THOUGHT LIKELY	Does not want to continue with bi-weekly sessions.	Behavior deteriorates placed in seclusion due to constant aggression.	Behavior is unacceptable to refer to program.	Stays in Hospital - no discharge plans.
LESS THAN EXPECTED SUCCESS		Behavior fluctuates - moves back and forth from locked to open units.		
EXPECTED LEVEL OF SUCCESS	Enjoys coun- selling - wants to con- tinue, is involved and finds it use- ful.	Behavior fluctuates - stays on same unit. *	Referred in 6 months - starts work- ing 1 day a week.	No discharge plans.
MORE THAN EXPECTED SUCCESS	Starts to express her feelings with a little prompting - wants to continue. *			Long term dis- charge plans 1 - 2 years time - work with community residence for integration.
MOST FAVORABLE OUTCOME THOUGHT LIKELY	Comes into the city to SCCA for counselling on a weekly basis.	Transferred to open unit - behavior improves and stabilizes No aggressive outbursts.	Attends Train- ing Program such as Employment Preparation Centre.	Discharged to Mental Health Facility in community.

Appendix C

GOAL ATTAINMENT SCALING - CLAIRE

LEVELS OF PREDICTED ATTAINMENTS	SCALE HEADINGS AND SCALE WEIGHTS			
	SCALE 1: 50 ATTENDANCE	**SCALE 2:** 40 APARTMENT SEARCH	**SCALE 3:** 30 CRISIS	**SCALE 4:** 20 JOB SEARCH
MOST UNFAVORABLE OUTCOME THOUGHT LIKELY	Does not appear for any appoint-ments.	Makes no effort toward find-ing apartment.	Weekly crisis arises that requires intervention.	Does not search for work – collects Welfare.
LESS THAN EXPECTED SUCCESS				Does not actively search for work – does not find job. *
EXPECTED LEVEL OF SUCCESS	Occasionally does not appear and does not call.	Makes reason-able effort – but finds apartment with * assistance.	Crisis situation every 1 – 2 months.	Actively looks for a job but is unable to find one due to past work history
MORE THAN EXPECTED SUCCESS	Cancels occasional appointments but contacts student to inform her. *			
MOST FAVORABLE OUTCOME THOUGHT LIKELY	Appears for all appointments.	Actively searches independently finds apartment.	Able to deal with situ-ation so does not become crisis-producing.	Actively looks for work – finds job and maintains it.

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