Personality and Social Development of Deaf Persons

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Most theories of personality and social development stress the importance of the individual's early experiences in helping to shape his behavior and his life adjustment. In the sense that many deaf people share a number of early life experiences, we might expect that they may share some common problems, and some common ways of coping with the environment. In this sense, it can be useful to consider the personality and social development of deaf persons in general terms. However, it is useful to talk in general terms only if appropriate caution is taken that damaging stereotypes are not formulated from over-generalizations. There is a wide a range of personality patterns among deaf persons as there is among persons with normal hearing. Although it is convenient to talk about personality patterns and social development "of deaf persons," there are many sub-groups within the general category of the hearing impaired. Some of the sub-groups of deaf people are based on the social or the demographic indicators that divide the general population: sex, age, race and social class. Additional classifications that reflect different social experiences or different social adaptations for deaf people include: degree of hearing loss, age at onset of deafness, etiology of hearing loss, hearing status of family members, type of schooling, preferred communication mode, and degree of identification with the deaf sub-culture. Understanding of a particular deaf client requires knowledge about all or most of these factors.

It is both convenient and meaningful to limit our definition of deafness to a hearing loss so profound as to preclude the understanding of speech, and one that pre-dated the acquisition of language. Thus, the primary handicap of deafness is the limitation of communication, in the same sense that the primary handicap of blindness is the limitation of mobility. Deafness is an exceedingly complex disability. It incorporates elements of medical, audiological, linguistic, sociological and psychological factors that influence the developmental process, and that contribute to some of the experiences that deaf children often share. It is these shared experiences, rather than the hearing deficit itself that lead us to talk about a "psychology of deafness." At least some of the noxious experiences shared by deaf persons are subject to change. Therefore, some of the apparently shared personality characteristics are not a necessary accompaniment of a hearing handicap.

Two major categories of shared early experiences are particularly important in the personality and social development of the deaf. First is the fact that communication between most deaf children and their parents is either absent or very rudimentary during the important early years of the child's life. These are the years when parents and children would ordinarily have the most constant and exclusive contact with each other. The second important major category of early life experience shared by deaf persons is the usual response of parents to the diagnosis of a hearing handicap in a young child. This early response is the first of a long series of social responses to handicap with which handicapped persons must cope. Parents, however, often respond to diagnosis with sorrow, shock, shame, guilt, and anger. Their attitudes about the meaning of deafness influence their treatment of the deaf child, thus influencing the child's personality and social development.

Social Development

Social and Emotional Maturity — The most frequently stated generalization about the psychological and social development of deaf individuals is that they seem to exhibit a high degree of "emotional immaturity." Levine has described this complex in terms of "egocentricity, easy irritability, impulsiveness, and suggestibility." Myklebust (1960) found that deaf persons were immature in "caring for others." Altshuler (1974) characterized deaf patients as demonstrating "egocentricity, a lack of empathy, dependency." The term "maturity" in a social sense often refers to an individual's ability to care for himself, to accept responsibility for his actions and his destiny, and to be independent.

The Vineland Social Maturity Scale was designed to measure children's capacity to care for themselves and to engage in activities that lead to ultimate independence. It measures abilities in self-help, self-direction, locomotion, occupation, communication, and social relations. A large number of studies of deaf children have been reported showing that deaf children received lower scores on the Vineland Scale of Social Maturity than did hearing children of comparable ages. One study was done with parents and children with a variety of handicaps, including deafness. All the handicapped children were found to be deficient in self-help skills. However, the more remarkable aspect of the report was the discrepancy between the tasks that the children were capable of performing and those that they actually did for themselves. This suggests that parents generalize from the narrow range of tasks that a handicapped child actually cannot do, and assume that there is a much larger spectrum of tasks of which he is incapable. Eventually, the assumed inability becomes a real inability because the child does not have the opportunity to practice tasks and develop new levels of expertise. In addition, it takes more patience and time for handicapped children to perform the trial-and-error process of skill acquisition – time and patience that parents may not have or be unwilling to give. For deaf children with deficient communication

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skills, it takes additional time and patience merely to communicate what is expected, required, and necessary for the performance of even a simple task.

Human development is a cumulative process. That is, readiness for the development of one age-appropriate skill is based on the development of another skill at an earlier age. By the same token, deficiencies in tasks requiring self-responsibility and maturity may be cumulative as well. Parents and other-care-takers who observe that a child or adolescent is unable to perform one kind of self-help task may be even more reluctant to demand or to allow him to perform another kind of task that is appropriate for the next age level.

Many deaf children and adolescents are educated in State residential schools. The National Census of the Deaf Population, as reported in Schein & Delk (1974), showed that one-half of deaf persons ages 25 to 64 in 1972 had been educated exclusively in residential schools. Residential living negatively influences the development of maturity, although most administrators today are aware of these factors, and attempt to create an environment that encourages independence. Some of the disadvantages of the residential setting stem from the nature of dormitory life and the administrative hazards inherent in large institutions. When children live together in groups, it is necessary that rules be made that can be applied to the group, sometimes conflicting with needs of individual children. Chores that might be assigned to children in their family settings may be performed by maintenance personnel in an institution. Opportunities for privacy, and space for private activities are less frequent in a residential school than in a home. When students reach the age when boy-girl relationships begin to develop, both parents and school personnel become anxious about the possible consequences of sexual activities. This leads to restrictive rules and fewer opportunities for the development of relationships than might be found in the family environment of other adolescents. Thus, the limited social opportunities of the deaf adolescent in the residential school can add to an already underdeveloped sense of self-responsibility and social immaturity.

One research study (Schlesinger & Meadow, 1972) conducted with deaf students in a residential school compared those whose parents were deaf to another group in the same school whose parents had normal hearing. These students were rated by their teachers and counselors on several dimensions of social and personal development. The students with deaf parents received consistently higher or more positive ratings for "maturity," "responsibility," and for "independence." The students with deaf parents had all experienced early family communication since the parents ordinarily used American Sign Language with them from infancy onward. In addition, the reactions of the deaf parents to the diagnosis of deafness in their child were considerably less traumatic than that experienced by hearing parents. (It should be noted that no more than ten percent of deaf children have both a deaf mother and a deaf father.)

Many of the traits that have been used to characterize deaf persons might also be used to describe a person who is thought to be "immature." Three traits that have been used again and again are "impulsivity," "egocentricity," and "rigidity." If we look at the meaning, or at the behavioral patterns that these trait descriptors are intended to summarize, it is not difficult to speculate that these characteristics develop readily among any group where early communication was absent or imperfect.

Impulsiveness refers to behavior that is not based on careful, coherent, advance planning. The impulsive person may be unable to plan a course of action and adhere to it. He may make rash choices based on a desire for immediate gratification rather than on the expectation of long-term gains. Building long-term goals may require an ability to think out, to imagine, or to live in fantasy, future possibilities that stem from one or another present decision. If we look to the early experiences of deaf children, we see that language is important for the expression of time. Those who do not have language are restricted by the tyranny of the present in terms of both time and space. Parents can communicate in a rudimentary way to their deaf children about things that are present in the same room, or about events that are current. Language is necessary if one wishes to communicate about events that occurred in the past or that will take place in the future. Thus, deaf children often have not had the experience of communicating about future plans, or reminiscing about memories from the past. Most parents, when they want their child to wait to receive a particular treat or experience, are able to tell him when he can expect to receive the desired object and *why* the delay is necessary. Without language, this is difficult or impossible. Thus, parents of deaf children often yield to immediate demands or temper tantrums that are uncomfortable for everyone. The deaf child does not learn easily to control his demands for immediate gratification by learning that sometimes he can expect to be given something at a later time.

Egocentricity describes a person whose world centers on or revolves around himself. A self-centered person is one who is unwilling or unable to consider the needs, the opinions, or the desires others. He is unaware or uncaring about the effect of his behavior on other people. A part of the normal developmental process involves first, the differentiation of oneself from others, and secondly, the realization that one's behavior affects the behavior of those around him in specific ways. Again, language or communication is important or perhaps even necessary if this process is to take place. One way in which a child becomes "socialized" to the ways of his society is through his desire to please his parents, who communicate to him the norms of his particular group. Group norms are expressed in the person of the parent. Social approval or disapproval consists of parental approval or disapproval in the early years. If a child is to take into account the wishes of others, he must understand what it is about his behavior that affects significant others in either positive or negative ways. An explanation of

emotions experienced by others is difficult without fairly complex language. The language of emotions is an area where deaf children are particularly deficient.

Rigidity refers to an inflexible approach to the world or to particular tasks. It reflects an inability to change one's demands or requests to conform to changing situations or events. It can also refer to a tendency to apply a once-learned rule indiscriminately. Thus, it is often said of deaf persons that they "live by the rule book of etiquette." It seems to be difficult for them to differentiate between the more and the less important situation for the application of a particular rule.

When deaf children are learning their first "rules" about acceptable and unacceptable ways of behaving, they may not learn the reasons surrounding a particular prohibition. The rule must be followed "because Mother says so," or "because Father will be angry." They do not have the benefit of learning explanations for the rules: "If you go too near the fire you will get burned;" "If you break my vase I will feel badly." Thus, rules are applied indiscriminately to new situations because the reasoning on which they are based is not understood. This indiscriminate application of rules then appears to be rigidity.

Deaf children seem to have particular difficulty in developing the idea of causality in both the physical world and the social world. The language of "why" and "because" does not come easily. It is hard to elicit a response to the question of, "Why did you do such-and-such?" Hearing children at about the age of two years threaten to drive their parents to the brink of insanity with incessant questions beginning with the word "why." Perhaps this stage of language is important for the incorporation of ideas of causality. A world that appears to be without rhyme or reason is more likely to be approached by means of a rigid set of rules.

Maturity: Implications for the Rehabilitation Counselor — Vocational maturity is closely related to social and emotional maturity. It is more difficult to place an "immature" client on a job and to help him to remain on the job. The client who has been sheltered by his family and who has continued to be sheltered by his teachers is less likely to be ready to take responsibility on the job. For the deaf person, there is often a thin line between tasks that he can be expected to do for himself, and tasks with which he needs some help because of his impaired hearing. In the same way that parents and teachers must tread this line in living and working with deaf children and adolescents, the rehabilitation counselor must tread the line in working with deaf adults. The rehabilitation counselor needs to foster independent behavior, rather than reinforcing old patterns of dependency. Clients with long experience in surrendering their independence to others usually become skillful in demanding maneuvering to continue their helpless ness.

A prime example of issues around dependency of deaf clients centers on their realistic need for help in the use of the telephone. In making job applications and in setting up appointments for interviews with prospective employers, telephone contact obviously can save time and is usually more efficient. If the counselor is unaware of the trap of dependency, and the long-term benefit to his client of increasing independence, he may make more telephone calls than are truly necessary. On the other hand, to insist that he will never make phone calls for deaf clients is a denial of the reality of the handicap.

Counselors can help deaf clients to become more mature by insisting that they find substitutes for direct telephone calls for changing or canceling appointments. This can become valuable experience for the kind of responsible behavior expected by employers for notification when absence from work is unavoidable. Helping a deaf client to make an on-going arrangement with a neighbor, or to develop a signal system with the telephone can be very useful. Deaf adults can sometimes learn to use the telephone in limited ways with people whom they know, but often find this a frightening and threatening experience. The rehabilitation counselor who has developed a relationship with a deaf client may be able to help him deal with some fears in this area. The importance of keeping appointments and of being on time is something that immature persons – handicapped or not – often have difficulty in understanding.

Another hallmark – or even definition – of immaturity is the absence of many life experiences that are frequently assumed. Thus, we assume that any adult has had experience in using public transportation, in managing a budget of some kind, and in dealing with everyday bureaucracies, encompassed in banks, medical services, and so forth. This is often not the case for persons who have led sheltered, dependent lives. The counselor may need to help some deaf clients with these basic experiential details before a successful job placement is possible. These kinds of considerations, all related to the relative maturity or immaturity of many deaf clients, lead to an important area for supervisors and administrators of rehabilitation services. One implication of the maturity level to be expected of deaf clients is that it often takes more counselor time to work with a case load of hearing-impaired clients. To expect the same rate of successful job placements, or to expect rehabilitation counselors for the deaf to carry the same case load as specialists with other kinds of case loads may be unrealistic. Some of the basic needs of deaf clients may be met as well, or perhaps even better, by a professional aide to the rehabilitation counselor. An aide who is deaf, or is fluent in sign language may be able to help in basic orientation that is pre-vocational in nature.

Finally, it is important to mention one more pitfall that is common for many helping professionals who work with deaf adolescents or young adults. This is the temptation to work with the client's parents rather than with the client himself. Often, parents are used in making decisions for their deaf children rather than

with them, or encouraging them to make their decisions independently. Parents often present themselves to the rehabilitation counselor along with the young deaf adult, expecting to be totally involved in the decision-making process for training or for vocational planning. Counselors need to be prepared with tactful ways of encouraging the process of disengaging parents and their grown-up deaf children. This is another part of the definition of maturity.

Self-Image — The growth of self-image, or identity, goes hand in hand with social development. As a child begins to be an object to himself, as he sees himself reflected in the appraisals of others, he begins to understand both their behavior and his own. The child sees himself "mirrored" in the responses that important others make to him, and gets a sense of his own worth from their reactions. Initially, a child's important others are his parents and his siblings. Gradually, his circle widens, and his self-image is affected by the responses of teachers, peers, storekeepers, and neighbors. Children who are handicapped begin to learn or to sense their difference very early. The positive or negative meaning attached to their definition of their "differentness" depends in large part on the feelings of significant others, particularly their parents. It is for this reason that parental responses to the diagnosis of deafness are so important to the development of the hearing-handicapped child. Parents who are ashamed or embarrassed about their child's deafness cannot help but communicate this to the child. He, in turn, incorporates their feelings about him, and they become a part of his self-image or self-concept.

The relative visibility of a handicap is important to the response that is evoked in others, or to the stigma imposed on the handicapped person. Ironically, deafness itself is invisible; it is the means through which deaf persons cope with their handicap that make them visible. Thus, it is the hearing aid that gives one clue to the presence of a handicap; it is sign language that gives another clue to the presence of a handicap; unusual or distorted speech patterns that give a third clue. Parents who are not reconciled to their child's deafness may give subtle and ambiguous messages to him about his worth by giving ambiguous messages about his means of coping with his deafness. Sometimes parents do not want their deaf children to wear their hearing aids when they are photographed. Or they may remove the hearing aid when they put on the party dress or the Sunday suit. These incidents reflect parental attitudes that edge a child toward negative identity feelings in relation to his deafness.

For many years, the educational controversy about the means of communication to be used with deaf children was couched in terms of either sign/manual language or spoken/oral language. The dichotomy created by educators and adopted by parents meant that many deaf children were bound to be placed in an "identity bind" at some point in the life span. If spoken communication was the only acceptable communication, and the deaf person's

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speech proved to be unintelligible for a majority of those he met, his identity became unacceptable to himself as it appeared to have been to his parents and teachers who insisted on speech only. If the deaf person learned sign language in adolescence, felt more comfortable using it for communication, and in relating to others who also used it, he might reject completely the use of hearing aids and speech that might serve to identify him with the non-deaf community.

Young deaf children rarely have the opportunity to meet deaf adults who might serve as positive role models for them. This means that some of them develop skewed ideas about their own identity and about their adult destinies. Some believe that they will develop hearing and speech as they grow older. Deaf teachers have been barred from teaching in most day schools and classes. Recently, as "Total Communication" became more acceptable, deaf teacher aides became assets in the classroom because of their fluent knowledge of sign language. In residential schools, where deaf people have found employment in the past, the kinds of jobs for which they could apply were limited. They usually were not hired to teach in the younger grades where instruction was probably by oral-only means. Thus, they could teach in the upper grades or they could apply for jobs as dormitory counselors or house-parents. The status differential between teaching and dormitory staffs favored the teaching staff. Thus, the deaf students in residential schools saw their possible role models — that is, the other deaf persons in their environment — in the less desirable status positions.

The research cited above comparing deaf students with deaf and with hearing parents also compared the self-image of the two groups. Students with deaf parents had significantly more positive scores on the self-image test than did the students with hearing parents. There were also some interesting differences in the children of deaf and hearing parents when different age groups were analyzed. Younger children of deaf parents had especially high levels of self-esteem; younger children of hearing parents had especially low levels of self-esteem. For older children, self-image scores were almost the same for the two groups with deaf and with hearing parents.

When day school students with hearing parents were tested later, their scores were almost identical to those of the residential students with hearing parents. Self-image was particularly low among those students whose hearing parents had high levels of educational achievement. This suggests that when deaf students feel that they are unable to fulfill their parents' expectations for them they may have negative self-concepts.

Self-Image: Implications for the Rehabilitation Counselor — Self-image, self-confidence, positive self-concept are important to the job effectiveness of everyone. This area is even more important for the handicapped person, and for the deaf client no less than others. The single most critical way in which the

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image of the self for the deaf client is different than for others is the special link between communication mode and self-image. The phrase "my language is me" has special significance for deaf persons. By respecting the language or the preferred communication mode of the deaf client two goals may be achieved: a positive sense of self is encouraged, and rapport between counselor and client is established.

The important facet of this discussion is the necessity for the counselor to accept the client's own definition of preferred communication mode, rather than attempting to impose the counselor's definition of what is "best." This means that ideally speaking the rehabilitation counselor needs to be fluent in the entire range of possible communication modes that might be used by an individual client. These include: Ameslan, Signed English, "SEE sings," oral English.

Ameslan refers to American Sign Language. This is a gesture language with its own grammar and syntax, and is used by most deaf adults who consider themselves to be members of the deaf sub-culture. Ameslan is, in fact, the major symbol of the cohesiveness of the in-group of the deaf community. For many deaf adults, acceptance of Ameslan is synonymous with acceptance of deafness. Thus, rehabilitation counselors of the deaf need to have some knowledge of sign language at the minimum. If they are not fluent, they need to learn, and to have a skilled interpreter available when needed. One of the requests for service that is most likely to be made of counselors is the provision of an interpreter for legal, medical, or educational needs. Thus, they should be aware of interpreters who qualify for certification by the Registry of Interpreters fro the Deaf in the particular area they serve.

Signed English approximates spoken English more closely than does Ameslan. It is the form of sign language that is utilized in the educational approach referred to as the "combined method" of speaking and signing simultaneously. However, it is like Ameslan in that verb tenses and noun modulations are not incorporated into the signed message. "SEE signs," on the other hand do include these features in the signs as well as in the spoken portion of the communication. SEE signs are utilized in the educational approach that is being called "Total Communication." Total Communication incorporates formal sign language, spoken language, and strict attention to amplification for deaf children both at home and in the classroom. More and more programs of deaf education are utilizing this approach at the present time. This means that the next generation of deaf students leaving schools will feel more at home with SEE signs, making it important for rehabilitation counselors to be fluent or at least aware and accepting of this form of communication as well. For two hundred years, there has been bitter conflict among educators about the use of oral vs. the use of manual communication with the deaf child. This conflict seems to be diminishing as the acceptance of Total Communication grows. A new controversy

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is brewing about the form that the sign language portion of Total Communication will take. While rehabilitation counselors may well form their own opinions about the educational issues, they need to accept their deaf clients' communication mode on an individual basis.

Some deaf clients will continue to rely exclusively on spoken communication with rehabilitation counselors. It takes the unfamiliar ear some time to learn and to become comfortable with deaf voices generally, and with individual voices specifically. Use of paper and pencil, or typewritten communication to help speed communication may be helpful. Often, young deaf adults who have grown up in strictly, or even militantly oral environments welcome referrals to sign language classes. Even if they continue to use spoken communication as their preferred mode with the general community, familiarity with sign language can broaden their social horizons, and sometimes make them more comfortable with their deaf identity. This is more likely to be true if the option is offered as a suggestion rather than as a prescription by the counselor.

Behavioral Problems of Deaf People — Deaf children are said to exhibit higher rates of behavior problems that comparable groups of children in the general population. Behavior problems have been described as of "epidemic proportions" among deaf children, with as many as ten or twelve percent exhibiting severe emotional or behavioral disturbances (Vernon, 1969). This is about five times the proportion that would be expected. The figures on which these estimates are based usually are collected from teachers of deaf students. Judgments are ordinarily made about the kinds of behavior that are most difficult to manage in a classroom. Thus, the aggressive, active, acting out child is more likely to be identified than the shy, withdrawn child. An important consequence for the child of this kind of behavior is frequently exclusion from school. Since so many deaf children are considered problematic by their teachers, it is somewhat curious that the prevalence of severe mental illness is no greater among deaf adults than is found in the general population. However, Ranier, Altshuler and Kallmann suggested, on the basis of their studies of the deaf population of New York State, that deaf adults display more "problems of living." These show up as higher crime and delinquency rates, higher rates of family and marital problems, agency referrals for problems of alcohol abuse or sexual acting-out (1969).

The developmental basis for this array of problem behaviors is, of course, diverse and varied. Many problems undoubtedly stem from frustration at the absence of communication, from family, school, and community response to handicap, and to negative self-image. Two other factors must be mentioned, however. One is the high rate of physical and neurological handicaps in addition to deafness that is found among the current generation of deaf children. Fully one-third of all deaf children have another handicap in addition to their deafness (Vernon, 1969). Secondly, the effect of societal response to the kinds of behaviors

that come to be labeled emotionally disturbed often reinforces the very behavior patterns that created difficulties in the first place. The child who is labeled a "bad boy" is defined that way not only by others but by himself. He then becomes the "delinquent adolescent" and the "problem adult." Breaking the cycle becomes more difficult at each developmental stage.

Behavior Problems: Implications for Rehabilitation Counselors — Deaf persons with additional problems of any kind are more difficult to train, to place and to counsel. When the additional problems take the form of additional physical handicaps, however, solutions can take a more specific form. If a solution takes the form of a mechanical device or a technical innovation, it is less likely that human "failing" is responsible for a breakdown in the counselor's planning. However, when deaf client's additional problems stem from behavior that is socially unacceptable, or that runs counter to institutional, legal or administrative regulations, it is more difficult to retain a non-judgmental point of view. The rehabilitation counselor's job is made harder with behaviorally difficult deaf persons because of the paucity of institutions designed to care for them. There are very few mental hospitals with wards where deaf patients can communicate with staff persons. There are few facilities for the treatment of deaf alcoholics. There are almost no halfway houses that are able to provide shelter for deaf patients. The rehabilitation counselor for the deaf needs more access to mental health consultants. He needs to be able to refer deaf clients for therapy with professionals who are skilled in various ways of working with deaf patients. The relative absence of these facilities, and of training centers for mental health professionals who can work with the deaf, means that the rehabilitation counselor must often serve the difficult deaf client less well than he would like.

Conclusion

Perhaps the most important summary point to be made is the reiteration of a cautionary statement: deaf people are not all alike; there is as much variation among deaf people as there is among hearing peers. The important facet of life experience that enables us to talk in terms of the "personality" or "psychology" of "the deaf" is the unfortunate shared factor of early language or communicative deficiencies. As more deaf children acquire language at the normal age and in an optimal, joyful family milieu we can expect to see fewer deaf adults with the social-emotional problems and personality traits that stem from retarded language acquisition. An important implication of this picture is the need for rehabilitation workers to be concerned with the early experiences of their future deaf clients. Preventive rehabilitation may be more important for this group of handicapped persons than for any other. Early language has important implications for the whole person. .The deaf person's communicative handicap cannot be entirely overcome in his adult years since early communicative deprivation has such profound consequences for personality and social development. For deaf persons,

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rehabilitation must begin in the cradle. Otherwise, the social and psychological consequences of the handicap are carried to the grave.

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