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Behavioral Disturbance in Deaf Adolescents and Adults – A Clinical Perspective*

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BEHAVIORAL DISTURBANCE IN DEAF ADOLESCENTS AND ADULTS – A CLINICAL PERSPECTIVE*

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In 1979, Jerome D. Schein presented a paper to the Association of Canadian Educators of the Hearing Impaired entitled "Educating Hearing Impaired Children to Become Emotionally Well Adjusted Adults". As he pointed out, the title seemed absurd. Who could believe that schools were not already doing so? He found the answer in the available research data. The then prevalence rates for behavioral disturbance in deaf students varied, ranging from 1 in 3 to 1 in 10 students (Annual Survey, 1971; Meadow & Schlesinger, 1971). Even if we accept the probably low lower estimate, then on average every second class of deaf children will contain at least one student whose educational program is seriously impaired by problems of emotional adjustment. Such students represent a challenge to the skills and professional practices of teachers, psychologists, counsellors and others.

BEHAVIOR AND ADJUSTMENT

In a survey undertaken by Denmark, Rodda and other colleagues in Great Britain (Denmark et al., 1979), the parents of hearing impaired adolescents were asked to describe those aspects of their child's behavior which had given them cause for concern and which were, in their opinion, a direct result of deafness.

Table 1 shows a very high prevalence of problems which parents associated with deafness at different periods in their children's lives, and there is little overall difference between the prevalence rates in the "profoundly deaf" and "partially hearing" respondents.[1] The "partially hearing" students did seem to present slightly fewer problems than their "profoundly deaf" counterparts when at school, but after and before that period the rates for the two groups are similar. In both groups there seems to be a general reduction of problems during the school years, with an increase once school has finished. The data also seems to show that during the school years there were fewer concerns reported by parents when the children were actually in school than when they were at home, but this may reflect on their lack of knowledge about minor problems which were not reported to the parents by the school of the student.

TABLE 1a
Deafness Associated with Behavior Problems at School – % Respondents with Problems

	Deaf (N = 43)	Partially Hearing (N = 32)
Primary School	37%	31%
Secondary School	37%	47%

TABLE 1b
Deafness Associated with Behavior Problems at Home – % Respondents with Problems

Age	Deaf (N = 43)	Partially Hearing (N = 32)
Pre-School	91%	84%
Primary	72%	63%
Secondary	61%	56%
Post Secondary	70%	72%

Table 2 shows the behavioral characteristics which the parents associated with deafness. For the main part they closely mirror characteristics identified by previous research (see Rainer & Altshuler, 1967, Myklebust, 1964 and Remvig, 1969). "Temper" and "agression" were identified by the largest number of parents as characteristic of their child, but the importance of these problems declined with age. About 1 in 6 parents described their children as those who in adolescence were "easily led" by "bad company". Even so, on occasions aggressive reactions resulted in "major delinquency" and "criminal activities". The survey also showed a considerable number of parents felt their

*A paper presented to the Joint North American Conventions on the Hearing Impaired, Winnipeg, 1983.
[1]Hard of Hearing respondents.

children to be withdrawn. With "profoundly deaf" children, the number falling into this category increased noticeably as they grew older. In contrast, the parents of "partially hearing" children reported a decline in withdrawal as their children became older.

TABLE 2a
Main Behavioral Anomalies Reported by Parents (Pre-School Years)

	% Deaf (N = 43)	% Partially Hearing (N = 32)
"Frustration"	40	31
Temper	65	63
Aggression	21	25
Eating/Toiletry	33	28
Withdrawal	16	19

TABLE 2b
Main Behavioral Anomalies Reported by Parents (Post-School Years)

	% Deaf (N = 43)	% Partially Hearing (N = 32)
Withdrawal	23	9
"Bad Company"	16	16
Temper	9	13
Problems at Work	7	9

RELATIONSHIP BETWEEN COMMUNICATION AND BEHAVIOR

In order to focus more closely on the problems described in the previous section, a Behavior Rating Scale was devised by John Denmark, Ann Abel, and the author. The scale assesses various behavior characteristics associated with deafness. It has twenty-three items which are grouped under the headings of 'Frustration', 'Unsociability', Egocentricity', and 'Impatience'. Parents (usually mothers) are asked to rate their child on a graded scale from good to poor adjustment for each item, and a total score is calculated for each adolescent. The data obtained in the original study seemed to indicate the "profoundly deaf" respondents were rather less well adjusted than their "partially hearing" peers (see Denmark et al., 1979).

In order to put these findings into persective the results of the main items of this scale were compared with results obtained from the U.K. National Child Development Study (NCDS), a study of a national representative sample of 11,086 hearing adolescents. This study also used a scale of behavioral problems completed by mothers (Fogelman, 1976). Table 3 shows that on the 5 matched test items, the present sample of profoundly deaf adolescents were consistently reported by their mothers to have a higher incidence of behavior problems than the hearing adolescents described in the NCDS.

TABLE 3
Comparison Deaf and Hearing Students on Specified Traits (Applies Certainty)

	% NCDS (N = 11,608)	% Deaf (N = 43)
Fighting/Quarreling	2	33
Irritable	11	9
Destroys Property	1	16
Often Lies	1	7
"Solitary"	14	14

CLASSIFICATION OF BEHAVIOR PROBLEMS

In 1974 Rodda (1974) published a clinical assessment of specific behavior problems that presented themselves in working with deaf adolescent clients (see Figure 1). In reviewing this classification, there are three diagnostic categories where little change has taken place. Delayed or Retarded Physical or Cognitive Impairments (A in Figure 1), Institutional Syndrome (E in Figure 1) and Depressive Reaction (G in Figure 1). There may be higher prevalence rates of multihandicapped deaf students, but the nature of the associated physical or cognitive impairments has not changed substantially (A). Deafness associated with other problems such as cerebral palsy, retarded deaf students, and students or adults suffering from, say, Usher's Syndrome present the same or similar characteristics. However recognition of "learning disability" as a common syndrome associated with certain exogenous causes of deafness has made it necessary to add a new classification to the original system – Multihandicapped Deaf People (I). As well as learning disability, this group includes a significant number of students/clients with perceptual processing problems and conditions such as autism and aphasia. Such conditions probably have a common etiology in Central Nervous System impairment (see Rodda, 1976, for arguments that these disabilities represent different functional levels of

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language impairment associated with CNS damage). The Institutional Syndrome also still exists (E), although we certainly are more aware of this problem and the need to prevent it. Moreover, Miller and Gwynne (1972) have analysed our approaches to treatment from the perspective of management systems, and concluded that a major shift is required in which the client becomes a part of the management team. They see both the traditional warehousing and the liberal horticultural approaches as defective, since both see the client as a recipient of "treatments" offered by the professional. They conclude that such treatments will be less than effective because of the passive role that the client plays in the process. Finally, despite Roth's work in Great Britain (see Garside and Roth, 1978, for a general review of their theory), there is still little evidence that deafness of early onset generates "depressive reactions" (G). Indeed, the data reported in earlier sections suggests that "withdrawal" is no more frequent in students with severe *early* impairments than it is in hearing students, and this seems to fit in with general perceptions based on clinical experience.

FIGURE 1
Original Classification (Rodda, 1974)

A. Delayed or Retarded Physical or Cognitive Impairments
B. Family or Environmental Based Problems
C. "Primitive Personality"
D. Inappropriate Impulse Control
E. Institutional Syndrome
F. Drug Problems
G. Depressive Reactions

The concepts of Primitive Personality and Inappropriate Impulse Control (C and D) can be refined as a result of clinical observation and reporting over the last decade. Provided it is not misunderstood or overused, the concept of Surdophrenia (developed by Basilier, 1970) is useful. Clients exhibiting surdophrenia have immagure ego development and are unable to relate adequately to feedback about the social effects of their behavior. Their problems probably stem from defective language. However, deaf people are not immune from what we might paradoxically call normal psychopathological mechanisms. Therefore, in refining this classification I have divided it into Surdophrenia and "Other Affective Disorders", such as the denial of affect which is carried to extremes in sociopathic behavior. A much more detailed and excellent analysis of this problem is found in George Montgomery's (1978) excellent but rarely cited publication on Deafness and Mental Health.[2]

FIGURE 2
Refinement of Original Classification

A. Delayed or Retarded Physical or Cognitive Impairments
B. Family or Environmentally Based Problems
   i) Family Problems/Poor Child Rearing
   ii) "Chip on the Shoulder" Syndrome
   iii) "Mainstream Failures"
   iv) Reflected Prejudice
   v) Parental Possessiveness
   vi) Second Language Failures
C/D. Primitive Personality/Inappropriate Control
   i) Surdophrenia
   ii) Other Affective Disorders
E. Institutional Syndrome
F. Drug Problems – Substance Abuse
G. Depressive Reactions
H. Psychosexual Adjustment and Marital Problems
I. Multihandicapped Deaf People

One of the major changes in the last decade has certainly been in our greater understanding and awareness of Family or Environmentally Based Problems (B). This part of the original system has become more refined, and, indeed, has generated a separate category focused specifically on psychosexual adjustment and marital problems. Within this group, we are much more aware of specific needs, such as the needs of homosexual deaf people, than we have been in the past. We are beginning to appreciate better that being deaf does not classify an individual into a homogeneous sub-group. Rather deafness is only an additional variable that determines reactions and behavior. Nevertheless and unfortunately, we are also still prone to view the family of the deaf individual as psychopathological (see, for example, Nolan and Tucker, 1981). There are

[2]For more information write to Dr. George Montgomery, Applied Psychology Unit, Edinburg University, Edinburgh, Scotland

some signs that this view is changing (see, for example, Freeman, Carbin and Boese's, 1981, text) but the rate of progress is slow.

In refining the category of Family/Environmental Problems a number of sub-groups have either become more widely recognized, or have developed in the last decade or so. Personally, it is the author's view that we are seeing more deaf people with a "chip on their shoulder" syndrome. Discrimination against deaf people meant that in the past most deaf people were "have nots". An increasing number of "haves" in the deaf population make it more likely that some deaf people become very resentful of their handicap and use it to protect themselves from critical self appraisal. They feel: "It is not my method of coping that is the problem, but rather my deafness." Conversely, greater opportunities for deaf people has led to greater "parental possessiveness". This phenomenon is distinctly different from parental overprotection, although the latter can form part of the syndrome. In parental overpossessiveness, the parent becomes over-concerned that teachers, deaf people and others are "taking over their child." They feel a loss of control over their own lives, and sublimate these feelings onto their deaf child and other deaf or surrogate deaf people. Finally, it is worth noting that an increasing number of deaf people are becoming aculturized to middle class values, and as part of this process are beginning to reflect prejudices against hearing and deaf people that reflect the values and attitudes of "hearing society" (see Higgins, 1980; and, in particular, his discussion of peddling, p. 107ff.). Most deaf people are still very tolerant of minority groups and of hearing people, but there has been a significant increase in the small number of deaf people who deal with an inadequate self-image by adopting derogatory attitudes towards other individuals or groups.

Introduced into the category of Family/Environmental Problems are two educationally based problems that reflect environmental deficiencies for the deaf child or adult. Second language "failures" always existed, but in the last decade we have grown to recognize and better understand the problem. Students who fall into this category are successful in their use of ASL or other sign languages, but fail to learn English. As a result they become educational failures, and a cyclical process begins with unfortunate consequences for the academic achievement and self esteem of the student. Perhaps of even greater significance are "Mainstream Failures". These students often emerge in mid- or late-adolescence by presenting major adjustment problems in the mainstream setting. They have not successfully mainstreamed, and have failed to develop adequate self esteem and social support networks. They are "lonely" and what might begin as "attention seeking behavior" or "an aggressive response to frustration" becomes an ingrained pattern of behavior. Often when such students are placed in a more empathetic environment, their problems disappear or are reduced. Indeed, after their difficulties in self identity are resolved many become highly successful both academically and socially.

FIGURE 3

Treatment Systems/Sources

	Source	Treatment
A. Delayed Environment	Teacher/ Worker/Community Development Worker	Child Rearing/ Environmental Modifications
C/D. Personality	Psychiatrist/ Psychologist	Drugs/ Therapy
E. Institutional	Educational Administrator Teacher/Child Care Worker	Milieu and Attitudes
F. Substance Abuse	Therapist/Social Worker	Therapy/ Retraining
G. Depressive Reactions	Psychiatrist/ Psychologist	Drugs/ Therapy
H. Psychosexual Adjustment	Therapist	Therapy
I. Multi-handicapped	Teacher/Child Care Worker/ Psychologist	Education/ Training

TABLE 4

Self Image and Environment (Schlesinger and Meadow, 1972)

	Family Climate		
	Positive	Neutral	Negative
Residential/ Deaf Parents	75% 37%	67% 47%	43%
Residential/ Hearing Parents	47%	58%	37%
Day/Hearing Parents	69%	40%	27%

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TYPES OF THERAPEUTIC APPROACHES

The previous discussion may be helpful in understanding why different approaches to therapy have developed for use with behaviorally disturbed deaf students/clients. However, of particular importance is the input of parents, counsellors and teachers using general strategies and "educational" practices that foster the development of an adequate self esteem. A nurturing environment is still the best way of ensuring that students and clients develop into well-rounded individuals, and, in the absence of such an environment, the parent, counsellor or teacher may require help from a number of other specialists or may have to direct remediation at the behavioral symptoms of underlying social, emotional, linguistic, and cognitive problems.. Post-hoc remediation of this type is always difficult and often unsuccessful.

Figure 3 tries to show how teachers and schools can begin to facilitate better social adjustment of deaf students. Data from Schlesinger and Meadow (1972) is revealing – it shows as understanding and acceptance of deafness increases so does the self image of the deaf student (table 4). As a result, teachers of the deaf need to be particularly conscious of the problem of "burnout" (see Lewis, 1983). Nevertheless, once counsellor and teacher attitudes are sound, there are three main areas where they *should be* one of the primary leaders in the multi-disciplinary team. Teachers can program their classrooms to help prevent or overcome developmental delay in both cognitive and language skills *and in emotional development*. Counsellors and teachers can also be very effective in ensuring that schools do not become institutions, and I include in this concept all kinds of schools, classes and programs. A mainstream program can be just as institutionalized as a residential school – it depends on the staff and how the program is organized. Finally, counsellors and teachers have a special role to play in the remediation of multi-handicapped students, particularly, but not only those with a learning disability.

CONCLUSION

Educational, vocational and remedial services have become defensive in a time of perceived declining enrollments and cutbacks. This reaction is unfortunate because the work of counsellors and teachers is likely to *increase not decrease* in magnitude and importance over the next decade. However, major changes in our pre-service and in-service training programs are needed if we are to meet those challenges, and counsellors have a major role to play in ensuring that these changes take place. In some senses the role of the teacher and counsellor remain separate, but, in many respects, they are becoming increasingly blurred. In particular, a shift in focus is needed that accepts a more broadly defined role for these specialists in which the client or student becomes a part of the multidisciplinary team, not just a passive recipient of services. When such changes occur, it is likely that the self image of deaf clients and students will increase, and we will start to see declining prevalence rates in a number of the problems described in this article. If changes do not take place, we are likely to see increasing prevalence rates.

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