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BEHAVIORAL DISORDERS IN DEAF CLIENTS

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This paper has two major aims: To describe some of the author's experiences in working with a rehabilitation (work adjustment and work evaluation) program for deaf clients; and to describe some of the author's views on the etiology, classification and remediation of behavioral problems with deaf adolescents and young adults. The rehabilitation project which the author has been particularly involved with in the United States is the Comprehensive Program for the Deaf of the Hearing and Speech Centre of Columbus and Central Ohio. The history of the Project is to be found in a federally funded project located in Goodwill Industries, Columbus, Ohio and has been described by Hairston (1971). More recent developments have been described by Carper (1972). The program has during the years changed to a wider view of rehabilitation than the original diagnostic and "job training" concept. As a result of the original program, the new program has both a more extensive and a more intensive view of rehabilitation. Hence, it offers a wide range of evaluative, counselling, therapeutic, remedial education and supportive services which concentrate on the behavioral and personal problems of the client as well as on his occupational problems. Indeed, the former are normally regarded as more important than the latter in the initial stage of rehabilitation.

The importance of training for rehabilitation workers in the behavioral problems of deaf clients is apparent when estimates of the number of deaf clients exhibiting such problems are considered. For example, even if representing something more than the tip of the iceberg, the referral of 96 clients to Project D.E.A.F. in the period June 1971 to January 1972 gives some, not very scientific, indication of need. An alternative approach to

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the problem would be illustrated in Table 1, which is based upon the State of Ohio, Indiana and Kentucky estimates of population and the author's more systematic findings of the incidence of severe and minor behavioral disturbance in a study of hearing impaired children in their final year of school in England. It can be seen from the following Table that in this tri-State region there are a minimum of 1930 deaf persons exhibiting behavioral problems sufficient to warrant specialized help of some type.

Estimated Prevalence of Severely Disturbed Deaf People

State	Total Population 1970 Census	Known Deaf Population*	Deaf Population (100/100,000)	Estimated Deaf Population with Behavioral Disorders+
Ohio	10,542,030	10,000	10,542	1170/1233
Indiana	5,143,422	4,500	5,143	526/601
Kentucky	3,160,555	2,000	3,161	234/370

*Bureau of Vocational Rehabilitation.

+Using 11.7% prevalence and two deaf population estimates.

The table shows estimated prevalence of severely behaviorally disturbed deaf people in the States of Ohio, Kentucky and Indiana. If all levels of severity from the very mildest were included an increase by a factor of approximately 4 would take place.

Leaving aside statistics, the experience of all projects accepting clients of this type is perhaps sufficient confirmation of need. All have experienced exponentially increasing demands resulting in long waiting lists and, oftentimes, physical exhaustion of very dedicated staffs.

In recent years psychiatric units for deaf patients have been established in New York, Washington, Chicago, San Francisco, England, and Norway. However, they have tended to work within a conventional psychiatric or psychological framework and to primarily emphasize the more pathological types of emotional/behavioral disorders. Moreover, to act on the remediation techniques they describe requires the availability of an intensive psychiatric treatment facility with in-patient provision. To work for, to plead for such facilities elsewhere does not answer the immediate need for treatment and remediation of deaf adolescents and their families who are unable to receive help from the existing units. Moreover, even if every State had such a unit or access to one, there still remains a large segment of the relevant population who do not need to be and probably should not be remediated through expensive and intensive

units of the type provided in the centers listed earlier in this paragraph. These clients, whether returning from, on route to, or in no way involved with a psychiatric unit, are the clear responsibility of vocational rehabilitation but their vocational rehabilitation of necessity frequently involved a prior rehabilitation within a framework best described as personal and social rehabilitation. It is with these clients that this paper is particularly concerned.

IDENTIFICATION OF TYPES OF PROBLEMS

The organization of this section is essentially a pragmatic one. While some reference will be made to a psychological conceptual base, the aim is more the attempt to group clients referred to Project D.E.A.F. into 7 types of frequently recurring problems. It is felt that this approach will better fit the needs of rehabilitation counselors than a more theoretically based approach. However, in interpreting the information available on different clients, the author has used the conceptual framework referred to in the previous section. The danger is that lacking the conceptual base, the rehabilitation counselor may be prone to misclassify if he uses the designated problem areas as an etiologically based classification system. If, however, he/she used this as a method of reorganization and referral then these dangers would be minimized.

DELAYED OR RETARDED PHYSICAL OR COGNITIVE IMPAIRMENTS

Clients falling in this classification are not essentially behavioral problems. Indeed, if they were, they would be more accurately classified in other sections of this system. The problem can be illustrated in two rather different ways by the following cases. In the first case the client had previously been institutionalized, described as being below average in intelligence and diagnosed as having a "passive-aggressive personality". However, extensive testing and observation showed him to have intelligence in the normal range and a stable adjustment pattern of a positive type. The second client has cerebral palsy as well as a hearing loss and was institutionalized in middle childhood in a state hospital. He has no family who take an interest in him. He relates well to adults and peers and has a pleasantly extroverted personality. He was reported as being retarded but careful testing showed that he functions at least in the lower end of the "normal" range. Behavior is stable and given his physical handicap he exhibits a surprising ability to relate well to both people and things in his environment.

These clients and many similar examples illustrate the most basic form of problems for rehabilitation. Whether physically, educationally or cognitively retarded they lack even the very minimal practical skills for survival in a competitive, technological world. In a simpler society, they would have no or fewer problems since the level of sophistication required for survival would be more compatible with their level of achievement. From the point of view of the rehabilitation counselor they are simultaneously the most easy and the most difficult clients to deal with. They are theoretically easy because given either remedial education or placement in an unskilled job coupled with basic skill training in social aspects of living such as how to take the bus from home to work, they will probably effectively habituate to the environment and once happily placed in a job they are unlikely to leave it of their own choice. They are difficult because invariably there is no remedial education, there is no unskilled job and there is no sympathetic and understanding environment available.

FAMILY OR ENVIRONMENTALLY-BASED PROBLEMS

A second group of clients characteristically referred to Project D.E.A.F. are family or environmental rather than individually based problems. In the beginning, these clients are often confusing from the point of view of evaluation and remediation. They are preceded, arrive with, or are followed by extensive "reports" of deviant behavior of varying degrees of accuracy, but without any reference to family background or any analysis of the relationships with their real or their surrogate families. They are confusing because they exhibit no or little deviant behavior in the Project and, lacking information, about the family and the environment, it reduces the staff to either rejecting the validity of the history (frequently accurately so) or utilizing indirect means such as the Bene-Anthony Family Relations Indicator (Bene-Anthony, 1969) or the Bristol Social Adjustment Guides (Stott, 1969) to give some insight into family and/or environmental relations.

A typical client of this type had a total score of 19 indicators of maladjustment on the Bristol Social Adjustment Guide placing her on the borderline between the Unsettled and Maladjusted classifications (0-4 Stable; 5-9 Quasi-Stable; 10-19 Unsettled; greater than 20 Maladjusted) and implying a considerable need for help and counselling. The profile suggests that most of her problems lie in her feeling of insecurity about adult interest and affection, and the danger is that she will adopt extremes of attention-seeking behavior involving, for example, promiscuous relationships with the opposite sex. Further tests using the Bene and Anthony Family Relations Indicator confirmed the pattern exhibited on the Bristol Social Adjustment Guides whereby strong paternal and maternal overpro-

tection and indulgence have given rise to anxiety about receiving adult interest and affection and an overdependence on adult authority figures.

The remediation of this type of problem has, in the long-term, to be directed at remediation of its environmental causes. This is not to say that the clients themselves may not need individual and/or group counselling/therapy. Specific remedial work in terms of educational attainments, occupational skills, etc. is important in that such techniques may provide some clients with the strengths and reserves to cope with a "hostile" environment. It is to say that much of the value of such help will be undone unless such programs can either through parent/family counselling or through providing appropriate parent/family surrogates enable some of the environmental stresses on the client to be minimized.

PRIMITIVE PERSONALITY

The first two groups of clients described are, for want of a better term, representative of the sociological or environmental casualties of deafness. The group described in this section is the first one which can truly be regarded as having a psychologically based etiology to their problem. Within it are two distinct sub-groups. The first group have failed to develop personality to a level regarded as "normal" in a comparable individual of the same age. The second group have developed personality traits to a given level but subsequently regressed to a developmental stage characteristic of a younger age group. The difference is important because the prognosis for remediation of the second group is much better than for the first group and because the techniques of remediation for the two groups are somewhat different. Unfortunately, the first group are by far the most frequently occurring in the deaf population (see Vernon, 1969) and the second group are rarely seen by practitioners in this field.

The following recommendations taken from the case report of one client showing problems of "primitive personality" show the kind of help that the rehabilitation counselor can provide. The recommendations were that the remedial program be directed at:

1. Improving the clients social skills and decreasing her extreme dependency on adults, both of which exhibit a considerable amount of social immaturity.
2. Enabling the client to achieve a sense of self-worth and self-identity.
3. Improving the client's present immature and somewhat uncared for appearance.
4. Clarifying the role definition of males and females and enabling the client to accept a clear indentity in male/female relationships.
5. Providing the client with opportunities for success in both practical and social ways as part of a program of increasing her own feelings of self-

worth as referred to in #2. Whilst work adjustment and job-training may form important supplemental means of facilitating the above goals, by themselves they are unlikely to prove successful.

The recommendations made in the above case are best described as facilitating the continuation of a developmental process leading to a maturer personsonality. In undertaking this, care would be needed to ensure that any specific traumatic situations which might have resulted in regressed rather than delayed development were dealt with. However, the general pattern and the client's history seem to preclude this possibility. In contrast to this approach, when dealing with problems involving regressed rather than delayed personality development, much of the emphasis has to be rightly placed on therapy aimed at discovering and remediating the specific causes of regression. In passing, it might be worthwhile noting that the first type of problem seems to be very amenable to supportive programs of behavior modification, whereas the latter seem usually to benefit little, in the long term, from such programs.

INAPPROPRIATE IMPULSE CONTROL MECHANISMS

It is widely accepted that one of the effects of early onset of profound deafness can be a lack of impulse control or, more correctly, socially unacceptable methods of dealing with impulse control. Klaber and Falek (1963) have clearly shown this by an analysis of criminal offenses in a group of deaf offenders. Characteristically, the offenses committed by the sample of deaf people showed a much higher frequency of offenses of a type particularly illustrative of a lack of impulse control (such as Indecent Exposure, Reckless Driving and Vagrancy). The most frequently accepted rationale for this phenomenon is the inability of the deaf person with poor linguistic skills to internally or externally mediate his impulses through language or language control mechanisms. For a hearing person, it is easier to control the impulse to physically assault another person either because through verbal mediation we can analyze the undesirable implications of such an action or, failing this, because we can directly sublimate such physical aggression into more socially acceptable verbal aggression. Similarly, acting out sexual behavior can be controlled either through verbal mediation or through direct sublimation into expressive verbal channels. Moreover, the problem is frequently compounded in the deaf person because, for some, considerable reinforcement of such acting out behavior has taken place in the past. Frequently, with such clients, the only action which has resulted in them attracting attention has been overt behavior, usually of an aggressive or sexual type, and therefore, it is not surprising that they have learned to behave in this manner when they need or want attention.

In a sense, many of the clients exhibiting this behavior are correctly classified as having delayed or arrested personality development but the syndrome is so frequently occurring in disadvantaged deaf populations as to warrant discussion in its own right. However, there are dangers in describing a group by symptom rather than by etiology in that the symptoms may be meaning of several different things, just as a headache may be meaning of several different physical ailments of differing degrees of severity. There are in fact, three main distinct sub-groups within the group of deaf clients exhibiting this syndrome. The first group particularly exhibit aggressive acting out behavior at isolated, infrequently occurring intervals usually related to a specific situation or environment. This group are representative of an essentially normal mechanism which means that, given enough stress, all of us are prone to exceed the limits of impulse control and exhibit more primitive forms of behavior. The question to be answered concerns the strength of the impulse control mechanism and the degree of stress required to break it down.

Unfortunately, the deaf person, unlike most hearing persons, is unable to explain his reaction since he oftentimes lacks the basic communication skills necessary to do this. Thus extremes of non-verbal aggression symbols such as gesticulation and facial grimaces are "mis-read" by authority figures, such as policemen or parents, and the deaf person or adolescent may find himself on an "assault" or "beyond parental control" charge. In actuality, clients of this type do not have behavioral problems, although they may need minimal counseling to enable them to better understand the reactions they generate, but rehabilitation workers need to be fully conversant with the existence of this group of clients, since they are frequently the only persons able to protect the client from lack of understanding in "the system" for the deaf persons problem. The second group of clients may be correctly classified as behaviorally disturbed, although even that is highly debatable unless one accepts a behavior modification system of classification. In a sense, this group has already been described when reference was made to the learning process whereby behavior symptomatic of a lack of impulse control is consciously or unconsciously utilized as an attention seeking mechanism. However, it is important to note that while it is possible that a deliberate conscious or unconscious choice is made to use this kind of behavior in this way, it is also frequently the case that the attracting of attention frequently reinforces a type of behavioral adaptation already pre-existing. If the behavior is just used for what it achieves, then frequently, ensuring that the client does not have to resort to this method to gain attention, will result in remediation. If, however, the reinforcement has merely strengthened a pre-existing condition then the behavior more correctly belongs within the third group in this classification.

The third group represent, as it were, the truly behaviorally disturbed group and, as previously suggested, they represent a special but frequently

occurring type of delayed or arrested personality development (often) or regressed personality development (less often). For this group the primary problem stems from the unability to verbally mediate the processes of impulse control *internally*. The external communication problem is once removed from the real basic difficulty, although it is, of course, usually present in cases of delayed development and frequently present in cases of regressed development. Many clients exhibiting this type of problem have a history of acting out aggressive tendencies. Frequently, they have been repetitively involved with the police and often they have been institutionalized as a result of incidents involving violence or sexually immature behavior such as indecent exposure. This overall pattern is easily confused, unless the person is familiar with the psychology of deafness, with psychopathic or sociopathic behaviour. Although having some similarities they are not the same and the prognosis of remediation is much better than in the latter instances. However, without remedial help there is high probability that the behavioral reactions will continue in their present form and, possibly, even become more extreme.

Remediation of clients of having the characteristics just described will obviously depend on the severity of the disorder but it is probable that successful remediation will only be achieved through an intensive combination of individual counselling/therapy, group counselling/therapy and a remedial learning program with objectives formulated in terms of a planned process involving the development of adequate control mechanisms. Such a program can only be mediated through psychiatric units offering services of the level and degree found in the already existing units referred to in the introduction to this article. Unfortunately, such facilities are rarely available and then the counselor has to fall back on his/her own resources. Perhaps understanding the mechanism will at least help in some way to alleviate the negativeness which clients of this type often generate in persons unable to understand the basis of their problems.

INSTITUTIONAL SYNDROME

One of the characteristic concerns of all programs working in the field of psychology and psychiatry of deafness is their finding that large numbers of deaf persons are either incorrectly institutionalized in mental hospitals or institutionalized in situations where no effective treatment program is offered. Thus a characteristic group of clients are to be found who display what is best described as the "institutional syndrome". Sometimes the syndrome is found in conjunction with other problems, but oftentimes the only problem facing the client is that the debilitating effects of long-term institutionalization has generated behavior characteristics completely incompatible with any independent social living in the wider community.

Usually such clients have poor work habits and a slow rate of working inevitably meaning that even if they are successful in finding a suitable job they are likely to be laid off. Such clients usually have an extremely limited social life, making only fringe contact with other persons in their environment. Characteristically, they are extremely inhibited and withdrawn and completely lacking in initiative. When directed they will complete a task requiring a very limited attention span and their behavior is very adaptable to an institutional framework. Basic self care is established. They never question and usually fail to respond to anything other than direct "orders". Particularly with younger clients of relatively limited institutional stay, the prognosis for remediation of this type of client is good. However, it does call for a carefully planned program of re-entry into society and a gradually increasing weaning away from a dependency relationship with autocratic figures. Ideally the program of remediation will incorporate at some point in time residence in a halfway house type of facility. While such a program might be correctly regarded as counselling and therapy, in the author's view it is much more accurately regarded as a program of social learning and/or remediation and the techniques of casework and groupwork are much more profitably used than the techniques of psychotherapy or group therapy.

DRUG PROBLEMS

In discussing the problems of drugs and the deaf population, it is important to bear in mind the difference between drug experimentation and drug abuse. In the former, the client has no real psychological or physical dependency on drugs, whereas in the latter he does. The true "addict" is a problem of drug abuse, but many deaf clients reputed to have a "drug abuse" problem are not addicted to drugs, although the fact they are experimenting means that there exists a high risk that they will become addicted, particularly to the physically addictive drugs. The drug prolonged experimenter is usually *relatively* sound, psychologically speaking, and experiments because he associates in some way with a "drug culture". The addict is usually relatively unsound psychologically and peers have only limited meaning to him. Cases of drug abuse do exist in the deaf community, but the average counselor will be much more frequently faced with problems of drug experimentation. Moreover, as with many "fashions", the drug problem in the deaf culture is about 10 years behind the hearing culture in the magnitude and severity of the drug problem. This means that the peak has yet to come.

One of the important differences between drug experimentation and addiction is the prognosis for remediation. Individual and group counselling and constructive educational programs have a fairly high probability

of success with clients involved in drug experimentation when they are practiced by skilled practitioners, and when they are coupled with improvement in the client's self-esteem and ability to relate to more constructive peer group models, irrespective of whether they are deaf or hearing. In the case of drug abuse, the prognosis is much, much poorer and remediation can only be achieved through specialized drug remediation programs. Unfortunately, no such specialized program exists at the moment specifically catering to the needs of deaf clients.

It is regrettable that, generally speaking, even with clients whose language level does not preclude their benefitting from an educational program on drugs, there still is in the deaf adolescent/young adult population an appalling lack of information about not only drugs but other equally critical social problems such as sex, venereal disease, alcoholism and marriage. This is not to say that the situation is necessarily that much better for many hearing persons, but given the increased isolation arising as a concommitant of deafness, the need to establish such programs is even greater than it is in the hearing population. Perhaps this is an area in which counselors could establish preventative rather than remedial programs since, at present, this certainly represents the best line of defense for a reduction in both drug experimentation and drug abuse.

DEPRESSIVE REACTIONS

Some controversy exists as to whether or not depressive reactions exist more or less frequently in the deaf population. Altshuler (1967) says they occur less frequently whereas Vernon (1969) seems to imply they occur more frequently. Nevertheless, excluding psychotic depression, it is clear that a small but significant number of clients exhibit depressive reactions either situationally to the environmental concommitants of deafness or to the loss of the ability to hear itself. Characteristically, in the Comprehensive Program for the Deaf this group shows a higher incidence of deafness of late onset, is more linguistically proficient and has a higher level of educational achievement. These differences would support Vernon's contention that defensive projection and externalizing of blame reduce the apparent incidence of depressive reactions in the deaf population since individuals with the above characteristics would be least able to adopt this kind of mechanism.

Clients of this type exhibit symptoms of withdrawal and listlessness. Analysis of their reaction show major behavioral descriptions of depression frequently coupled with ambivalent hostility/anxiety reactions towards authority figures and a relatively large number of symptoms indicating a general lack of social/emotional responsiveness. In the absence of specific situational reactions it seems probable that such reactions represent general depressive responses to severe deafness frequently of progressive and late onset.

Environmental manipulation providing a supportive environment enabling the client to increase his self-awareness and self-esteem is helpful in remediating clients exhibiting depressive reactions to deafness of itself is not sufficient. The client needs to gain insight into the causes of his depressive reaction whether or not these are situational in nature or generalized reactions to hearing impairment. Such insight can only come through individual and group counselling and/or therapy. Thus the major aim of counselling with this kind of client has to be directed towards the achievement of this goal. Even so, it will require a considerable amount of intensive counselling before it is achieved.

CONCLUSION

The paper has very deliberately not dealt with psychosis and deafness. Remediation of problems of this type along with more severe cases of psychoneurosis and personality disturbance has to be effected through a properly equipped psychiatric unit for deaf persons. It has tried to deal with a range of social/emotional casualties which ought to form the main bulk of the caseload of the rehabilitation counselor of the deaf. To conceptualize the role of such a counselor in terms of purely vocational rehabilitation is naive. Those clients whose needs are purely vocational will be unlikely to seek help from vocational rehabilitation in the first place unless it is for a specific service only available through this source. Thus the service should, if for no other reason than self survival, come to grips with problems broadly subsumed under social work and its methods; its training programs and its services need considerable reappraisal from this point of view. Ohio is fortunate in that it has a service which does take an extensive and intensive point of view in this matter, but even so it is not immune from the general failing of seeing job placement as the immediate rather than, as it frequently is, the far distant aim of the rehabilitation program. If other services existed to meet the needs of clients for pre-vocational services, the limited role of vocational rehabilitation would be more acceptable. The reality is that such services are not available to the bulk of the deaf population and are unlikely to become available for some considerable time. Thus the rehabilitation officer of the deaf has to become much more analogous to his British counterpart, the social worker for the deaf. Putting it another way, maybe there is need for the service to critically appraise its values and consider whether or not in many instances it has not internalized the frequently occurring American ethic that only those who "don't want to work can't work".

It is also important that rehabilitation and professional workers in the field stop either blaming education for *all* the problems of deaf

adolescents and adults or assuming that the use of total communication from an early age would by some mystical means remove the problems of behavioral adjustment which form the subject matter of this article. There are faults in the educational system for deaf children which sometimes cause and sometimes magnify the adjustment problems of deaf persons in later life, but there are, equally, problems which would remain either in the same or to a lesser degree to be dealt with by vocational rehabilitation even if we had a more perfect educational system. In the meantime, if we spent more time getting on with the job rather than spending it at workshops going through the same negativism for the fiftieth time in a decade, maybe we could show not only what needs to be done, but also how it can be done.

It is a fault of the author's, although his colleagues assure him he only does it in writing, to leave the last word to somebody else. I shall do this again, although I only wish I had enough space to reproduce the whole of Chapter XI of Dr. Jerome D. Schein's book on the Deaf Community. Suffice it to quote one paragraph:

> "When you hear about the difficulties of educating deaf children or counselling deaf adults, be sympathetic if you wish to. Or you may prefer to share the picture that enters my mind under such circumstances. I fantasy a sales manager explaining a poor sales record to his board of directors: Gentlemen, the United States citizen cannot grasp our product's merit; they cannot understand its abstract qualities; they are poorly motivated; they do not listen when we present our messages to them. Gentlemen, they are buying all they can or ever will buy. There is nothing wrong with our sales force. The fault is in the customers." (Schein, 1970)

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