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LINK

Official Publication of The National Association for the Deaf



AUTUMN 1985



Swimmers Alan Turner, left, and Paul Keating who performed so magnificently at the World Games for the Deaf in Los Angeles, winning six medals.

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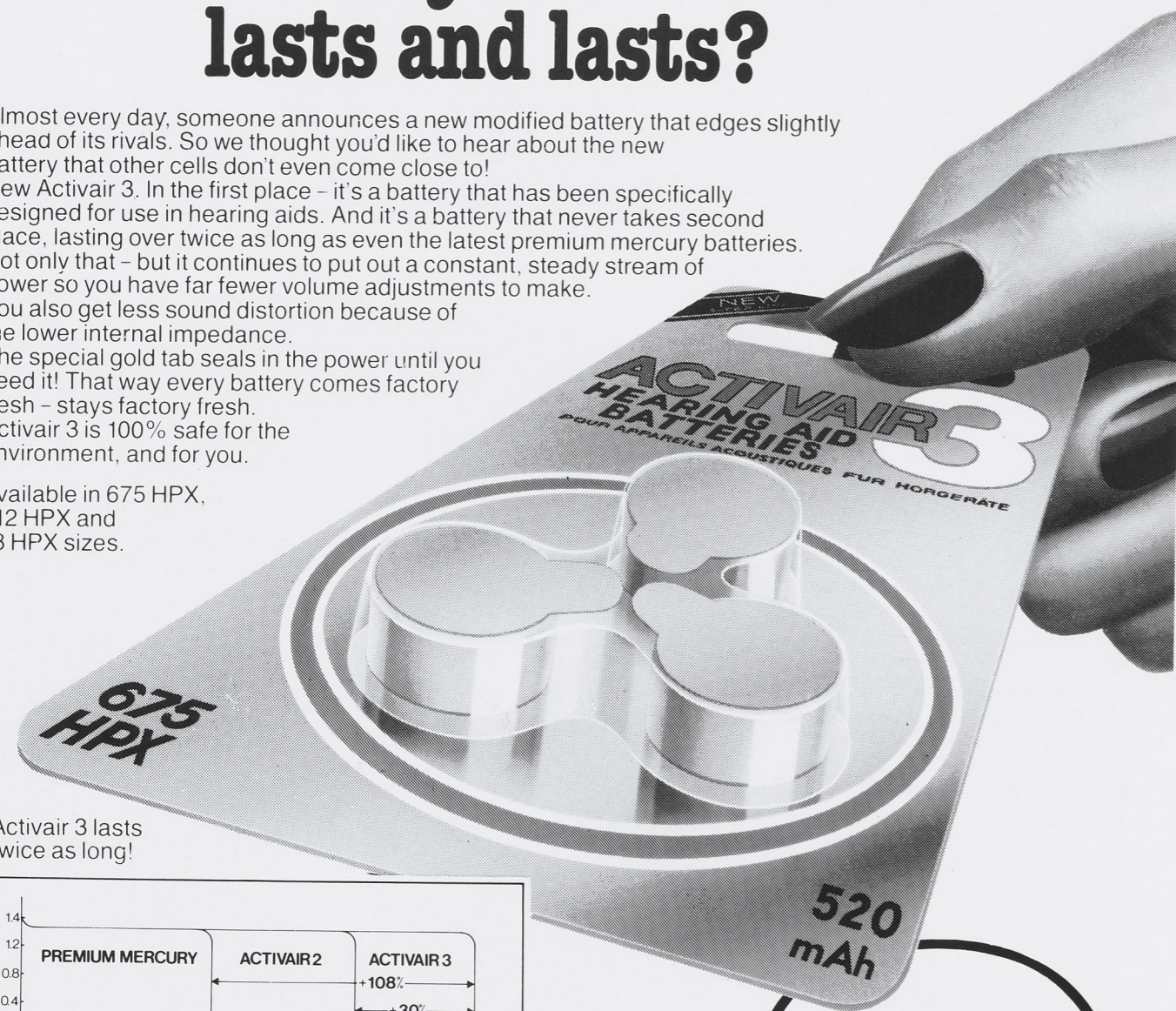
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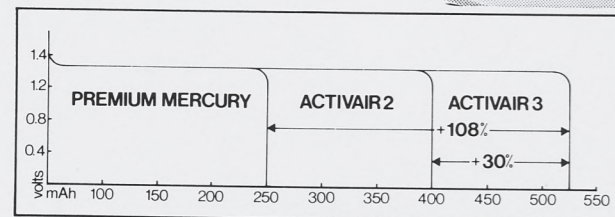
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Magnificent triumph for Irish at Deaf Olympics

What a triumph for Ireland in the World Games for the Deaf in Los Angeles with Alan Turner (Dublin) and Paul Keating (Waterford) winning four gold medals, one silver and one bronze. And they set four new World deaf swimming records at the Games. It was the best result ever achieved by Irish swimmers in a World international event.

Ireland were among the smaller teams at the Games with only twenty-three, five swimmers, two athletes, one table tennis player and fifteen footballers. Another table tennis player, Linda Nugent, was selected but had to cry off at the last minute due to illness. There were six officials and two CISS Congress delegates with the team.

The U.S.A. finished on top with a total of 109 medals while Ireland were in 9th place which is a great achievement considering the small team as compared with the U.S.A. who had 212 competitors, West Germany had 107, Italy - 86, Great Britain - 67.

The Irish swimmers had their first practice session in the Olympic pool at Pepperdine University on their arrival on July 6. After a few days of training in the 50 metre pool the Irish swimmers did not feel at a disadvantage by swimming in the Olympic pool. The pool arena had seating accommodation for 3000 people and at some of the swimming finals the pool arena was packed to capacity.

Alan Turner won Ireland's first gold medal on the opening day of the Swimming Championships. Alan won the men's 100 metres breaststroke in a new world record of 1:10.05 and it is also a new IASA senior long course record.

D. Filippi from France took the lead on the first lap and held it up to the 80 metres mark and Alan, showing great determination, surged ahead to take the gold medal. It was a close finish between Alan and Filippi. Alan deserved to win his first international gold medal.

Katherine O'Grady was 7th in the final of the women's 400 m individual medley and her time was 5:50.13. For Katherine this was an improvement of over 9 seconds on her European championships time in the same event.

Padraic Joyce did 2:17.97 in the



The Irish Officials at the Deaf Olympics, from left, John Doyle (Table Tennis), Dermot Saunders (Hon. Treas IDSA), Sean Kelly (President IDSA), June O'Mahony (Swimming), Kevin Lynch (General Secretary, IDSA), Tony McElhatton (Vice-President IDSA), Eamonn Hayes (Football).

men's 200 metres freestyle and this was a personal best time. Geoffrey Foy did 1:19.96 in the men's 100 m breaststroke.

On the second day of the swimming events Alan Turner won a silver medal in the men's 400 metres individual medley and Alan's time was 4:56.08. The winner was Stuart Wilson (U.S.A.) and his time was 4:48.61, a new world record.

In the women's 200 metres free-

style Katherine O'Grady did 2:25.29 and she was 7th in the final. The winner was Cindy-Lu Fitzpatrick (Australia) in 2:13.41.

Paul Keating won Ireland's second gold medal on the third day when he was first in the men's 200 metres backstroke and he set a new world games record of 2:16.25. Paul led from start to finish and at the end he was over 5 seconds ahead of the runner-up, James Davenport

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(U.S.A.). The spectators were amazed by Paul's swimming speed and power, because at the 100 m mark Paul was just outside the 100m world record. His time at the half-way mark was 1:03.91.

The men's 100 m freestyle was won by Stuart Wilson in a new world record time 52.66 sec. and Alan Turner won the bronze medal in a new European record of 54.49 sec. which ranks Alan as the No. 1 freestyle swimmer in Ireland.

In the women's 400 m freestyle final Katherine O'Grady was 6th and her time was 5:03.52, a personal best in a long course pool.

The next day Alan Turner won Ireland's third gold medal in the men's 200 m breaststroke and his time was a new world record 2:33.43. Alan had the race under control after the first lap and at the finish he was three seconds ahead of D. Filippi from France. Third was K. Goulston (U.S.A.).

Alan's win was remarkable, because in Cologne, four years ago, Alan was last in the men's 200 m breaststroke.

In the men's 4 x 100 m freestyle relay Ireland were fifth fastest in the final and the team members were: Paul Keating, Padraic Joyce, Geoffrey Foy, Alan Turner. The four boys are pupils at St Joseph's School for Deaf Boys, in Cabra. The Irish relay team set an Irish record of 4:02.94 an improvement of 14 seconds on the previous record.

Paul Keating won Ireland's fourth gold medal in the men's 100 metres backstroke on July 15 in a new world record time. Paul's time of 1:02.79 shattered the previous record held by A. Gavaza (U.S.S.R.).

At the 50 m mark Reed Gershwind (U.S.A.) and James Davenport (U.S.A.) were ahead of Paul and when the three swimmers turned Paul got a great turn, and came out about 10 inches ahead of the two Americans. On the last lap Paul increased his lead and at the finish he had two seconds to spare on James Davenport.

Paul's 100 metres time is the fastest achieved by an Irish swimmer in a long course pool in 1985. The last time that Paul swam in a 50 m pool was in 1983, at the European Deaf Swimming Championships in Antibes.

Katherine O'Grady had her best swim of the Championships when she came fourth in the final of the women's 800 m freestyle and her



At the Olympic Swimming Pool, Bro. Wall, Alan Turner, Paul Keating, Sean Kelly, June O'Mahony and Bro. Drohan.

time was 10:30.05. The winner was Katherine Bates (U.S.A.) in 9:42.25.

On the last day of the swimming events Ireland were very unlucky not to win another medal. Our best hope was in the men's 4 x 100 m medley team relay event. The team members were: Paul Keating; Geoffrey Foy; Alan Turner and Padraic Joyce. All team members tried their best but we lost the medal by less than one second.

The Irish medley team relay did 4:26.48 and two years ago, at the European Swimming Championships for the Deaf, France won the gold medal in 4:28.28, and Ireland was fourth in 4:48.15. We have made good progress in two years.

In the men's 200 m individual medley Alan Turner did 2:19.87 and he was fourth in the final. The race was won by Stuart Wilson in a new world record of 2:12.95.

Sixteen countries took part in the swimming and water-polo events and 24 new world deaf records were set. Ireland had the distinction of creating 4 world records and we were the top European country in the medals table.

Ireland finished in seventh place in the football competition.

Ireland 0 West Germany 3

The opening match was delayed for 1½ hours because there were no goalposts and nets in position.

The Irish played well in the early stages and due to a miscalculation in a throw-in, the Germans grabbed a goal just before the half time.

In the second half, John McHugh almost got a goal for Ireland when the ball hit the post. Though Irish goalkeeper, Pat Gallery made many fine saves, the Germans were too good and broke through to score two more goals.

Medals Table for Swimming

	Gold	Silver	Bronze
U.S.A.	17	13	14
Australia	5	0	2
Ireland	4	1	1
France	2	4	2
West. Germany	1	7	3
Britain	0	4	6
Canada	0	0	1



Competitors and Officials on their arrival back home at Dublin Airport.

U.S.A. 2 Ireland 0

The Irish had reason to believe that they would win this game, having heard that the Americans were trounced 9-0 by Holland two days earlier. Unfortunately they were physically tough and Ireland were shocked 2-0.

The Irish had the game in complete control throughout and played fine football. O. Ballintine was fouled inside the box. Gerard O'Grady took the penalty kick and for some unknown reason sent the ball straight into the hands of the U.S. goalie.

Later on, the U.S.A. were lucky to get a goal when they were awarded a penalty kick which shook the Irish.

In the second half Martin O'Neill was injured and had to be replaced by Michael Bell. Despite constant shooting and attack on the U.S. goal by the Irish forwards, they could not score. It looked like there was an invisible wall at the U.S. end!

Eventually, the U.S.A. made the final score 2-0 which shattered the Irish who in fact were the better team but lost.

Ireland 3 Holland 3

This was a very good game with Holland scoring first and obviously thinking they were going to have it easy. But Ireland fought back and equalised through Martin O'Neill. Holland took the lead again and

Ireland lost James Maguire who was replaced by Don Conway. Ireland were dogged by injuries but fought back once more to get on terms again with goal from Noel McLoughlin.

Holland were really staggered as John Moloney scored to put Ireland ahead 3-2. Unfortunately Ireland could not hold out and the Dutch equalised.

Ireland 3 Japan 0

In the 7th/8th places play-off, the Irish dominated the game right from the start but the Japanese were strong in defence. Eugene Thornton was recalled from the subs' bench replacing the injured O. Ballintine, and he was on the right spot to pick up a cross and score a beautiful goal. The other scorers were Noel McLoughlin and John McHugh.

Group A Results

West Germany 3 Ireland 0;
U.S.A. 1 Holland 9
Ireland 0 U.S.A. 2
West Germany 1 Holland 2
Ireland 3 Holland 3
U.S.A. 1 West Germany 7

Group Placings: 1. Holland 5 pts; 2. West Germany 4 pts; 3. U.S.A. 2 pts; 4. Ireland 1 pt.

Final classification:

1. Italy; 2. Britain; 3. West Germany; 4. Holland; 5. U.S.A.; 6. Colombia; 7. Ireland; 8. Japan.

Despite his inexperience sprinter Martin Power did quite well reaching the semi-finals of both the 100 and 200 metres. In the 100 he finished ninth overall in 11.59 seconds. Winner of the gold medal was C. Smith (U.S.) with a time of 10.86.

Smith completed a double in picking up the 200 as well. Martin was tenth overall in this event in 23.66. Smith's winning time was 22.07.

Richard O'Mahony (Cork), was one of the twenty-three runners who set out on the marathon which was run through Santa Monica on a figure-of-eight course which had to be covered twice. Richard was lying fourth in the closing stages but found the 90 degree heat too severe in this twenty-six mile plus race and eventually finished in eighth place in 2 hours 55 minutes. The winner in 2 hr. 24.54 mins was T. Tounsi of France. Only thirteen completed the gruelling race.

In the Table Tennis Graeme Stanford of Belfast went straight into the second round of the men's singles with a bye. He came up against the Hungarian G. Vigguala and lost the first set. However he fought back magnificently to win the next three to reach the third round. Here he faced Britain's J. Addy who had an unusual off-putting style. A confused Stanfield lost 17-21; 11-21; 17-21.

The members of the team who represented Ireland at the Games were:

Swimming: 1. Paul Keating (Waterford); 2. Alan Turner (Dublin); 3. Padraic Joyce (Aran Islands); 4. Geoffrey Foy (Dublin); 5. Katherine O'Grady (Dublin).

Team Coach: Patrick Quinn
Manager/Chaperon: June O'Mahony.

Athletics: 1. Richard O'Mahony (Cork); 2. Martin Power (Dublin)
Manager: Dermot Saunders.

Table Tennis: 1. Graeme Stanfield (Belfast).

Manager: John Doyle.

Football: 1. Patrick Gallery (Clare); 2. James Maguire (Dublin); 3. Thomas Murray (Sligo); 4. Niall Fearon (Tyrone); 5. John Moloney (Kerry); 6. Osborn Ballintine (Tyrone); 7. John McHugh (Galway); 8. Eugene Thornton (Dublin); 9. Martin O'Neill (Down) Captain; 10. Michael Bell (Dublin) 11. Paul Canning (Derry); 12. Don Conway (Tyrone); 13. Gerard O'Grady (Sligo); 14. James Doyle (Wicklow); 15. Noel McLoughlin (Sligo).

Manager/Coach: Eamon Hayes.

Football Assistant: Anthony Mc Elhatton.

Ireland's Delegates to the C.I.S.S. Congress and E.D.S.O. Congress — Sean Kelly, President; and Kevin Lynch, General Secretary.

Travel Organiser: Dermot Saunders.

Donations and Bequests

Donations to the National Association for the Deaf are always welcome. If you would like to leave something to us in your Will, you can word your bequest as follows:

"I give and bequeath to the National Association for the Deaf of 25, Lr. Leeson Street, Dublin 2, the sum of

£

for the general purposes of said Association and I declare that the said sum be paid free of duty and that the receipt of the Treasurer or other authorised Officer shall be sufficient discharge therefor."

Congress on education proves a most stimulating experience

BY DORIS NELSON

The International Congress on Education of the Deaf was held in Manchester from 5-9 August. I was privileged to attend as a delegate on behalf of the National Association for the Deaf. For me it was a most informative and stimulating experience. In this article I hope to give my general impression of the Congress. The Congress was officially opened in the Palace Theatre, Manchester on Monday August 5 by the Duke of Devonshire, P.C., Chancellor of the University of Manchester and President of the National Deaf Children's Society. An estimated 1,400 delegates were in attendance. It was truly an international gathering, with a noticeable number of delegates from Third World Countries. Speeches of welcome were made by City of Manchester Dignitaries, P. G. Daunt, of the E.E.C. Directorate of Education and Robert Dunn, English M.A. and Parliamentary Under Sec. of State for Education and Science also addressed the meeting. Unfortunately the Rt. Hon. Jack Ashley who was also to address the delegates was unable to do so because of illness. Professor T. G. Taylor, Chairman of the Organising Committee gave the keynote address.

The Plenary Lecture was given by Dr S. Richard Silverman Chairman of the International Committee.

After lunch we returned to the Palace Theatre for the afternoon session. The topic, cochlear implantation, gave rise to a demonstration by The British Deaf Association, outside the Theatre. They feel very strongly that Cochlear Implants should not be carried out on deaf children; that the adult deaf should play a greater part in the education of deaf children, and they want sign language retained as the natural language of the deaf. The discussion on Cochlear implantation was indeed an interesting one. Taking part were such prominent people as W. F. House and his assistant A. M. Selmi both from the U.S.A., E. Douek

and A. J. Fourcin, J. E. J. John and J. M. Harris all from the U.K. Professor House gave details of how the Cochlear Implant operation was performed, and he assured us that thorough screening is carried out on children before the implantation is considered. In cases where a conventional hearing aid will benefit, a child would not be considered a suitable candidate for an implant.

An open discussion on cochlear implantation brought the first session to an end. From these discussions my conclusion was that Cochlear Implantation is not a miracle cure for deafness. Those who would benefit most from Cochlear Implants are profoundly deafened adults who had known speech and who can not be helped by conventional hearing aids.

A reception by the University of Manchester in the Whitworth Art Gallery on Monday evening gave delegates from the different countries the chance to relax and get to know each other.

The next few days of the Congress were a whirl of activity. Each day the choice of lectures on all aspects of education of the deaf was vast. For me the greatest problem was that I could not be in two places at once.

So many prominent people were presenting papers that it was very hard indeed to make a choice. I must confess, however, that I found some of the speakers used such technical jargon that, as a mere lay person, I found some of the papers a trifle confusing.

What really interested me at the Congress was the Trade Exhibition. This was held in the large Whitworth Hall of Manchester University. The exhibition comprised of an extensive range of audiological instruments and equipment made by the World's leading manufacturers and included hearing aids, hearing test boxes, audiometers, impedance bridges and electric response and audiometric systems.

There were also displays of educational materials and a comprehensive range of books.

I had never realised that such a

variety of Hearing Aids were available. Speaking to the trained personnel who manned the various stands I was made aware of the huge advances that have been made in Hearing Aids and testing equipment in recent years and how imperative it is that each deaf child should have ear moulds that fit to perfection and a Hearing Aid that will meet that child's particular requirements.

While examining a speech trainer at the Siemens Stand I met a most attractive vivacious deaf lady who was trying out a mini-phonator. This is a vibrotactile aid, designed for profoundly deaf children or adults who are unable to benefit from a conventional hearing aid. The mini Phonator consists of a wrist worn single channel vibrator, attached by a cord to a pocket sized unit, which could also be attached to a belt.

This lady had not been born deaf but became deaf through illness in her teens. She had excellent speech and told me she was a lecturer in Manchester. She told me a hearing aid was useless to her. She was delighted when trying out the Mini Phonator to discover that she was able to feel the sound of her voice



Mrs. Doris Nelson with Paddy Lade from BBC's 'See Hear' Programme in Manchester.

and feel sounds around her. She felt the Mini Phonator would help her enormously in her work as she would be able to control the volume of her voice from almost a shout to normal speech.

A visit to the National Deaf Children's Society was for me as a parent of a deaf child a most rewarding experience. I was warmly welcomed by Harry Cayton the Director of the Society and by Peter Sheldon. They had invited parents of the deaf to come together and discuss the possibility of forming an International Parents' Association. By having such an association they felt that it would give parents the opportunity of learning from each other what advances were being made in different Countries regarding education and technical advancement.

I met and talked with many parents. One parent who most impressed me was Mrs Marie Gunn, founder member of the New Zealand Parents of Deaf Children Association. She held the strong view that parents working together have the power to force authorities to provide the best possible benefits and facilities for both deaf children and adults.

She feels that "Parents who are at the Pithead of the Problem should play a very big part in the education of their deaf children". For parents

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to do this they themselves need to be educated in all aspects of deafness. That day I met parents from England, Holland, West Germany, Bombay, America, Australia, Belgium, New Zealand, Finland, Spain and France. Even though we were continents apart we all felt drawn together by a common bond. We shared views and ideas and discussed problems.

The problems covered such things as badly fitting ear moulds, lack of understanding on the part of professionals; not enough involvement of parents in Special Schools; the apathy of parents themselves towards their deaf children; the lack of counselling services for parents.

At the end of this session the National Deaf Children's Society in England agreed to act as a link between parents from different countries.

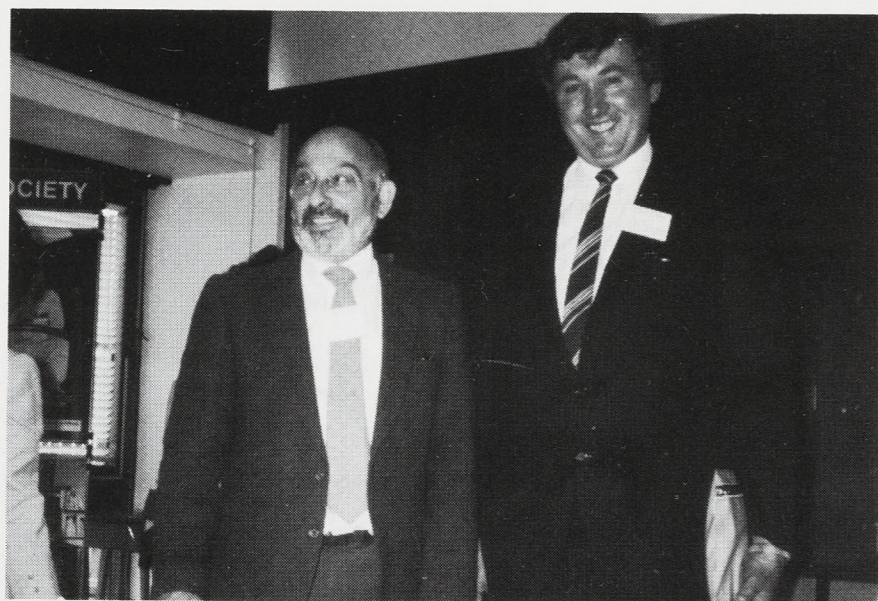
A visit to the British Deaf Association Exhibition Rooms proved very interesting. On display were a large range of books and videos for those wishing to use sign language. As I mentioned before the B.D.A. are most anxious to retain sign language and deaf culture.

I was warmly welcomed by Paddy Lade who most people will know from the See Hear programme on T.V. Paddy sends his best wishes to the deaf in Ireland and also heartfelt congratulations to the Irish swimming team who did so well in Los Angeles. Paddy also made me promise that if we meet again I will be able to use sign language.

I would like to think that I will meet Paddy again and, who knows, with a little help from my deaf friends maybe I might also sign. On the subject of signing, I would like to say how impressed I was by all the interpreters at the Congress. At most of the main lectures and all the important functions, interpreters were present. Some of the foreign interpreters had first to translate from English into the language of other countries and then into sign language.

As I previously mentioned the choice of lectures one could attend and various exhibitions one could go to see was vast. To enable us to obtain as much information as possible, Matt Coss who was the other delegate sent with me by the N.A.D., went to different lectures and exhibitions.

I recall as most interesting a paper



Matt Coss with Peter Sheldon of the National Deaf Children's Society.

read by Prof. D. Ling from the University of Eastern Ontario, Canada on Auditory Training and Experience. Professor Ling was a most eloquent speaker and I found his paper most interesting and informative.

Ken Pierce, headmaster at the Mary Hare Grammar School in England read a paper on the aims and objectives in the Education of Hearing Impaired Children of Secondary School Age and Examples of Success. Fr Van Uden from Holland proved so popular with his paper on Deaf Children in a new Age that he was asked to speak again for the benefit of those unable to attend his first lecture. All who heard Fr Van Uden speak were lavish in their praise of his work for and his dedication to the deaf.

A very popular speaker with deaf delegates was Prof. Harlan Lane from North Eastern University, Boston. Prof. Lane very kindly gave me permission to have his paper on Mainstreaming of Deaf Children — From Bad to Worse, printed in Link.

I was very interested to hear the views expressed by Derek Burton of the Royal National Institute For The Deaf in his paper Improving Community attitudes towards the Deaf Child in Adult Life. Mr Burton suggested that perhaps we should not be dealing with the education of the deaf rather the education of the hearing towards deafness.

If I have one small criticism to make about the Congress it is that too many papers were accepted, this enforced a very rigid timing on the

speakers and left very little time for open discussion which was unfortunate because all discussions were lively and stimulating.

Exhibitions by professional organisations included the Alexander Graham Bell Association U.S.A., The British Association of Teachers of the Deaf, Northern Ireland Branch; The British Deaf Association; Gallaudet College, U.S.A.; The Japanese Delegation; The National Aural Group U.K.; The National Centre for Cued Speech for the Deaf U.K.; The National Deaf Children's Society, U.K.; The National Technical Institute for the Deaf, U.S.A.; and the Royal National Institute for the Deaf, U.K.

I was truly delighted to see the work done by children from Sr. Melissa's class in Northern Ireland. Praise indeed is due for all the hard work that went into mounting such an exhibition.

The Congress closed on Friday August 9. Once again this ceremony was held in the Palace Theatre. The atmosphere now was very much one of friendship. During the previous days delegates had come to know each other and though many of us had differing views on the education of the deaf, somehow the overall feeling was of tolerance. The old arguments were still there, special schools versus mainstreaming, oralism versus signing. Total communication. However coming through very strongly now from all sides was the opinion that the deaf child in paramount and we must do what is best for the child.



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INTRODUCTION TO DEAF STUDIES

This intensive introductory course is designed for those in daily contact, whether in a professional or personal capacity, with hearing-impaired or deaf people.

The course will be held on Wednesdays from 8 January to 19 March 1986 from 10.00am-4.00pm at the Masserene Hospital, Antrim. The fee is £225.00.

Further information and application forms may be obtained from:

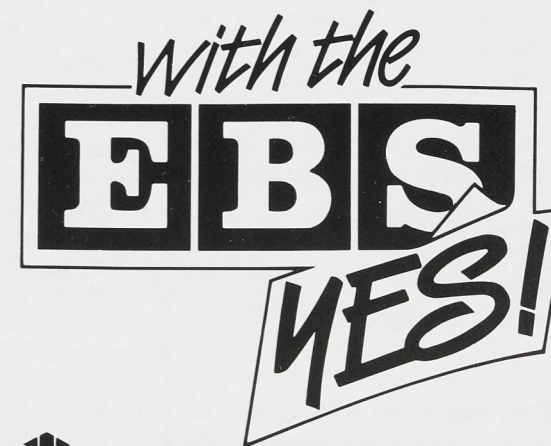
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Notice
**Annual
General
Meeting**

Notice is hereby given that the
Twentieth Annual General Meeting
of the
National Association for the Deaf
will be held at

ST. VINCENT'S CLUB
RICHMOND HILL,
RATHMINES
DUBLIN 6.

on

November 2, 1985 at 2.30 p.m.

For the following purposes:

1. To receive the Auditor's Report and Statement of Accounts for the year ended 31st December 1984.
2. To Elect Directors.
3. To transact any other business of an Ordinary General Meeting.

By Order of the Board

Peigin Coleman

Hon. Secretary

Dated this 4th day of July 1985.

Audited Statement of Accounts for the year ending 31st December 1984 are available on request from the Secretary, NAD, 25 Lower Leeson St., Dublin 2.

The Stress Perspective and the Hearing Disabled

Common behavioural results of stress include increased use of the social drugs, tobacco, and alcohol, the use and abuse of both licit and illicit drugs, increased proneness to accidents, increased aggressive behaviour and disturbances in appetite. It should be noted that many of these behavioural effects serve to increase risk for many diseases e.g. increased smoking, an effect of stress, is a risk factor for such conditions as, in the short-term, acute bronchitis and indigestion, while long-term risks include cancer and heart disease.

The psychological outcomes associated with stress include sleep disturbances, disruption of mood state — increased levels of anxiety, depression, irritability and fatigue can occur, disruption of interpersonal relations, and family problems. The medical conditions associated with stress are many and varied. Some authorities would argue that almost all medical conditions have a stress related component. These conditions include backache and headache, and more serious diseases and conditions like heart disease and stroke, arthritis, ulcers and some cancers.

A further effect of stress which has been noted recently is that the experience of stress tends to suppress or damp down the activity of the immune system, which is our body's natural defence against infectious disease. This means that we are likely to be more susceptible to conditions such as colds and flu.

The effects of stress on the individual can be viewed as threatening the physical and psychological functioning of the individual. Similarly, the effects of stress on the family affect family functioning.

The functions of the family which might be affected by stress include the capacity of the family to function as a health care unit, as an educational and socialising unit and as an economic unit. A further important effect of stress on families is that it can threaten the emotional environment of the family to the detriment of individual family members.

While it is beyond the scope of this

Part 2 of a paper by THOMAS RONAYNE, B.A. Research Sociologist, and RICHARD WYNNE, Research Psychologist of the Research Department of the Eastern Health Board, presented to the NAD Annual Seminar at Portlaoise.

paper to elaborate on the stress perspective as it is relevant to the family as a unit, it can be noted that many of the concepts and terms we have used to describe the stress response for the individual are similar.

The word coping has many meanings and is a very difficult concept to describe accurately. The research literature concerning coping with stress is not as advanced as other areas concerning the stress process. Given these limitations, we can talk about coping in fairly general terms.

How does coping fit into the stress process? Whenever we come under stress we do not accept the stress passively. We engage in a complex series of thoughts feelings and behaviours which are designed to address the stressor and/or the effects of the stressor. These are called coping attempts. These coping attempts vary across time, so that our initial reactions to the stressor may not be the same as our subsequent reactions. Our coping with the stressor may be modified by our previous or ongoing experience of the stressor. And of course, our reactions will differ in response to different stressors.

It is beyond the scope of this paper to give a detailed account of the nature of coping attempts. However we will try to draw your attention to some of the more salient features of coping, which we feel will be useful in helping to manage stress in your own lives.

There are three basic types of coping, each of which serves a different function. The first of these is problem-focussed coping. This type of coping occurs in response to the presenting stressor, such that we try to remove the stressor at source. For example, people with hearing disability often report being sensitive about their disability,

particularly in conversation. Because of this, many do not admit their disability to hearing people, which leads to communication difficulties. If the hearing disabled person makes his/her disability known at the beginning of a conversation this direct, problem-focussed coping strategy will quite often remove the stressor at source.

A second type of coping is called emotion-focussed coping. This type of coping is characterised by attempts to manage different aspects of the stress reaction. Thus we try to manage the psychological effects of the stressor. This type of coping is typical of situations where the stressor is too powerful to be addressed directly, or situations where the stressor is adjudged to be beyond our powers of effective influence.

An example of this type of coping would be when we try to relax in the face of everyday stress. Having a good cry, particularly if there is somebody sympathetic around to listen is another example. A slightly different, but often used type of emotion-focussed coping occurs when we try to control the meaning

the stressor has for us, in order to lessen the stressfulness of the stressor. Sometimes this process takes the form of denial, i.e. denying that the stressor even exists.

An example of this type of coping which often appears in the literature concerning the hearing impaired, is when parents of newly-diagnosed hearing impaired children initially deny the diagnosis. This can lead to what has been called "shopping behaviour" by the parents, as they seek second, third, fourth and sometimes more opinions in the hope that a positive outcome will ensue.

A third type of coping which has received relatively little attention might be called anticipatory coping. The difference between this type of coping and the previous two is that it is not directed at a particular stressor. In many ways it refers to the beneficial spin-offs we receive from good mental and physical habits. There is an enormous amount of research detailing the ill effects of disruption to these habits. The habits we are referring to concern in the main, sleeping, eating and exercising. Good habits in all of

these areas ensure that we have the maximum of resources to bring to bear on the management of stress in our daily lives. Furthermore, the maintenance of good habits in these areas builds up resistance to the effects of stress, both in the short and longer terms.

A further point concerns mental hygiene: those who like themselves, who feel good about themselves, are less prone to the effects of stress. These feelings of self-esteem can be encouraged by giving yourself credit for your achievements, by setting realistic goals and tasks for yourself, and by realising that all of your failures are not attributable to you.

A point which must be made about coping concerns what has been called the level of coping at which coping attempts are employed. The impression might have been created that all coping attempts are the sole prerogative of the individual. This is not the case, firstly because relatively few stressors are caused by the individual, and also because individual coping attempts are not necessarily the best way of dealing with stress.

For example, unemployment



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today is in many cases not the fault of the unemployed individual, and it often is extremely difficult for the individual to cope effectively with this stressor except in an emotion-focussed way. The only effective way of coping with the stressor, i.e. removing it by providing a job, is largely in the hands of the government and society at large. Similarly in the case of the hearing impaired, it is unrealistic to expect the individual to cope with their disability on their own.

A consequence of this point about the levels of coping concerns the social resources of the individual. We all live in society with others. This fact can have negative implications, as was outlined earlier in the paper. It can also have positive implications concerning our social resources. These resources can be more or less informal, such as the social network of our friends, relatives and acquaintances, or more formal, such as organisations and services like health and social welfare services.

In the case of the deaf, examples of important sources of social support include the National Association for the Deaf and the visiting teachers of the deaf. These social resources function to provide us with sources of material and social support. The importance of social support cannot be over-emphasised, since the latest research has conclusively shown that social support acts as a buffer between the stresses of living and the negative outcomes associated with stress. It should be emphasised that in order for social supports to moderate the effects of stress, we have to engage with them. In other words, we have to communicate with people about our problems if we are to experience the beneficial effects of social support.

We have had a certain difficulty in applying a stress model to the experience of being hearing impaired, because of the relative lack of stress oriented literature concerning deafness. While we feel that we have few conclusions to offer on the basis of our preparations for this paper, we feel we can raise a number of issues which we feel are important as a result of our experience as stress researchers. We feel that these issues point to the usefulness of the stress perspective, since they illustrate the importance of examining the role of factors in the person, the

environment and the coping strategies of the individual.

The first issue concerns the time of onset of hearing disability and the related issue of the actual extent of hearing loss. The late onset of hearing loss, the so called deafened adult, experiences a major stressful event. This loss of hearing in adult life means moving from a world in which hearing and communication were taken for granted, to a new situation in which communication skills must be relearned. It is clear that nobody is prepared for such a trauma. This reflects the fact that for the hearing population, the possibility of losing our hearing, and thinking about the implications of this for the hearing disabled, rarely crosses our minds.

This mirrors the situation that hearing loss is usually an invisible disability, and it is only those who have contacts with the hearing disabled who have an awareness of their problems. Not alone must the deafened adult relearn his/her communication skills, but it also necessitates readjustment in the arenas of the family, work and the larger world. The research literature has shown that for many deafened adults, such readjustments are presumably not fully accomplished, since social isolation is a relatively common phenomenon among this group. Furthermore, considerable readjustment is also demanded of the family and friends of the deafened adult.

Fortunately, the incidence of total loss of hearing in adult life is rare. However the incidence of acquired hearing losses of varying severity is common in later adult life. Estimates of hearing loss in those aged 65 years or over suggest that as many as one in three may have some level of hearing loss. For many, such hearing loss may be the result of exposure to high levels of noise during their working lives. There is reason to believe that there are many adults in mid-life who have acquired noise induced hearing losses.

While such hearing losses do not necessitate the relearning of communication skills, research has shown that it can no longer participate in many previously enjoyed social events. Additionally, these acquired hearing losses are often not recognised by the individual. This often results in tensions in the persons relationships with family

and friends, because of misinterpretations of conversation.

Some recent research conducted among a sample of adults with acquired hearing losses has underlined the difficulties experienced both by themselves and their families. Over one third reported that they "frequently" missed out in family conversations while a further quarter reported that they "sometimes" missed out on this aspect of family life. Over one third reported being "upset" or "very upset" at missing out on these family conversations and a similar proportion reported that their hearing loss had negative effects on their marriage.

Frequent sources of stress reported by the other family members included having to "repeat things", having to have the volume of the television too loud for their own comfort, and the general difficulty of involving the person with acquired hearing loss in family "small talk".

The level of hearing disability can bring it's unique pressures. In childhood for example the level of hearing loss will have implications for both the parents and the child. Prelingual hearing losses place considerable demands on the resources of the parents to ensure that the child develops language competence. Mild undiagnosed hearing loss can lead to the child experiencing educational deficits, with attendant implications for the coping resources of the adult. However, given adequate levels of motivation, intelligence and educational input, the level of hearing loss may have only a small part to play in the development of the child to it's full potential. If the hearing disability, however leads to experiential and environmental deprivation during childhood and adolescence, it is this process rather than the hearing loss, per se, which can result in the failure of the person to develop both communicative competence and the more general and personal and social competences needed to function in an adult, hearing society. It is this failure which can render the adult more vulnerable to stress.

The second issue we would like to raise concerns the communication skills of the hearing disabled. For all of us the ability to communicate is an important and central aspect of our

lives. Among the hearing population difficulties in communication can be major sources of stress, particularly when trying to relate thoughts and feelings which are important to us. Our feelings of frustration and anger when we are misunderstood are evidence of this.

In terms of the stress perspective, we can say that being misunderstood can threaten our sense of identity. It is important to note, however, that communication not only involves expressive skills, such as our capacity to accurately express verbally and non-verbally what we mean, but also listening and comprehension skills. The latter are often overlooked.

In examining the role of communication among the hearing disabled, particularly in those who are profoundly or severely deaf, we must note that it is the knowledge of language that provides the basis for communication with both the hearing and non hearing populations. In this sense, knowledge of language can be seen as a basic resource for interacting and communicating with other people and as a coping



Richard Wynne, left, and Thomas Ronayne, guest speakers at the NAD Seminar in Portlaoise.

resource for dealing with everyday stresses.

Among those with no hearing disability, the vast bulk of communication involves speech, though non-verbal communication also plays an important role in many situations. For the hearing disabled the capacity to function and to feel com-

petent in the hearing world is a particularly important resource. The lack of this resource generates considerable stress for the hearing disabled when interaction with hearing people is desired or is necessary even when not desired. An indication of the stress caused by this is the fact that some hearing

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disabled withdraw from contact with the hearing world, or only make such contact as is absolutely necessary.

While we ourselves have had rather limited contact with those who are severely or profoundly deaf, it was evident from our contacts, from the questionnaires that others have returned to us, and from research in the area that those with good communication skills in the areas of lipreading and speech generally experience less stress in those situations where contact with the hearing world was desired or necessary. The basic lesson from this is that effort should be made to maximise the communication skills of the hearing disabled, and to provide them with general resources to cope with the difficulties that arise in communicating with hearing people.

There is no doubt that many of the hearing disabled find communication with the hearing world very stressful. Even among those who have achieved full acceptance of their disability, many find such communication to be difficult, tiring and liable to break down easily, or indeed fear that it may break down. For those who have less than fully accepted their disability, such communication is often minimal and is actively avoided by some.

Many of the difficulties of acceptance may relate back to their level of hearing disability and its associated visibility as an impairment. For those with limited hearing loss, acceptance is a more difficult state to achieve. However the benefits which accrue, both to the individual and to those around him or her, on acceptance of the disability are substantial. When the hearing impaired admit to themselves, and perhaps more importantly, to others the fact of their impairment, the process of acceptance of the disability is begun, not only in the individual but also in the people he or she meets.

The process of informing others, not only of the disability but also of the various communication needs of the hearing disabled leads to an improved understanding and ultimately increased consideration of the hearing disabled person. This can reduce the stress involved in communication both for the hearing disabled person and for the hearing person. This is especially important in the light of the low levels of

awareness among the general public of issues which affect the hearing disabled. Furthermore, this acceptance of the disability and its subsequent admission to the outside world, illustrates in a powerful way the usefulness of direct, problem-focussed modes of coping with problems. In addition, in this instance this type of coping has a social dimension to it: those around the hearing disabled person become actively involved in helping the person to cope with his or her disability.

Moving from the hearing disabled themselves to those in contact with them, an issue that arises concerns the impact of the process of diagnosis of hearing impairment on the parents of the child. A wide literature exists which documents parental reactions to the birth of a disabled child. Parents typically undergo a sequence of reactions which have been likened to the bereavement response. The stages of this sequence include shock at the initial event, followed by feelings of panic and uncertainty about one's ability to care for the child, followed by denial of the disability or even of the child itself followed by grief in response to this unwanted event.

During this bereavement-like process, a variety of more common stress responses occurs. These include loss of sleep, confused decision making, difficulties in interpersonal relationships and apportioning unfounded blame to oneself. While this sequence of reactions is perhaps an inevitable consequence of the diagnosis, its resolution in the form of acceptance of the child and his disability is a desired and important result.

While the birth of a disabled child is clearly traumatic for any family, the birth of a hearing disabled child presents additional difficulties and stresses. Unlike the child who is born with a visible physical or mental disability, a hearing impaired child appears to be normal at birth. (Unless there is a reason to suspect that the child is likely to have a hearing impairment at birth due for example, to the mother contracting rubella during pregnancy).

This apparent normality at birth and during the first months of life makes the eventual recognition and subsequent acceptance of a hearing disability all the more difficult a process for the parents to bear. In

effect, the apparent normality of the child during early infancy reinforces the parents desire to have a normal child. In many cases, a considerable length of time will have passed during which all family members will have regarded and interacted with the child as if no disability existed.

This desire to have a normal child allied to the ease with which the hearing disability can be denied has the possible consequence that early warning signs of hearing disability will be ignored and early diagnosis is thereby prevented. In many ways the diagnosis process itself can be an extremely stressful situation for the parents. The fact that a full diagnosis usually is not possible until the child has reached the age of seven months compounds the doubts which already exist in the parents minds. Furthermore, the Ewing tests, which are an apparently low-technology, but reliable method of diagnosis, can occasionally function to sow doubts in the parents minds as to the validity of the diagnosis. This occurs particularly where the parents are engaging in "shopping behaviour" with their child, and they have become aware of the apparently more scientific, high technology method of evoked potential audiometry.

In the United States research has shown that properly administered Ewing tests are more reliable than evoked potential audiometry. Unfortunately, a trend has been reported in this country towards administering the test individually, when strict practice requires joint administration by two people.

Once the hearing disability is recognised and diagnosed, however, the stress caused by the event would tend to exceed that caused by a disability which is visible at birth. In particular, the fact that accurate diagnosis is not possible until after the age of seven months, means that the process of acceptance of the disability by the parents is made more difficult. It is important to note that the acceptance of the disability on the part of the parents, especially the mother, forms the basis for the future development and wellbeing of both the child and the family.

Full acceptance of the child's disability is not achieved by all parents. This situation may be due to the initial high expectations of the parents concerning their child, or may be due to the psychological threat which the acceptance of a



Delegates enjoy a tea break during the NAD Seminar at Portlaoise.

disabled child in the family presents to the parents. It has been suggested that this failure to achieve full acceptance may be more common among parents from higher socio-economic backgrounds. This failure to accept the disability can be seen as an attempt on the part of the parents to cope with the stress of the situation by exercising unreasonable amounts of denial.

While the use of denial as a coping strategy is in some instances useful, it is important to distinguish those situations in which it has beneficial consequences from those in which it has negative consequences. In the case of a family with a hearing disabled child it may be beneficial to deny some of the implications of the disability for the child and the family (e.g. that the child will be inevitably unsuccessful in life or be continually dependent on the parents).

This may allow the development of a range of more positive and realistic aspirations for the child. Indeed it has been found that parental aspirations concerning the hearing impaired child is an important influence on their sense of self competence and ability. In other

words if a hearing impaired child is given the idea that he is inferior or is treated as being inferior, it is unlikely that he will acquire the attitudes, skills and knowledge that enable effective participation in society. Of course, unrealistically high expectations can be also be damaging. What is clearly damaging however, is the denial of the fact that the child has a hearing disability.

Another issue we want to raise concerns the achievement of social competence and autonomy among the hearing disabled. What we are essentially interested in here is the achievement of skills, knowledge and behaviours which allow people to manage themselves and their environments and to interact with the various arenas of the family, work and society in general.

A key period in every person's life occurs during late adolescence and early adulthood and involves the transitions from emotional and economical dependence on one's parents to independence in these areas of life. At a practical level there is the transition from the sheltered world of school to the world of work. It is also a period

during which we must develop the capacity to relate to the opposite sex, and to develop long term relationships.

It is recognised that this is a difficult and stressful period for many. The successful achievement of these various transitions requires adequate preparation in the home and school and access to a variety of formal and informal learning contexts which provide the individual with the opportunities to develop the skills and resources necessary for adult life. International studies have shown this period to have special relevance for the hearing disabled. Serious questions have been raised with regard to the adequacy of general social knowledge among the hearing disabled.

One of the possible causes of this deficit in social knowledge and competence is the restricted social experience which seems to characterise the hearing disabled. This restriction has the important consequence that both the general coping skills and resources required to meet the changing demands of life, and the specific coping skills required of the hearing disabled for

operating in hearing world can fail to develop sufficiently. The lack of these coping skills can in turn make many common situations stressful for the hearing disabled.

An issue related to the hearing disabled and the world of work concerns the preparation for and access to the world of work i.e. preparing for and actually getting a job. For many hearing disabled young adults this not alone involves the difficult process of going on training courses, attending interviews and hopefully starting work, but also involves directly confronting the hearing world. It is increasingly being recognised that people need guidance and support during this period. The necessity for this is all the greater given the shortage of jobs for young people.

It is important to recognise that the difficulties which arise in this area do not solely reside with the hearing disabled. Employers and workmates often show a lack of knowledge of the difficulties faced by the hearing disabled. An example in this context is in the lack of awareness among potential employers of particular requirements necessary to properly interview and, more generally, to relate to the hearing disabled.

A point that has been repeatedly made to us during our preparation for this paper is the difficulties and consequent stress experienced by those with hearing disabilities in their jobs. The sources of stress typically mentioned in this context included lack of promotion opportunities at work, the experience of social isolation at work, the lack of opportunities to use the skills they possess, and especially among the older hearing impaired the constant fear of being made redundant. The latter issue reflects the fact that there are rather limited employment opportunities available to those with hearing disabilities, a situation not helped by the current recession and the government embargo on public service employment.

We know from studies in the area of occupational stress that these very stressors can and do have quite marked effects on the long-term health and general wellbeing of individuals. Indeed, one of the sources of stress mentioned — the constant fear of being made redundant — has been shown to be especially stressful.

A final issue concerns attitudes and perceptions towards hearing disability and the hearing disabled. There are a number of strands to the research literature concerning these attitudes. The bulk of the literature examines the attitudes of the able-bodied population towards the disabled, though recently a number of studies have examined the attitudes of the disabled towards themselves and their disability. It should be noted that relatively little of this research concerns the hearing disabled in particular.

It is quite well established that the able-bodied have quite negative perceptions of the disabled in general. The disabled are often seen as being dependent, isolated, emotional unstable and socially inadequate. Consequently, they are often seen as being incapable of a range of so-called "normal" behaviours. These stereotypic views of the disabled are usually born from ignorance, since it has been shown that contact, especially genuine human interaction with the disabled by the able-bodied population, will break down these stereotypic views.

It has been argued that it is these stereotypic, negative views which constitute the major handicap of the disabled rather than their specific disability. Among the consequence of these stereotyped views is that they lead to limited and restricted ideas about what disabled people can do and also to limited expectations about the prospects for disabled people. One area in this context that has received attention in this country is the campaign by the National Rehabilitation Board to improve the employment prospects of the disabled by trying to break down any preconceived ideas employers may have about the disabled.

Research on attitudes towards the hearing disabled has shown that negative attitudes towards the deaf affect such things as their educational aspirations, socialisation, vocational ambitions and their work adjustment. These negative attitudes then, can be seen to increase the stressfulness of everyday life for the hearing disabled, not only in day to day interaction with the hearing world, but also in a structural way such that the hearing disabled do not have the opportunity to achieve their full potential.

Recently, there has been some research examining the attitudes of

the hearing disabled towards themselves and their disabilities. While this research was not as comprehensive as it might have been, it was found that while the hearing population held negative attitudes towards deafness, the deaf themselves had more negative attitudes towards their disability than the hearing population. Furthermore, the deaf believed the hearing population to have more negative attitudes towards deafness than they actually had. These negative attitudes concerned their ability to participate in a social life, their ability to integrate with the hearing world, and their communication problems, amongst others.

These negative attitudes contribute to low self-esteem among the hearing disabled. It has been suggested that the low self-esteem of hearing disabled may contribute to the low expectations of the hearing population. Perhaps more likely, however, is the possibility that the low expectations of the hearing world contribute largely to the negative self-evaluations and low self-esteem of the hearing disabled. These findings emphasise the need for real communication between the hearing disabled and the hearing populations if the needs of the hearing disabled are to be met.

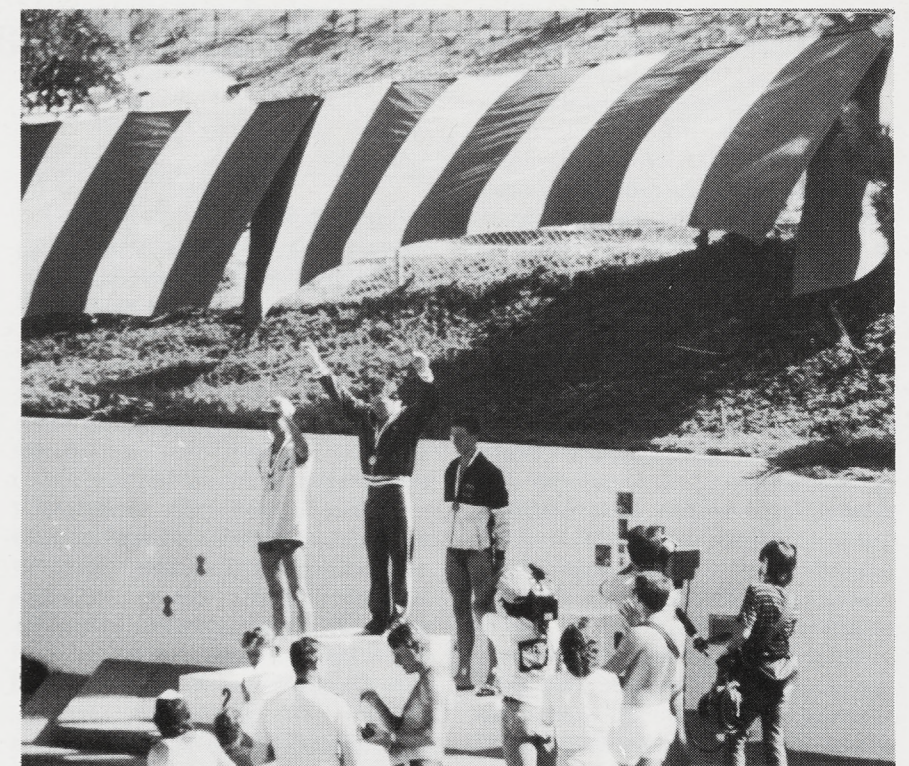
Conclusion

In our presentation we have started from the belief that nobody lives a stress free existence, and to a greater or lesser extent we all experience the effects of stress in our lives.

Today we are aware from research that has been undertaken on the effects of stress that these effects are quite widespread. In the short-term it can affect our sense of wellbeing, while in the long term it can have serious effects on our physical and mental health. While little direct research has been carried out examining the sources and effects of stress specifically among the hearing disabled — an area where much more research needs to be done — it is clear that the stress perspective can be useful in understanding some of the problems associated with hearing disability.

While there are numerous areas of stress in peoples' lives and, no doubt, numerous sources specific to the experience of being hearing disabled, we have concentrated on

six areas where stress might potentially arise. We see the value of the stress perspective as focussing on the relationships between the person, the environment and coping responses. Through focussing on these it is possible to examine potential solutions to problems. Generally, these can consist of changing the environment in order to remove sources of problems or stress, (e.g. ensuring that there are sufficient jobs available for the hearing disabled and increasing public awareness of the needs of the hearing disabled), increasing the personal and social resources (e.g. providing specific pre-employment and general life skills training) improving our coping skills (e.g. by learning how to relax in the face of stress, by altering our views of the meaning of a stressor, by developing our problem-solving skills). We feel that this way of looking at problems and ways of coping can lead to short and longer term improvements in wellbeing and quality of life for the hearing disabled.



Alan Turner holds his hands high in triumph after he received Ireland's first gold medal in Loss Angeles.



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Problem of hearing impairment among elderly

The advances in nutrition, sanitation, and medicine that enable us to live longer have as yet not defended us against one of the most prevalent disabilities associated with senescence — hearing impairment. Indeed, as our life span has increased, it appears to have done so at the expense of our hearing ability. The sensitive end organ that keeps us in auditory contact with the environment suffers disproportionately from the innumerable daily assaults upon it. These accumulate, and as the years advance, hearing ability declines.

Hearing impairment is the single most prevalent chronic physical disability in the United States and probably in most nations with mature populations. Of persons over 64 years of age, four of every 10 suffer a significant impairment of hearing. Among elderly persons living in nursing homes, nine in 10 have significant hearing problems. The prevalence rate for hearing impairment is expected to increase, with nearly six in 10 persons over 64 years of age being affected by the year 2050. These rates will, of course, differ somewhat from country to country, but the basic finding remains: the correlation between hearing impairment and age is clear and startling in its strength.

For the majority of the people represented by these numbers, their hearing impairment became significant late in life. The effects of late-occurring hearing impairments differ greatly from those occurring at birth or in childhood. Both the early and late deafened individuals face problems peculiar to senescence, but the nature of their problems is dissimilar. Early deafened people generally do not have the same disruptions within their community life as do those deafened late, because their adjustment to ageing is not complicated by the onset of hearing impairment. There are further differences that justify addressing ageing in the two groups separately.

Granted that hearing impairment is epidemic among elderly people, how are their lives affected by it? In responding to that question, the first

BY JEROME D. SCHEIN
PhD, FAPA, Professor of Deafness Rehabilitation and Director of Deafness Research and Training Centre, New York University

thought is about *communication*. Persons unable to hear often do not co-operate effectively in their own care, becoming passive recipients of external controls. Unquestioning acceptance of medicine, food, or whatever from others becomes habitual, because raising questions provokes unheard answers that merely frustrate hearing-impaired persons.

With reduced or absent ability to communicate often comes withdrawal from social contacts and loss of zest for life. Even the simple joys of mass entertainment — radio, television, films, concerts and theatre — pall. But focusing on the obvious communication impediments of hearing loss does not expose fully its psychological impact. There is more.

Hearing serves a *signalling* function, warning us of danger and alerting us to approaching threats; a honking horn or a whistling kettle. Similarly, not hearing cheerful sounds that herald pleasant thoughts lowers the joyful tone of the environment.

Sounds also provide a background that *orients* us. The onset of morning traffic noises defines the time to arise for city dwellers just as evening quiet prepares them for sleep. To some extent, we pace ourselves in accordance with sounds that are not at conscious level, working faster or slower in response to background rhythms. Music accompanying a film clearly influences our mood; crowd noises or crickets chirping, thunder or tinkling silver bells can set the scene for city or country drama or for ominous or spiritually uplifting events. What we hear provides us with a delicate spicing of life; a soupçon of this or a pinch of that sound can change our perceptions dramatically.

Newly deafened veterans of World War II complained most that their environment had become

'dead'. What they said they missed was the continuous sonic array, not the specific deprivation of communication. Whether that applies to elderly people who are deafened has not received the study it deserves. But regardless of age, the auditory process is hierarchical, ranging from primitive background to sophisticated communication functions. Most scientific attention to hearing impairment has been focused on its interference with communication, even though hearing impairment disturbs more than that. Indeed its non-communication aspects probably contribute heavily to its emotional impact.

Reaction to a loss, whether of a loved one or of a physical ability, follows a course that appears to differ only in the length of time and degree of reaction. From shock, people typically move through stages of denial, then anger, to some level of adjustment. (Early deafened people who become elderly adjust at much younger ages.) The rehabilitation specialist assigned to work with newly deafened elderly persons must not overlook these stages in planning for individual treatment. Psychological readiness to undertake a rehabilitation programme needs to be developed before the programme begins, else it is more apt to fail than succeed. That is why counselling is so vital.

Treatment in the form of electronic amplification has not been satisfactory to large numbers of the elderly. A major factor appears to be the site of lesion. As it moves from peripheral to central the success rates fall from 94 per cent to 6 per cent. Other factors — ecologic, social, economic, emotional — deserve much more research than they have been given up to now. Even small changes in the engineering of aids can improve their usefulness; for example, designing switches that are amenable to manipulation by arthritic fingers.

The cochlear implant may one day find a stable place in treatment of hearing impairment. In its present configuration, however, it does not offer sufficient benefit relative to its high cost for many elderly people.

Counselling, which is basic to rehabilitation procedures, is often woefully lacking in management of elderly persons' hearing losses. Carefully structured, professionally managed programmes of audiologic rehabilitation — group and individual — represent a critical component in the treatment of geriatric hearing losses.

In the United States, the self-help movement has been gaining substantial momentum with the emergence of a variety of local and national groups. Largely made up of late-deafened people, these organisations focus on accessing major societal events. They have lobbied for infrared and loop systems that enable hearing-impaired people to enjoy theatrical performances and to participate in meetings and in settings where there is a great deal of competing noise. Most of all, these self-help groups provide peer counselling, both formal and informal. The need for this support has been underestimated. Too little recognition has been given to hearing impairment's disruption of the elderly person's social life. Groups like Self Help for

Hard of Hearing People (with its delightful acronym, SHHH) have experienced rapid accretion to their membership in the few years they have been in existence, demonstrating their attraction for hearing-impaired elderly people.

One of the old, well-established programmes for retired deaf persons was started by graduates of the Ohio School for the Deaf about 90 years ago. These early deafened people built a retirement home that has now grown into an apartment complex, a nursing home, and a special facility for those who are deaf and blind.

Unfortunately, such efforts are unusual in the States. The deaf community has been energetic in creating organisations to manage their own affairs, like the National Fraternal Society of the Deaf, a highly successful insurance company built in response to prejudices against deaf applicants for life insurance. Yet the deaf community shows little zeal to provide for its elderly members' needs.

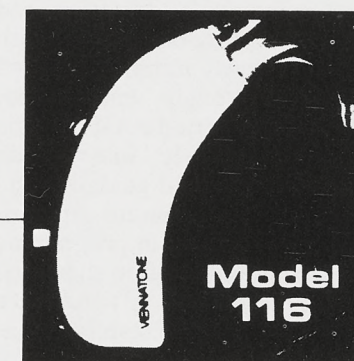
Perhaps at some point in the near future, early and late deafened people will join together and work for those things that are important to

both. As of now, however, the two groups have not found common ground, and there is almost no communication between them.

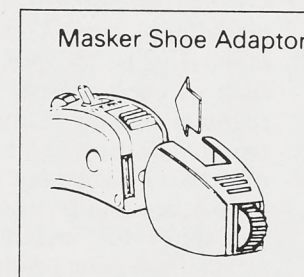
Throughout this article, I have been careful not to say that ageing *causes* hearing impairment. Simply becoming older does not necessarily mean one must lose hearing sensitivity. The two events are correlated without a doubt. But that association may be the result of another cause or causes related to both. Indeed, the point of view I regard as most plausible at this time is that a large proportion of the hearing impairment seen in elderly people reflects the summation of a variety of injuries to the auditory system over the years — injuries from noise, illnesses, air pollutants, drugs, accidents, diet, and possibly other causes as yet unidentified. This view rejects Time alone as the villain in the decline of sensory functions, until it can be indicated by other than circumstantial evidence. To those of us holding this optimistic position, prevention becomes a critical matter. Emphasis shifts from palliation in later years to modifying life styles in youth.

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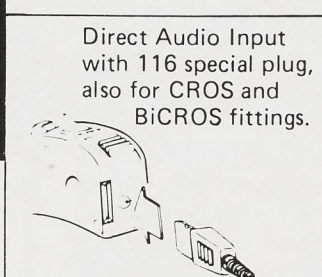
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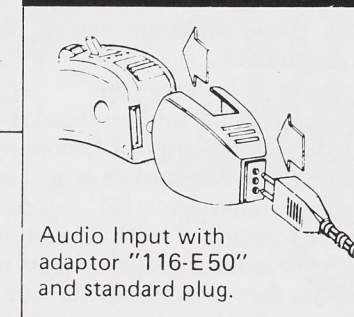


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Prevention should be our primary concern in facing the difficulties that hearing impairment impose on people of all ages. For elderly people, protecting what hearing they have — and some have excellent hearing ability — should be a major goal, for the severe consequences of impaired hearing have often been underestimated. Hearing is, for the majority of the population, integral to their lives. Failing to care for it means risking a major share of their productive capacity.

An apocryphal story has a young man brashly approaching Sir Bertrand Russell on his eightieth birthday and inquiring about his health. The octogenarian replied with his characteristic wit, 'If I had known I would live this long, I would have taken better care of myself!'

Demographers now promise average citizens increasingly long lives.

Alternative approaches on education — UNESCO Report

The final report of a UNESCO Consultation on Alternative Approaches for the Education of the Deaf, held June 18-22, 1984 in Paris, has been issued. Twelve specialists representing all regions participated, together with observers from non-governmental organisations. The purpose of the meeting was to advise UNESCO on priorities in the field of education of deaf people in the next decade. The meeting was asked to focus discussions on solutions or alternative strategies applicable to countries with limited resources.

As a background to the discussions, participants from developing countries were asked to outline the most pressing needs. They stressed: (1) the low status accorded to special education, (2) lack of co-ordination and sharing of resources among services and facilities, (3) lack of information flow on new trends and approaches, (4) lack of technical equipment for deaf people and associated problems of maintenance and replacement of parts, (5) need for on-going education of teachers (6) multilingualism within countries, (7) sign language imported to the detriment of national sign language and (8) the promotion of awareness of the needs of deaf children leads to an increase

in demand for services which are already severely strained. It behoves them to take better care of themselves. Those already deaf should take measures to protect other functions, especially vision. One of the ominous trends recently observed in the United States is the growth of the deaf-blind population. Previously thought to be relatively insignificant — in numbers, not in severity of the syndrome — deaf-blindness now appears to be much more prevalent than previously estimated.

The current prevalence rate in the US depends upon the definition used. The most conservative definition yields a rate of 20 per 100,000; the most liberal definition, 346 per 100,000! Even based upon the lowest rate, the US has about 50,000 deaf-blind persons, the largest share of them being 65 years of age and older. It should be sobering to reflect that every blind person and

every deaf person is halfway to becoming a deaf-blind person.

Hearing impairment is so great a problem amongst the elderly population that I am loath to leave this brief discussion without another few words. They are not mine; they were spoken recently to a symposium in the United States by The Right Honourable Jack Ashley, CH, MP. He described a programme of recommended actions to serve elderly hearing-impaired people, and concluded: 'But when the programme is achieved, the future of deaf people will be in the right hands. It will be in their own hands. They can then free themselves from patronage, discrimination and dependency, and fulfil their potentialities. That should be the aim, and the aspiration of every one of us.'

Reproduced from "Soundbarrier"

There were a number of practical suggestions for the future developed by the meeting and a summary follows.

Concerning early detection and intervention in collaboration with parents: (1) early detection, which should be strongly encouraged, should only be carried out if it can be coupled with early intervention services; (2) parental guidance and the promotion of parent organisation and their roles in programme support and collaboration should be a high priority; and (3) guidance centres should be established as meeting and training sites for parents, deaf children and other family members.

Regarding language and methods, (1) deaf children should be given the opportunity of becoming competent both in spoken language and sign language; (2) parents should be provided with education about different language systems in order that they can choose the mode of communication best suited to their environment and child's capabilities, for example: sign language, bilingualism, combination of methods such as sign language + cued speech + oral language; and (3) parents and

teachers should be encouraged to adopt a natural pattern of communication with deaf children as this will accelerate language learning, ease the school curriculum and enrich its content. Regarding international co-operation, the participants requested that UNESCO provide leadership in the following areas: (1) support national identification and development of sign language systems in co-operation with the World Federation of the Deaf, (2) guidelines for development of manual aids to spoken language such as cued speech, (3) establish regional training centres, (4) international sharing of information and materials on language development techniques and instruction, (4) guidelines for including disability aspects in regular teacher training to facilitate integration, (4) encourage initiatives to bridge the gap between technical knowledge and the high cost of hearing aids and equipment and (5) every effort should be made to assist developing countries acquire the basic equipment needed for identification, diagnosis and residual hearing utilization.

Copies of the report are available from the Special Education Program, UNESCO, 7 place de Fontenoy, 75700 Paris, France.

NAD's new secretary



The NAD has a new National Secretary Jacintha Sheils who joins us on the departure of Sylvia Hand.

Ever efficient and courteous Sylvia made a lot of friends in the world of the deaf and all will wish her joy and happiness in her new life in Germany.

Introduction to Deaf Studies

The University of Ulster under its Adult and Continuing Education Short Course Programme will present an Introduction to Deaf Studies on Wednesdays, 10 a.m. to 4 p.m., from 8th January to 19th March 1986.

The course is an introduction to the causes and treatment of pre-lingual and acquired deafness; the problems of hearing loss and their repercussions in infancy, childhood, adolescence, adulthood and old age.

Full details from Mrs Faith Gibon, Senior Lecturer, Department of Applied Social Studies, University of Ulster, Cromore Rd., Coleraine, Co. Derry. (Closing date for enrolment in 2nd December 1985.)

The tenth Congress of the World Federation of the Deaf takes place in Helsinki, Finland, July 1987.

Information: Kuurohen Liito ry Liisa Kaupinen, P. O. Box SF-02211 Espoo, Finland.

The 18th Congress of the International Society of Audiology, is at Prague, Czechoslovakia, 1986.

Information: Prof. K. Sedlacek, Foniatricka Laborator, University Karlovy, Zitna 24, 00 Prague 2, Czechoslovakia.

The Annual Conference of International Federation of Hard of Hearing will take place at Vancouver, Canada, 1986.

Information: H. Hartmann, Pirolkamp 18, D-2000 Hamburg 65, Federal Republic of Germany.

Let us know

If you have any problems regarding the services for the deaf please notify your local National Association for the Deaf Branch or write direct to the Secretary, NAD at 25 Lower Leeson Street, Dublin 2.

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Guide to Branches and Clubs for the Deaf

Ballina: Chairman, P. J. Loftus, Hon. Sec. Mrs. Catherine O'Hara, Carrowcarden, Enniscrone.

Ballinasloe: Midlands Deaf Club, Society Street. Hon Sec., Peter Price. Club meets Wednesday evenings 7.30 to 11 p.m. and on third Sunday of each month 3 to 11 p.m. in Ballinasloe Town Hall.

Carlow: Chairman, Mrs. Angela Dunne, Secretary, Mrs. Joan Corcoran, Ballybromhill, Fenagh.

Cavan: Hon. Sec., Rev. Fr. D. O'Dowd, C.C., The Presbytery, Cavan Cathedral, Cavan.

Clare: Hon. Sec., Noel Ball, 65 Hermitage Road, Ennis, Deaf Club, Ennis Vocational School. Open every Wednesday and last Sunday of each month.

Cork: St. Catherine's Club for the Deaf, 5 MacCurtain St., (021-505944). Open Tuesdays, Thursdays, Sundays. 8 p.m.-11 p.m.

Donegal: Chairman Father J. Shiels, Hon. Sec., M. B. Finn, 'San Antonio, Admiran, Stranorlar

Galway: President, Mrs. M. Monaghan, Chairman, Pascal McDauid, Sec., Niall Kearns, Barna Road, Ballymoney, Treas., Paul Rowan. Club meets every Wednesday 8 p.m. at Seaman's Club, Galway. Hon. Sec., Deaf Club, Martin Conroy.

Kerry: President, Larry White, Chairman, Fr. S. Cunningham, O.P., Vice-Chairman, Mrs Ann O'Dowd; Sec., Mrs Kitty Enright.

Alderwood Rd., Tralee. Treasurer: Kevin Sweeney. Club at Social Service Centre, Tralee. Open Wed. and Fri. 8 to 11 p.m. and Sun. 3 to 6 p.m. and 7 to 11 p.m.

Kilkenny: Hon. Sec., Miss Helen Landers, Lawcus, Stonyford, Co. Kilkenny (056-72777). Meetings held first Monday each month at Metropole Hotel, Kilkenny.

Kildare: Hon. Sec., Mrs. Joan Quinn, 83 Woodlands, Naas. Club meets Chandelier Room, Manor Inn, Naas, first Friday each month 8 to 11.15 p.m.

Laois: President, Michael Morrissey; Chairman, Matt Coss; Vice-Chairman; Mrs. Josephine Phelan; Treasurer, Mrs. Maeve Jacob; Vice-Treasurer, Mrs. Kathleen Morrissey; Hon. Secretary, Eileen Quinn, Main Street, Abbeyleix. Ast. Hon. Sec. Mrs. Patty Donnellan, P.R.O., Ben McEvoy; Interpreter, Reggie Carroll.

Limerick: Hon. Sec., Mrs. N. Condon, Caherdavin, Limerick, Club Chairman and Hon. Sec., Gerald Ledger, 2 Castle Street, Limerick.

Listowel: Hon. Sec., T. P. Enright, Asdee, Listowel.

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Louth: Sec: Mrs Bernadette Mullen, Greenview, Kilkierley, Dundalk, Hon. Treas., Mrs Dolores McElroy.

Mayo: Chairman, P. J. Loftus, Vice-Chairman, Mrs. P. Tolan, Sec., Mrs. Mary O'Neill, Station Road, Foxford (094-56186), Treas., Mrs. Smith.

Meath: Hon. Sec., Mrs. F. Traynor, Dunmore, Navan.

North Tipperary: (Meetings held at Muintir na Tire Hall, Thurles). Hon. Sec., Miss Jane Hanafin, Corner House, Parnell St., Thurles.

Roscommon: Hon. Sec., Mrs. Conama, Ballintubber, Castlereagh.

Sligo: Chairman, P. Kearns, Carraroe, Sligo.

Sth. Tipperary: Chairman, Mrs. Maureen Finn, Hon. Sec., Rev. Sister M. Aloysius, Presentation Convent, Clonmel, Treasurer, Mrs. Ena Sullivan. Club meets third Sunday of month in St. Mary's Parochial Hall Clonmel.

Waterford: Hon. Sec. Mrs Margaret Burke, Ceannt Rd., Waterford. Club meets weekly on Wednesdays.

Westmeath: Hon. Sec., Sean Markham, Drummond, Castlepollard. Midland Deaf Club meet at Dr. Dobb's Memorial Hall, Athlone on Wednesdays 7.30-11.00 except first Wednesday of each month.

Westport: Hon. Sec., Mrs. M. Callaghan, Cloonshill, Newport.

Wexford: Hon. Sec., Mrs. Margaret Bennet, (PPN), Ballybanogue, Edermine, Enniscorthy. Deaf Youth Club meets, St. Senan's Community Centre, Enniscorthy. Contact Fr. F. Barron (054-34169).

OUR BOARD OF DIRECTORS

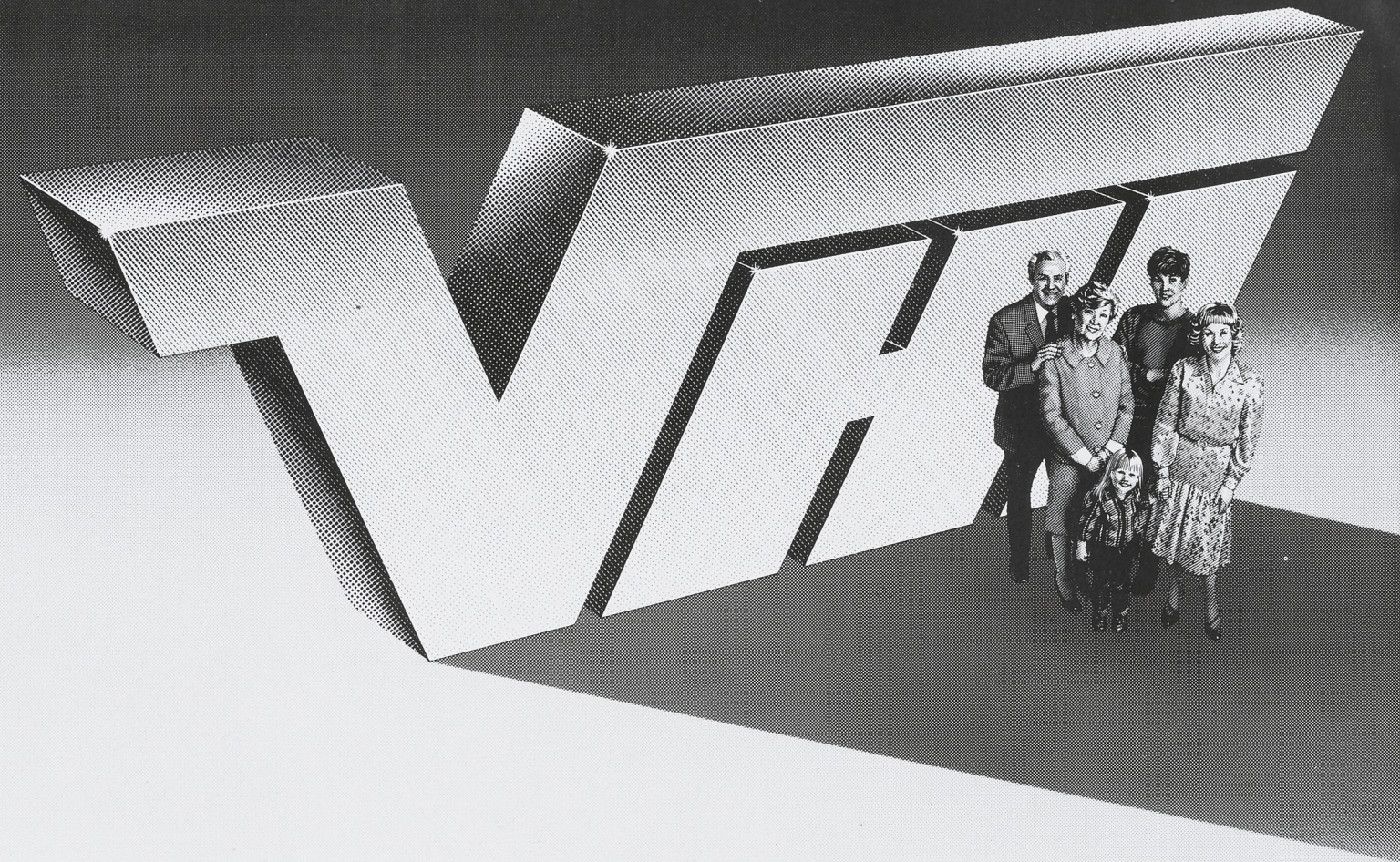
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NAD Membership includes free copies of LINK — official magazine of NAD, other publications, notifications of lectures, social events, etc.

Please enter my name on the Register of Members in accordance with the Memorandum and Articles of Association.

I enclose £3.00 for Annual Membership or £30.00 for Life Membership.

Signature

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Date

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Please pay immediately the sum of at the Allied Irish Bank Ltd., 1-3 Lr. Baggot Street, Dublin 2. Credit the National Association for the Deaf, 25 Lr. Leeson Street, Dublin 2, and the same sum each year on the 31st day of December.

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VHI House, 20 Lower Abbey Street, Dublin 1. Tel: (01) 724499. Telex: 32991. Cork VHI House, 70 South Mall. Tel: (021) 504188. Dun Laoire 35/36 Lower George's Street. Tel: (01) 800306. Galway Ross House, Victoria Place. Tel: (091) 63715. Limerick 62 O'Connell Street. Tel: (061) 316122.

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