

HABILITATION OF THE DEAF ADULT

by
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In September of 1968, the Bill Wilkerson Hearing and Speech Center had the opportunity to participate in a comprehensive program of habilitation for the deaf adult. In brief summary, the Tennessee Division of Vocational Rehabilitation has coordinated for the broad spectrum of habilitative services, from communication skills through vocational training and placement, required by the deaf adult before he can become a contributing member of a community. While the total habilitation schema is worthy of description, the current discussion will be limited to the phase of services dealing with the development of communication skills.

The therapeutic problem faced by the Wilkerson Center was relatively dramatic. The choice of the word "habilitation", above, was premeditated. The Vocational Rehabilitation clients referred to the center had, as a common denominator, an almost total lack of language. The ages of the six ranged from 24-38 years. Each was unemployed, unemployable, and deficient in language to the extent that Vocational Rehabilitation was unable to assess their vocational potential. Unfortunately, they represented the failures of conventional deaf education, or were the result of no educational exposure. The problem called for the application of a flexible and, as will be seen, relatively unconventional approach to aural rehabilitation.

The immediate therapeutic goals became 1) the development of sufficient language to permit vocational evaluation, and 2) the development of sufficient communication ability to permit each member of the group to move about the normal hearing community without excessive difficulty. In September of 1968 a twice weekly, two hour class was begun under the sponsorship of Vocational Rehabilitation. Prior to that all members of the class were evaluated at the Center, were fitted with hearing aids and introduced to their use and management. The next steps were directed toward language acquisition, lip reading, and auditory training.

Audiologists are well aware of the problems faced in the initial evaluations of these patients. Speech audiometry was a practical impossibility. In reviewing the cases prior

to scheduling for therapy, it became clear that the initial phases of therapy would have to be conducted through signs. The Center staff, fortunately, includes a teacher of the deaf whose experience has provided her with a reasonable degree of proficiency with both the manual alphabet and the sign language. Of necessity, the classes began with manual communication concomitant with speech. While manual techniques are being employed, auditory training and lipreading are not relegated to a secondary role. Such training is initiated as soon as practical and is used whenever practical. Beginning with the development of vocabulary, which introduced the class to reading and writing, language structure was taught. Such fundamental concepts as, who, what, where, and when, required attention. With the introduction of noun, verb, adjective, and adverb classifications, sentence structure was taught. It may be of interest to note that the group had no awareness of the difference between a statement and a question.

Throughout the course of instruction, adjustment of the curriculum has been required to meet additional needs which arose. With the emerging awareness of language, vocalization increased and attempts at speech required the introduction of speech training. When the teacher became aware of the group's inability to handle money, basic arithmetic was introduced. The relative social isolation in which the group had lived led to the inclusion of basic standards of behavior, personal hygiene, and dress into the sequence of topics covered in class. The inclusion of such topics does not imply that the nature of the course was significantly altered. Rather, it reflects the conviction that the unhabilitated deaf adult is in need of complex matrix of services, some of which are normally beyond the scope of conventional approaches. Further, it reflects the broader ranges of services which were implied in the earlier statement of therapeutic goals and the flexibility of approach needed to attain those goals.

In evaluating the progress made since the class began, several observations are heartening. All but one of the class members now have specific vocational objectives. Each member is observably more proficient in interacting with both his peers and with the normal hearing community. Each member of the class has begun to communicate both by writing and by rudimentary speech.

Aside from the discernible improvements mentioned above, two additional observations are worthy of note. First, it is clear that the teacher's ability to sign and fingerspell

materially increased the effectiveness of the program. The ability to provide relatively clear and unambiguous instructions greatly facilitated the effective use of class time and the efficiency with which the class could focus on the lipreading and auditory training sessions. Second, it was noted that the grouping of patients into a class provided benefits beyond the more efficient use of the teacher's time. Each member of the class had come from a socially isolated background, the vast majority of his social contacts having been with his immediate family. The group situation provided an unthreatening atmosphere in which to develop and test the ability to interact with other people.

In summary, this program has demonstrated that manual communication is an invaluable device by which the development of aural communication may be facilitated. It permits the initial establishment of interaction with the patients which, in turn, can be expanded to include aural communication. The importance of this ability to come to intellectual grips with the patient seems to have been relatively ignored by the vast majority of hearing clinic programs. That assertion was vividly confirmed at the recent (April 13-16, 1968) workshop on community services for the deaf in Dallas, Texas, sponsored by the National Association of Hearing and Speech Agencies. The workshop was unusual in that the participants included not only representatives of vocational rehabilitation agencies and hearing and speech agencies, but also each of the participating centers' teams included a representative of the deaf community. The reiterated plea at that workshop was that individuals proficient in manual communication be included in the rehabilitative team.

The second point has been that a hearing center does not have available the ranges of therapeutic services necessary for effective rehabilitation. Some more broadly based agency, such as Vocational Rehabilitation, must provide the overall guidance and management needed to insure that all the services required for effective habilitation are implemented.