A PERSONAL THEORY OF COUNSELING

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INTRODUCTION

It so happens that my lifestyle is inextricably interwined with deafness and deaf people, personally, socially and professionally. Hence, I feel most comfortable in undertaking the task of writing a personal theory of counseling and in limiting it to the area in which I function.

THE NATURE OF MAN

1. I believe that man is a rational being who, given sufficient information about his own psychological, sociological, cultural, biological (that is, total environmental) development, will be able to make those choices which will enable him to achieve a satisfactory adjustment.
2. A man may guide his own destiny only to the extent that he is conscious of the forces and controls at work upon his life, and resists them with determination to achieve a goal in opposition to those forces. His brain is capable of learning new behavior, of independent thought, of intuitive "leaps to new levels" which cannot be ascribed directly to learned behavior.
3. I believe that if man does not have the perception to understand himself, then he will be easily manipulated and his behavior controlled by the dominant forces in his life.
4. I believe that people who are handicapped by deafness develop certain perceptual differences. That is, they perceive the world

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somewhat differently than the person who has normal hearing. Sound gives meaning to events that influence development of the organism, i.e., the stimulus-response chain is interrupted and behavior is thereby affected.

5. Man as handicapped by deafness has the same psychological needs as the normally hearing person: Love, esteem, acceptance, social contact–indeed, the same hierarchy of needs as defined by Maslow.
6. Man is a social being. His healthy adjustment to his particular environment will be directly proportional to his meaningful and satisfying contacts with other people.

HUMAN GROWTH AND DEVELOPMENT

1. Behavior is learned. The earliest behavior arises from the satisfaction or frustration of biological (physical) needs, such as for survival. For example, a newborn baby responds to environmental change (warmth, cold, noise) with a startle response, or cries, either of which may be natural (unlearned) organismic behavior, but the stimulus-response behavior pattern is quickly established by the reinforcement received (the noise stops, or the wet diaper is changed). In other words, in accepting behavior that is biologically based, I feel that all subsequent behavior is learned.
2. Heredity is chiefly a biological-genetic function; the traits that may affect behavior would be only those which limit the organism or confer special qualities. For example, the tendency to mental retardation may run in a family; there may be genetic deafness; or a family may be blessed with a long "line" of physically beautiful persons (sometimes the result of selective human breeding). Those qualities may affect the ability of the person to learn appropriate behavior.
3. Normal behavior–or what we can call normal behavior in our particular culture–develops in an environment that is controlled. The physical-biological needs of the developing person are carefully controlled so that the necessities of survival are omnipresent–food, warmth, shelter, love, acceptance, protection from threat or danger, and *constant communication.* I am personally dismayed that so many theorists seem to overlook the vitality of the mechanics of communication; they seem to *assume* that it is present, and give it attention only when it breaks down in the counseling interview.
   a. Normal development in a deaf person takes a different slant. There is now evidence to indicate that the deaf child of deaf parents (and who thus has adequate communicative skills as a result of constant usage of visual modes–sign language and the

manual alphabet, pantomime, and body language) develops better adjustment and better achievement than the deaf child of hearing parents who lack this basic communication.

b. Abnormal development or behavior in a deaf child is frequently if not always learned as a result of the frustration arising from the breakdown of meaningful communication with the parents—excepting, of course, pathological conditions with organic bases, such as brain dysfunction. As a practicing counselor, I meet many instances of behavioral problems in my clients which can be traced directly to parental ignorance of the need for clear, meaningful, adequate and visual communication; and these problems are, with rare exceptions, the deaf-child/hearing-parent relationships, not those of the deaf-child/deaf-parent. This is confirmed by psychiatrists with whom I have worked at the University of Utah Medical School, and by other psychiatrists in clinics in various parts of the country.

Abnormal behavior that arises in the parent-child relationship carries over into school, where teachers, supervisors and administrators who may be of one particular philosophy enforce it to extremes, continuing the vicious circle of stimulus/response/reinforcement.

While it is dangerous to generalize, and while I realize that I am more or less the product of my own experiences, education and training, I feel that the most powerful influence in the shaping of behavior, whether normal or abnormal, is that of the parents and their particular culture or lifestyle. Subsequent environmental influences will, of course, affect behavior, but the previously established behavior patterns affect perceptions, which guide one's actions.

THE GOALS OF THERAPY

In presenting my personal goals of therapy, I must agree with other rehabilitation counselors in general in their perception of their roles, but differ in specific ways because of the peculiar nature of counseling deaf people.

Therapists capable of working with deaf persons are rare; in all of the United States there are perhaps ten or twelve psychiatrists and psychologists who are sufficiently skilled in the American Sign Language to understand and be understood by deaf people. Thus, with no professional help available, the rehabilitation counselor with the special deaf caseload is called upon to do "everything." A redeeming feature is that the special caseloads are permitted to be smaller since deaf people take longer to rehabilitate, longer to talk with, longer to find, and require more travel by the counselor since most do not have telephones.

With this background, I make the following distinctions:

Goals of therapy apply to those in need of such therapy, and not just to any client who appears before the counselor.

Goals of rehabilitation *may* include therapy, but in general are aimed at vocational objectives; i.e., there is a difference between *vocational* rehabilitation and *behavioral* rehabilitation or change.

This particular section will deal only with the goals of therapy, and not with those of rehabilitation, although there may be some unavoidable overlapping.

1. Because deaf people usually present a severely limited experiential perception of life (especially those youths fresh from school, or from an institution) I believe in actively helping an individual determine what his own goals will be. *My goal* will be to help him develop a realistic and attainable goal. I will help him set his goals high enough to be an interesting challenge, but not so high that he will become discouraged and fail. Thus, if he wishes to change from a spoiled brat (and *if he knows* he is a spoiled brat) to a paragon of virtue, I will stress the reality of the here and now, where there are few paragons but many people who are reasonable facsimiles, and help him understand the influences that shaped his behavior, and behavior that would be more mature and appropriate for his particular lifestyle. If he sets a goal that I believe is unrealistic, I will tell him so and why I feel that way, but do so in a non-threatening and noncritical way. . . .but I will also make it plain to him that those are *my feelings,* and not necessarily his, and he does not have to give in to me.

2. On the other hand; if the client happens to be a highly intelligent and literate deaf person whose education and experience are such that he can grasp concepts and abstractions, then my goal again would be to assist him in setting his own goal of therapy but I would not be strongly directive. Rather, I would attempt to make conditions conducive for development of understanding between us; non-threatening, warm, friendly, and accepting with the basic idea being Rogerian in approach to unconditional positive regard. I would attempt to develop an understanding of the individual's lifestyle, so that I could assist him in bringing his experience and perceptions into congruence. In short, help him face reality through his experience, and trust his experience and inner organismic reactions instead of inappropriate learned behavior.

Hence, my chief goal will be to assist each individual to learn to function within his particular culture or environment in a manner that is acceptable to those with whom he must work and socialize.

CHARACTERISTICS OF THE CLIENT

Deaf clients bring a widely varying assortment of social, psychological, physical and educational problems into the counseling situation. It is impossible to categorize behavioral expectations of them. In general, however, I would expect them to realize that they are in therapy for a particular reason—they need it or they would not be there—whether voluntarily or involuntarily. Most would be cooperative; however, those who demonstrate paranoia and schizophrenia of long-standing, or of developing status, are unpredictable. Deafness complicates their perceptions, and all too often leads to transference of their fixations to the counselor, putting just about an impossible burden on him in terms of the time he has available for the therapeutic relationship.

Some clients will be incredibly naive, ridiculously easy to influence or manipulate, wide open to suggestion—thereby putting the counselor in the position, occasionally, of playing God. If play God I must, then I try to do so with maximum restraint and understanding.

CHARACTERISTICS OF THE COUNSELOR

In dealing with deafness, I believe strongly that the counselor should have a deaf parent, preferably both parents being deaf. Only thus can he develop a deep understanding of the impact of deafness on the psychology, personality, and lifestyle of the deaf person. This is, of course, an idea; there are many such persons (I have three of them working with me!) but not all agencies are so fortunate. Another ideal person will be deaf himself; he will bring to the counseling situation unique understanding.

Educational considerations should be that at least the counselor should have a bachelor's degree in psychology, sociology, or the liberal arts. Advanced work in psychology is a requisite if one is to engage in psychotherapy—particularly if one is to work within agencies where stress is upon degrees—with deaf people. (Note: The attorney general of Utah recently ruled that only a psychiatrist may practice psychotherapy in Utah.) A counselor who possesses a master's degree may have adequate skill for the helping professions, and indeed may learn by practical experience over a period of time what doctoral students take intensive study to learn. But as a practical matter, the counselor who possesses the doctorate will achieve status and prestige (skill, of course, is to be *hoped* for!) and *possibly* the confidence of the client.

The counselor with deaf people will find that the various approaches to counseling put too much stress upon "intelligent" clients, assuming they have the normal language development of hearing people. Yet deaf

people as a whole have such a low reading achievement that we get into serious difficulty with cognitive approaches. It is my feeling that the directive approaches may be somewhat more effective with the low-verbal deaf person, and the nondirective (Rogerian) better with the more literate class of clients.

I would expect a counselor to be open and friendly, and accepting of deaf people regardless of their other handicaps. An aggressive person would be a poor counselor with deaf people, since they are acutely sensitive to attitudes (deaf people with low verbal functioning skills frequently are quite resentful of "college educated" persons who demonstrate by attitude or manner their "superiority.").

THERAPEUTIC METHODS

1. The therapist must agree to see the client regularly, and the client to attend regularly.
2. The therapist will take a detailed history from the client (and from other sources if available) and be alert to strong behavior-shaping influences.
3. The client must accept and cooperate in the process.
4. There must develop between the counselor and the client a mutual respect, trust and openness.
5. The counselor must accept and expect some aggression on the part of the client as he touches upon sensitive feelings, but must never react in such a way as to degrade or demean the client.
6. As the client develops deeper trust, the counselor may lead him toward here and now (reality) experience and show him how his perceptions of reality have been distorted by learned behavior of inappropriate nature. At this point the client must be genuinely open to his experience, with his defenses down, and the counselor must know of this readiness.
7. As readiness is ascertained, the counselor may help the client determine what behavior will be more suited to his lifestyle, help him set up a concrete goal or a particular behavior to be practiced (for example, he *will say* good morning to his co-workers, something that he has never said before, and observe their responses).
8. The counselor will ask for definite evidence that new behavior patterns are being established; the client must deliver evidence (which can be written memos of particular behavior and times when it took place). As a further check, the counselor might quietly inquire of the supervisor, or of a co-worker, if there has been a change in behavior, as a confirmation of readiness to "close" a case.

"LABELS"

I do not know what label I could put upon such a course of therapy; "eclectic" is what I have chosen to call it, because I do see in it certain elements of Rogers, Thorne, and Williamson, all of whom have influenced me, and something of Bozarth, C. H. Patterson and L. Stewart. I am also inclined to rely much upon E. Mindel for crystallization of my feelings on deafness and childhood development and learning. Alfred Adler impressed me, as did Glasser.

I hesitate, from a personal sense of inadequacy, to enter into deep relationships with clients when there are alternatives open to me. Counseling deaf people is a serious challenge, and the more I learn about deafness, about psychology and psychotherapy, the more I am impressed with how little man knows about himself.

SUMMARY

In a description of my personal theory of counseling I have outlined my approaches to and thinking on the nature of man, human growth and development, goals of therapy, characteristics of the client and the counselor in a therapeutic relationship, and therapeutic methods. The brevity of the presentation precludes exhaustive detail and qualifications.

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