INDIVIDUAL COUNSELING OF THE SEVERELY HANDICAPPED DEAF PERSON

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INTRODUCTION

This paper deals with counseling approaches and techniques that can be used effectively with the severely handicapped deaf person. I would like to briefly review what we have learned about this person from R.S.A.funded demonstration and other researches. This information, on the whole, is very sound; it is the prime source from which our counseling assumptions, approaches, and techniques should be derived.

CHARACTERISTICS

Our information is that, besides the presence of secondary disabilities such as mental retardation, cerebral palsy, visual problems, behavioral disorders, and others, the client suffers handicaps described as communication deficiencies, illiteracy (or low literacy), deficient social and emotional functioning, extreme dependence, poorly developed identity and self-concept, and vocational and work naivete (1,2,5,7,8,9).

Persons with such handicaps tend to expect failure and are prone to be passive and to under-invest in new tasks; their reality is virtually what they can see — here and now. As a consequence, training and treatment experiences must be as functionally relevant to the person's immediate reality as possible; and a series of experiences over a long period of time and graduated in exposure and complexity, is required to help them achieve a reasonable control of their own lives.

APPROACHES

Approaches relevant to counseling the severely handicapped and suggested from this above information are that:

(1) The client often will need to receive many services; social, vocational, educational and psychological;

(2) Many people will indirectly, but most often directly influence and/or interact with the client during the provision of those services;

(3) A constant monitoring, even a coordination, of relevant services and people involved with them must be provided, thus allowing for informational, tactical and strategy exchanges to occur between a counselor, the client, the client's relatives and/or significant other persons interested in the client's welfare;

(4) The client must be accepted as he is, on his current level of functioning;

(5) Individual counseling of the client as one of several services offered is of vital importance; it is the central, the underpinning service and should contribute the most

toward the continuity and unification of all other services, and toward their desired outcomes;

(6) Individual counseling must be Reality Oriented; the client's "view of his world, i.e. his reality", must be understood while the realities of his environment are introduced to him.

ROLES AND TECHNIQUES

The service of individual counseling involves two basic roles for the counselor: he is first a "shaper"; second, he is a friend and confidant of the client.

As "shaper" the counselor acts on behalf of the client, representing the client's interests by sharing his knowledge of the client with other professionals, staff persons or family members; he has a hand in the planning, structuring, and to some extent, the implementation of client tasks and activities. His chief goals in this role are to make sure the others understand the client better so that their interventions are not contradictory but are relevant and effective; to be intimately familiar with what others are doing for the client and to the client so that he can communicate to the client some sense of what is going on, in effect, to help the client experience a measure of orderliness and purpose around him.

As "friend and confidant" the counselor interacts directly with the client. (This interaction is not necessarily characterized only by counselor/client conversation during structured "interviews" or "sessions"; it also includes, importantly, the counselor's being present with the client in and during different, sometimes informal, situations, activities and assignments engaged in by the client). The counselor is available and accessible, and he communicates by this a willingness to be with the client and an acceptance of him.

And, it is during these encounters between counselor and client that the most important work of counseling takes place, i.e., to help the client realize that he is growing, that he can confront some of his problems alone, when needed, and find solutions to them; that he can accept and feel comfortable with himself when alone and/or when in the presence of others; that he can take pleasure in and value achievement in employment. In sum, the counselor and the client together come to grips with the client's most serious handicaps: dependence, poor self-concept, and deficient social and emotional behavior.

PROCESS

To repeat, these hoped-for outcomes do not happen overnight, but over months, perhaps years. And, a counseling process over this period of time is unfolding. This "process" is anchored on the premise that significant communication between client and counselor has taken place. As crucial as this factor is, however, it (communication) should be viewed within a broader framework, such as outlined by Kaufer (7):

> ". . . . the availability of personnel with special communication skills is not a complete answer for many deaf clients: their deficiencies in language and concept development are so great that considerable effort must be devoted to improving their ability to comprehend and to communicate. The dimension of communication, therefore, is not simply one of interpreting or translating. It includes also an appreciation and understanding of deafness combined with specific knowledge of the communication patterns of deaf persons with low literacy and capacity for empathy and establishing rapport with such individuals" (p. 16).

Other elements in the counseling process are related to the following considerations:

(1) Awareness by counselor that failure has been a "way of life" for the client; that rehashing the client's previous failures and pointing out his current ones sets him up for the next failure, prompts him to court it;

(2) Recognition by counselor that the client must experience success, that success opportunities must be designed in small steps and intermediate goals;

(3) The client must know and understand what is expected from him; expectations must be realistic and positive but not exceeding the client's ability to live up to them;

(4) The client must be held to an accounting for his behavior, to accept responsibility for his actions and interpersonal relationships;

(5) That, for this client, engaging in required, structured and desirable behavior is more likely to result in improved attitudes; and that attempts to change client attitudes hoping this will lead to behavior change are not likely to be effective.

(6) The client must be treated as an important source of information about himself. . . and helped to realize that he is;

(7) Background and diagnostic information must be put together in such a way by the counselor that an overall concept of the client, i.e., of his salient handicaps and needs, is determined. The counselor must integrate or reject this data as it is his responsibility to build hypotheses of client problems and service needs.

This client is highly suggestible; often he is told (or comes to feel it from his observation of counselor behavior) that dubious treatments or mechanical aids recommended by others are "good for him" and therefore he should accept them, and does to no good purpose.

(8) Services: Specificity. . . the counselor arranges services of various kinds to be delivered at *specific* points in time and for *specific* purposes. Specificity and relevant sequencing of services are crucial factors in client growth.

(9) Counselor's use of services/treatments for his client by others, e.g., a workshop, tutoring, etc., must be characterized by continued counselor responsibility for client's progress; the counselor works *with* others for the sake of the client instead of "turning the client over" to others and thereby abdicating his responsibility.

CONCLUSION

Attending this conference are several people who in the course of their work have literally lived among and with severely handicapped deaf persons, e.g., Sid Hurwitz, Larry Stewart, Ed Carney, Edna Adler, Ann MacIntyre, Gary Blake, Allen Sussman, Ernest Hairston, Doug Watson, Doug Rice, Tim Milligan, Brian Bolton, Bob Gonzales and myself. I think the others would agree with me that there is no way that written words can adequately convey our true experiences as counselors to the severely handicapped. At best words convey the flavor of the experience but not its conviction.

For one thing, like the client we worked with, we had to experience a counseling "process" in order to understand it, and "process" had a different meaning for each of us although we all experienced certain elements common to each meaning. It was the aim of this paper to faithfully represent the flavor of those elements.

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