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THE PROVISION OF MENTAL HEALTH PROGRAMS AND
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PUBLIC DAY SCHOOL PROGRAMS FOR THE HEARING
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THE PROVISION OF MENTAL HEALTH PROGRAMS
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DAY SCHOOL PROGRAMS FOR THE HEARING IMPAIRED

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Dolores Marie Fowlkes, B.A., M.A.

* * * * *

The Ohio State University
1976

Reading Committee
John O. Cooper, Chairman
James L. Collins
Vance Cotter
W. Frederick Staub

Approved By

John O. Cooper
Adviser
Faculty for Exceptional Children
ACKNOWLEDGEMENTS

I wish to express sincere appreciation to my adviser and friend, Dr. James L. Collins, for his patience, guidance, and valuable recommendations during the writing of this dissertation. Appreciation is also extended to the other members of my doctoral program committee, Drs. John O. Cooper, W. Fredrick Staub, and Vance Cotter for their counsel. I also wish to thank Drs. Keith Brooks and W. Bruce Walsh for serving as Graduate School representatives during my oral examinations.

Special thanks to the following persons:

Dr. Leonora Hamlin and Mrs. Harriette Richardson for inspiring me to begin this endeavor;

Dr. Susan Rose for her friendship and encouragement;

Dr. James E. Norman and his wife Norma Jean for sharing this experience with me;

Mrs. Birta Fowlkes Allen, Ms. Rosemary L. Fowlkes, Mr. Willie H. Fowlkes II, my sisters and brother, for their confidence, devotion and constant support;

And finally, my beloved parents, Mr. Willie H. Fowlkes Sr. and Mrs. Dorothy Wright Fowlkes for EVERYTHING.
May 14, 1937.............. Born, Muncie, Indiana

1955-1959.................... B.A., Indiana University, Bloomington, Indiana


1962-1963.................... M.A., Ball State University, Muncie, Indiana

1963-1967.................... Teacher, Indiana School for the Deaf, Indianapolis, Indiana

1967-1971.................... Supervisor for the Deaf, Indiana Department of Public Instruction, Division of Special Education, Indianapolis, Indiana.


1974-1976.................... Graduate Research Associate, The Ohio State University, Columbus, Ohio
PUBLICATION

Operation Springboard: Preschool Programs and Services for the Hearing Impaired in Indiana, Hoosier Schoolmaster, Indiana Department of Public Instruction, 1968.

FIELDS OF STUDY

MAJOR FIELD: EDUCATION OF THE HEARING IMPAIRED

Studies in the Hearing Impaired.
Professor James L. Collins

Studies in Learning and Behavioral Disorders.
Professor John O. Cooper

Studies in Educational Administration and Supervision.
Professor W. Frederick Staub
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CHAPTER I
INTRODUCTION

Background

The education of the hearing impaired in the United States has witnessed numerous innovations since its inception. The literature designates various types of techniques, methodologies, and philosophies that have helped to resolve some of the educational problems of the deaf child and his family. However, one problem that has been difficult to resolve relates to the provision of programs and services for the multiply handicapped deaf child. Babbidge (1965, p. xvii) states that programming for the multiply handicapped deaf person is a relatively untouched field. For the purpose of this study, the deaf, a specific subset of the hearing impaired was considered.

In the late 1960's programs for the mentally retarded deaf and the deaf-blind emerged, but few comprehensive programs for the school age emotionally disturbed deaf child have been documented. Educators of the deaf have been aware of mental health problems involving their students and their families, but the usual solution was to discipline the child be keeping him busy (Taylor, 1890, pp. 291-293) or to refer the child to available programs
or services outside the school environment (Anderson, 1966, p. 33) where the child's communication competencies make services unlikely.

After a rubella epidemic of 1964-1965, more comprehensive mental health programs and services began to be investigated. In an attempt to justify the need for such programs and services, educational programs for the deaf began to more actively recruit supportive personnel. School social workers, school psychologists, and special education teachers from other disability areas were employed to remediate the problems. Often having supportive personnel who were unfamiliar with the scope of the problems associated with deafness and the sub-culture of the deaf resulted in more frustration for the child, the family, and the professional than remediation of the problems.

Until the New York State Psychiatric Institute undertook a national study of the mental health problems of the deaf few definitive programming options were available to the deaf. As a result of this initial effort several mental health programs and services have evolved. (Rainer, 1969, p.1) The better known programs are hospital programs that have emulated the New York model. These programs are the following:

1. St. Elizabeth's Hospital; Washington, D.C.
2. Langley Porter Neuropsychiatric Institute; San Francisco
3. The Psychosomatic and Psychiatric Institute of Michael Reese Hospital; Chicago
4. Children's Psychiatric Hospital; Austin, Texas

Fortunately, each of these hospital programs documented procedures not only for hospital intervention of the severely emotionally disturbed, but also for family prevention and community based programs and services. However, there remains a paucity in the literature regarding program advancement in educational programs for the emotionally disturbed deaf child. One reason for the slow advancement of these educational programs may be the lack of concise, sequential recommendations regarding minimal guidelines needed to implement such programs. Another reason for the unresponsiveness of the schools to address this problem may be their unwillingness to accept further responsibility for a population with severe learning and behavior problems. A third reason may be that administrators are unaware of funding sources that will support such programs.

Statement of the Problem

The problem addressed in this research was to determine what type of mental health services and programs were provided to deaf children with severe behavior disorders in public residential schools and public day school programs and by whom.
Objectives of the Study

The objectives of this research were:

1. To determine the current educational program policy regarding the emotionally disturbed deaf child.

2. To determine who the individuals were that provide mental health programs and services to the deaf child and his family.

3. To determine the extent of program planning done for the family of the emotionally disturbed deaf child.

4. To determine how teachers were assigned to work with the emotionally disturbed deaf child.

5. To determine what funding sources, local, state and/or federal support programs for the emotionally disturbed deaf child.

Definition of Terms

Hearing Impairment. A generic term indicating a hearing disability which may range in severity from mild to profound: it includes the subsets of deaf and hard of hearing.

A deaf person is one whose hearing disability precludes successful processing of linguistic information through audition, with or without a hearing aid.

A hard of hearing person is one who, generally with the
use of a hearing aid, has residual hearing sufficient to enable successful processing of linguistic information through audition.

Emotionally Disturbed. The term used when difficulties interfere significantly with the child's personality development, his adjustment at home or at school, his view of himself, or his relationship with others.

Mental Health Programs and Services. The term used to indicate the systematic provision of psycho-educational services by a trained professional. i.e., teacher, psychiatrist, psychologist, social worker, and guidance counselor.
CHAPTER II

REVIEW OF RELEVANT LITERATURE

The Early History of the Education of the Deaf

It is imperative that the history of the deaf be reviewed in order to better understand many of the present controversies that have been traditionally associated with the education of the hearing impaired. For the purpose of this study, deafness is considered a subset of the hearing impaired.

The philosophy of Aristotle had considerable influence upon the problems of the deaf. His writings allege that when a person is deaf that dumbness will coexist. (Di Carlo, 1965, p.12)

Bender (1960, pp.20-21) contends that translated statements from Aristotle's original work, History of Animals, have been distorted, taken out of context, and given an entirely different meaning than was intended. Over the centuries, one sentence has been distorted to such a degree that it finally became the following:

Original sentence
1. Men that are deaf are in all cases also dumb: that is they can make vocal sounds, but they cannot speak.

Literally translated
2. Those who become deaf from birth also become altogether speechless. Voice is certainly not
lacking, but there is no speech.

The words "kophoi" meaning deaf and "eneos" meaning speechless have been translated to mean "dumb" and "stupid".

Final translation

3. Those who are born deaf all become senseless and incapable to reason.

Because of Aristotle's authority, his pronouncements were accepted without challenge. His adherence to the philosophy that the instinctive nature of thought as the basis of learning and language served to verify that the deaf could not be taught speech and language and would remain backward, delayed the beginning of education for the deaf by several years. (Di Carlo, 1965, p.12) There is no proof that he understood the relationship of speech to hearing or that dumbness was the developmental consequence of deafness. (Goldstein, 1933, p.13) For more than two thousand years it was accepted that the deaf could never be taught to speak. "Knowledge degenerated into folk-lore; hypothesis into superstition; intellectual conviction into uncritical credulity." (Hodgson, 1954, p.65)

The Romans adopted much of the Greek philosophy when they came to power. The reign of Emperor Justinian, A.D. 530, provided continued protection to the deaf and added another dimension of legal classifications. These classifications had nothing to do with the cure, prevention, or education of the deaf. They did, however, categorize
the deaf according to the extent of their disability, considering the time of onset. (Di Carlo, 1965, p.12)

Goldstein (1933, p.13) states that religion also contributed to the misunderstanding of the deaf. He reports that...

The Mosaic Law directed that the deaf be not cursed and that those stricken dumb were possessed of the devil. In the Talmud the deaf and dumb are classes with a fool and a child, not responsible for their actions and exempt from the ordinances of the law.

From these attitudes, the religious myths about the deaf flourished. Divine responsibility for the deaf was accepted. In Isaiah XXXV, 5-6, ...The eyes of the blind shall be opened, and the ears of the deaf shall be unstopped. Then shall the lame man leap as an hart, and the tongue of the dumb sing. (Hodgson, 1954, p.66)

This acceptance that only Divine intervention could heal the deaf, was a great disservice to the deaf. It perpetuated the belief that they were beyond human help. (Hodgson, 1954, p.67)

The Talmud discriminated between the deaf and dumb and those who were deaf only and dumb only. It was accepted that the deaf and dumb could not be taught, therefore, they were free of obligations. (Hodgson, 1954, p.70)

After the Roman Empire fell, the Christian Church became the only salvation for the deaf. The Church offered only comfort to the deaf, since it seemed apparent that
the Creator had not endowed them with divine and instinctive knowledge. No attempt was made at any educational instruction because it was believed that the deaf could not profit from it. Only one historical reference was made before the fifteenth century regarding the education of the deaf. In 700 B.C. the Venerable Bede wrote about John of Beverly whose accomplishment to teach a deaf and dumb person to speak was attributed to a miracle. (Di Carlo, 1965, p.13)

During the Renaissance the deaf became associated with the curiosity of a few men who were interested in the philosophical question, what is the nature of the mind or soul. Leonardo da Vinci observed that the deaf were capable of understanding conversation by watching gestures and movements of the speakers. (Di Carlo, 1965, p.14)

Jerome Cardan (Girolamo Cardano) is credited with the correction of many fallacies regarding the deaf and their educational capacity. (Goldstein, 1933, p.13) He was born in 1501, the illegitimate son of a lawyer. He received no formal training until he was twenty-one. But when he entered the university he made fantastic progress. By age twenty-five he was a doctor of medicine and a Rector of the university. By age fifty he was at the head of his profession in Europe. (Hodgson, 1954, p.78) Cardan was endowed with an ability to stand outside the realm of
traditional thinking. He concluded that education was possible for the deaf. He was true to his unconventional manner of life and thought when he proclaimed that the deaf could be taught to hear by reading and speak by writing. (Hodgson, 1954, p.79)

Cardan's Philosophy and work marked a turning point in the attitudes toward deafness. (Hodgson, 1954, p.80) Also during this era, deaf individuals began to make contributions to society. Pierre de Ronsard who became one of the foremost poets in France during this period was deafened at age sixteen. (Di Carlo, 1965, p.14)

Another contributor was Juan Fernandex Ximenes de Navarette. He was afflicted with a disease that at the age of three left him deaf. Because of his deafness and consequent lack of speech, he became known as El Mudo, the mute. (Bender, 1960, p.34) El Mudo, became a painter and protege of Titian of Venice. His artistic ability was recognized by King Phillip II of Spain. El Mudo was commissioned to decorate the royal burial place. (Di Carlo, 1965, p.14)

Juan Pablo Bonet produced the first book about the education of the deaf. His book, Simplification of the Letters of the Alphabet and Method of Teaching Deaf-Mutes to Speak, was published in Madrid, Spain, in 1620. His thesis was that speech was the basis of the education of
the deaf. The manual alphabet was learned, but all other manual signs were excluded. (Goldstein, 1933, p.18)

Bonet advocated the teaching of the one hand alphabet using pictures to illustrate the position of the hands for each letter of the printed symbol. (Bender, 1960, p.44) He was intensely interested in his work with the deaf. He is reported to have had a brother who was deafened at an early age, which may account for his interest.

Bonet used every method possible to instruct his students. He began by using natural gesture or sign and at the same time teaching the written alphabet. He then progressed to associating the printed alphabet, the manual alphabet, and their sounds starting with the vowels. Then the nouns, verbs, and other parts of speech. These continued exercises of comparisons and classifications were to equip Bonet's students with powers of reasoning.

Pedro Ponce de Leon, a Spanish monk, is recognized as the first teacher of deaf-mutes. His teaching aim was to instruct deaf students in speech, although he saw signs as the quickest way to language. Signs were a crutch used only when writing was impractical or inconvenient. His fame among his contemporaries grew because his students learned to read and write as well as to speak. (Hodgson, 1954, p.81) His students were only the wealthy deaf from noble families. His rationale for this segment
being educated was that they would achieve religious salvation, and through the use of some form of communication be permitted to inherit their family properties. (Di Carlo, 1965, p.15)

Several centuries passed before education of the deaf was to become recognized as a profession. General education provided considerable structure for the philosophical basis of education of the deaf. Comenius, Bacon, and Locke had considerable input. (Di Carlo, 1965, p.18)

John Amos Komensky, Comenius--1592-1671, advanced the theory that education must follow nature smoothly and easily. (Hodgson, 1954, p.88) His educational principles were that things come before words, and experiences precede the symbols which stand for experience. Sir Francis Bacon's writing influenced the education of the deaf. He believed that those students who began learning late do not learn as well as those who begin early, because they are not as flexible. (Di Carlo, 1965, p.18) John Locke (1632-1704) suggested that the primary step in education should be the training of the senses. (Bender, 1960, p.49) For the first time realism in education was being appreciated as a basic principle of learning. (Bender, 1960, p.50)

In the eighteenth century interest in the problems of the deaf came to the forefront in Europe. The previous
centuries had implanted the notion that the deaf could be educated. It became the challenge of this century's teachers to develop and apply educational techniques.

Schools for the deaf began to flourish on the Continent and the profession began to attain dignity. Students were no longer selected only from noble families. Since the state was unprepared for publicly financed schools for the deaf, the responsibility for financing such schools fell to the headmaster. (Di Carlo, 1965, pp.23-24)

The question of methods and the future destiny of the deaf revolved around two formidable opponents: Abbe Charles Michel de l'Epee and Samuel Heinicke. (Goldstein, 1933, p.33) Charles Michel de l'Epee was born in Versailles, France, November 24, 1712. He had studied for the priesthood, but found that the philosophy of the sect he preferred, the Jansenists, were out of favor in France. He tried law, but his preference was still the priesthood. He became the protege of his uncle who was impressed with his piety and zeal. When his uncle died, he was again at odds with his religious superiors. De l'Epee spent the next twenty five years living quietly as an obscure priest. His interest in the deaf was piqued when he met deaf twin sisters who were unable to speak. The mother of the sisters had explained to de l'Epee that they were without religious instruction because the friend who had been instructing
them had died. De l'Epee was disturbed that these good sisters would be lost because they could not find the way to salvation. From that time on de l'Epee devoted his life to teaching the deaf. (Bender, 1960, pp.79-80)

In 1784 de l'Epee published La Veritable Maniere which outlined his method for educating the deaf. His entire life was spent refining his method. His method emphasized the manual alphabet. He dramatized the usage of verbs and pronouns and illustrated each part of speech. (Di Carlo, 1965, p.24) De l'Epee contended that "lip alphabet" was different in every language, but that a manual alphabet and signs would be applicable to all languages. (Bender, 1960, p.84) De l'Epee also became an instructor of other teachers of the deaf, and his signing techniques spread throughout Europe. (Di Carlo, 1965, p.25)

In Germany at the same time of de l'Epee, Samuel Heinicke developed an educational approach for teaching the deaf that was based solely upon an oral approach. He opposed teaching anything other than speech during the initial stages of language development. Heinicke, like de l'Epee, also became an instructor of teachers of the deaf. These two opposing methodologies existed for a number of years before becoming public property.
An impartial group of scholars at the Zurich Academy were gathered to resolve the problem of which method was better; the French manual method or the German oral method. The French manual method was judged better because more information was made available to the Academy on it than on the oral method. (Di Carlo, 1965, pp.25-26) The Academy had not been able to pass judgement on his work because they had learned so little. Heinicke refused to divulge his methods except for money. (Bender, 1960, p.106)

Deaf children from the United States were usually sent abroad to be educated. (Giangreco, 1970, p.22) Francis Green, an American, took his eight year old deaf son to Edinburgh, Scotland, to be taught the oral method by Thomas Braidwood. Braidwood had been successful in teaching a few deaf students at his school. He had hoped for public support of his school and his techniques, but he did not receive it. (Di Carlo, 1965, p.29) After being rebuffed, Braidwood withdrew his methods to the secrecy of his family. Each family member and anyone he taught was placed under a bond of secrecy. (Bender, 1960, p.112) Although Braidwood was completely secretive about his successful teaching methods, he was no more callous than the times demanded of him. Braidwood had a complete monopoly that was maintained within the family. (Hodgson, 1954, p.143)
As business prospered, Braidwood brought in his nephews John Braidwood and Joseph Watson. When Thomas died, control of the family's school was left to his widow and Joseph Watson. (Hodgson, 1954, p.148) Not until Thomas Braidwood died was it possible for Joseph Watson to make public any of the family's methods and techniques. (Hodgson, 1954, p.160)

Thomas Hopkins Gallaudet of Hartford, Connecticut, is credited for the permanence of the education of the deaf in the United States. Gallaudet had been the teacher of Alice Cogswell. Through his association with Alice, Gallaudet became intrigued with the problems of deafness. (Di Carlo, 1965, p.29)

In 1815 Alice's father, Dr. Mason Fitch Cogswell, a campaigner for the education of the deaf in America, and a group of interested clergymen took a census of the deaf in Connecticut and found eighty deaf children of educable age. From this census they projected their estimation to include 400 such persons in New England and 200 plus in the United States. (Bender, 1960, p.123)

There was considerable jealousy and secrecy by the early teachers of the deaf about their teaching techniques. This spirit of secrecy indirectly influenced the introduction of the manual method into the United States. Dr. Gallaudet visited Europe in 1815 to acquire the teaching
techniques for the deaf. He visited Dr. Joseph Watson the successor to Thomas Braidwood and principal of the Asylum for the Deaf and Dumb, in London. The methods used at the school founded by Braidwood were articulation, writing, reading, and knowledge of language. (Goldstein, 1933, p.31)

Gallaudet proposed to remain at the Braidwood school to learn their method then combine it with Sicard's Manual method, and then select the best from both methods for his own use. This proposal was denied by the Braidwood family, but they suggested several options that were not satisfactory to Gallaudet. (Bender, 1960, p.124) While waiting for a decision in the negotiations with the Braidwood family, Gallaudet attended a lecture in London. Abbe Sicard was touring and demonstrating with his deaf students, Massieu and Clerc. (Hodgson, 1954, p.126) Gallaudet was so impressed by what he saw that he left London, at Sicard's invitation, and immediately began to study. In Paris he was welcomed by Abbe Sicard, the successor to Abbe de l'Epee. (Goldstein, 1933, p.32) Gallaudet was bitter against the British teachers of the deaf and their methods because he had been unable to find out anything about them. (Hodgson, 1954, p.181)

During his stay in France he was not only interested in the French teaching method, but was converted to the
French doctrines of nationalized education. When he returned to Connecticut to become a leader in the campaign for State Schools Board. (Hodgson, 1954, p.182) When Gallaudet returned to the United States he brought Laurent Clerc, a deaf man who had become an assistant teacher at the Paris School, with him. (Di Carlo, 1965, p.30) Together the two men established the American Asylum for the Deaf in Hartford, Connecticut, April 15, 1817. This school, later named the American School for the Deaf, established the trend for state schools for the deaf. (Giangreco, 1970, p.24)

The primary system of education of the deaf in America became the manual system through Gallaudet's early influence. However, two educators, Horace Mann and Samuel Gridley Howe, had visited schools for the deaf in Europe, and were convinced of the benefits of an oral education for the deaf. The Hartford school opposed their efforts.

Mann and Howe were undaunted and solicited the assistance of Mr. Gardiner Green Hubbard of Massachusetts whose daughter was deafened at age four. The Hubbard's had decided that despite the opposition of the Hartford school that their daughter would not be denied the speech of normal children. Many attempts to open an oral school in Massachusetts were thwarted by the Hartford school.
Finally, in 1866 at Chelmsford, Massachusetts, Miss H. Rodgers opened her private school. Several petitions to the state legislature for the school's financing were voted down. The Governor of Massachusetts contacted Hubbard to inform him that he had received a letter from John Clarke, a philanthropist who was interested in donating money to establish an oral school for the deaf in Massachusetts. In 1867 the Clarke School for the Deaf was opened in Northampton. (Di Carlo, 1965, pp.31-33)

Other states began to consider the problems of education of the deaf, and state schools for the deaf began to grow. The earliest schools for the deaf were residential schools. (Fauth, 1967, p.168)

Ewing (1954, p.24) states that by 1870 in the United States there were thirty-three residential schools for the deaf. The majority of the students in those schools were taught sign language, fingerspelling, and writing as their chief means of communication.

Thomas Gallaudet outlined what these schools should contain and how the classrooms should be arranged at the first Convention of American Instructors of the Deaf. Papers on the purpose of the institution, the need for a board of trustees, location, and buildings were also presented. (Fauth, 1967, p.168) The Convention of American Instructors of the Deaf was the first national convention
of the deaf in the world. It was founded in 1850, and is among the four oldest national educational organizations in the United States. (Fauth, 1967, p.4)

Early recommendations on the administration of the residential school are varied. One recommendation was that the central authority for the school become the responsibility of the principal. (Fauth, 1967, p.21)

At the sixth Convention it was stated that the Superintendent should assume the responsibility for student discipline because he was in loco parentis, and he was the only person familiar with each department in the school. It was stated that the rod should be the last resort in discipline problems. Instead demerit marks, reprimands, temporary imprisonment, deprivation of a meal, tasks requiring continued and fatiguing physical effort were suggested. (Fauth, 1967, p.26) At the twelfth Convention Elizabeth R. Taylor of the Pennsylvania Institution (1890, pp.291-293) contended that to maintain discipline within the school day, the child should be kept busy every minute. Keeping the child busy prevented discipline problems.

Family life within the early residential schools was chaotic. Talbot, an instructor at The Ohio Institution for the Deaf and Dumb, (1893, pp.174-177) described the difficulty of finding persons capable of being parents to the residential child. It was his feeling that too
much was done for the child and not enough was expected from him. Robinson, an instructor at The Wisconsin School for the Deaf in Delavan, (1893, pp.177-180) contended that these children should be exposed to "hard knocks" in order to develop self-reliance, independence, and habits of thrift and industry.

The earliest papers on curriculum and course of study dealt predominately with what should be taught to the deaf and what was being taught. (Fauth, 1967, p.50) George W. Chase (1878, pp.267-271) in his presentation to the 1878 Convention stated that although the deaf were taught English, French, Latin, arithmetic, algebra, history and other subjects, they were not being prepared for success outside the residential school. He advocated a more practical curriculum that would include bookkeeping, business training, and mechanical trades. Educating the deaf was discussed at the tenth Convention. Goodman (1882, pp.131-138) outlined education in terms of the following:

1. Students
2. Institutions
3. Methods
4. Teachers

He concluded that of the four components involved in the education of deaf children that the teachers were the most important.

The earliest teachers of the deaf were men, many of whom were themselves deaf. (Fauth, 1967, p.22) Babbidge
(1965, p.14) reports that historically the training of teachers of the deaf was the responsibility of the schools and the classes for the deaf. The schools assigned the teachers in training to master teachers. This kind of training often perpetuated a limited viewpoint and poor teaching techniques by new teachers.

Another early problem that arose in the education of the deaf was how to get students to attend school. Some parents wanted their children out of the home and in school to keep them out of trouble. Other parents wanted to keep their children at home because the parents were poor and needed the children at home to work. (Fauth, 1967, p.24)

In 1868 the attendance problem was cited as having caused a problem in classifying students. Talbot (1859, pp.43-46) stated that the remedy for such classification problems was having a uniform entrance age for class placement; his suggestion was ten years for boys and twelve years for girls. It was later recommended that students also be classified according to age, talent, attainments, intellect, and ability.

In 1933 the Convention purposed changes in the constitution which made the total program more functional. New committees for supervision, preschool and kindergarten, speech development, auricular training and rhythm, curriculum content, vocational training and art, health and
physical education, social and character training, and publications were established. (Fauth, 1967, p.15)

Summary

The quest for direction in the education of the deaf is a continuous one. A review of the history of educational services provided to the deaf reveals that there are few issues that exist today that were not considered long ago. The education of the deaf evolved from religious, philosophical, political, and scientific attitudes of the past. The stigmas of deafness are slowly eroding and educational methodologies are providing opportunities for deaf people. However, the struggle continues for occupational and social recognition for personal identification. (Di Carlo, 1965, p.10)

The scope of the profession today has been expanded to include the deaf population's contributions by realistically investigating their daily life problems. This element is a major issue in the education of the deaf that encompasses the total sphere of academic instruction. The academic instruction of the deaf continues to be important. How best to provide programming in the areas of language development, modes of communication, speech development, reading, sex education, mathematics, and science are being investigated. However, the primary issue appears to be who and/or what influences the deaf child until he is
present Issues Regarding the Education of the Deaf
Parents of the Deaf Child

The emotional impact of the realities of the child's deafness is difficult for parents. (Mindel, 1971, p.7) Usually parents are not experienced in rearing a deaf child, and few of these parents have had an opportunity to interact with other parents of deaf children. (Mindel, 1971, p.11)

Rainer (1969, pp.11-12) suggests that behaviors a child displays to parents, teachers, and others stems from developmental difficulties of the ego. The normal progression goes from the newborn's dependence on maternal care to the young adult's emotional and material self-reliance. In the hearing child anxiety and depression have been described when maternal care is deprived. There is some question as to whether the quality of the early maternal relationship perpetuate depression or whether the anxiety aspect is predominate in the deaf child. The deaf child has no outlet for his needs and restlessness, and may, therefore, display anti-social behaviors. If the process of learning how to relate to people is shut off in the formative years by communication isolation, the child may grow up with a severe deficiency. Other
developmental difficulties encountered by the deaf child may be the development of conscience, the ability to handle power and strength.

The responsibility of a parent for a deaf child's emotional adjustment is that he become a functioning parent rather than an actual parent. The functioning parent is able to communicate with his child. (Schroeder, 1970, p.26)

Collins (1973, p.196) contends that one of the tragedies of deafness is the limited amount of implicit learning which deaf children acquire when compared to the hearing population. He states the following:

...Implicit learning is defined as the acquisition of knowledge or behavior when there is no deliberate attempt to teach or learn this knowledge or behavior. Explicit learning on the other hand occurs when either or both the intention to teach and/or learn is present.

The facility the family has in communicating with their deaf child will enable the child to become an active, involved family participant. A knowledge that he can belong, contribute, and has recognition are an important part of the deaf child's childhood experience. (Mindel, 1971, p.55)

Vernon (1973, p.127) suggests that the healthy psychological adjustment of congenitally deaf adults is evidenced by a form of communication called "body language."
...Only because basic affect is communicated by the body, i.e., nonverbally, does the deaf child have sufficient affective interaction with his parents to permit normal psychological growth...If verbal language were the major vehicle for affective interaction, children whose deafness deprives them of this input would experience severe psychopathology. They do not.

Another form of communication that parents may wish to learn is manual communication. It involves five basic modes of communication: the primary mode being sign language.

1. **Sign Language** is a language in which gestures are used for words. It has its own morphology, syntax, and semantics.

2. **Signed English** is the use of English syntax in a rapid succession of signs by the interpreter to convey meaning to the addressee.

3. **Simultaneous Method** is used when the speaker-signer conceives, encodes, and utters English at the same time he accompanies the utterances with signed English.

4. **Fingerspelling** is a system of making English utterances visible with hand positions.

5. **Manual English** augments the signs that translate the semantic component of English words with signs invented to represent more important functional morphemes, i.e., tenses, prefixes, suffixes. (O'Rourke, 1974, pp.vii-viii)

The current philosophy of contending with the oral only, manual only debate has been formulated by Roy K. Holcomb. Holcomb (Note 1) states that:

...so great of a handicap is deafness that it justifies a total approach in order to provide the individual with every opportunity to realize his potential for full growth. A total approach is using everything that might help the deaf student
overcome his handicap, such as hearing aids, a relevant curriculum, understanding teachers and parents, Total Communication, and the development of positive relationships with the hearing community. Total means all, and the Total Communication means all of the communication. Deaf people receive most of their Total Communication through vision, and hearing people most of theirs via hearing. While all things are essential in a total approach, Total Communication is basic; it is crucial during the early years when the mind must be stimulated and when learning takes place at its best.

Switzer and Williams (1967, p.250) state that the communication problem of the deaf influences all aspects of his life. The deaf person's personal adjustment and his levels of achievement are directly related to his communication skills.

The parent must be able to explain to the child what is expected of him and the reasons why. In order to do this they must learn to communicate with the deaf. The association with deaf adults will ease the learning process, and give parents a better understanding of the problems of the deaf. (Schroeder, 1970, pp.27-28)

Schein (1970, p.8) emphasizes the fact that the deaf child not only derives some of his self-image and his attitudes about himself from his parents, but from his teachers as well. Many teachers of the deaf find that they devote much of their time dealing with the emotional problems of their students instead of teaching. These problems can usually be traced back to a lack of communication between parent and child. (Schroeder, 1970, p.27)
Mindel and Vernon (1971, p.56) state that when the family of a deaf child does not resolve their reaction to that child, the child's emotional development may be retarded. The older the child becomes, the greater the family's frustration to the child's problem becomes. Baldwin (1974, p.172) supports this premise by stating that a specific handicap may create a problem which some families have difficulty resolving, and may, therefore, predispose the child to the development of a particular disorder.

Babbidge (1965, p.27) states that there is a need for parent education, counseling, and guidance. This service should be available to parents for the extended period of their child's education and duration of the child's dependency on them. Other supporters of parent education are Wheeler, Mayes, and Holcomb.

Mayes (1970, p.28) states the following:

"We need more parent involvement in the planning of educational programs...it is not so painful as some administrators had feared, because well informed parents are not hard to work with."

Holcomb (Note 1) contends that:

"Parents are "first base" in the education of the deaf. For far too long now we have not been touching "first base." It is pretty hard to score without touching "first base."

And finally, Ned Wheeler, a deaf civil engineer, active in the educational and vocational pursuits of the deaf relates the confusion caused by uninformed parents of the deaf.
The obvious need for parent guidance and counseling is clearly outlined. Wheeler (1967, p.26) states the following:

...The emotional parent often puts so much pressure on the school administration, both directly or through political routes, to pattern the child's training along the line they feel necessary to achieve their dream for the child's future that both the academic and the vocational education suffer greatly. It is a sad fact that many of these parents realize after the child has matured that they have been wrong; however, by then it is often too late to correct this situation.

Parents should be contacted earlier and presented realistic views regarding their child's educational and vocational future. (Ott, 1967, p.13a) Most professionals are inclined to offer parents sympathy as a means of resolving their problems. This relieves the situation only temporarily and may cause critical delays initiating more effective procedures. (Mindel, 1971, p.23)

Summary

When parents have been informed of their child's deafness, they should receive comprehensive mental health counseling. It becomes the mental health professional's responsibility to secure direct services for the family and to enlighten other professionals regarding the psychological aspects of the situation. This is advised because many hearing individuals unfamiliar with the problems of deafness incorrectly interpret the implications of
deafness. This procedure will enable all the professionals involved to handle the situation with sensitivity. (Mindel, 1971, p.23)

The Deaf Person and Deafness

Deaf persons cannot be generically described. The use of the term "the deaf" is often used as a descriptor in reference to all deaf persons. Schein (1970, p.10) suggests that this description "the deaf" ...is more than discourtesy: it contributes to dehumanization.

Babbidge (1965, p.xxvii) emphasizes that deaf individuals vary considerably in the degree of hearing loss, the age of onset of the loss, the communication method used, and their attitudes about their deafness. Much of the deaf person's identity is a reflection of what hearing persons assume are his capabilities. Alice Streng (1970, p.12) contends that the deaf are members of a minority group,

...they have been dealt with paternalistically and have had to accept second-class citizenship, and they have been underestimated and underemployed... However, the ordinary citizen is not aware of the existence of the problems of the deaf as it is the other minorities.

There must be no confusion between the attempt to describe a deaf person, and the attempt to define his hearing impairment. Since there is no typical description of a deaf person, attempts to do so are inappropriate.
But it is both appropriate and necessary to define hearing impairment for purposes of diagnostic, educational, and vocational placement.

Switzer and Williams (1967, p.250) describe deafness as a primarily psychosocial handicap. They state that deafness:

...manifests itself in many ways, each of which is in turn an important life problem of deaf people: under-involvement in the main stream of community life; limited sharing with fellow men; lack of acceptance among family, under-employment.

There is no single definition of deafness that would be appropriate to professionals who provide services to the deaf. (Anderson, 1965, p.7) Both Schein and Silverman as reported by Anderson (1965, p.8) are in agreement that as of 1964 there were no suitable standard classifications for hearing impairment.

As a result of such controversy in the profession, the 1973 Ad Hoc Committee of the Conference of Executives of the American Schools for the Deaf took the matter under advisement. They submitted a newly revised definition to the full membership of the 1975 Conference, and the new definition was unanimously adopted. (American Annals of the Deaf, 1975, p.511) The new definition gives educational and diagnostic considerations for placement, and replaced the former definition that had been operational since 1938.
The general definitions consist of the following:

**Hearing Impairment.** A generic term indicating a hearing disability which may range in severity from mild to profound: it includes the subsets of deaf and hard of hearing. A deaf person is one whose hearing disability precludes successful processing of linguistic information through audition, with or without a hearing aid. A hard of hearing person is one who, generally with the use of a hearing aid, has residual hearing sufficient to enable successful processing of linguistic information through audition. 

Definition related to onset:

**Prelingual deafness:** deafness present at birth, or occurring early in life at an age prior to the development of speech or language.

**Postlingual deafness:** deafness occurring at an age following the development of speech and language. (*American Annals of the Deaf*, 1975, pp.509-510)

**Summary**

There is no typical description of a deaf person. All deaf individuals vary in the degree of hearing loss, the communication method used and attitudes about their deafness. The personal attitudes of deaf persons vary considerably, but the life problems of the deaf are very similar. The life problems of deaf persons have a wide
range from under-involvement in the main stream of community life to under-employment.

Many professionals consider it inappropriate to attempt to describe deaf persons because of their individual differences. However, it is appropriate to define hearing impairment for diagnostic, educational, and vocational purposes.

There has been a controversy among professionals regarding suitable definitions for hearing impairment. In 1973 the Conference of Executives of the American Schools for the Deaf selected an Ad Hoc Committee to consider the problem of definitions for hearing impairment. The committee chose to define hearing impairment as a generic term that includes the subsets of deaf and hard of hearing.

The diagnostic information obtained on a child with a hearing impairment is essential in considering appropriate educational programming and services for him. The type of programs that are available in school systems for children with hearing impairments are varied.

**Educational Programs for the Deaf**

Babbidge (1965, p.31) states that the four types of educational programs offered to deaf students in school systems are the following:

1. Residential schools
2. Day schools
3. Day class programs
4. Classes for hearing children into which deaf children are mainstreamed.

The National Advisory Committee on Education of the Deaf (1973, p.3) reports that in 1973 there were approximately 55,000 school-age children enrolled in schools and classes for the deaf in the United States. Less than 50 percent of the deaf children are enrolled in residential schools for the deaf. The others are enrolled in day schools and day classes for the deaf.

Residential schools provide not only the instruction, but a home for the student as well. (Fauth, p.168) Within the residential program there is a component that is called the day school program. This program permits the student to attend the residential school, participate in the school's academic and social functions, and return to his home at the end of the day. Most residential schools for the deaf accept hard of hearing children from local school districts who experience continued failure in regular day school programs. It is reported that approximately one-third of the children in schools for the deaf are educationally hard of hearing. This lack of appropriate placement has resulted in many children being shaped into functionally deaf individuals. (U.S.H.E.W., A Study of Current Practices in Education of Hard of Hearing Children, 1969, p.35)
The students in the day school receive instruction for several hours each day and are then returned to their homes. The school is not responsible for the student at the completion of the school day. Mulholland (1968, p.49) identifies day school programs by referring to them as the following:

...several classes for hearing impaired children housed under one roof and restricted to the instruction of deaf children homogeneously grouped.

Day class may refer to a single homogeneously grouped class or to a single class of hearing impaired children of various chronological ages, degrees of hearing loss, and educational attainment, the class being located in a public school for normally hearing children.

Babbidge (1965, p.35) reported that day schools enjoy an advantage over day class programs because of the following reason:

...each day school has a principal whose administrative and educational concern is focused on the instruction of deaf children.

Babbidge (1965, p.xvii) further states that the overall status of programming for the deaf lacks a continuum of services for most programs.

A sound administrative structure and significant professional staff are essential in establishing, operating, and supervising a comprehensive educational program for the deaf. The line staff is generated from the head administrator downward. This person is usually the superintendent, director, president, headmaster, or executive
director. Next in line is the department head who serves as the immediate backup to the classroom teacher. This may be the principal, supervising teacher, director of the primary department, etc. Additional staff may be available depending upon the size and the services of the comprehensive program; assistant superintendents, administrative assistants, educational directors, assistant principals, vocational rehabilitation directors. (Curtis, 1970, p.107)

Collins (1973, p.199) suggests that educators of the deaf should do the following:

...consider the purposes our schools can and should serve in the education and development of deaf persons.

There is no dispute that the teacher is the person who is responsible for delivering direct services to deaf children. The teacher becomes the primary resource person responsible for considering the education and development of her deaf students. In order to do this the teacher of the deaf must have many skills and know how to relate to each student. Kopp (1968, p.376) describes the duties of the teacher of the deaf as the following:

The teacher of the deaf is beset by pressures. She is expected to teach expertly all facets of the communication skills, to understand linguistic theory, and to apply it in her language teaching; to evaluate competing philosophies and methods of teaching and to align herself with a particular set; to be a specialist in elementary and intermediate subject content areas and to adopt and adapt the latest
trends in these areas; to participate in curriculum planning; to develop appropriate mediated teaching materials and to incorporate media in her teaching; to assess her students on a longitudinal continuum; to use the principles of diagnostic teaching to minimize learning problems; to counsel with parents as well as students; to teach the multiple-handicapped deaf; to meet the needs of the language disordered and the emotionally disturbed; and to cope effectively with an age range from infancy to adulthood, an intelligence range from mentally retarded to genius, a wide range of hearing loss, and an extensive range in socioeconomic background.

There are also other personnel working in the area of instruction with the teacher, but these people are not assigned the responsibility of a regular class. These are teacher aides, adjustment teachers, speech teachers, auditory training teachers, media specialists, and others working with children individually or in small groups. Other fields are also concerned with the education of the deaf. These include audiologists, psychologists, child guidance directors, vocational rehabilitation counselors, social workers, and field agents. A general guideline for a comprehensive instructional program, median size 250-325 students, would include at least the following:

1. head administrator
2. regular classroom teachers
3. one principal
4. three department heads
5. two teacher aides

The National Advisory Committee on Education of the Deaf (1973, p.4) has stated:
...Resources for some deaf children are so scarce that entire families move from low-density population areas to metropolitan areas. They move not only from city to city but from State to State... the educational failure of one State may become the lifetime burden of another State. This problem... is a national problem that can only be solved through creative interaction by each part of the Nation sharing its responsibility, i.e., Federal, State, and local resources.

Summary

Educational programs that are offered to deaf students in school systems are the following:

1. Residential schools
2. Day schools
3. Day class programs
4. Classes for hearing children into which deaf children are mainstreamed.

In each of these programs a sound administrative structure is necessary for establishing, operating, and supervising a comprehensive educational program for the deaf. The continuum of programs and services is generated from the head administrator downward.

The teacher is the primary resource person responsible for considering the overall educational development of her deaf students. This responsibility has caused the teacher of the deaf to extend her multivariety expertise to include programming for the multihandicapped deaf student.
The Multiply Handicapped Deaf

The traditional subdividing of handicaps into classifications is a reflection of the medical model for disease. In the last decade professionals working with the handicapped have begun to view the field of the handicapped as merging into one another with the emphasis being placed on each child coping with his individual problem. (Baldwin, 1974, p.169)

Barlow (Note 2) stated that professionals working with the handicapped tended to ignore the "real world" problems of the handicapped. The data on programs reveals a migration toward the easy problems rather than the more difficult ones. An effort must be made to change the imbalance to assure that profoundly handicapped children receive an equal educational opportunity. Babbidge (1965 p.17) views the education of the multiply handicapped deaf as a major issue in the profession. The changing philosophies and current awareness to educating children with handicapping conditions has resulted in more administrators of programs for the deaf reporting children with multiple handicaps. (Anderson, 1965, p.2)

The comprehensive programs for hearing impaired children are now absorbing large numbers of multiply handicapped children. A child with a hearing impairment may also be mentally retarded, physically handicapped,
socially and/or emotionally maladjusted, neurologically impaired or suffer from numerous other combinations of handicaps. These children are referred to as the multiply handicapped. Thousands of these children are products of the Rubella epidemic of 1964-1965.

Schein (1975, p.93) reports that the 1968-1972 Annual Survey of Hearing Impaired Children and Youth revealed that the most common additional handicap that was reported was emotional or behavioral problems. The rate of emotional and/or behavioral problems was 10.6 percent of all the students in the survey.

Anderson's survey of programs for the mentally retarded deaf in residential schools also revealed that in a sample of six of the reporting schools, 73 deaf children were classified as having a third impairment in addition to deafness and intellectual deficits. Emotional disturbance was listed as the most frequently occurring in the third category. (1965, pp.57-58)

One possible explanation for the increase in the area of behavioral and emotional problems in educational programs for the deaf is provided by Mindel and Vernon. Mindel and Vernon (1971, p.5) suggest that deaf children often become the pawns to educational systems that supposedly were originated for their benefit. Usually, the deaf child is not equipped to protest the frustrations of the system.
This frustration is often manifested in throwing tantrums or hitting or loud noises; such protest brings the child grief.

Meadows and Schlesinger (1971, p.346) surveyed a state residential school to identify students who were severely emotionally disturbed or exhibited behavior demanding excessive amounts of staff time. Of these students surveyed, 12 percent were identified as emotionally disturbed (five times greater than the estimates of the general school population); and 20 percent were identified as mildly disturbed (three times greater than expected). Meadows and Schlesinger (1971, pp.346-347) further state that little is known about the extent of emotional-behavioral problems of the deaf child.

...Although this large-scale survey was conducted at a residential school for deaf students, we have no reason to believe that the prevalence of emotional problems among deaf students attending day schools is significantly less.

Anderson (1965, p.51) alludes to what may be the future of teachers of the deaf who serve deaf children with other types of handicaps. The survey cites the method in which teachers were assigned to classes for the deaf retarded. Of the 150 teachers responding, 33 taught the mentally retarded by choice and 117 were assigned classes by the administration. Ninety-eight teachers reported that they preferred to teach deaf children with
no other handicaps. Forty-two teachers preferred to teach mentally retarded deaf students, and 8 teachers had no preference.

Meadows and Schlesinger (1971, p.348) state that the establishment of special programs for emotionally disturbed deaf children will necessitate teachers with special training. The role of the teacher must now be expanded to accommodate the needs of deaf children with multiple handicaps. Anderson (1965, p.3) supports the need for additional special training for teachers. He cites that teachers may be uncertain about how to proceed in revising curriculum and cope with the many nebulous classification terms that provide no clues as to how to educationally program for these deaf children.

In June, 1970, the American Annals of the Deaf published a directory of services that specifically concentrated on information for parents and service administrators regarding programs and services for the multiply handicapped hearing impaired. (Curtis, 1970, p.110)

The American Annals of the Deaf annually publishes a cumulative index of national programs and services for hearing impaired. Some of the information included in the index is the following:

1. Educational Programs and Services
2. Rehabilitation Programs and Services
3. Community Programs and Supportive Services
4. Research and Information Programs and Services
   (American Annals of the Deaf, 1975, pp.82-83)
Summary

The education and/or training of the multiply handicapped deaf child is a major issue among professionals in the field of the hearing impaired. As a result of the 1964-1965 Rubella epidemic, more administrators of programs for the deaf are reporting children with multiple handicaps. Some of the types of multiple handicaps that are being reported are mental retardation, physical impairments, neurological impairments, and emotional disturbance.

The 1968-1972 Annual Survey of Hearing Impaired Children and Youth revealed that the most common additional handicap reported was emotional or behavioral problems. Meadows and Schlesinger (1971, p.348) state that special programs for emotionally disturbed deaf children will necessitate teachers with special training. The responsibility of programming for the emotionally disturbed deaf child cannot be left to the whim of unwilling, untrained, and uninformed teachers and/or administrators.

Mental Health Programs and Services

The original interest in the emotional welfare of the deaf was shown in the schools for the deaf. Educators began to think about individualizing instructional approaches to meet the students' needs, and to be concerned for the development of character in deaf students. Difficulties inherent in the whole field of working with the
deaf tended to isolate the few people in each professional discipline which could benefit the deaf students; thus, the students' mental health problems were left to the educators. The regular psychiatric and social work agencies seldom saw deaf clients, and were usually helpless if they did. (Rainer, 1969, p.7) Babbidge (1965, p.xvi) suggests that education of the deaf has been characterized over the years as having accepted emotion as a substitute for research in the field, because of the many controversies over methods. He further states that improved education of the deaf is unlikely without a new research effort to extend our knowledge about the deaf and how they learn.

Dean Richard Phillips of Gallaudet undertook a survey of one state's mental health hospitals. His data revealed a large number of deaf patients in these facilities. In 1952 at an American Psychological Association meeting, Dr. Edna S. Levine of New York University reacted to the implications of these data. Two professions, rehabilitation and psychology, realizing the need for a coordinated attack on the problem, approached the psychiatric organization and encouraged its members to research mental health services for the deaf. As a result of efforts by Dr. Levine and others, a search for a psychiatrist interested in the implications of Dean Phillips' data was begun
Dr. Franz Kallmann agreed to direct the project which was sponsored by a grant to the New York State Psychiatric Institute. This was the pioneering effort in the field of mental health services for the deaf. The New York State Psychiatric Institute has implemented a three phase program which is today responsible for numerous improvements to the welfare of the mentally ill deaf. It is the center for research and teaching in psychiatry. It is also associated with the College of Physicians and Surgeons, Columbia University Medical School, and other hospitals and clinics. Dr. Boyce R. Williams has stated, "because of this program the psychiatric sphere of mental health work for deaf people is now sufficiently well established, in a small way, to maintain itself." (Rainer, 1969, pp.1-9)

The initial approach to this mental health puzzle was to investigate three general areas: research, psychiatric guidance, and training specialized workers. An intensive study ensued covering the following areas:

1. Genetic aspects of early profound deafness.
2. Particular demographic aspects such as number, distribution, marriage and fertility rate.
3. Intelligence tests in deaf twins.
4. Sexual patterns and family relationships.
5. Patterns of socialization and community integration.
6. Educational background and vocational adjustment.
7. Outstanding achievement of deaf persons.
8. Delinquency and crime.
9. Psychological testing.
10. Psychotherapy with the deaf.
11. Deafness and schizophrenia.
   (Adler, 1970, p.40)

The original project began in 1955, and included a pilot outpatient clinic, and a survey of deaf patients hospitalized for mental illness throughout the New York state. This phase of the project required a statewide census of the deaf, the gathering of statistics, and the establishment of normative data covering areas of basic life experience in approximately 300 randomly selected deaf persons and families. A card system maintained at the Psychiatric Institute listed all deaf people living in New York state both alphabetically and by geographic region. (Rainer, 1966, p.11)

A second phase of the project was begun in 1963. Its contribution was to remedy previous limitations by opening a special inpatient unit for the deaf. The inpatient unit is located at Rockland State Hospital in Orangeburg, New York, and is under the administrative direction of the State Department of Mental Hygiene and the director of the hospital. Rockland State Hospital is twenty miles from the Institute. Both the units were supported by the State and staffed by the same professional personnel. (Rainer, 1969, p.15)

The third phase was the school program at the New York School for the Deaf in White Plains. This program
was established out of concern for several problems.

1. Problems parents of deaf children had in fitting them into the family unit and relating to them on their own merit.

2. The school years were ideal for presenting genetic aspects of deafness.

(Rainer, 1969, pp.11-12)

Because of the significance of the early efforts of Dr. Kallman and his staff at the New York State Psychiatric Institute to increase the understanding of the life problems of the emotionally disturbed deaf person and his family, the following section will give a detailed review of their program. As a result of this program, other important programs have emerged such as the one at the Psychiatric and Psychosomatic Institute of Michael Reese Hospital in Chicago. Each program has made generous contributions to what is presently known about comprehensive programming in educational, vocational, and life skills planning for the emotionally disturbed deaf.

**New York State Psychiatric Institute's Mental Health Program for the Deaf**

With some understanding of the severely mentally ill deaf's problems, Dr. Kallmann and his associates began to structure the inpatient hospital program. Patients were referred by organizations for the deaf, the Division of
Vocational Rehabilitation, hospitals, physicians, correctional and welfare agencies, and deaf persons themselves. (U.S.D.H.E.W., Expended Mental Health Care for the Deaf, 1970, p.8)

The patients composed a wide ranging heterogeneous group, types of illness, deprivations caused by the illness on intellectual and social abilities, communication abilities, etc. (Rainer, 1966, p.35)

The Department of Mental Hygiene made it a part of its permanent policy to transfer any patient in its 20 State hospitals to the special Rockland unit. It also provided for the patient's return to the original hospital if it was felt that the patient could not benefit from the program. Two weeks after all the patient's data were gathered, the patient was presented at a general staff conference. A diagnostic evaluation was considered, and a plan for treatment determined.

When admitted the patient was assigned to a doctor who familiarized him with the routine of the unit. The doctor then began to develop a case history on the patient, and arrange for whatever testing that was needed. Of the patients admitted to the program, a conservative interpretation was that those who scored in the dull normal range would test as normally intelligent if there had been no cognitive gap due to deafness. The intelligence
level refers to performance I.Q. which is less diminished by deafness than verbal test scores. (U.S.D.H.E.W., Expanded Mental Health Care for the Deaf, 1970, pp.18-19)

A single ward was the treatment unit for up to 30 patients (15 female and 15 male) interacting together daily. (Rainer, 1969, p.16) Treatment varied with each case. A variety of therapeutic techniques were tried ranging from caring for baby chicks and plants to viewing captioned films. Occupational therapy, vocational evaluation, pharmacotherapy and electroshock treatment were also provided when needed. (Rainer, 1969, p.17)

Individual and group therapy was tried with fascinating results. Many psychiatrists believed that group therapy would be impossible with deaf patients. There were no established procedures for the first formal group sessions. They were conducted once a week for an exclusively female group, later the sessions were increased to twice a week at the patients' request. (Rainer, 1966, p.18)

In January, 1964, male patients were included in the group sessions. Immediately the staff observed increased interest in all the patients in grooming and group cohesiveness. Role playing was tried. Patients were assigned to conduct group sessions under the supervision of the psychiatrist. This enabled the therapist to better
observe the group and concentrate on individual behaviors of the members.

Patient enthusiasm and interest in the sessions increased, and again more therapy sessions were requested. Group therapy was being held three times a week. In at least one meeting each week patients were discussion leaders. At this point, the group format began to be shaped. Rules were devised, and although the sessions were animated, order was maintained.

The experience of the group was broadened through these sessions. No longer were there concerns regarding self-care. Now the patients were able to cope with complex decision making issues. They tried to understand mental changes in the group's members and provide suggestions for remediation.

The group forced pressure on some patients to relinquish repeated personal grievances and establish interpersonal relationships with others. Gradually, uninhibited criticism and free expression became group policy.

Transference and multiple transference, childhood attitudes and emotions displayed in present relationships, were as common to the deaf as to the hearing. However, there were few subtleties in the patients' exaggerated and repetitive expression. Often members would angrily leave the sessions. After leaving, the patient usually
realized that the sessions would continue without him. When he returned there was never any punitive action taken against him. Personal situations which could not be effectively handled in the group sessions were elaborated upon in individual therapy. (Rainer, 1966, pp.55-63)

All the sessions were conducted in sign language. These sessions were monitored on closed circuit television. Such a plan permitted feedback for both the patient and the therapist. No oral communication was used by the patient population. Many were trained in the oral method, but used sign language regardless of early training. It was concluded that manual communication (sign language, fingerspelling) was essential in the diagnostic evaluation of emotionally disturbed deaf patients. (U.S.D.H.E.W, Expanded Mental Health Care for the Deaf, 1970, pp.33-36)

Group sessions with the family were also conducted to attempt to pull together all the pieces of the patients fragmented communication. This format also gave the parents an opportunity to vent their own emotions and begin to relate to the patient clearly. Individual and group therapy for the inpatients proved to be viable and valuable. It required firm and flexible leadership, alertness to group and individual needs and conceptual limitations of its members. (Rainer, 1966, pp.63-64)
Each patient had a special rehabilitation program designed from his/her admittance to his/her discharge. The vocational staff endeavored to provide a positive simulated work environment that would assure that no patient was chronically idle. Several previous studies substantiated the staff's conviction that meaningful work experiences would assist in the patients' recovery. All of the patients had to resolve problems of emotional instability, social immaturity, and educational deficiency before their vocational inefficiency could be viewed in its proper perspective. (Rainer, 1966, pp.68-69)

The patient was initially motivated to work by using occupational therapy in the group setting. Emphasis in this setting was upon observing each patient's reaction to supervision and authority general behavior, punctuality, work habits, and stress. (Adler, 1970, p.21) Additional information was gathered on each patient by using manipulative vocational aptitude tests. Those components of these tests that measured mechanical aptitude, eye-hand coordination and manual dexterity were most useful. Pencil tests were not used because of the patients low reading ability, approximately fourth grade.

Regular individual counseling sessions were held by the vocational rehabilitation counselor for each patient. All the patients were placed in hospital jobs
which related to their stated post-hospital choices. For those unskilled patients who stated no job choices, jobs such as ground and paint crew, laundry and kitchen work was appropriate.

When the patient was presented at a staffing for discharge, a training program leading to a successful vocational goal was outlined for him/her. The patient would then be referred to the State Division of Vocational Rehabilitation. The vocational counselor made every effort to secure job placement for the ex-patient in his community. (Rainer, 1966, pp.68-71)

The inpatient clinic also had a community based program at Fountain House in New York City for its improved patients who were not yet ready to be self-supporting outside of the hospital. The half-way house concept was also a positive step in the vocational rehabilitation of these patients. (Rainer, 1966, p.74)

The patients in the outpatient clinic had some structured home environment to sustain them as a part of their support system. This was not the case for the inpatients who had been hospitalized for years and had no interested relatives. Home visits, trips outside the hospital, and visits from family and friends were encouraged to prevent the hospitalized patient from being isolated from society. As has been previously mentioned,
many of the deaf patient's problems stem from the inability to relate to family and society. These privileges eased the transition from hospital to community life. (U.S.D.H. E.W., Expanded Mental Health Care for the Deaf, 1970, p.31)

One phase of the program was supervised apartment accommodations. (Rainer, 1966, p.74) Before discharge the patients were brought to Fountain House to familiarize them with their surroundings. The interaction with the other patients, most of whom were hearing, was a vital step in helping the deaf patient make a smoother transition from the dependency of the hospital to the independence of life outside it.

During the three year inpatient project phase 96 inpatients were served. Seventy-two were discharged and 24 continued as inpatients, but were improved and awaiting discharge. Twenty-nine patients above the age of 40 were discharged which emphasized that intervention could always occur. Several of these 29 had more than 10 years of hospitalization and a prognosis of indefinite custodial care. The largest portion of the discharged patients clustered at age 20-29. This finding supports the concept that reaching patients as early as possible in their illness will prevent prolonged disability, emotional stagnation, and institutional regression. Approximately half of the discharged patients were schizophrenic.
Schizophrenia is the most common psychiatric disorder in the psychotic range. The basic disturbances are clustered in the splitting of thought processes, in concept formation and in emotional reaction and expression. (Rainer, 1966, p.37) Most resorted to tantrum and acting out behavior when confronted with life problems and existence in the hearing world; adjusting to society norms. Such problems were typified among the younger age groups and relief of extraneous pressures often allowed for growth and maturation. (U.S.D.H.E.W., Expanded Mental Health Care for the Deaf, 1970, pp.21-27)

Psychiatric and Psychosomatic Institute of Michael Reese Hospital's Mental Health Program for the Deaf

On September 1, 1966, the Psychiatric and Psychosomatic Institute of Michael Reese Hospital in Chicago obtained a federal grant from the Rehabilitation Services Administration to begin program implementation for the deaf. The grant was awarded to further an understanding of deaf people in the region centering around Chicago. Dr. Roy Grinker, Senior, Director of the Psychiatric and Psychosomatic Institute, visited the New York Psychiatric Institute program at Rockland State Hospital. There he observed the therapy and research done by Drs. Rainer, Altshuler, and staff relative to psychiatry and deafness. Dr. Grinker discovered in his conversations with Drs.
Rainer and Altshuler that one of the major problems Dr. Kallman faced in instituting the New York project was the lack of insight regarding the implications of early profound hearing loss in children. The loss that occurs prior to the child's acquisition of language leaves the child with no verbal language. (Vernon, 1969, p.13)

The staff of Michael Reese Hospital assumed the original planning for the mental health aspects of the project. They cooperated with Jewish Vocational Service in the placement, job counseling, and work-training needs of the patients.

Funding costs for two years for five beds for the hospitalization of deaf patients was provided by the State of Illinois, Division of Vocational Rehabilitation. The Department of Mental Health of the State of Illinois permitted a survey of all state hospitals in search of deaf patients. (Vernon, 1969, p.9)

The project group met weekly. There was no rigid design for the accumulation of statistics. The problems under investigation were the prelingually deaf children and their families. The group discussed observations which resulted in better defining useable techniques.

The data were treated from both a practical and theoretical approach. The practical aspects of deafness were questioned such as diagnosis, treatment, and
prevention of psychiatric disorders in the deaf. The group became interested in studying "ego functions in the adult and growing child, how the deaf child thinks without words, how he solves problems, and what are the dynamic relations between mother and deaf child that later become internalized as nuclei health or pathology." (Vernon, 1969, pp.9-10)

The Michael Reese project outlined four basic purposes for its research and demonstration unit.

1. To gain the experience and knowledge needed to provide therapy to deaf persons who are mentally ill. This work would build from, and add to and/or modify, the pioneering efforts of the Rainer-Altshuler work in New York.

2. To train professional personnel in the mental health field to provide therapeutic services for deaf patients.

3. To establish in the State Mental Health system of inpatient and outpatient facilities for the deaf and to train personnel to staff them.

4. The major research emphasis of the first year was to development a research hypotheses regarding deafness as a variable in human behavior.

Summary

Administrators of programs for the deaf will need to review the results of the pioneering efforts in the area of the emotionally disturbed deaf that have eminated from hospital programs. The New York State Psychiatric Institute has carefully documented its program philosophy and implementation. This documentation has served as a
model for other hospital programs, such as, the Psychiatric and Psychosomatic Institute of Michael Reese Hospital; school programs, the New York School for the Deaf at White Plains; and community mental health programs that are expanding their services to provide for the needs of deaf persons.
CHAPTER III

RESEARCH METHOD

Restatement of the Problem

The problem addressed in this research was to determine what type of mental health services and programs were provided to deaf children with severe behavioral and emotional disorders in public residential schools and public day school programs and by whom.

Sample

A mailing list for the survey was compiled from the American Annals of the Deaf, Directory of Programs and Services, 1975. (Appendix A) Programs and services were organized by state in the Directory of Programs and Services. Each state residential school(s) was listed first, and the public day schools, public day programs, and public day classes followed in alphabetical order by city. To insure that the day school programs were randomly selected, every third such program listed in the directory (by each state) was selected. Every public residential school(s) in each state was also selected to be included in the sample. Three hundred and seven programs were represented on the mailing list.
Methods

Each of the school programs on the mailing list was sent a cover letter (Appendix B) explaining the intent of the survey and a questionnaire (Appendix C) directed to the head administrator for completion. The survey questions had been developed from the five proposed objectives stated in Chapter I, page 4. Additional space was provided at the end of each question for any pertinent information that the respondents wished to include.

A stamped self-addressed envelope was submitted with the questionnaire. The questionnaire was dated with the time sent, and the deadline date for it to be returned. To facilitate an immediate response from the respondents to the survey, no more than 35 items were included in the questionnaire. A 10 day response time was requested for the return of the questionnaire.

The cover sheet of the questionnaire was used as a response checklist. It indicated, by staff position, whose comments were used in response to the survey. To insure reliable responses, the respondents were informed on the questionnaire that in the final publication of the study no names or programs would be identified.

Data Analysis

A discussion regarding the findings relevant to the response data was recorded in the text of Chapter 4.
The results of the survey include sample size, number of programs responding to each item, the percentage of response, and the comments of the respondents. Each response to the items on the questionnaire were analyzed individually, and the results were recorded in raw scores and percentage of response. A computer program was written and used in the quantitative analysis of the data. Not all of the questions that were analyzed were represented in the Tables. Those questions that required a written statement from the respondent were analyzed separately and recorded in narrative style. Only those questions that presented choices to the respondent were included in the Tables.

Summary

A national survey of public residential and public day school programs and services for the hearing impaired was completed utilizing a questionnaire as the polling instrument. The questionnaire items were taken from the proposed objectives of the study as stated in Chapter I, page 4.

A mailing list was compiled from the American Annals of the Deaf, Directory of Programs and Services, 1975. The mailing list included each state's residential school(s) and every third public school program or service.
One hundred and eighty-three responses to the survey questionnaire were returned. Thirty-seven of the respondents considered their program not applicable to the study, and were omitted in the results. The study sample consisted of one hundred and forty-six respondents. A computer program was written and used in the quantitative analysis of the data. Each of the respondents written statements were analyzed separately and documented in Chapter IV.
CHAPTER IV

RESULTS

General Background

Three hundred and seven (307) questionnaires were sent to public residential schools and public day school programs for the hearing impaired to assess the type of mental health services they provided to their students. One Hundred and eighty-three (183) responses to the questionnaire were returned (60%). One hundred and forty-six (146) questionnaires were used in the sample for the study. Forty-one (41) state residential school programs and one hundred and five (105) public day school programs and services responded to the survey. Hospitals, university clinics, and speech and hearing centers were included in public day services. Thirty-seven (37) of the respondents listed their programs as not applicable to the study, and were omitted. Listed in Table 1 are the reasons for these programs' omission.

Respondents to the Questionnaire

The respondents to the questionnaire were categorized according to their staff position within each program. This was done to determine who was addressing themselves
TABLE 1

REASONS FOR OMITTING PROGRAMS FROM THE STUDY

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No explanation</td>
<td>17</td>
</tr>
<tr>
<td>2. Program discontinued or Managed by another agency</td>
<td>7</td>
</tr>
<tr>
<td>3. Inadvertently sent to private school or private agency program</td>
<td>3</td>
</tr>
<tr>
<td>4. Time limit too restrictive</td>
<td>3</td>
</tr>
<tr>
<td>5. Program primarily for Mentally Retarded</td>
<td>4</td>
</tr>
<tr>
<td>6. Resource room program for moderately hard of hearing</td>
<td>2</td>
</tr>
<tr>
<td>7. Specific school board procedures required before responding</td>
<td>1</td>
</tr>
<tr>
<td>Total-(raw scores)</td>
<td>37</td>
</tr>
</tbody>
</table>

to the issues presented in the questionnaire. There was a varied range of staff titles. Many of the titles may have assumed the same or similar job responsibilities, i.e., coordinator of special education in one state may have been titled director of special education in another state. No attempt was made to compile the position titles into a line staff arrangement of authority.

The four major categories responding were superintendents of residential schools, principals in residential and day school programs, program supervisors, and teachers. Only one respondent gave no designation of staff position. The staff positions and titles of the questionnaire respondents are shown in Table 2.
TABLE 2

STAFF POSITION/TITLES OF QUESTIONNAIRE RESPONDENTS

<table>
<thead>
<tr>
<th>Title</th>
<th>Number Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Superintendent</td>
<td>18</td>
</tr>
<tr>
<td>2. Assistant Superintendent</td>
<td>1</td>
</tr>
<tr>
<td>3. Administrator for the deaf</td>
<td>1</td>
</tr>
<tr>
<td>4. Director of educational services for the deaf</td>
<td>3</td>
</tr>
<tr>
<td>5. University director of program for the deaf</td>
<td>2</td>
</tr>
<tr>
<td>6. Department head for the hearing impaired</td>
<td>2</td>
</tr>
<tr>
<td>7. Assistant to dean of University program</td>
<td>1</td>
</tr>
<tr>
<td>8. Principal</td>
<td>14</td>
</tr>
<tr>
<td>9. Assistant principal</td>
<td>7</td>
</tr>
<tr>
<td>10. Administrative assistant for the deaf</td>
<td>1</td>
</tr>
<tr>
<td>11. Program supervisor</td>
<td>20</td>
</tr>
<tr>
<td>12. Director of special studies</td>
<td>1</td>
</tr>
<tr>
<td>13. Director of program for deaf and hard of hearing</td>
<td>2</td>
</tr>
<tr>
<td>14. Coordinator of deaf program</td>
<td>2</td>
</tr>
<tr>
<td>15. Curriculum specialist</td>
<td>1</td>
</tr>
<tr>
<td>16. Program specialist</td>
<td>2</td>
</tr>
<tr>
<td>17. Teachers</td>
<td>16</td>
</tr>
<tr>
<td>18. Team teacher leader</td>
<td>3</td>
</tr>
<tr>
<td>19. Curriculum resource teacher</td>
<td>1</td>
</tr>
<tr>
<td>20. Director of special education</td>
<td>8</td>
</tr>
<tr>
<td>21. Assistant director of special education</td>
<td>2</td>
</tr>
<tr>
<td>22. Coordinator of special education</td>
<td>9</td>
</tr>
<tr>
<td>23. Director of pupil personnel</td>
<td>6</td>
</tr>
<tr>
<td>24. Assistant director of pupil personnel</td>
<td>2</td>
</tr>
<tr>
<td>25. Coordinator of pupil services</td>
<td>1</td>
</tr>
<tr>
<td>26. Director of student and family service</td>
<td>1</td>
</tr>
<tr>
<td>27. Director of testing and family service</td>
<td>1</td>
</tr>
<tr>
<td>28. Director of medical and social services</td>
<td>1</td>
</tr>
<tr>
<td>29. Director of diagnostic clinic</td>
<td>1</td>
</tr>
<tr>
<td>30. Director of diagnostic consultation service</td>
<td>1</td>
</tr>
<tr>
<td>31. Acting director of counseling and evaluation</td>
<td>1</td>
</tr>
<tr>
<td>32. Coordinator of Aural Habilitation</td>
<td>1</td>
</tr>
<tr>
<td>33. School psychologist</td>
<td>4</td>
</tr>
<tr>
<td>34. Speech pathologist</td>
<td>1</td>
</tr>
</tbody>
</table>
Responses to the Questionnaire by Item

Questions one through three were concerned with the admission of multiply handicapped children, specifically deaf children with severe behavior disorders, to public residential schools and public day school programs.

Question 1:

**TABLE 3**

DO YOU ROUTINELY ADMIT MULTIPLY HANDICAPPED HEARING IMPAIRED CHILDREN TO YOUR PROGRAM?

<table>
<thead>
<tr>
<th>Title</th>
<th>Number Responding (Raw source)</th>
</tr>
</thead>
<tbody>
<tr>
<td>35. School social worker---------------------------------------------</td>
<td>1</td>
</tr>
<tr>
<td>36. Head; speech, hearing, and vision-------------------------------</td>
<td>3</td>
</tr>
<tr>
<td>37. Coordinator; hearing and vision---------------------------------</td>
<td>3</td>
</tr>
<tr>
<td>38. No designation---------------------------------------------------</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong>----------------------------------------------------------</td>
<td><strong>146</strong></td>
</tr>
</tbody>
</table>
Seventy-nine percent (79.17) stated that they do routinely, as common practice, admit multiply handicapped hearing impaired children regardless of the secondary handicap. However, three percent (3.47) of the programs indicated by written statement that these children are admitted on a trial basis. The remarks that accompanied this question state that multiply handicapped children are admitted to public residential and day school programs for the following reasons:

The child is admitted if the primary handicap is a hearing impairment, the secondary handicap is mild, and the child can be mainstreamed into other programs within the school.

Seventeen percent (17.36) of the respondents stated that they did not admit multiply handicapped hearing impaired children.

At no time was a definition for multiply handicapped hearing impaired, emotionally disturbed deaf, or severe behavioral disorders given in the questionnaire. This was done because each school district and state agency uses a different criteria to define these categories. The study indicates that any child who deviates too far from the norm of normal hearing impaired children is referred to another program as a child with a secondary handicap. The referral is usually made to a hospital, a university diagnostic clinic, or a special training unit within a residential school or public school district.
Question 2:

TABLE 4

IF YES, DO YOU ADMIT DEAF CHILDREN WITH BEHAVIOR DISORDERS (EMOTIONALLY DISTURBED)?

<table>
<thead>
<tr>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes (#) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>No (#) Residential Day</th>
<th>No (%) Residential Day</th>
<th>No (#) Other Residential Day</th>
<th>No (%) Other Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>146</td>
<td>132</td>
<td>37</td>
<td>14</td>
<td>108</td>
<td>81.82</td>
<td>81.82</td>
<td>19</td>
<td>81.82</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Eighty-two percent (81.82) stated that they did admit deaf children with behavior disorders. The comments following this question stated that admission was contingent upon the severity of the problem and the availability of other programs to which the child could be admitted for better service. Fourteen percent (14.39) of the respondents stated that they did not admit deaf children with behavior disorders. Question three shows those programs that qualified their reasons for not admitting these children.
Table 3:

TABLE 5
IF NO TO #1 AND #2, PLEASE ANSWER THE FOLLOWING:

| a. The physical facility is too small         | 8.57% |
| b. Inadequate number of trained teachers     | 17.14%|
| c. Philosophy of the school forbids it        | 17.14%|
| d. Too expensive to program for this population | 2.86% |
| e. Other                                      | 54.29%|

In the "other" category two schools reported that they were established by statute "to provide for deaf students with no other major physical handicap." Three other schools described their programs as being geared toward academic mainstreaming of hearing impaired children whose primary handicap is the hearing impairment, and causes the child's educational difficulty. One school reported,

Emotionally disturbed are sent to a special program just for them. They drain off too much of the teacher's energy and attention; robbing time from the majority of the other children.

Four schools reported that programming for the emotionally disturbed deaf child presents no problem, because none of these children have been referred to their programs.

We'd meet their needs if we could for sure. We'd take them for evaluation and refer if we couldn't serve.
Another respondent stated,

*If the staff feels that our facility best meets his needs, the child is admitted. If, however, we find that he needs services of other experts that we are unable to provide, we do not admit the child, but keep the door open for future consideration.*

Three schools, two residential and one day program, reported that inadequate funding sources made it impossible to properly staff a comprehensive program for the emotionally disturbed deaf child. One respondent summarized the sentiments of many when stating, "If regionalization is accomplished, some progress may be made."

Many programs have a cooperative agreement between school districts to provide a service and/or program for multiply handicapped children. Although a service or program is provided, there is considerable resentment on the part of one public school program respondent. He stated the following:

*They come to us because the planned and present programs are not financed as they should. So the next alternative on the screening committee recommendation is us.*

Sixty-six percent (65.96) of the programs reported that they did not have an exclusion policy. In the "other" category the responses were yes they did have a policy, but it was not used. For those who stated that they did have a student exclusion policy for the multiply handicapped hearing impaired, it was found that nationally the
policies have similar criteria components. The respondents stated that the children must meet one or more of the following criteria components to be eligible for admittance to their program. It is recognized that each of the cases to be admitted are individual and based on the welfare of the child and his peers. The criteria for admission to programs for the hearing impaired are shown in Table 7.
## TABLE 7
CRITERIA FOR ADMISSION TO PROGRAMS FOR THE HEARING IMPAIRED

<table>
<thead>
<tr>
<th>Description</th>
<th>Raw Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Present no danger to himself, other students and staff</td>
<td>14</td>
</tr>
<tr>
<td>2. Educable</td>
<td>13</td>
</tr>
<tr>
<td>3. Hearing impairment must be the major disability</td>
<td>6</td>
</tr>
<tr>
<td>4. Physically able to maintain self-care</td>
<td>4</td>
</tr>
<tr>
<td>5. Mandatory legislation causing the necessity to provide placement and service options for the multiply handicapped hearing impaired child</td>
<td>4</td>
</tr>
<tr>
<td>6. Age</td>
<td>3</td>
</tr>
<tr>
<td>7. Must be semi-ambulatory or ambulatory</td>
<td>3</td>
</tr>
<tr>
<td>8. Placed on a trial basis if no other appropriate program is available</td>
<td>2</td>
</tr>
<tr>
<td>9. State resident</td>
<td>1</td>
</tr>
<tr>
<td>10. Must have moderate or mild behavioral problems</td>
<td>1</td>
</tr>
<tr>
<td>11. Must have no severe medical problems that would inhibit his accommodation in the dormitory and/or classroom</td>
<td>1</td>
</tr>
</tbody>
</table>

Question 5:

If yes, please explain--

Twenty-eight percent (27.66) of the respondents replied that they did have an exclusion policy, but they made minimal use of it. The reasons given for minimal use of the policy were the following:

1. The advent of mandatory special education necessitates more viable program and service options be considered for all handicapped children instead of utilizing student exclusion.
2. The student exclusion procedure is lengthy, and usually requires school board action, as well as, the student's right to a hearing.

Question 6:

**TABLE 8**

DO YOU CONSIDER IT NECESSARY TO HAVE SEPARATE LIVING AND/OR EDUCATIONAL FACILITIES FOR DEAF CHILDREN WITH EMOTIONAL DISORDERS?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No response Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>No (%) Residential Day</th>
<th>No (%) Residential Day</th>
<th>Other (%) Residential Day</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>40</td>
<td>92</td>
<td>14</td>
<td>13</td>
<td>34</td>
<td>17</td>
<td>25.76</td>
<td>42.36</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Twenty-six percent (25.76) of those respondents who answered "yes" to this question were in agreement that each individual case should be considered prior to separation of living and/or educational facilities for deaf children with emotional disorders. The outstanding feature in determining the inclusion of a deaf emotionally disturbed child with other normal deaf children depended upon the severity of the child's emotional problem. In some cases children with mild behavior disorders were included in a classroom with "normal" deaf children if the teacher had the assistance of an aide. However, many programs lacked
the financial support to staff the ancillary personnel needed for these children. One respondent stated that teachers should be provided with the services of "...social workers and counselors who know sign language who can intervene if needed."

Question 7:
If yes, please explain--

Many felt that separate educational facilities seem necessary in most severe cases, due to the special demands on the teachers. Another point-of-view in favor of separate educational facilities was stated as follows:

...more consistent carryover of intervention is possible, as well as, more appropriate programming. Separate facilities allow a child to cope with his problems without additional pressures of the 'norm'.

Another suggested that for the severely disturbed a separate facility is necessary "...to have a milieu that can focus on the unique needs of such a youngster." Others responded that emotionally disturbed deaf children "...should be separated from the regular classroom until such time as their behavior can be modified." Another response was that the child should be separated only during therapy and mainstreamed with normal children as soon as possible.

The living arrangements of these children is important and may have considerable relationship to their academic functioning. A residential school superintendent stated,
It is bad enough to have this additional handicap, but to make such a person live with 'normal' deaf children only increases the stress he is faced with. Most deaf children tend to ostracize these type of children.

A residential school principal who operates a Multiply-Impaired Unit stated,

We do not have or need separate facilities for our lowest functioning students (emotionally and academically), but we have not been in existence long as a Multiply Impaired Unit. We are seeing more and more (and already have some) who could be better served in separate living facilities and/or educational facilities.

The general response among the sixty-eight percent (68.18) who responded "no" to the question was that their programs were too small to have separate facilities for emotionally disturbed deaf children. The incidence is so small that few multiply handicapped children apply to public day school programs as a first choice.
Question 8:

TABLE 9

IF A CHILD WITH BEHAVIOR DISORDERS IS EXCLUDED FROM YOUR PROGRAM, IS ANOTHER REFERRAL PLACEMENT OBTAINED FOR HIM?

<table>
<thead>
<tr>
<th>Totals</th>
<th>146</th>
<th>122 Responding</th>
<th>Residential</th>
<th>Day</th>
<th>24 No Response</th>
<th>Residential</th>
<th>19 Day</th>
<th>101 Yes (%)</th>
<th>Residential</th>
<th>29 Day</th>
<th>82.79 Yes (%)</th>
<th>Residential</th>
<th>72 Day</th>
<th>80.56 Yes (%)</th>
<th>Residential</th>
<th>11 Day</th>
<th>83.72 Yes (%)</th>
<th>Residential</th>
<th>7 Day</th>
<th>90.02 No (%)</th>
<th>Residential</th>
<th>14 Day</th>
<th>9.11 No (%)</th>
<th>Residential</th>
<th>7 Day</th>
<th>18.14 No (%)</th>
<th>Residential</th>
<th>10 Day</th>
<th>8.20 Other (%)</th>
<th>Residential</th>
<th>3 Day</th>
<th>6.33 Other (%)</th>
<th>Residential</th>
<th>8 Day</th>
<th>8.14 Other (%)</th>
<th>Residential</th>
<th>7 Day</th>
<th>6.86 Other (%)</th>
<th>Residential</th>
</tr>
</thead>
</table>

Question 9:

If no, please explain---

A residential school superintendent stated, "...this (referral) has been problematic and has forced us to look carefully at our role." Because of the lack of appropriate programs and services for the emotionally disturbed deaf child some programs responded that they had developed cooperative regional projects to serve the child's needs. One respondent has suggested that the matter of appropriate referral and placement "...has resulted in inservice for our teachers in management techniques for such children."

In many cases the respondents stated that they at least notify state and local agencies that an emotionally
disturbed deaf child has been identified, but there may be no program or service available to that child. In these cases, if the child's disorder is minimal, he is considered in an existing program. A respondent stated the following:

We always work with the parents and student to attempt to find another program, when it becomes necessary to exclude the student. Often we leave open the possibility for return at a later time if it seems the student is ready to come back.

Question 10:

TABLE 10

IF CHILDREN ARE REFERRED TO AN OUTSIDE AGENCY, DO YOU FEEL THAT THE PERSONNEL PROVIDING THE MENTAL HEALTH SERVICES ARE FAMILIAR WITH THE PROBLEMS ASSOCIATED WITH DEAFNESS?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No response Residential Day</th>
<th>Yes (#) Residential Day</th>
<th>No (%) Residential Day</th>
<th>Yes (#) Day</th>
<th>No (%) Day</th>
<th>Yes (#) Residential Day</th>
<th>No (%) Residential Day</th>
<th>Other (#) Residential Day</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>126</td>
<td>93</td>
<td>20</td>
<td>12</td>
<td>52</td>
<td>10</td>
<td>40:30</td>
<td>50:40</td>
<td>8:12</td>
<td>7:55</td>
</tr>
</tbody>
</table>

Question 11:

If yes, please explain---

Most of the programs that responded "yes" to questions 10 and 11 have compatible working conditions in regard to referrals. They had affiliated referral services with
agencies, schools for the deaf, and hospital programs for the mentally ill that have personnel trained in the area of the hearing impaired. Several agencies have hired hearing impaired personnel specifically to deaf with referrals. Many of these people have positions as social workers and counselors.

A large residential school's assistant superintendent stated that in his state "...institutions, due to cross referrals, are becoming more familiar with such problems." Through experience in referring cases to outside agencies, it takes little time to determine which agencies are not providing an adequate service. When this is the situation, another referral agency is sought.

One respondent of a school for exceptional children felt that the area of referral was one in which they received very little help. Another program responded that their referrals were handled poorly, but that the agency personnel were "...making an effort to educate themselves through inservice." A superintendent responded that in his state a recent survey of programming at the district level for emotionally disturbed deaf students indicated "...referral services are inadequate."

Although many programs are fortunate enough to be in a geographic location that abounds with referral facilities, other programs are less fortunate. One
respondent stated that the nearest referral agency for an emotionally disturbed deaf child would be a distance of 150 miles away.

A final alternative to programming and service for this population was suggested by another respondent; the juvenile court. Those emotionally disturbed deaf children receiving no programs and services may become acquainted with a less than understanding court system that may compound the child's problem. In this case, the respondent stated, "the juvenile court system does not provide interpreters or counselors for the deaf."

Question 12:

**TABLE 11**

DOES YOUR SCHOOL PROVIDE ANY KIND OF INSERVICE PROGRAM ABOUT THE PROBLEMS OF DEAFNESS TO THE AGENCY PERSONNEL WITH WHOM YOU CONTRACT FOR SERVICE?

<table>
<thead>
<tr>
<th>Totsl</th>
<th>Sample</th>
<th>Responder Residential Day</th>
<th>No Response Residential Day</th>
<th>14</th>
<th>Yes (%)</th>
<th>15</th>
<th>Yes (%)</th>
<th>34.83 Resid day</th>
<th>40.54 Resid day</th>
<th>15</th>
<th>Yes (%)</th>
<th>32.63 Resid day</th>
<th>No (%)</th>
<th>76</th>
<th>No (%)</th>
<th>57.58 Residential Day</th>
<th>45.95 Residential Day</th>
<th>75</th>
<th>No (%)</th>
<th>13.51 Residential Day</th>
<th>5.26</th>
</tr>
</thead>
</table>
Fifty-eight percent (57.58) of the programs responded no, they did not provide inservice to referral agencies. This was because most of the agencies were in a better position to counsel students than the referring program. For example, in many states the residential school for the deaf was the agency to which public day programs refer their students for extensive evaluation and family counseling. In the "other" category, those programs responding indicated that they did not provide inservice, "...but it's a good idea."

Question 13:

If yes, please explain---

Thirty-five percent (34.85) responded "yes" that they did provide inservice to agency personnel. The inservice mostly consisted of sign language classes and other services upon request of the agency.
Question 14:

TABLE 12

DOES YOUR SCHOOL EMPLOY DEAF PERSONS?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes (#) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>No (#) Residential Day</th>
<th>No (%) Residential Day</th>
<th>Other (#) Residential Day</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>143</td>
<td>102</td>
<td>3</td>
<td>48</td>
<td>61.54</td>
<td>97.56</td>
<td>45</td>
<td>47.06</td>
</tr>
</tbody>
</table>

Sixty-two percent (61.54) responded that they did employ deaf persons in some phase of their educational programs. The four largest areas of employment were teachers, counselors, instructional assistants (teacher aides), and houseparents. Each of the choices were placed on a frequency chart in which one or more different positions may appear in any one program.
Question 15:
If yes, please identify their positions---

<table>
<thead>
<tr>
<th>Title</th>
<th>Number Responding (Raw Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superintendents</td>
<td>4</td>
</tr>
<tr>
<td>Assistant Superintendents</td>
<td>4</td>
</tr>
<tr>
<td>Principals</td>
<td>9</td>
</tr>
<tr>
<td>Counselors</td>
<td>29</td>
</tr>
<tr>
<td>Teachers</td>
<td>65</td>
</tr>
</tbody>
</table>
| Others:
  Academic supervisor, supervising teachers
    head teachers                                           | 5                             |
| Dean of Students                                            | 3                             |
| Houseparents, cottage parents, Dormitory counselors         | 18                            |
| Housekeeping, maintenance, custodial                        | 10                            |
| Kitchen help, dietary, food service                         | 9                             |
| Instructional assistants, teacher assistants
    teacher aides                                            | 22                            |
| Media Specialists                                           | 3                             |
| Artist                                                      | 1                             |
| Recreation worker                                           | 1                             |
| Social worker                                               | 2                             |
| Medical technologist                                        | 1                             |
| Department head                                             | 1                             |
| Computer programmer                                         | 1                             |
| Secretary                                                   | 2                             |
| Consultant                                                  | 1                             |

Thirty-two percent (32.17) responded that they did not employ deaf persons in their programs. However, several made the following similar comments:
1. We would possibly, but none have applied.
2. I checked, we haven't had any deaf people apply.
3. Would consider qualified person anytime...one applied, and was rejected because she was not an American citizen.
4. No policy procedure or practice against it...
5. There is no policy against it, but at present we have none on staff.

Several other public school programs stated that at one time or another they did employ deaf persons, but they were no longer on staff. One public school program stated that deaf persons would be employed in their program "...as of 1976-1977."

Question 16:

**TABLE 14**

WHO CONSULTS WITH TEACHERS REGARDING SEVERE BEHAVIOR PROBLEMS OF STUDENTS?

<table>
<thead>
<tr>
<th>Title</th>
<th>Number Responding (Raw Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Superintendent</td>
<td>24</td>
</tr>
<tr>
<td>b. Principal</td>
<td>76</td>
</tr>
<tr>
<td>c. Department Supervisor</td>
<td>80</td>
</tr>
<tr>
<td>d. Social worker</td>
<td>67</td>
</tr>
<tr>
<td>e. Nurse</td>
<td>57</td>
</tr>
<tr>
<td>f. Psychiatrist</td>
<td>39</td>
</tr>
<tr>
<td>g. Psychologist</td>
<td>114</td>
</tr>
</tbody>
</table>

Each of the programs were asked to check the person or persons who consulted with the teacher. Any staff positions that were not already listed were to be placed in the "other" category. Each program may have checked
one or more persons per program. A frequency count of all the positions was tallied and reported in raw scores. The four highest positions listed for consulting with teachers on student behavior problems were psychologists, department supervisors, principals, and social workers. In the "other" category it was stated that any one or more persons listed were combined to provide consultation services as they were needed.

Question 17:

TABLE 15
WHAT TYPES OF PROBLEMS ARE MOST OFTEN REFERRED?
PLEASE LIST IN ORDER OF HIGHEST REFERRAL.

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes (#) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>Other (#) Residential Day</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>115</td>
<td>32</td>
<td>31</td>
<td>94</td>
<td>1</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>83</td>
<td>29</td>
<td>32</td>
<td>32</td>
<td>1</td>
<td>1.20</td>
</tr>
</tbody>
</table>

One hundred and fifteen (115) responded to the question. Those responding were listed under the "yes" and "other" categories. The "other" category was used for respondents who gave a written statement instead of making a listing. One public school program respondent
stated that in their district "...children with hearing disabilities are seldom, if ever, referred for behavioral problems." Another principal of a public school day program stated that he seldom had occasion to make referrals.

Thirty-one (31) programs did not respond to the question. Most of the programs stated that they felt that they could not give a highest referral to this question, and instead gave a listing of all their referrals. Therefore, a composite of their answers are presented without rating the referrals. The behaviors were listed by the programs in both psychoanalytic and behavioral terms.
TABLE 16
THE MOST OFTEN REFERRED TYPES OF BEHAVIOR PROBLEMS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gross inappropriate behaviors</td>
</tr>
<tr>
<td>2</td>
<td>Any behavior that interferes with daily living skills</td>
</tr>
<tr>
<td>3</td>
<td>Truancy</td>
</tr>
<tr>
<td>4</td>
<td>Disruptive behavior that is harmful to others: assaults on teachers and peers</td>
</tr>
<tr>
<td>5</td>
<td>Self-abuse</td>
</tr>
<tr>
<td>6</td>
<td>Temper tantrums</td>
</tr>
<tr>
<td>7</td>
<td>Withdrawn and sullen children</td>
</tr>
<tr>
<td>8</td>
<td>Destructive behavior</td>
</tr>
<tr>
<td>9</td>
<td>Acting out behavior</td>
</tr>
<tr>
<td>10</td>
<td>Self-stimulating activities</td>
</tr>
<tr>
<td>11</td>
<td>Parent child problems: parental rejection and over-protection</td>
</tr>
<tr>
<td>12</td>
<td>Family problems affecting the student: divorce, remarriage, and separation</td>
</tr>
<tr>
<td>13</td>
<td>Helping teachers understand and deal with problems of children who are multiply handicapped</td>
</tr>
<tr>
<td>14</td>
<td>Sexual perversion</td>
</tr>
<tr>
<td>15</td>
<td>Drug and alcohol abuse</td>
</tr>
<tr>
<td>16</td>
<td>Aggressive behavior</td>
</tr>
<tr>
<td>17</td>
<td>Hyperactivity</td>
</tr>
<tr>
<td>18</td>
<td>Short attention span</td>
</tr>
<tr>
<td>19</td>
<td>Not progressing academically in accordance with age and expectations</td>
</tr>
<tr>
<td>20</td>
<td>Not developing socially in accordance with age and expectations</td>
</tr>
<tr>
<td>21</td>
<td>Stealing</td>
</tr>
<tr>
<td>22</td>
<td>Intimidation of other students</td>
</tr>
<tr>
<td>23</td>
<td>Disrespect to adults</td>
</tr>
<tr>
<td>24</td>
<td>Rejection of deafness</td>
</tr>
<tr>
<td>25</td>
<td>Worrying about health</td>
</tr>
<tr>
<td>26</td>
<td>Depression</td>
</tr>
<tr>
<td>27</td>
<td>Anxiety reactions</td>
</tr>
<tr>
<td>28</td>
<td>Psychosis</td>
</tr>
<tr>
<td>29</td>
<td>Hysteria</td>
</tr>
<tr>
<td>30</td>
<td>Anti-social behavior</td>
</tr>
<tr>
<td>31</td>
<td>General dormitory living problems; personal hygiene, destruction of property</td>
</tr>
<tr>
<td>32</td>
<td>Running away</td>
</tr>
<tr>
<td>33</td>
<td>Teasing</td>
</tr>
<tr>
<td>34</td>
<td>Tardiness</td>
</tr>
<tr>
<td>35</td>
<td>Lying</td>
</tr>
<tr>
<td>36</td>
<td>Identity crises</td>
</tr>
<tr>
<td>37</td>
<td>Adolescent crises</td>
</tr>
</tbody>
</table>
TABLE 16 - continued

38. Lack of impulse control
39. Personality disorders
40. Refusal to cooperate

Question 18:

TABLE 17

DO YOU HAVE A FULL OR PART TIME PSYCHIATRIST AVAILABLE TO YOUR SCHOOL FOR CONSULTATION?

<table>
<thead>
<tr>
<th>Totals</th>
<th>Sample</th>
<th>146</th>
<th>138</th>
<th>40</th>
<th>98</th>
<th>8</th>
<th>7</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>49.28</th>
<th>50</th>
<th>70</th>
<th>49.50</th>
<th>45.00</th>
<th>51.00</th>
<th>48</th>
<th>48.90</th>
<th>48.90</th>
<th>50.72</th>
<th>55.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responding Residential Day</td>
<td>No response Residential Day</td>
<td>Residential Day</td>
<td>No (%)</td>
<td>Residential Day</td>
<td>No (%)</td>
<td>Residential Day</td>
<td>Yes (%)</td>
<td>Residential Day</td>
<td>No (%)</td>
<td>Residential Day</td>
<td>Yes (%)</td>
<td>Residential Day</td>
<td>No (%)</td>
<td>Residential Day</td>
<td>Yes (%)</td>
<td>Residential Day</td>
<td>No (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.63</td>
<td>10</td>
<td>5.26</td>
<td>9</td>
<td>84.38</td>
<td>54</td>
<td>94.74</td>
<td>18</td>
<td>80.00</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fifty-one (50.72) responded "no" to the question. Several programs did state that although they did not have a psychiatrist, they did have a psychologist, and could request psychiatric staffings if it were necessary. One respondent was emphatic in his response to the question. He stated, "No, a regular psychiatrist would be more of a hurdle than just a plain counselor for the deaf." Another
replied that in rare cases the health department would provide a psychiatrist, but "...usually a private practitioner would be most available."

Forty-nine percent (49.28) responded "yes" to the question. Several respondents who had part time psychiatrists (84.38) replied that this service was provided in cooperation with a local university medical school. One respondent, of the sixteen percent (15.63) who had a full time psychiatrist, replied that their psychiatrist was kept busy at the hospital "...his admission responsibilities limit the time available for campus students." And finally, a public school program with the service of a full time psychiatrist stated that he does not consult on problems of deaf children.
Question 19:

TABLE 18

IS THERE A HOSPITAL OR MENTAL HEALTH FACILITY IN YOUR GEOGRAPHIC LOCATION THAT WILL ACCEPT YOUR SEVERELY EMOTIONALLY DISTURBED STUDENTS?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential</th>
<th>No response Residential</th>
<th>Yes (%) Residential</th>
<th>No (%) Residential</th>
<th>Day</th>
<th>Residential Day</th>
<th>Other (%) Residential</th>
<th>No (%) Residential</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>128</td>
<td>91</td>
<td>18</td>
<td>14</td>
<td>94</td>
<td>72</td>
<td>73.44</td>
<td>59.46</td>
<td>79.42</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>14</td>
<td>16</td>
<td>23.44</td>
<td>37.48</td>
<td>84</td>
<td>16</td>
<td>23.44</td>
<td>37.48</td>
<td>17.58</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3.13</td>
<td>3.70</td>
<td>3.30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Twenty-three percent (23.44) responded "no" to this question because they had never had occasion to refer severely emotionally disturbed students. Some of the comments were the following:

1. This has never become necessary, so I am unaware.
2. No, not that we are aware.
3. No area hospital has ever been approached with such a request that I know of.

Seventy-three percent (73.44) of the programs replied "yes" to this question. They responded that even though facilities were available, they had no necessity to make referrals. One response was "...on occasion we have referred a student to a residential home."
The procedures that the respondents used in placing a child in residential care for short or long term treatment were similar. A composite picture from all the respondents is represented in Table 19.

Question 20:

TABLE 19
IF YES, PLEASE EXPLAIN THE REFERRAL AND PLACEMENT PROCEDURES

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes (#) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>No (#) Residential Day</th>
<th>No (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>90</td>
<td>23</td>
<td>56</td>
<td>38</td>
<td>1</td>
<td>1.49</td>
</tr>
</tbody>
</table>

REFERRAL AND PLACEMENT PROCEDURES

1. Parents are notified of the situation in writing using due process procedures.

2. Referral is initiated following a thorough diagnostic evaluation by one or more professionals associated with the child's case; the program's psychologist, a private physician, the mental health clinic, or the court.


4. An appointment is made with the receiving agency for the parents and the child.
5. If needed, an interpreter is provided.

6. An admission age requirement for the child may be imposed by the receiving agency (usually 16).

7. Placement is usually made in the child's home county or in a geographic location near the child's parent or guardian.

8. Treatment is begun.

If residential placement is not advised, the respondents similarly stated the following:

A social worker from the mental health clinic works on an outpatient basis, residential care is available if necessary. He will come out to meet for consultation and/or session on request.

Question 21:

<table>
<thead>
<tr>
<th>TABLE 20</th>
</tr>
</thead>
</table>

**DOES YOUR SCHOOL PROVIDE INSERVICE EDUCATION TO PARENTS REGARDING THE PROBLEMS OF DEAFNESS?**

<table>
<thead>
<tr>
<th>Totals</th>
<th>Sample</th>
<th>Responding</th>
<th>Residential Day</th>
<th>No Response</th>
<th>Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>146</td>
<td>143</td>
<td>41</td>
<td>102</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>115</td>
<td>31</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75.61</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>82.35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17.48</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19.51</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.88</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.98</td>
</tr>
</tbody>
</table>

Eighty percent (80.42) responded "yes" to the question. The sessions vary from very specifically outlined inservice program topics on a regular ongoing basis
to general inservice program topics with guest speakers on a yearly basis. One respondent outlined their parent inservice as the following:

Parent orientation includes six sessions with guest speakers; program coordinator, audiologist, psychologist, language development teacher, the children's teacher, and the evaluation specialist... also have parent 'rap groups' where we sit and talk about kids, families, siblings, etc.

The reason given for the infrequent use of parent inservice by the seventeen percent (17.48) of the respondents that replied "no" to the question was that parents have their own organization. One respondent stated,

Parents are counseled to some extent when the child is diagnosed as hearing impaired, and there is a parent group which meets occasionally.

In the "other" category replies were that programs had provided inservice in the past and were considering reinstituting it. Another program respondent stated, "teachers make home visits for this purpose."

Question 22:

If yes, how is the parent inservice conducted?

The majority of the inservice was done in a combination of group and individual sessions as they are needed. A frequency count was done of all the programs that responded to this question. Seventy-six programs reported they preferred being flexible by conducting parent inservice individually or in groups as the situation
demanded. Eighteen programs conducted their parent inservice in individual sessions, and twenty-three programs preferred to utilize group inservice for parents.

Question 23:

TABLE 21
ARE THE PARENTS ACTIVELY INVOLVED IN SOME PART OF THE EDUCATIONAL PROGRAMMING OF THEIR CHILDREN?

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>145 Responding Residential Day</th>
<th>105 No Response Residential Day</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No (%)</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No (%)</th>
<th>Yes (%)</th>
<th>3.45</th>
<th>2.50</th>
<th>3.81</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>146</td>
<td>145</td>
<td>105</td>
<td>1</td>
<td>0</td>
<td>31</td>
<td>80</td>
<td>76.55</td>
<td>77.50</td>
<td>76.19</td>
<td>29</td>
<td>21</td>
<td>20.00</td>
<td>20.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Other (%)</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>3.45</td>
<td>2.50</td>
<td>3.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Seventy-seven percent (76.55) responded "yes" to this question. The involvement in these programs was considerable, in some cases taking on aspects of administrative duties. One program respondent stated,

They (parents) interview teachers to fill a vacancy on the staff. Parent selection and approval of staff is important.

Other programs replied that mandatory special education, in their state and local program planning, mandated certain duties for parents. Many of the comments relating to those program plans were similar. One statement that
summarized those comments was that parents "...must agree to the instructional program by signature." Another program respondent replied,

We have a very active and vocal parent association which addresses itself to all such educational policies and recommendations.

Question 24:

If yes, please explain---

The following are a few other ways in which parents participate in their child's educational programming.

1. Field trips
2. Fund raising
3. Direct observation of teaching techniques and methods
4. Participation in therapy
5. Parent conferences and home follow-up
6. Case conferences and staff meetings
7. Developing student goals
8. Teacher aides
9. Volunteers when needed

Twenty percent of the respondents replied that parents were not actively involved in their child's educational program. The three percent (3.45) in the "other" category stated that they had little success with parent involvement. "They certainly can be, most are not."

Respondents stated that they tried to encourage more parent participation because they realized its importance. One response was "...we would love more active involvement."
Question 25:

TABLE 22
HOW MANY OF YOUR TEACHERS, WHO WORK WITH THE EMOTIONALLY DISTURBED CHILDREN, HAVE SPECIAL TRAINING IN ADDITION TO CERTIFICATION IN THE AREA OF THE HEARING IMPAIRED?

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>126</th>
<th>30</th>
<th>20</th>
<th>15</th>
<th>12</th>
<th>11.90</th>
<th>18.33</th>
<th>12</th>
<th>74</th>
<th>12</th>
<th>56</th>
<th>46</th>
<th>38</th>
<th>22</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Responding</td>
<td>Residential</td>
<td>Day</td>
<td>No</td>
<td>One</td>
<td>Teachers</td>
<td>Additional</td>
<td>Teachers</td>
<td>Additional</td>
<td>Teachers</td>
<td>Additional</td>
<td>Teachers</td>
<td>Additional</td>
<td>Teachers</td>
<td>Additional</td>
</tr>
<tr>
<td>a. All of them. Number of responses = 15. Percentage = 11.90</td>
<td></td>
<td>126</td>
<td>30</td>
<td>20</td>
<td>15</td>
<td>12</td>
<td>11.90</td>
<td>18.33</td>
<td>12</td>
<td>74</td>
<td>12</td>
<td>56</td>
<td>46</td>
<td>38</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>b. None of them. Number of responses = 74. Percentage = 58.73</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td>$\frac{6}{6}$ of $\frac{6}{6}$. Number of Responses = 23. Percentage = 22.22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Other. Number of Responses = 9. Percentage = 7.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Twelve percent (11.90) responded that all their teachers have special training in addition to certification in the area of the hearing impaired. Fifty-nine percent (58.73) of the programs stated that none of their teachers had additional training. One program respondent replied that although none of the teachers had additional training, they did have practical experience. An encouraging twenty-two percent (22.22) of the respondents indicated, similarly, that some of their teachers are getting certification in the area of learning disabilities and the emotionally impaired or some other area of special education. The highest number of teachers in a program working on additional certification was four out of six or sixty-seven percent, and the lowest was two out of thirty or six percent.
Question 26:

### TABLE 23

**IS THE TEACHER PROVIDED WITH A TEACHER'S AIDE?**

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>Sample</th>
<th>Responding</th>
<th>Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes (%)</th>
<th>Yes</th>
<th>Residential Day</th>
<th>No (%)</th>
<th>No</th>
<th>Residential Day</th>
<th>Other (%)</th>
<th>Other</th>
<th>Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>127</td>
<td>36</td>
<td>91</td>
<td>19</td>
<td>14</td>
<td>91</td>
<td>26</td>
<td>65</td>
<td>31</td>
<td>22</td>
<td>24.41</td>
<td>25.00</td>
<td>24.18</td>
<td>3.94</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>146</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Seventy-two percent (71.65) responded "yes" to the question. One respondent stated that the teacher is given an aide "...if she has more than ten students." Another program replied that all their classes were provided with teacher aides. Twenty-four percent (24.41) replied that their programs did not have teacher aides. One reason advanced by two respondents was that the staff of teachers was larger than the available number of teacher aides, therefore, not all teachers were assigned aides. For example, six aides for forty-four teaching positions and in another situation, five aides for thirty teaching positions.

In the "other" category, one response was that teachers were given aides only if they had a preschool...
class. Another respondent stated, "We don't have aides, but student teachers are placed in classes."

Question 27:

TABLE 24
WHAT IS THE MOST WORKABLE CLASS RATIO FOR THIS TYPE CLASS?

<table>
<thead>
<tr>
<th>(raw scores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. one teacher/one child. ..........................</td>
</tr>
<tr>
<td>b. one teacher/two children. ........................</td>
</tr>
<tr>
<td>c. one teacher/three children. ........................</td>
</tr>
<tr>
<td>d. one teacher/four children. ...........................</td>
</tr>
<tr>
<td>e. one teacher/five children. ............................</td>
</tr>
<tr>
<td>f. other. ...........................................</td>
</tr>
<tr>
<td>Total. ..............................................</td>
</tr>
</tbody>
</table>

One hundred and twenty-one (121) programs responded to this question. Twenty-five (25) programs did not respond. The majority of respondents clustered around the ratios of one teacher to three, four, or five students. Many of the respondents indicated that obviously a one to one ratio would be the best working ratio, but in a school program, depending upon the make up of the class, the ratio must be larger. One respondent that did maintain a one to one ratio indicated that this was necessary because theirs was a clinic program. Other respondents replied that if a ratio of one teacher to five children were used for emotionally disturbed children then the teacher should
be assigned a teacher aide.

One program designated the class ratio in terms of the child's school level; elementary—one teacher/three children, junior high and high school—one teacher/four or five children. Another program designated the class ratio by the child's age: three years to nine years—one teacher with aide/six students; nine years to twenty-one years—one teacher with aide/eight students.

The most outstanding comments made in the "other" category by many programs was in regard to self-contained classrooms for the emotionally disturbed deaf child. One respondent stated, "We have no class consisting of all multiply-handicapped deaf children. We scatter them throughout our seven classes." A similar comment from another program stated, "We do not classify children in any program as emotionally disturbed, and in particular, have no special classes for emotionally disturbed deaf children." And finally, another programming point-of-view emerged, "...our program for multihandicapped auditorially impaired children does not program for specific exceptionalities. A group may include one child with emotional difficulties, visually limited, or mentally retarded."
Question 28:

<table>
<thead>
<tr>
<th>TABLE 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW ARE TEACHERS ASSIGNED TO WORK WITH MULTIPLY HANDICAPPED DEAF CHILDREN?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample</th>
<th>Residential</th>
<th>Day</th>
<th>No Response</th>
<th>Residential</th>
<th>Day</th>
<th>a (%) Residential</th>
<th>Day</th>
<th>Residential</th>
<th>Day</th>
<th>b (%) Residential</th>
<th>Day</th>
<th>c (%) Residential</th>
<th>Day</th>
<th>Residential</th>
<th>Day</th>
<th>d (%) Residential</th>
<th>Day</th>
<th>Other (%) Residential</th>
<th>Day</th>
<th>Other (%) Residential</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>116</td>
<td>136</td>
<td>95</td>
<td>1</td>
<td>14</td>
<td>46</td>
<td>20</td>
<td>26</td>
<td>4</td>
<td>62</td>
<td>20</td>
<td>4.51</td>
<td>11.89</td>
<td>12.27</td>
<td>4.26</td>
<td>3.59</td>
<td>12.60</td>
<td>11.58</td>
<td>4.21</td>
<td>4.51</td>
<td>11.89</td>
</tr>
<tr>
<td>a.</td>
<td>Teacher volunteers</td>
<td>b.</td>
<td>Superintendent assigns</td>
<td>c.</td>
<td>Principal assigns</td>
<td>d.</td>
<td>Department supervisor assigns</td>
<td>e.</td>
<td>Other</td>
<td>One hundred thirty-three (133) programs responded to this question. Each program marked one or more persons that were responsible for the assignment of teachers for multiply handicapped deaf children. The figures, if taken separately, may be misleading because in most cases the assignment procedure is a team effort. The majority of the comments in the &quot;other&quot; category stipulated that the teacher and any combination of superintendent, principal, or supervisor work together to assure a compatible working arrangement for the teacher and the multiply handicapped deaf child. One respondent commented, &quot;...joint planning was done regarding the best grouping for any given child.&quot; The teacher's abilities, interest, and specific educational background are taken into consideration before any</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
assignment is made. Another program respondent explained that if a department supervisor were the person responsible for the teacher's assignment, it would be done upon the request and approval of the teacher. Another program replied, "teachers are employed for this particular assignment. No one is assigned arbitrarily." A teacher may be assigned to a class on a trial basis, and remains there by choice.

Question 29:

TABLE 26

DOES YOUR SCHOOL PROVIDE CONTINUING EDUCATION WORKSHOPS FOR TEACHERS' PROFESSIONAL IMPROVEMENT?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No response Residential Day</th>
<th>Yes ( # ) Residential Day</th>
<th>Yes (%) Residential Day</th>
<th>No ( # ) Residential Day</th>
<th>No (%) Residential Day</th>
<th>Other ( # ) Residential Day</th>
<th>Other (%) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>145</td>
<td>104</td>
<td>119</td>
<td>35</td>
<td>84</td>
<td>22</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>

An overwhelming response of eighty-two percent (82.07) to this question indicated that the majority of programs provided some type of continuing education workshops for their teachers. Unfortunately, workshop specifics were not detailed by any of the respondents,
but many workshop needs were mentioned in Table 27.

Question 30:

**TABLE 27**

**IF YES, WHAT AREA DO YOU FEEL IS OF THE GREATEST PRIORITY FOR TEACHERS?**

<table>
<thead>
<tr>
<th></th>
<th>(Raw Scores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Curriculum development.</td>
<td>51</td>
</tr>
<tr>
<td>b. Classroom behavior management techniques</td>
<td>60</td>
</tr>
<tr>
<td>c. Language development.</td>
<td>53</td>
</tr>
<tr>
<td>d. Other:</td>
<td></td>
</tr>
<tr>
<td>individualized instruction.</td>
<td>4</td>
</tr>
<tr>
<td>parent counseling.</td>
<td>3</td>
</tr>
<tr>
<td>total communication.</td>
<td>3</td>
</tr>
<tr>
<td>speech development.</td>
<td>3</td>
</tr>
<tr>
<td>diagnostic and prescriptive activities</td>
<td>2</td>
</tr>
<tr>
<td>auditory training.</td>
<td>2</td>
</tr>
<tr>
<td>self-improvement and upgrading skills</td>
<td>1</td>
</tr>
<tr>
<td>creative therapy.</td>
<td>1</td>
</tr>
<tr>
<td>crises intervention; handling children utilizing residential treatment techniques</td>
<td>1</td>
</tr>
<tr>
<td>mainstreaming.</td>
<td>1</td>
</tr>
<tr>
<td>human effectiveness training</td>
<td>1</td>
</tr>
</tbody>
</table>

Most of the programs indicated that a,b,c, of this question were of equal importance because one area overlapped the other. Therefore, all areas were checked and a notation made that there was no greatest priority. One respondent indicated that the priorities depended upon the needs of the teachers at any particular time.
A residential program respondent stated, "...two and a half hours each week for professional development and in-service programs are required." It was also the contention of another respondent that inservice workshops for teachers are a program necessity. This respondent stated, "regular classroom teachers need inservice exposure to calm their fears and feelings of not being able to cope."

Question 31:

TABLE 28

ARE YOU AWARE OF FEDERAL AND STATE FUNDING THAT IS AVAILABLE FOR THE IMPLEMENTATION OF SPECIAL PROGRAMS TO ELIGIBLE SCHOOLS?

<table>
<thead>
<tr>
<th></th>
<th>Yes (#)</th>
<th>Yes (%)</th>
<th>No (#)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Day</td>
<td>102</td>
<td>78.39</td>
<td>31</td>
<td>22.46</td>
</tr>
<tr>
<td>Other (%) Residential Day</td>
<td>29</td>
<td>73.91</td>
<td>24</td>
<td>18.92</td>
</tr>
<tr>
<td>Other (%)</td>
<td>4</td>
<td>23.76</td>
<td>1</td>
<td>3.62</td>
</tr>
</tbody>
</table>

There were few written statements in response to this question. However, one respondent who was aware of funding sources was most specific in his remarks regarding the allocation of these funds. He stated the following:
Most of this money goes directly to the county department of education and not to programs run by specific districts. Most is now in a state of confusion due to the state master plan for special education that was developed by the professionals in the state and turned down by the Governor. It is educationally naive to believe state and federal funds will cause districts or counties to adopt new programs without putting in a permanent provision for continuous funding from the state and federal levels.

Question 32:

If yes, how was this information made available to you?

**TABLE 29**

**STATE AND FEDERAL FUNDING INFORMATION SOURCES**

| 1. Local director of special education |
| 2. State department of education educational resource center |
| 3. State department memorandum |
| 4. Congressional Record |
| 5. Business and Commerce Daily |
| 6. School board personnel |
| 7. Professional special education organization newsletters |
| 8. Mailing list of state agencies administering funds |
| 9. Daily newspapers |
| 10. "Keeping my eyes open; contacts with other schools..." |
| 11. "Word of mouth" |
| 12. "Grapevine; know it is there, don't know how to go about getting it or know if after all the paperwork whether it's worth it or not." |

Question 33:

What types of special programs are you now providing that are either totally or partially federally funded?

Many of the public school programs and service respondents to this question responded that they were aware
that their districts were receiving funding for the handicapped, but none was specifically designated for programming for the hearing impaired. The public school program and services that did list their programs and funding source used Title VI-B as their major source of maintaining quality programs for the hearing impaired by providing increased professional and ancillary personnel, equipment, and supplies.

Two school districts mentioned that they had developed innovative programs utilizing Title III funding. Several public school programs and services (university clinics) stated that they were receiving Title VI-C funds for programming for the deaf-blind multiply handicapped child.

The residential schools made almost exclusive use of Title I, 89-313, funding for program development and maintenance, staff, and equipment. Title VI-C funds were also used to provide for deaf-blind children, and Title II funds for library services were mentioned. Only one superintendent stated that their school was using Title XX funding to support a preschool homebound program. "...I learned of Title XX through meetings held in the state last year." Two schools, one a day school program and the other a residential school, are both entirely federally funded. Another residential school has its unit for the
multiply handicapped federally funded.

The list of all the programs either totally or partially federally funded was extensive. For the purpose of this study, a small sample of only those programs that related to the multiply handicapped deaf was selected.

**TABLE 30**

**STATE AND FEDERALLY FUNDED PROGRAMS**

<table>
<thead>
<tr>
<th>I. Public School Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title VI-B Programs:</strong></td>
</tr>
<tr>
<td>1. Infant parent training</td>
</tr>
<tr>
<td>2. Preschool program for the handicapped</td>
</tr>
<tr>
<td>3. Diagnostic personnel: audiologist, psychologist, counselors</td>
</tr>
<tr>
<td>4. Program to locate unserved handicapped children</td>
</tr>
<tr>
<td>5. Regional program for multiply handicapped preschoolers ages 2-6</td>
</tr>
<tr>
<td>6. Multiple handicapped trainable mentally retarded deaf</td>
</tr>
<tr>
<td>7. Deaf education program</td>
</tr>
<tr>
<td><strong>Title VI-C Programs:</strong></td>
</tr>
<tr>
<td>1. Deaf-blind programs and services</td>
</tr>
<tr>
<td>2. Specific programs for the development of the deaf child</td>
</tr>
<tr>
<td><strong>Title III - Innovative Programs:</strong></td>
</tr>
<tr>
<td>Videolanguage program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Residential School Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title I, 89-313, Programs</strong></td>
</tr>
<tr>
<td>1. Psycho-social services</td>
</tr>
<tr>
<td>2. Parent/Infant education program</td>
</tr>
<tr>
<td>3. Learning disabilities teacher/consultant</td>
</tr>
<tr>
<td>4. Individualizing instruction through aides</td>
</tr>
</tbody>
</table>
TABLE 30 - continued

5. Diagnostic clinic  
6. Classes for the multiply handicapped  
7. Preschool homebound  
8. Teacher aides  
9. Part time psychiatrist  
10. Crisis teacher/crisis room  
11. Counseling program  

Title XX Program:  
Preschool homebound program

Question 34:

TABLE 31

DO YOU HAVE A STAFF PERSON ASSIGNED TO YOUR SCHOOL WHO HAS THE MAJOR RESPONSIBILITY OF INVESTIGATING LOCAL, STATE, AND FEDERAL FUNDING SOURCES?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential Day</th>
<th>No Response Residential Day</th>
<th>Yes ( # ) Residential Day</th>
<th>No ( % ) Residential Day</th>
<th>Yes ( % ) Residential Day</th>
<th>No ( % ) Residential Day</th>
<th>Other ( # ) Residential Day</th>
<th>Other ( % ) Residential Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>138</td>
<td>99</td>
<td>8</td>
<td>6</td>
<td>55</td>
<td>11</td>
<td>44</td>
<td>39.85</td>
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</tbody>
</table>

Forty percent (39.85) responded that they did have a person responsible for investigating funding sources. One respondent commented that this person also has other
responsibilities in addition to program funding. Another respondent replied that they did have an informant, but that their major need was a project writer.

Fifty-eight percent (57.97) responded that they had no one in this position. Several program administrators wrote in the "other" section that this responsibility was an additional task for them.

Question 35:

TABLE 32

HOW DO YOU FEEL THE NEEDS OF THE MULTIPLY HANDICAPPED DEAF CHILD WITH SEVERE EMOTIONAL AND/OR BEHAVIORAL PROBLEMS CAN BEST BE SERVED?

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Responding Residential</th>
<th>No response Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>146</td>
<td>125</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>88</td>
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<td>21</td>
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<td></td>
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<td>4</td>
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<td></td>
<td>17</td>
</tr>
</tbody>
</table>

Several programs responded that they were doing an adequate job. One respondent stated, "It depends upon which is their greatest handicap. Usually we can program for them. We are big enough to provide small groupings..." Another program stated, "We are a small program (44
students, 17 teachers), and have not had a totally unmanageable situation in recent years...thank God!" However, there were other programs whose sentiments were summarized in the following statements. "I don't really feel these children are currently being served adequately in many situations." And finally, a statement that is almost a plea,

We really need to have the availability of a teacher to handle small groups of multiple and behavioral handicapped deaf children. Presently, we have to pretty much lump all students of a general academic area together...

The comments of the following respondents confirm a definite need for programming and services for the emotionally disturbed deaf child. Only those statements that gave supportive evidence for their comments were included. Single word comments regarding the answer to this question, such as, 'residential school' or 'public school' were omitted in the text.

Many programming components emerged during the analysis of this question. Each component was analyzed individually and grouped according to their similarity. The components were listed as subtitles and were the following:

1. Philosophical program foundation
2. Residential and public school program placement
   a. Mainstreaming
   b. Parent involvement
   c. Staffing patterns
3. Counseling
4. Modes of communication
5. Teacher qualifications
   a. Personal characteristics
   b. University training
6. Funding commitments (state and federal)
7. Specific programming components

**Philosophical Program Foundation**

It was suggested by one respondent that the role of programming should be two-fold:

A. Prevention
   1. Try to alleviate the deafness as early as possible by early fitting of hearing aids
   2. Very strong parent-infant programs
   3. Family counselors

B. Remediation

Experienced teams who see the child and family first, and then are trained to understand deafness and its attending problems.

A similar response,

I believe in providing the least restrictive alternative educational setting, with the provision of special personnel, programs, etc. to fit the needs of the student population. This is the crux of the problem--such settings require that the people who make the decisions concerning the child, parent, educator, mental health personnel consider the whole child before deciding how to serve his needs best.

Other respondents stated that we should not consider severe emotional disturbance as the child's problem. "It is a mini-society problem involving the total school staff which has contact with the child and the total family unit..." Another replied, "No easy answer. Much of the decision has to be viewed from the standpoint of the home
and the school. If they are supportive, the program is hopeful." A final response was the following: "A specific program must be designed based on individual needs. No general rules can therefore be applied."

Residential and Public School Program Placement

Residential Program Placement

Many respondents stated that the best educational placement for the severely emotionally disturbed child was in a residential school for the deaf or a mental health facility with staff trained to work with the deaf. One respondent in favor of residential care for severe problems stated:

I am in favor of residential care for severe problems if the family is unable or unwilling to mediate the problems of the child. The care provided by residential educational centers is far more complete than a public school program i.e., counseling, peer support, and opportunities. And in some cases, I have found residential centers were the only solution and the students far happier there.

Another respondent commented that in this type of situation the child could be treated in a structured environment with the necessary support personnel. Another opinion was that the children could best be served as follows:

...in an educational program for the deaf, but within a separate living and perhaps learning facility with the major thrust of the program being provided by mental health professionals who are skilled in manual communication and have a rich understanding of the problems of deafness. The treatment plan should be devised by mental health professionals in an educational setting.
A respondent who operates a unit for the multiply handicapped hearing impaired, in a residential school for the deaf, agreed that residential placement may be the answer, but that something more was needed.

Many of these children seem to need the structured, secure environment that a hospital or treatment facility may provide. However, they also need a school program that can meet their educational needs. We are finding that we cannot handle some of these children in any multi-handicapped program.

My thoughts now are that two facilities may be needed. A hospital or treatment facility and a school program for the deaf with the student moving from one to the other as needed. The two agencies would need to work cooperatively so that their programs are consistently meeting the child's needs in the appropriate manner. If they do not work in a similar manner with a particular child, the change of programs could be very confusing.

Another respondent replied that mainstreaming these children was also vital to the development of the child in a residential situation. It was stated that the best service could be provided in the following manner:

Through a restricted isolated individualized approach with a gradual entrance into a less restrictive environment, then mainstreamed into regular classrooms with "normal" deaf students and last into a "normal" dormitory living skills program.

The special school programs at Riverside, California, and Columbia, Maryland, were suggested as examples of the type of good programming where these children are served by trained staff members, and gradually mainstreamed into regular classes for deaf students. One respondent was in favor of special training at residential schools for the 
deaf, but replied, "...most residential schools don't want them!" A residential school superintendent who is aware that residential schools for the deaf are receiving criticism for not programming for these children gave additional insight into the problem.

There should be one location within the state for this type of handicap with trained personnel so that the child may be able to return to our facility. It is felt that this phase is sadly neglected in our state and also in adjoining states...in spite of many requests and recommendations, nothing concrete has ever been done.

Regionalization of programs for the emotionally disturbed deaf child within states was again mentioned.

Regional institutional programs will best serve such children. They may never be totally rehabilitated, may never be fully integrated into society, and probably will always require some form of sheltered setting. Regional institutions will keep them close to home, parents, and siblings.

Another program respondent confessed to being in quandary about how to serve these children. It was stated, "I really don't know. Some kind of day program so the child can remain at home and the special program can also work with the parents."

A series of comments favoring a special facility with trained personnel and varied mental health services is the following:

1. Special facilities with special trained worker; mainstreamed with other deaf as each individual is able.

2. A program such as that which is at Riverside, California, is probably best staffed and equipped.
3. (a.) Special programming within the regular (residential) school program with provisions for flow, one level to the next. (b.) Social integration with regular student overlapping in certain areas i.e., vocational, physical education, driver education, extracurricular activities.

4. In a special unit associated with a school for the deaf with full support personnel, specially trained teachers, and appropriate teacher-pupil ratio.

5. Special facility with teachers with dual training; support services of all kinds; correct ratio of teacher-pupil; residential for those with unstable homes.

6. A center provided for those cases for part or full time attendance.

7. Demonstration unit; diagnostic and evaluation services, consulting services.

8. In special schools specifically designed to serve children having these problems (separate from the schools serving normal deaf children).

9. By special professional people, special residential accommodations, provide travel for parents, a 'national or regional' facility with necessary staff.

10. It is my opinion that the students need a program in which twenty-four hour services can be provided. This might be a residential school or community based group home. Irregardless, educational as well as residential personnel should have training in the area of the hearing handicapped.

11. A diagnostic unit staffed with full time psychological and educational services. Psychiatric and social worker services should be available full or part-time depending on specific needs of enrollment. The program should be ongoing twelve months of the year. A student should be phased out when he does not need the service.
12. In a special mental health facility with teachers of the deaf on the staff.

Public School Program Placement

Another opposing point-of-view was that these children should not be grouped together, but should remain within the regular public school program and receive the services of the necessary support personnel.

They need good appropriate models. If such a child or children is in a classroom, additional support can be given to the teacher through instructional aides in the classroom. Outside the classroom such persons as psychologist, social worker, and principal are available.

Agreeing with this position, another respondent stated,

In a self-contained resource class in a regular public school. Isolation in schools for the deaf and other institutions provides no models of normal behavior. In a regular public school there's room for slow weaving back into regular class. Severely deaf emotionally disturbed would probably be in contained class for most of the day.

Finally, a respondent stated the following:

In the same ways other children can be served—as close to the "mainstream" as possible, with as little interference as possible from psychologists, psychiatrists, audiologists, social workers, etc.

Other comments on programming for these children within the public schools were the following:

1. In a special class taught by a teacher of the hearing impaired, keeping teacher-pupil ratio to under 1/4.

2. Their needs can be served with a highly structured program with behavior management techniques and a one to one ratio; teacher to pupil.
3. Small classroom ratio, support people to help teacher, and parent education and conferences.

4. (a) Early intervention--develop rapport with parents
(b) Aides for classrooms with teachers having background in E.D. with deaf education
(c) Close working relationship with mental health personnel in community.

5. One to one daily program with properly trained teachers.

Counseling

The area of training counselors to work with the deaf emotionally disturbed child and his family was mentioned repeatedly. A few of the comments follow:

1. There should be someone, knowledgeable in the problems of the hearing impaired, who is trained to work with behavioral disorders and who can do intensive counseling with the parents or guardians and the child.

2. The best service would be...continual parent/teacher counseling sessions, bring in the specialists as needed. Individual counseling to child if needed.

3. The best service would be from...people who have training in both counseling and in the nature and needs of the deaf--plus skill in Total Communication.

Modes of Communication

Several comments were stated in regard to the use of various modes of communication by the staff who work with the emotionally disturbed deaf child. One public school respondent felt that the behavioral problems that have occurred in their program was a direct result of the child's
lack of communication skills. It was stated that these children could best be served in the following manner:

Through learning a system of communication that will make the English language useful to them. We are having marked success with oral "failures" using a system based on Seeing Essential English. It seems when they are able to express frustrations, anger, fears, and worry in language code they are better able to resolve their problems.

Another respondent replied,

...as a primary requirement persons working with deaf should be specifically trained in methods of communication with the deaf...

Teacher Qualifications

There was no disagreement that teachers working with severely emotionally disturbed deaf children should have dual certification or consistent upgrading of skills in the area of the emotionally disturbed that would lead toward additional certification. A respondent stated the following:

...teachers of the deaf can also be trained (outside of a college or university) to work with these types of problems. I feel it MOST important that the teacher be a trained, experienced teacher of the deaf. She can then learn how to deal with children with behavior disorders if needed...It would be much harder for a teacher who specialized in the emotionally disturbed to work with a deaf child than it would be for a teacher of the deaf to work with children with emotional problems, unless emotional problems were very severe.

Another suggestion that was offered in lieu of dual certification was to offer teachers of the hearing impaired the following:
...inservice and/or course work in behavioral management techniques or behavior disorder teachers and psychologists should be given inservice and/or coursework in hearing-impairment related problems.

Another respondent indicated:

Experience through four years in this program indicates parents and teachers can be trained to change children's behavior. (In) exceptional cases where this cannot be done, the state residential school has been the best resource.

The university's role in this problem was not omitted. One respondent stated, "There is a crying need for the university to provide training programs that can adequately equip a person to assume such a role."

Two respondents mentioned personal qualities that a teacher of the deaf should possess in addition to academic certification. One respondent replied, "First the person(s) working with the deaf child must be sincere, patient, dedicated, and well trained. Too often our teachers of the deaf do not have these qualities." The other respondent stated, similarly, the teacher should be "...vivacious, energetic and competent..."

**Funding**

The area of funding was the major concern of many of the respondents. Realistically, no program can be a comprehensive program if it is inadequately funded. One respondent, familiar with the dissolution of what he considered to be a quality program, stated the following:
Dr.'s attempt to start a "ranch" for the severely emotionally disturbed deaf child (outside of a large city) was highly commendable, especially when Dr. and his partner were using their own funds. The refusal of the federal government to cooperate with this venture is certainly deplorable.

Other respondents stated that this was a state problem and that the state should be responsible for supporting such programs.

This would require a state planning and organizing board which my state does not have. There are no state coordinated or administered services for these children. The institutions reject these youngsters and the local programs are not equipped to handle them. I feel the state should set standards, locate the programs to handle them, and support them by providing teacher training and classroom assistance.

A superintendent of a residential school for the deaf also felt that the funding responsibility should be at the state level. He stated as follows:

...I think funding should be at the state level. I also feel that the incident rate places a lot of responsibility on the residential schools for the deaf. Some are ready to accept it, and others are not. If residential schools do need to meet the need, then there should be appropriate funding (state level) and staff.

Another residential school program that supported state funding responsibility suggested a similar solution as to how to best serve this population.

By some agency assuming the responsibility, obtaining funding and developing an appropriate program... due to the low incidence this should be done at the state level.

Other respondents agreed that these programs should be funded sufficiently to support both of the following:
1. Training of teachers and staff
2. Adequate therapy and mental health services

And finally, a respondent replied,

More planning and commitment at the state department level for regional training--workshops and college--a push for local programs when in any way feasible--one or two good programs at institutions serving that community...have these people go to other areas to begin diagnosing and training.

Specific Programming Components

Thus far, programming components such as the following have been mentioned throughout this chapter.

1. Individualized instruction
2. Training of instructional staff and ancillary personnel
3. Utilization of behavioral techniques
4. Adequate funding for consistent comprehensive programming
5. Class ratios
6. Parent involvement in programming
7. Modes of communication

However, several of the respondents have been specific in response to this question of how to best serve the emotionally disturbed deaf child, and their comments deserve to be stated without abstraction. The comments in many cases are similar and overlap, while in other cases, they directly oppose one another.

1. (a) Strong affective intervention as early as identified
(b) Intensive Total Communication under rigid structure has served to give them means of communication and of subsequently dealing with feelings.
(c) Carefully structured program for Behavior Modification and for development growth to
allow for success and improvement in self-image.

(d) Program designed to specific need of individual child.

2. (a) Psychologist trained in sign language who can work directly with parents and their children
(b) Psychologist trained in sign language who can work directly with the teacher.
(c) Psychologist or social worker who can coordinate services for multi-problem families.

3. (a) Adequately trained staff (college curriculum B.A. and M.A.) teachers with experience/training in E.D./M.R. and hearing impaired; psychologists--behavior modification/classroom management/counseling/testing; dormitory staff with same qualifications as classroom people.
(b) Specifically geared vocational program
(c) Social workers for work in community with parents for future placement (of graduates).
(d) Halfway house, group home, sheltered workshop environment designed for graduates.

4. They can best be served by teachers and counselors who are trained in that field--in a setting that is most conducive to that individual child's learning. It would have to be individualized perhaps, part time in a self-contained special class and then mainstreamed into a regular class for the deaf with counseling available. Also his needs could be met by educating teachers of the hearing impaired about the child and how to help him.

5. A team approach is probably best. Such a team should include persons trained in education of physically handicapped, mentally retarded, and emotionally disturbed children. Extensive psychological consultation is suggested, and should include educational planning, techniques of behavior management, and family counseling. Those working directly with the children need firsthand knowledge of the children's abilities--strengths and limitations. They also need at least minimal exposure (e.g., a workshop) to the psychological principles which operate in the "control" of behavior and in learning. This
seems necessary because people tend not to support systems which are foreign to them.

Finally, program planning for such students should be done only by those persons who have the kind of training suggested in this statement.

6. This can only be stated on an individual basis considering the educational facility available, grouping of students, parent support, and individual problems of the student.

However, no progress will take place of a student if that student is educated for the classroom or educational facility and there is not support from the parents. An individual program must be planned on a yearly basis with the parent involved. Realistic goals and objectives must be set for the student with long term goals for that student after completion of (school at) the age 18. Goals and objectives must be set in academic, social, motor, family living skills, and communication areas for each student on an individual basis at this level.
CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

The problem addressed in this research was to determine what type of mental health services and programs were provided to deaf children with severe behavioral and emotional disorders in public residential schools and public day school programs and by whom.

The objectives of this research were:

1. To determine the current educational program policy regarding the emotionally disturbed deaf child.

2. To determine who the individuals were that provide mental health programs and services to the deaf child and his family.

3. To determine the extent of program planning done for the family of the emotionally disturbed deaf child.

4. To determine how teachers were assigned to work with the emotionally disturbed deaf child.

5. To determine what funding sources, local, state, and federal support programs for the emotionally disturbed deaf child.
It was established by analyzing these data that the public educational programs for the deaf are becoming more aware of the problems of the multiply handicapped deaf child and his family. As a result of this awareness, public educational programs have begun to consider programming options for multiply handicapped children with severe behavioral and emotional disturbance instead of excluding them from programming. Two reasons for the minimal use of student exclusion are suggested.

1. The advent of mandatory special education necessitates more viable program and service options be considered for all handicapped children instead of utilizing student exclusion.

2. The student exclusion procedure is lengthy, and usually requires school board action, as well as, the student's right to a hearing.

The incidence of severe behavioral and emotional problems among deaf school age children is minimal in regular public day school programs, but is an increasing concern to other public referral programs. Some of the public referral programs are special diagnostic and therapy units within the public school districts, state residential schools for the deaf, community mental health facilities, and university centers. The low-incidence of these children in regular public day school programs for the hearing impaired may be because few parents seek public school admission as a first choice, if the child has a severe secondary handicap.
Public day school programs and residential school programs for the hearing impaired both have admission criteria that must be considered prior to the placement of a child in their educational program. Multiply handicapped deaf children are admitted to these programs if the primary handicap is a hearing impairment, the secondary handicap is mild, and the child can be mainstreamed into other programs within the school. One of the major considerations for the admission of a deaf child with severe emotional disturbance is that he is not harmful to himself or others. The multiply handicapped deaf child is usually admitted to a public educational program on a trial basis. The trial period continues until the child and his family's problems can be resolved or until another program can be recommended.

The persons who usually provide consultation services to parents and teachers regarding the multiply handicapped child with severe behavioral and emotional problems are school psychologists, department supervisors, principals, and social workers. Another area that is expanding is the counselor for the hearing impaired. This person is trained in counseling and guidance techniques as well as the hearing impaired. Any one or more of these persons may be called upon separately or collectively as needed.
The school psychologist was the primary person teachers consulted with on severe behavioral problems of their students. Forty-nine percent of the programs surveyed also had the additional service of a full or part-time psychiatrist to assist in consultation and therapy.

Teachers are assigned to work with these children upon their own request. Usually, joint planning with the supervisor, principal, and the teacher is done to provide the best working arrangement for the teacher and the child. A teacher's abilities, interest, and specific educational background are taken into consideration before an assignment is made. In several cases teachers are employed for a specific job assignment. A teacher may be assigned to a class on a trial basis, and remains there by choice.

The degree of the deaf child's behavioral or emotional disturbance is the prime element in the educational program planning and placement of that child. There are two points-of-view regarding the placement of the severely disturbed child; residential programs and public day school program placement.

Public School Programs

Many advocates of public school placement maintain that emotionally disturbed deaf children should not be grouped together, but should remain within the regular program for the hearing impaired. In this placement they
would remain in the classroom with a teacher of the deaf, an aide, and various support personnel. The implication is that in such a program the child would have more appropriate models of normal behavior than in a residential setting.

**Residential Placement**

Advocates of the residential placement of the deaf child maintain that residential programs, specifically those within schools for the deaf, provide a more structured, secure environment for the severely disturbed deaf child. The child would have the benefit of twenty-four hour services from trained teachers of the deaf and support personnel who are trained in counseling, behavioral techniques, Total Communication, etc. The residential school placement can also provide opportunities for both hospital and educational programs. When the child is able he would then be mainstreamed into a regular educational program for the normal deaf child.

A comprehensive program for the severely emotionally disturbed deaf child should consider the following components:

1. Strong affective intervention as early as identified
2. Intensive Total Communication
3. Utilization of behavior modification techniques
4. Individualized program of instruction and therapy
5. Small teacher-student class ratio
6. Availability of teacher aides
7. Parent involvement  
8. Inservice workshop for teachers  
9. Vocational programs  
10. Halfway or group homes for graduating students  
11. Comprehensive follow-up  

The parents of the severely emotionally disturbed deaf child are of major importance in the educational program planning of their child. Recognizing this factor, many programs have initiated inservice workshops that enable parents to understand and cope with their child's handicap. Parents participate in many phases of their child's educational program. This participation ranges from teacher aides to membership on program advisory boards. In many programs parents have formed or affiliated with parent organizations that are independent of the school.

The area of state and federal funding for program development and services for the severely emotionally disturbed deaf child remains a problem. The low incidence rate of this problem places a lot of responsibility upon the state residential schools for the deaf. Survey respondents commented that one agency should have the responsibility for obtaining funds and developing the necessary program. If the residential schools for the deaf, or any other public agency, commit themselves to this task, they must also have a state commitment for continuous funding in sufficient amounts to support a quality program.
Discussion

The major criticisms from the respondents regarding the questionnaire were the following:

1. Too lengthy..........................1
2. Poorly worded.........................1
3. Disseminated at inappropriate time for public school programs.......3
4. Untrue assumptions regarding the needs of public programs for the hearing impaired.............1

The survey was conceived out of the current need and quandary that administrators and teachers of the hearing impaired have expressed via professional journals and professional meetings over the last few years. The survey questions were a direct result of an extensive review of historical and current literature relevant to the topic. As a result of the survey, nine requests from the respondents for information have been received.

The survey questionnaire as it was originally written was a good instrument for assessing the programming and placement needs of the emotionally disturbed deaf child and his family. However, it could have been better if the instrument had been pretested prior to its dissemination. Pretesting would have enabled the author to make any word or phrase changes that would have clarified the questions for the respondent. In some questions the wording was vague.
For example:

If a child with behavior disorders is excluded from your program, is another referral placement obtained for him?

Several respondents struck the word obtained and inserted the words suggested or recommended. The author's rationale for this word selection was that it implied that the child would not be released from one program's caseload until another actual placement was achieved. Many respondents stated that in most cases a recommendation for alternative placement was the extent of what their program could do for the child.

One respondent, who was omitted from the results, felt that the thirty-five question survey was too lengthy. It was suggested that a one page survey would be required before a reply to the survey would be received.

As a result of the critics' observations regarding the survey, the following list was compiled for any future endeavor.

1. Pretest the instrument on a small sample of respondents prior to dissemination. The pretest should request any word changes that would clarify the questions for the respondents. Also, the amount of time that was taken to complete the questions should be requested.

2. Dissemination of survey materials should be done during the ongoing school year; neither at the beginning of the year, nor at the end. There is no good time to do surveys, but during the ongoing school year was the preference of the respondents.
Recommendations

Mild Behavior Disorders

One function of the educational programs for the deaf should be to prevent behavioral crisis situations for the child and his family before they become severe. In order to do this, the teachers, supervisors, principals, and ancillary personnel who work with the deaf child must be trained to identify and remediate mild behavior disorders. Each program should have a psychologist, social worker, or counselor, who is familiar with the problems associated with deafness, available to counsel the instructional staff. All instructional and supervisory personnel of the educational programs should receive training in behavioral techniques and behavioral class management included in their university curriculum or through professional inservice workshops.

Children with mild behavior disorders that can be remediated in the regular classroom program for the deaf, should not be taken out of the mainstream of normal participation in the school's program and activities. Those children who have severe behavioral and emotional disorders that cannot be successfully remediated within the regular classroom and/or dormitory should have special referral facilities and services available to them that can cater to their individual needs. It was to this population that this study addressed itself.
Severe Behavioral and Emotional Disorders

1. A general and educational definition of the problem should be considered such as was done by the Ad Hoc Committee of the Conference of Executives of American Schools for the Deaf to redefine hearing impairment in 1975.

2. The educational planning and placement of the severely emotionally disturbed deaf school age child should be made a state education priority. It should be addressed directly to the state superintendent of public instruction, the state school board, and the state director of special education.

3. Each state's legislative appropriations committee should be made aware of the paucity of service for this population, and made aware of projected program costs.

4. Each state should assess their individual state need based upon the current incidence of the problem. Canvassing should be done in hospitals for the mentally ill, residential homes for the mentally retarded, juvenile detention centers, etc. for the school age child.

5. A proposal should be submitted to the federal government agencies (Bureau of Education for the Handicapped, National Institute for Mental Health, etc.) for seed money for planning and program implementation.
6. State regional or cooperative program planning should be considered.

7. Similar ongoing low-incidence programs, such as, the deaf-blind regional programs should be studied to ascertain how their programs were implemented and maintained.

8. Provisions should be considered for the funding of incentive programs for teachers and ancillary personnel to encourage them to pursue additional certification.
MAILING LIST

Alabama

Alabama Institute for Deaf and Blind
205 South St. E.
Talladega 35160

Birmingham Public School and Speech and Hearing Center
2801 Clairmont Ave.
Birmingham 35205

Lewis-Slossfield School
1900 25th Ave., N.
Birmingham 35234

Mobile Public Schools Hearing Impaired Classes
5750 Summit Ave.
Mobile 36601

Holt Elementary School Preschool Hearing Impaired
7 Nunnelly Drive
Tuscaloosa 35401

Alaska

Alaska State Program for the Deaf
2220 Nichols Street
Anchorage 99504

Barnette Elementary School
10th and Barnette
Fairbanks 99701

Arizona

Arizona State School for the Deaf and the Blind
P.O. Box 5545
Tucson 85703

Mesa Public Schools Hearing Impaired Classes
940 W. University
Mesa 85201
Arizona (Continued)

Phoenix Union High School District Regional Room for the Hearing Impaired
2526 W. Osborn Phoenix 85071

Easter Seal Society Preschool for Deaf and Hard of Hearing
1329 N. Swan Road Tucson 85712

Arizona Training Program at Coolidge
Box 1467 Coolidge 85228

Arkansas

Arkansas School for the Deaf
P.O. Box 3811
2400 W. Markham Street
Little Rock 72203

Jenkins Memorial Children's Center
2410 Rike Drive
Pine Bluff 71601

California

California School for the Deaf
2601 Warring St.
Berkeley 94704

California School for the Deaf
3044 Horace Street
Riverside 92506

Carlsbad Unified School District
Magnolia School for the Hearing Impaired
1905 Magnolia Ave.
Carlsbad 92008

Marin County Schools Hearing Impaired Program
250 Stadium Way, A.E. Kent Annex
Kentfield 94904
California (Continued)

Mary E. Bennett School for the Deaf
166 S. Burlington Ave.
Los Angeles 90057

Tulare County Department of Education
Tulare Regional Auditory Education Center
202 County Civic Center
Visalia 93277

John Tracy Clinic
806 W. Adams Blvd.
Los Angeles 90007

Alhambra City Schools Aural Education Program
900 S. Almansar
Alhambra 91801

Starr King Exceptional School
4848 Cottage Way
Carmichael 95608

Chula Vista City School District
Vista Square School
540 G Street
Chula Vista 92010

Covina Valley Unified School District
519 E. Badillo Street
P.O. Box 269
Covina 91723

Escondido Union Elementary School District
Central School
122 W. 4th Ave.
Escondido 92025

Solaro County Auraly Handicapped Classes
655 Washington St.
Fairfield 94533

Glendale Unified School District
Aurally Handicapped Program
233 N. Jackson Street
Glendale 91202
California (Continued)

La Mesa-Spring Valley School District
Aurally Handicapped Program
4750 Date Ave.
La Mesa 92041

Lompoc Unified School District
La Canada Elementary School
P.O. Box H
Lompoc 93436

Madera County School District
Sunbeam School
118 W. Lewis Street
Madera 93637

Placer County Office of Education Special Education
Valley View Drive
1228 High Street
Auburn 95603

Bret Harte Junior High School Day Classes
for the Hearing Impaired
2874 Florida
Oakland 94602

John Swett School
4551 Steele Street
Oakland 94619

Mesa Vista Hearing and Language Center
3 County Center Drive
Oroville 95965

Pittsburg Unified School District
Los Medanos Elementary School for the
Hearing Impaired Classes
610 Crowley Ave.
Pittsburg 94565

Pomona Unified School District
800 S. Garey Ave.
Pomona 91766

Berglund Unit
Mistletoe School
1225 Mistletoe Lane
Redding 96001
California (Continued)

Sacramento City Schools Aurally Handicapped Classes
P.O. Box 2271
Sacramento 95810

San Diego Unified School District Deaf
and Hard of Hearing Program
6404 Linda Vista Road
San Diego 92111

Hillcrest School
810 Silver Ave.
San Francisco 94134

Edwin Oster School
Hearing Impaired Classes
1855 Lencar Way
San Jose 95124

San Mateo County Classes for the Deaf
3601 Curtiss St.
San Mateo 94403

Santa Clara Unified School District
Classes for the Hearing Impaired
Haman Elementary School
865 Los Padres Blvd.
Santa Clara 95051

Little Lake City School District
10515 S. Pioneer Blvd.
Santa Fe Springs 90670

Cedarcreek Special Education Units
19409 Cedarcreek Street
Saugus 93534

Stockton Unified School District
Stockton Junior High School
350 E. Harding Way
Stockton 95204

Stockton Unified School District
Cleveland School
20 E. Fulton Str.
Stockton 95204
California (Continued)

Tulare Union High School
Deaf and Severely Hard of Hearing Program
755 E. Tulare Str.
Tulare 93274

Tulare County Department of Education
Tulare County Auditory Training Classes
202 County Civic Center
Visalia 93277

East San Gabriel Valley School for Multi-Handicapped Children
4400 N. Roxburgh
Covina 91722

Greely Special Education Assessment Center
401 City Drive, South
Orange 92668

Porterville State Hospital
Sensory Development Program (IV)
P.O. Box 2000
Porterville 93257

Colorado

Colorado School for the Deaf and Blind
Kiowa and Institute Streets
Colorado Springs 80903

Aurora Public Schools
Hearing Impaired Program
2055 Moline St.
Aurora 80010

Denver Public Schools Special Education
Hamilton Junior High School
840 E. 14th Ave.
Denver 80218

University Northern Colorado Laboratory School
Weld County School District No. 6
Special Education Services
Greeley 80631
Colorado (Continued)

Jefferson County Public Schools
809 Quail Street
Lakewood 80215

Adams County Cooperative Program for the
  Aurally Handicapped
810 Epinger
Thornton 80229

Porter Memorial Hospital
Speech and Hearing Department
2525 S. Downing St.
Denver 80210

Connecticut

Mystic Oral School
Oral School Road
Mystic 06355

American School at Hartford for the Deaf Inc.
139 N. Main St.
West Hartford 06107

Hazardville Memorial School
68 N. Maple St.
Enfield 06082

Holmes School Integrated Hearing Impaired Program
Nye Road
New Britian 06053

Capital Regional Educational Council Hearing
Impaired Program
Greenfield School
Wethersfield 06019

Delaware

Margaret S. Sterck School for the Hearing Impaired
Chestnut Hill Road
Newark 19711
District of Columbia

Model Secondary School for the Deaf
Florida Ave. at 7th St., N.E.
Washington 20002

Kendall Demonstration Elementary School
Gallaudet College
Florida Ave. at 7th St., N.E.
Washington 20002

Florida

Florida School for the Deaf and the Blind
San Marco Ave.
St. Augustine 32084

West Pensacola Elementary School
801 N. 49th Ave.
Pensacola 32506

Kate M. Smith Elementary School
Sinclair Ave.
Chipley 32428

Alachua County Board of Education
Gainesville Hard of Hearing Class
619 E. University Ave.
Gainesville 32601

Polk County Exception Child Education
P.O. Box 391
Barton 33803

Orange County Public Schools
Hearing Impaired Program
408 N. Tampa Ave.
Orlando 32805

Leon County Hearing Impaired Program
W.T. Moore Elementary School
Route 7, Mayo Road
Tallahassee 32303

Tampa Bay Blvd. Elementary School
Hearing Impaired Classes
3113 Tampa Bay Blvd.
Tampa 33607
Florida (Continued)

Sunland-Miami Multi-Handicapped
Hearing Impaired Class
20000 N.W. 47th Ave.
Opa Locka 33054

Georgia

Georgia School for the Deaf
Cave Spring 30124

Atlanta Area School for the Deaf
890 N. Indian Creek Drive
Clarkston 30021

West Broad Elementary School
Primary 1 and 2 Hearing Impaired Classes
West Broad Street
Athens 30601

Douglas County Board of Education
P.O. Box 1077
Connally Drive
Douglasville 30134

Cobb County Program for Hearing Impaired
700 Allgood Road
Marietta 30060

DeKalb County School System
Special Education Department
385 Glendale Road
Robert Shaw Center
Scottdale 30079

Georgia Center for the Multi-Handicapped
2477 Coralwood Drive
Decatur 30033

Guam

Guam School for Deaf and Blind
New Piti School
P.O. Box DE
Agana 96910
Hawaii

Hawaii School for the Deaf and Blind
3440 Leahi Ave.
Honolulu 96815

Kahala Elementary School
4559 Kilauea Ave.
Honolulu 96816

McKinley High School
Auditory Program for the Deaf and Hard of Hearing
1039 S. King
Honolulu 96814

Idaho

Idaho State School for the Deaf and Blind
14th and Main Streets
Gooding 83330

Preschool Communications Laboratory
Idaho State University
Speech Pathology and Audiology Department
Pacatello 83201

Illinois

Illinois School for the Deaf
125 Webster
Jacksonville 62650

East Central Regional Program for the
Hearing Impaired--Champaign
703 So. New St.
Champaign, 61820

South Metropolitan Association for Low
Incidence Handicapped
250 W. Sibley Blvd.
Dolton 60426

Evanston School District No. 65
Department of Special Services
Hearing Impaired Program
944 Ashland Ave.
Evanston 60202
Illinois (Continued)

Educational Regional Association
420 N. Raynor Ave.
Joliet 60435

Williamson County Special Education District
Hearing Impaired Program
S. Carbon St., Box 39
Marion 62959

Mid-Central Association
Low-Incidence Handicap
3202 N. Wisconsin Ave.
Peoria 61603

Springfield Public Schools District No. 186
444 W. Rynolds
Springfield 62702

Illinois State Pediatric Institute
Auditory Habilitation
1640 W. Roosevelt Rd.
Chicago 60608

Indiana

Indiana School for the Deaf
1200 E. 42nd Street
Indianapolis 46205

Bailly School Hearing Impaired Class
800 S. 5th Street
Chesterton 46304

Elkhart Community Joint Schools Center
Rice Elementary School
425 Goshen Ave.
Elkhart 46514

School City of Gary
Hearing Impaired Children Program
620 E. 10th Place
Gary 46402

Logansport Area Joint Special Education
Classes for the Hearing Impaired
2829 George St.
Logansport 46947
Indiana (Continued)

Muncie Community School Corporation
600 N. Mulberry St.
Muncie 47305

South Bend Community School Corporation
Speech and Hearing-Oral Deaf Programs
635 S. Main St.
South Bend 46623

Trade Winds Rehabilitation Center
Pre-School Deaf Education Program
5901 W. 7th Ave.
Gary 46406

Iowa

Iowa School for the Deaf
Highway 375
Council Bluffs 51501

Black Hawk-Buchanan County Schools
for Partially Hearing
314 E. 14th Street
Cedar Falls 50613

Des Moines Hearing and Speech Center
700 6th Ave.
Des Moines 50309

Agassiz School Resource Program for
the Hearing Impaired
608 E. Williams
Ottumwa 52501

Kansas

Kansas State School for the Deaf
450 E. Park St.
Olathe 66061

Kansas City, Kansas Public Schools
Mark Twain Elementary School
625 Minnesota Ave.
Kansas City 66102
Kansas (Continued)

Unified School District No. 383
Hearing Impaired Program
Bluemont School
7th and Bluemont
Manhattan 66502

Institute of Logopedics
2400 Jardine
Wichita 67219

Kentucky

Kentucky School for the Deaf
So. 2nd Street
Danville 40422

Center for Acoustically Handicapped
Fourth District School
1516 Scott Street
Covington 41011

Kentucky Easter Seal Society
Hearing and Speech Center
233 E. Broadway
Louisville 40202

Louisiana

Louisiana State School for the Deaf
504 Mayflower Street
Baton Rouge 70821

State School for the Deaf
Southern University System
P.O. Box 10147
Baton Rouge 70813

Hilda Knoff School for the Deaf
8800 Crochet St.
New Orleans 70123

Lafayette Parish Resource
Program for Hearing Impaired
600 Foreman Drive
Lafayette 70501
Louisiana (Continued)

Broadmoor Jr. High School
441 Atlantic
Shreveport 71105

Pinecrest State School
Box 191
Pineville 71360

Maine

Governor Baxter State School for the Deaf
Mackworth Island
P.O. Box 799
Portland 04104

Northeast Hearing and Speech Center, Inc.
477 Congress Street
Arcade Annex, Ste. 403
Portland 04111

Maryland

Maryland School for the Deaf
101 Clarke Place
Frederick 21701

Carver School for the Deaf
Route 3, Crain Highway
Gambrills 21054

Garrison Jr. High School (P.S. No. 42)
3910 Barrington Rd.
Baltimore 21207

Kent County Board of Education
Chestertown 21620

Prince George's County Board of Education
Upper Marlboro 20870

Rosewood School
Rosewood Center
Owings Mill 21117
Massachusetts

Beverly School for the Deaf
6 Echo Ave.
Beverly 01915

The Boston School for the Deaf
800 N. Main St.
Randolph 02368

Horace Mann School for the Deaf
20 Kearsage Ave.
Roxbury 02119

Alden Elementary School Hearing Impaired Department
Alden Street
Duxbury 02332

Springfield Day Classes for Deaf
Milton Street
Indian Orchard 01051

Reading Day Class for the Deaf
Killam School
333 Charles Street
Reading 01867

Newton Secondary Education Program
for the Hearing Impaired
88 Chestnut Street
West Newton 02165

Worcester Day Classes for the Deaf
20 Irving St.
Worcester 01609

The Boston College Campus School
for the Multihandicapped Children
Roberts Center
Chestnut Hill 02167

Michigan

Michigan School for the Deaf
W. Court and Miller Rd.
Flint 48507
Michigan (Continued)

Grand Rapids Public Schools
Shawnee Park Oral Deaf School
2036 Chesaning S.E.
Grand Rapids 49506

Huron High School
Hearing Impaired Section
2727 Fuller Rd.
Ann Arbor 48105

Bay-Arenac Intermediate School District
Wilder Road
Bay City 48706

Brighton Area Schools Hearing Impaired Department
Brighton 48116

Branch Intermediate School
200 Bishop Ave.
Coldwater 49036

Redford Union Schools Oral Hearing Impaired Program
18499 Beech-Daily Road
Detroit 48240

Garden City School District
Douglas, Harrison, Burger Schools
Box 218
Garden City 48135

Monroe County Program for Hearing Impaired Children
Ida Public Schools
3145 Prairie Street
Ida 48140

Lansing School District Special Education Division
Hearing Impaired Program
3426 S. Cedar Street
Lansing 48910

Owosso Central Elementary School
600 W. Oliver
Owosso 48867

Port Huron Area Schools Hearing Impaired Program
2715 South Blvd.
Port Huron 48060
Michigan (Continued)

Utica Community Schools Hearing Impaired Program
Graebner Elementary School
41875 Saal Road
Sterling Heights 48078

Warren Consolidated Schools
29900 Lorraine Blvd.
Warren 48093

Ypsilanti Public Schools Hearing Impaired Program
300 W. Forest St.
Ypsilanti 48197

Lapeer Public Schools
Woodside School
W. Genesee at Millville
Lapeer 48446

Minnesota

Minnesota School for the Deaf
Box 308
Fairbault 55021

Anoka-Hennepin School District No. 11
Box 191
Anoka 55303

Minneapolis Hearing Impaired Children Program
807 N.E. Broadway
Minneapolis 55413

Fairbault State Hospital
Deaf/Mentally Retarded Program
Fairbault 55021

Mississippi

Mississippi School for the Deaf
1253 Eastover Drive
Jackson 39211

Biloxi Public School Classes for Hearing Impaired
Popp's Ferry Elementary School
600 Nelson Rd.
Biloxi 39531
Mississippi (Continued)

Mississippi University for Women
Demonstration Preschool for the Hearing Impaired
College Street
Columbus 39701

University of Southern Mississippi Preschool for
Hearing Impaired Campus--Speech and Hearing Clinic
Box 92
South Station
Hattiesburg 39401

Meridian Municipal School System
Parkview Elementary School
1225 26th Street
Meridian 39301

Waltham County Public Schools
Tylertown Elementary School Speech and Hearing Class
705 Broad Street
Tylertown 39667

Missouri

Missouri School for the Deaf
5th and Vine Streets
Fulton 65251

Gallaudet School for the Deaf
1616 So. Grand Blvd.
St. Louis 63104

Bryan School Hearing Impaired Class
400 W. Lee Street
Nevada 64772

Springfield School District R-12
Delaware School
1505 S. Delaware
Springfield 65804

Montana

Montana State School for the Deaf and the Blind
3911 Central Ave.
Great Falls 59402
Montana (Continued)

Hellgate High School Integrated Classes
900 S. Higgins Ave.
Missoula 59801

School District No. 1 Hearing Impaired Program
Roosevelt High School
500 Edith St.
Missoula 59801

Nebraska

Nebraska School for the Deaf
3223 N. 45th Street
Omaha 68104

Central Nebraska Hearing Center
318 S. Clark St.
Grand Island 68801

Omaha Public Schools
3902 Davenport Street
Omaha 68131

Nevada

Washoe County School District
425 E. 9th Street
Reno 89502

Clark County Day Classes for the Deaf
1560 E. Cherokee
Las Vegas 89106

New Hampshire

Crotched Mountain Center
Educational Services Division
Greenfield 03047

Amoskeag Center for Educational Services
4 South Elm Street
Manchester 03103
New Jersey

Marie H. Katzenbach School for the Deaf
Sullivan Way
West Trenton 08625

Bergen County Program for the Hearing Impaired
Special Services School District
334 Union Street
Hackensack 07601

Bruce Street School
45 Bruce Street
Newark 07103

Avon School Hard of Hearing Classes
Mercer Drive and Avon Road
Barrington 08007

Clara Barton School
Hard of Hearing Classes
100 Crosswicks Street
Bordentown 08505

Clifton Public Schools
School N. 14
St. Andrew's Blvd.
Clifton 07011

A. Harry Moore Laboratory School
Jersey City State College
2078 Kennedy Blvd.
Jersey City 07305

Mount Carmel Guild Preschool Program
for Hearing Impaired Children
17 Mulberry Street
Newark 07102

Passaic County Technical and Vocational High School
45 Reinhardt Road
Wayne 07470

New Mexico

New Mexico School for the Deaf
1060 Cerrillos Road
Santa Fe 87501
New Mexico (Continued)

Cortez Elementary School Partially Hearing Classes
2332 San Mateo Place, N.E.
Albuquerque 87110

Hobbs Preschool, NMSD
New Mexico State University
College Education Building
Las Cruces 88001

Albuquerque Hearing and Speech Center
Preschool Deaf Classes
1011 Buena Vista Drive, S.E.
Albuquerque 87106

New York

St. Mary's School for the Deaf
2253 Main St.
Buffalo 14214

Lexington School for the Deaf
30th Ave. and 75th St.
Jackson Heights 11370

Rochester School for the Deaf
1545 St. Paul Street
Rochester 14621

New York State School for the Deaf
401 Turin Street
Rome 13440

New York School for the Deaf
555 Knollwood Road
White Plains 10603

St. Joseph's School for the Deaf
1000 Hutchinson River Parkway
Bronx 10465

BOCES School for the Hearing Impaired
Longwood Rd.
P.O. Box 161
Middle Island 11953
New York (Continued)

Clearley School - Western Campus
984 N. Village Ave.
Rockville Centre 11570

BOCES Hearing Impaired Classes
Schenectady-Albany-Schoharie Counties
Guilderland Middle School
Johnston Road
Albany 12203

Erie County No. 1 BOCES Hearing Disability Program
455 Cayuga Road
Box J
Cheektowaga 14225

BOCES Hearing Impaired Program
Farnsworth Middle School
State Farm Road
Guilderland 12084

Resource Room Program
Bureau for Hearing Handicapped Children
500 E. 78th Street
New York 10021

Demonstration Home Program
1545 St. Paul Street
Rochester 14621

Westchester County BOCES II
Integrated Hearing Impaired Children Program
Sreenville School
Glendale Road
Scarsdale 10583

School No. 14 Hearing Conservation Class
Congress and Christie Streets
Troy 12180

Board of Cooperative Education Services, BOCES
2285 Broad Street
Yorktown Heights 10598

Suffolk Developmental Center
Education Program
Education Department, Building 9
Melville 11746
New York (Continued)

Percy M. Hughes School
345 Jamesville Ave.
Syracuse 13210

North Carolina

North Carolina School for the Deaf
Rutherford Road
Morganton 28655

Central North Carolina School for the Deaf
3320 Garner Road
Raleigh 27610

Eastern North Carolina School for the Deaf
Highway 301 N.
Wilson 27893

Hearing Impaired Program
Charlotte-Mecklenburg School System
1400 N. Graham Street
Charlotte 28203

North Dakota

North Dakota School for the Deaf
Devils Lake 58301

Regional Program for Hearing Impaired Children
S.W. 18th and 5th Ave.
Minot 58701

Ohio

The Ohio School for the Deaf
500 Morse Road
Columbus 43214

Alexander G. Bell School for the Deaf
11815 Woodland Ave.
Cleveland 44120
Ohio (Continued)

Interdistrict School for the Hearing Impaired
2080 Quail Ave.
Lakewood 44107

Stark County Education Department
Special Education
Whipple Heights Elementary School
4800 12th St., N.W.
Canton 44708

James Ford Rhodes High School
South High School
C/O A.G. Bell School
11815 Woodland Ave.
Cleveland 44120

Dayton Public Schools Hearing Impaired
Children Program
348 W. 1st St.
Dayton 45402

Lorain City Schools Hearing Impaired Classes
1020 7th Street
Lorain 44052

Springfield City Schools Hearing Impaired Program
49 E. College Ave.
Springfield 45504

Bloomfield School
300 N. Miami St.
Trenton 45067

Zanesville City Schools Hearing Impaired Classes
C/O Pioneer School
9th and Main Street
Zanesville 43701

Oklahoma

Oklahoma State School for the Deaf
E. 10th and Tahlequah
Sulphur 73086

Midwest City-Del City Public School System
P.O. Box 10630
Midwest City 73110
Oklahoma (Continued)

Oklahoma City Public Schools
900 N. Klein
Oklahoma City 73106

Child Study Center Preschool Program
214 E. Madison
Oklahoma City 73125

Oregon

Oregon State School for the Deaf
999 Locust St., N.E.
Salem 97310

Southern Oregon Regional Facility for the Education of the Deaf, Jackson County
101 No. Grape Street
Medford 97501

Washington County Intermediate Education District
172 S. 1st Ave.
Hillsboro 97123

Salem Public School Speech and Hearing Program
2825 Commercial St., S.E.
Salem 97302

Pennsylvania

Pennsylvania School for the Deaf
7500 Germantown Ave.
Philadelphia 19119

Western Pennsylvania School for the Deaf
300 Swissvale Ave.
Pittsburgh 15218

Pennsylvania State Oral School for the Deaf
1800 N. Washington Ave.
Scranton 18509

W. and E. Martin School
22nd and Brown Streets
Philadelphia 19130
Pennsylvania (Continued)

Bloomsburg Demonstration Class for Hearing Impaired
Bloomsburg State College, Communications Department
Bloomsburg 17815

Appalachia Intermediate Unit 08
Department of Exceptional Children
214 W. Sample Street
Ebensburg 15931

Arin Intermediate Unit No. 28
Itinerary Hearing Therapy Program
Indiana County Courthouse
Box 175 Rt. 2865
Shelocth 15774

Midwestern Intermediate Unit IV
Primary Class for the Hearing Impaired
Grove City 16127

St. Christopher's Hospital for Children
Nursery School for Handicapped Children
2603 N. 5th Street
Philadelphia 19133

Pittsburg Hearing and Speech Society Preschool
355 5th Ave., 8th Floor, Park Building
Pittsburgh 15222

Carbon-Lehigh Int. Unit
2370 Main St.
Schnecksville, 18078

Chester County Child Development Center
1525 E. Lincoln Highway
Coatesville 19320

Pathfinder—Hearing Impaired Resource Room
Donati Road
Pittsburgh 15228

Puerto Rico

(Puerto Rico lists only private schools, and, therefore, will be deleted from this study.)
Rhode Island
Rhode Island School for the Deaf
Corliss Park
Providence 02908

Meeting Street School
Visually Impaired-Multi-Handicapped Unit
667 Waterman Ave.
Providence 02914

South Carolina
The South Carolina School for the Deaf and the Blind
Cedar Spring Station
Spartanburg 29302

Pate Elementary School Hearing Impaired Class
Indian Branch Road
Darlington 29532

Charleston County Hearing Impaired Programs
Berry Elementary School
250 Iroquois Ave.
North Charleston 29464

School District No. 7 Class for the Hearing
Impaired Speech and Hearing Clinic
Route 1
Spartanburg 29302

South Dakota
South Dakota School for the Deaf
1800 E. 10th Street
Sioux Falls 57103

Rapid City Schools Preschool Hearing Impaired Class
827 Franklin
Rapid City 57701

Tennessee
Tennessee School for the Deaf
2715 Island Home Blvd.
P.O. Box 886
Knoxville 37901
Tennessee (Continued)

Red Bank Jr. High School
Morrison Springs Road
Chattanooga 37415

East Tennessee State University
Preschool Deaf Program
Department of Special Education
College of Health
Johnson City 37601

Metropolitan Schools Department of Special Education
Hearing Impaired Program
2601 Bransford Ave.
Nashville 37204

Arlington Developmental Center
P.O. Box 399
Arlington 38002

Texas

Texas School for the Deaf
1102 S. Congress Ave.
Austin 78704

Jefferson-Orange County School for the Deaf
1800 Tulane Street
Beaumont 77703

Callier Center for Communication Disorders
1966 Inwood Road
Dallas 75235

Bell County Rehabilitation Center
2000 Marland Wood Road
Temple 76501

Abilene Independent School District
1317 N. 8th
Lamar Building
Abilene 79604

Bryan Independent School Preschool Deaf Class
Ross School
Parkway Terrace
Bryan 77801
Texas (Continued)

El Paso County Wide Day School for the Deaf and Hard of Hearing
4500 Clifton Ave.
El Paso 79903

Hereford Independent School District
Northwest School
400 Moreman
Hereford 79045

Kilgore Public Schools
1200 Dudley Road
P.O. Box 1541
Kilgore 75662

Ector County Independent School District
Box 3912
Odessa 79760

Santa Rita School
Oral Deaf Unit
615 S. Madison
San Angelo 76901

Tomball Independent School District
701 W. Main
Tomball 77375

Region IX Education Service Center
Classes for the Hearing Impaired
3015 Ave. I
Wichita Falls 76309

Capital Area Rehabilitation Center
919 W. 28½ Street
Austin 78705

Farias Elementary School
1510 Chicago Street
Laredo 78040

Lubbock State School
P.O. Box 5396
Lubbock 79417
Utah

Utah Schools for the Deaf and the Blind
846 20th Street
Ogden 84401

Hartrigsen School
Deaf and Blind Program
350 E. 3605 Sq.
Salt Lake City 84115

Vermont

The Austine School for the Deaf
120 Maple Street
Brattleboro 05301

Austine Educational Unit
Ira Allen Early Essential Education Center
Fletcher Place
Burlington 05401

Virginia

Virginia School at Hampton
700 Shell Road
Hampton 23661

Virginia School for the Deaf and the Blind
E. Beverley Street
Stauton 24401

Charlottesville Public Schools
Jefferson Bldg - 4th St. N.W.
Charlottesville 22901

Harrisonburg City Public Schools
P.O. Box 551
Harrisonburg 22801

Prince William County Public Schools
Consultant and Itinerary Services for the Hearing Impaired
Box 389
Manassas 22110

Dilenowisco Education Cooperative
Hearing Impaired Children Project
1032 Virginia Ave.
Norton 24273
Virginia (Continued)
Richmond Hearing Impaired Program
Fisher School
3701 Garden Road
Richmond 23235

Virgin Islands
Alfredo Andrews School
Estate Fredensborg
Christiansted 00820
St. Croix

Washington
Washington State School for the Deaf
611 Grand Blvd.
Vancouver 98661

Tacoma Public Schools
District No. 10
8th and Tacoma Ave.
P.O. Box 1357
Tacoma 98401

Columbia Basin Children's Hearing Program
60 H. Street, S.E.
Ephrata 98823

Washington State University
Communication Disorders Clinic
Daggy Hall
Pullman 99163

Seattle Public Schools Special Education
550 Mercer
Room 130
Seattle 98109

West Virginia
West Virginia Schools for the Deaf and the Blind
Romney 26757

Fayette County Board of Education
Mount Hope Middle School
Box 239
Fayetteville 25840
Wisconsin

The Wisconsin School for the Deaf
309 W. Walworth Ave.
Delavan 53115

Eau Claire Area Schools
Hearing Impaired Classes
1606 Park Ave.
Eau Claire 54701

Madison Public Schools Hearing Impaired Program
545 W. Dayton Street
Madison 53703

Juneau Jr.-Sr. High School
Milwaukee Board School Directors
Exceptional Education P.O. Box 10K
Milwaukee 53201

Lincoln School
Oshkosh School for the Deaf
608 Algoma Blvd.
Oshkosh 54901

Waukesha County Hearing Impaired Program
175 S. Barker Road
Waukesha 53186

Gaenslen Orthopedic School
Milwaukee Board School Directors
Exceptional Education
P.O. Drawer 10K
Milwaukee 53201

Wyoming

Wyoming School for the Deaf
539 S. Payne
Casper 82601

Eastridge Hard of Hearing Classroom
Logan and Pershing
Cheyenne 82001
Dear Administrator,

I am a graduate student at the Ohio State University in Columbus, Ohio, pursuing a doctoral degree in the Education of the Hearing Impaired. At the present time I am collecting data to be used in my dissertation entitled, The Provision of Mental Health Programs and Services in Public Residential Schools and Public Day School Programs for the Hearing Impaired.

I would appreciate your assistance by completing the enclosed questionnaire, and returning it on or before June 18, 1976, so your school's program may be included in the study. In the final publication of this study, no names or school programs will be identified.

If the questionnaire is not applicable to your particular program, please check the box N/A in the right hand corner, and return it in the enclosed self-addressed envelope. Thank you in advance for your immediate response to this questionnaire.

Sincerely,

Dolores M. Fowlkes
Graduate Research Associate
The Ohio State University
PROVISIONS OF MENTAL HEALTH PROGRAMS
AND SERVICES IN PUBLIC RESIDENTIAL SCHOOLS AND
PUBLIC DAY SCHOOL PROGRAMS FOR THE HEARING IMPAIRED

QUESTIONNAIRE

Directions:
1. Please answer each question
2. Include any additional information in the
   space following the questions

IN THE FINAL PUBLICATION OF THE STUDY, ALL NAMES AND
PROGRAMS WILL BE KEPT CONFIDENTIAL.

Name of person completing form

Staff position

Name of School

Address of School

City, State Zip code
1. Do you routinely admit multiply handicapped hearing impaired children to your program?
   Yes(  )  No(  )

2. If yes, do you admit deaf children with behavior disorders (emotionally disturbed)?
   Yes(  )  No(  )

3. If no to #1 and #2, please answer the following:
   a. the physical facility is too small (  )
   b. inadequate number of trained teachers (  )
   c. philosophy of the school forbids it (  )
   d. too expensive to program for this population (  )
   e. other, please explain--

4. Does your school have a specific student exclusion policy?
   Yes(  )  No(  )

5. If Yes, please explain--
6. Do you consider it necessary to have separate living and/or educational facilities for deaf children with emotional disorders?
   Yes( ) No( )

7. If yes, please explain--

8. If a child with behavior disorders is excluded from your program, is another referral placement obtained for him?
   Yes( ) No( )

9. If no, please explain--

10. If children are referred to an outside agency, do you feel that the personnel providing the mental health services are familiar with the problems associated with deafness?
    Yes( ) No( )

11. If yes, please explain--
12. Does your school provide any kind of inservice program about the problems of deafness to the agency personnel with whom you contract for services?
   Yes( )     No( )

13. If yes, please explain--

14. Does your school employ deaf persons?
   Yes( )     No( )

15. If yes, please identify their positions--
   a. Superintendent ( )
   b. Assistant Superintendent ( )
   c. Principal ( )
   d. Counselors ( )
   e. Teachers ( )
   f. Other, please identify--

16. Who consults with teachers regarding severe behavior problems of students?
   a. Superintendent ( )
   b. Principal ( )
   c. Department Supervisor ( )
   d. Social worker ( )
   e. Nurse ( )
   f. Psychologist ( )
   g. Psychiatrist ( )
   h. Other, please identify--
17. What types of problems are most often referred?  
Please list in order of highest referral.  
1.  
2.  
3.  
4.  
5.  

18. Do you have a full or part time psychiatrist available to your school for consultation?  
Yes(  )  No(  )  
Full time(  )  Part time(  )  

19. Is there a hospital or mental health facility in your geographic location that will accept your severely emotionally disturbed students?  
Yes (  )  No (  )  

20. If yes, please explain the referral and placement procedures.  

21. Does your school provide inservice education to parents regarding the problems of deafness?  
Yes(  )  No(  )
22. If yes, how is the parent inservice conducted?
   a. In groups ( )
   b. Individually ( )

23. Are the parents actively involved in some part of the educational programming of their children?
    Yes ( )    No ( )

24. If yes, please explain--
   a. on advisory board ( )
   b. on special committees ( )
   c. other ( ) please explain--

25. How many of your teachers, who work with the emotionally disturbed children, have special training in addition to certification in the area of the hearing impaired?
   a. all of them ( )
   b. none of them ( )
   c. ______# out of ______#

26. Is the teacher provided with a teacher's aide?
    Yes( )    No( )

27. What is the most workable class ratio for this type class?
   a. one teacher/one child ( )
   b. one teacher/two children ( )
   c. one teacher/three children ( )
   d. one teacher/four children ( )
   e. one teacher/five children ( )
   f. other ( ) please explain--
28. How are teachers assigned to work with multiply handicapped deaf children?
   a. teacher volunteers ( )
   b. superintendent assigns ( )
   c. Principal assigns ( )
   d. Department supervisor assigns ( )
   e. other ( ) please explain--

29. Does your school provide continuing education workshops for teachers' professional improvement?
   Yes( )        No( )

30. If yes, what area do you feel is of the greatest priority for teachers?
   a. Curriculum development ( )
   b. classroom behavior management techniques ( )
   c. language development ( )
   d. Other ( ), please explain--

31. Are you aware of Federal and state funding that is available for the implementation of special programs to eligible schools?
   Yes( )        No( )

32. If yes, how was this information made available to you? Please explain--
33. What types of special programs are you now providing that are either totally or partially federally funded? (Please identify funding source and type of program)

34. Do you have a staff person assigned to your school who has the major responsibility of investigating local, state, and federal funding sources?
   Yes( ) No( )

35. How do you feel the needs of the multiply handicapped deaf child with severe emotional and/or behavioral problems can best be served? Please express your frank opinion.

Thank you for completing this questionnaire. Please return it by June 18, 1976 in the self addressed envelope.
BIBLIOGRAPHY


Bender, Ruth E. The Conquest of Deafness. The Press of Western Reserve University, Cleveland, 1960.


Index, American Annals of the Deaf; Volume 120, Number 2, April, 1975.


Rainer, John D., and Kenneth A. Altshuler, Comprehensive Mental Health Services for the Deaf, Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, New York, 1966.

Rainer, John D., Kenneth A. Altshuler, Family and Mental Health Problems in a Deaf Population, Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, New York, 1963.


