

TABLE OF CONTENTS

	Page Number
CHAPTER 1	
INTRODUCTION	10
1.1 MOTIVATIONS FOR THE RESEARCH	12
1.2 PROPOSED AIMS OF THE RESEARCH	13
1.3 DESIGN OF THE RESEARCH	14
1.4 CHAPTER REVIEW	15
CHAPTER 2	
HEARING IMPAIRMENT	19
2.1 INTRODUCTION	19
2.2 THE MECHANISMS OF HEARING	19
2.2.1 The ear	19
2.1.1.1 <i>The inner ear</i>	19
2.1.1.2 <i>Central auditory pathways</i>	21
2.3 THE MECHANISM OF SOUND	22
2.3.1 Intensity	22
2.4 DEFINING HEARING IMPAIRMENT	23
2.5 CLASSIFICATION OF HEARING LOSS	23
2.5.1 The Location of the Disease in the Ear	24
2.5.1.1 <i>Conductive impairment</i>	24
2.5.1.2 <i>Sensorineural impairment</i>	24
2.5.1.3 <i>Mixed deafness</i>	25
2.5.1.4 <i>Non-organic deafness</i>	25
2.5.2 The Onset of the Hearing Loss in Relation to Language and Speech development	26
2.5.2.1 <i>Pre-lingual hearing loss</i>	26
2.5.2.1 <i>Post-lingual hearing loss</i>	26
2.5.3 Based on the Cause of the Problem within the Ear (Congenital/prenatal)	26
2.5.3.1 <i>Genetics and deafness</i>	26

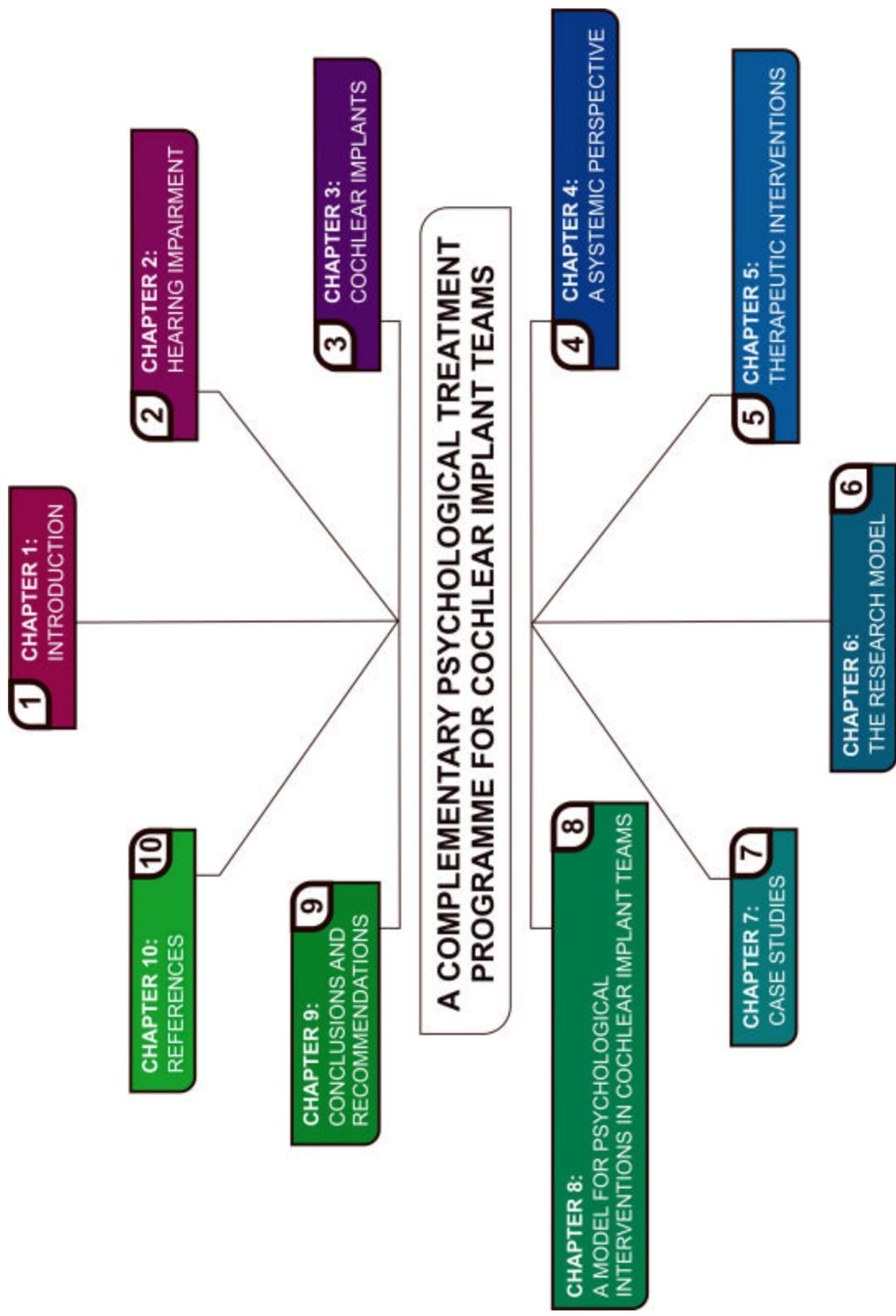
2.5.3.2	<i>Rubella</i>	27
2.5.3.3	<i>Cytomegalo virus</i>	27
2.5.3.4	<i>Perinatal disorders</i>	28
2.5.4	Acquired disorders	28
2.6	THE IMPACT OF HEARING IMPAIRMENT	29
2.6.1	The Impact of Diagnosis on the Child and Family	29
2.6.2	Social-emotional Context of Development in the Early Years	33
2.6.3	Social and Personality Development During the School Years	36
2.6.4	The Hearing-impaired Child and Education	40
2.6.5	Parental Concerns and Professional Responses	42
2.6.6	The adult	45
2.6.6.1	<i>Effects of acquired hearing loss on the family</i>	49
2.6.6.2	<i>Acquired hearing loss and the informal network level</i>	52
2.6.7	Hearing Impairment, Self-esteem, Self-image and Communication	53
2.7	CONCLUSION	56
CHAPTER 3		
COCHLEAR IMPLANTS		
3.1	INTRODUCTION	59
3.2	WHAT IS A COCHLEAR IMPLANT	59
3.3	THE FUNCTIONING OF THE COCHLEAR IMPLANT	61
3.4	GENERAL CRITERIA FOR CONSIDERING COCHLEAR IMPLANTS	65
3.5	THE EVALUATION PROCESS FOR HAVING AN IMPLANT	67
3.5.1	Psychological evaluation	68
3.6	THE SURGICAL PROCEDURE FOR THE COCHLEAR IMPLANT	68
3.7	RISKS INVOLVED WITH THE COCHLEAR IMPLANT	69
3.8	'MAPping' PROCEDURE	70

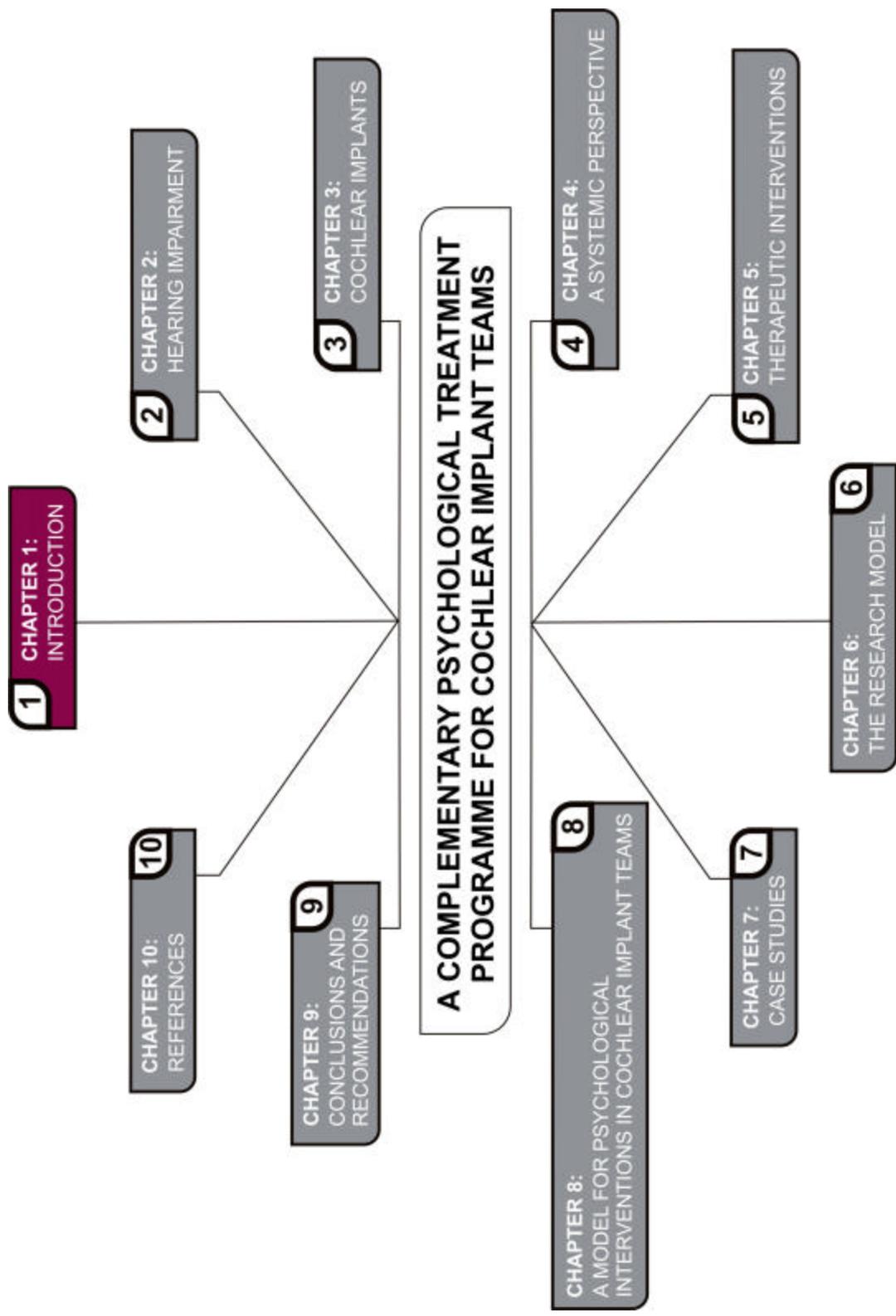
3.9	THE LIMITATIONS OF THE DEVICE	71
3.10	QUALITY OF SOUND	71
3.11	BENEFITS FROM A COCHLEAR IMPLANT	72
3.11.1	Communication Benefits	72
3.11.2	Benefits in Speech and Language	73
3.11.3	Psychological Benefits	75
3.12	EXPECTATIONS, GRIEVING AND FEARS	77
3.13	CONCLUSION	84
CHAPTER 4		
A SYSTEMIC PERSPECTIVE		
4.1	INTRODUCTION	88
4.2	THE INTERSYSTEMIC PERSPECTIVE	91
4.2.1	Family	91
4.2.2	Professional	92
4.2.3	Informal networks	93
4.2.4	Cultural	93
4.3	INTRASYSTEMIC PERSPECTIVE	94
4.3.1	Biological	95
4.3.2	Psychological	96
4.3.2.1	<i>The disconnected self and the connected or Spontaneous self</i>	96
4.4	INTERACTION OF THE SYSTEMIC LEVELS	97
4.5	THE QUALITIES OF SYSTEMS	98
4.5.1	Stability and change	98
4.5.2	Recursive cycle	99
4.5.3	Rules and Boundaries	100
4.5.4	Openness and Closedness	101
4.5.5	Entropy/Negentropy	101
4.5.6	Equifinality/Equipotentiality	102
4.5.7	Communicating and Information Processing	102
4.6	CONCLUSION	103

CHAPTER 5	
THERAPEUTIC INTERVENTIONS	107
5.1 INTRODUCTION	107
5.2 FAMILY THERAPY	110
5.2.1 The Structural Approach	110
5.2.1.1 <i>Basic concepts/Theoretical Constructs</i>	111
5.2.1.2 <i>Theory of Health/Normalcy</i>	116
5.2.1.3 <i>Therapeutic Strategies/Interventions</i>	117
5.3 THERAPLAY	120
5.3.1 The Six Phases of Theraplay	124
5.3.1.1 <i>The introduction phase</i>	124
5.3.1.2 <i>The exploration phase</i>	124
5.3.1.3 <i>The tentative acceptance phase</i>	124
5.3.1.4 <i>The negative reaction phase</i>	125
5.3.1.5 <i>The growing and trusting phase</i>	125
5.3.1.6 <i>Termination</i>	125
5.3.2 Indications and contraindications of Theraplay	126
5.4 SPONTANEOUS HEALING INTRASYSTEMIC PROCESS (SHIP®)	128
5.4.1 Distracters and Coping styles	133
5.4.2 The Disconnected Self and Helplessness	135
5.4.3 Interference, Imprints and the Disconnected memory Imprint Centre	136
5.4.4 The Disconnected-memory Imprint Centre and the Involuntary System	139
5.4.5 Activators	140
5.4.6 Chain Statements	141
5.4.7 Chronic systemic stress reactions ('CSSR')	142
5.4.8 Spontaneous healing	143
5.4.9 Process	146
5.4.10 The different phases of SHIP®	146
<i>Phase 1: The history of the client</i>	147
<i>Phase 2: The Doors</i>	149

7.2.3	Therapeutic strategies/interventions	208
7.3	CASE STUDY 2	210
7.3.1	Therapeutic strategies/interventions	213
7.3.2	Summary of all the sessions	223
7.4	CASE STUDY 3	226
7.4.1	Psychotherapeutic strategies/ interventions	229
	<i>Phase 1: The Life Sketch</i>	229
	<i>Phase 2: The Doors</i>	234
	<i>Phase 3 The Tunnel</i>	240
	<i>Phase 4 The Well</i>	242
	<i>Phase 5 Integration</i>	244
7.4.2	Summary of all the sessions	247
7.5	CONCLUSION	248
CHAPTER 8		
A MODEL FOR PSYCHOLOGICAL INTERVENTIONS IN		
COCHLEAR IMPLANT TEAMS		
		252
8.1	INTRODUCTION	252
8.2	THE ROLE OF THE PSYCHOLOGIST	252
8.2.1	Readiness for Implant Surgery	253
8.2.2	A Concluding Remark on Assessment and Intervention	256
8.3	A DESCRIPTION OF FIGURE 8.1	257
8.4	CONCLUSION	264
CHAPTER 9		
CONCLUSION AND RECOMMENDATIONS		
		267
9.1	INTRODUCTION	267
9.2	GENERAL REVIEW	267
9.3	EVALUATION OF THE RESEARCH	269
9.3.1	Strengths of the Research	269
9.3.2	Limitations of the study	270
9.4	RECOMMENDATIONS FOR FUTURE RESEARCH	272
9.5	CONCLUSIONS	274

	APPENDIX 1	275
	APPENDIX 2	276
10	REFERENCES	305





1.1 MOTIVATIONS FOR THE RESEARCH

1.2 PROPOSED AIMS OF THE RESEARCH

CHAPTER 1 : INTRODUCTION

CHAPTER REVIEW **1.4**

1.3 DESIGN OF THE RESEARCH

CHAPTER 1

INTRODUCTION

How we feel about ourselves, how much we value and accept ourselves underlie every meaning we give to our experience, every prediction and decision we make and every action (Corker, 1994). Being hearing impaired may have a profound impact on the way a person feels about him/herself. According to Myklebust (1960) a sensory deprivation limits the world of experience and it deprives the organism of some of the material resources from which the mind develops. The reduction of experience leads to an imposition on the balance and equilibrium of all psychological processes. When one type of sensation is lacking, it alters the integration and function of all of the others.

Wagenfeld (1987) states that hearing loss is arguably the most devastating form of sensory deprivation for the sufferer. Not only does hearing loss interfere with the ability to perceive sounds in the environment, but if present from birth in a severe degree, it also prevents the acquisition of speech and, more importantly, language, unless treated actively and continuously.

While huge strides have been made in the treatment of various forms of hearing loss, there is an unfortunate group of patients who suffer from a profound hearing loss and who derive no benefit from amplification.

Research involving cochlear implants originated in an attempt to provide these patients with an alternative sensory device (Millar, Tong & Clark, 1984). Cochlear implants have been used by hearing health professionals for more than a decade to treat both adults and children with profound bilateral sensorineural hearing loss. The effectiveness of these devices varies and is dependent on a number

of factors. Although the implant enables the hearing-impaired person to hear better, it does not cure the hearing impairment. The process of cochlear implantation is a complex one. Human qualities like emotions, anxieties and expectations influence the process and can determine the success of the implant. Hearing and hearing impairment play a major role in the intrasystemic as well as the intersystemic functioning of a person. In this research the experience of hearing impairment and cochlear implants are studied from a systemic perspective.

1.1 MOTIVATIONS FOR THE RESEARCH

Prior to her masters studies in psychology the researcher was a speech therapist and audiologist. Working as a speech therapist and audiologist, she became aware of the complicated nature of the human being, where speech or hearing impairment can have a psychological effect and where psychological factors can lead to speech and hearing impairment. At that stage the researcher felt incompetent to facilitate change in these people and this led to her furthering her studies in the field of psychology. As a psychologist on the cochlear implant team at the University of Pretoria, the researcher has to date interviewed more than 100 cases of hearing-impaired people who received cochlear implants. Her involvement in the cochlear implant team and with the cochlear implantees made her once again aware of not only the psychological impact of hearing impairment, but also of the psychological impact of the cochlear implant. The field of cochlear implants is relatively new and research in this domain has been done mainly from the perspective of audiology, speech therapy and surgery.

Exploring the literature, the researcher became aware of the lack of research concerning the psychological aspects of the cochlear implant, and specifically relating to a systemic point of view. Interaction with hearing-impaired people and their families indicated that hearing impairment is not only a biological impairment, but has a

profound effect on the person as a whole and/or on the family. Advanced technology will no doubt lead to more and more cochlear implants, with younger and younger children as recipients. The researcher - through this study – wants to create a greater awareness in cochlear implant teams of the impact of cochlear implants on the implantee on an inter- as well as intrasystemic level. This awareness can lead to change in the perception of cochlear implants and their resulting effect on and in the particular systems involved. As this awareness grows, hopefully more psychologists will become involved with cochlear implant teams. This research can provide them with guidelines in their important contribution towards improving the functioning of the hearing-impaired person and his/her family.

1.2 PROPOSED AIMS OF THE RESEARCH

The aim of this study is to develop a complementary psychological treatment programme for cochlear implant teams by observing cochlear implantation and hearing impairment from a psychological and systemic point of view. In other words, an individual and his/her family are viewed as systems within a biopsychosocial hierarchy and the behaviour of these systems is described by tracking the changes that occur within that system and its subsystems and the system as a larger whole. This circular nature of causation is discussed in more detail in Chapter 4. The outcome of this perception is, as pointed out above, to create awareness within the cochlear implant teams of the many levels of organisation in human experience so that these teams can be aware of the impact of their interventions on the individual and his/her systems. This complementary treatment programme can be used as a guideline for psychologists involved in cochlear implant teams. Literature regarding cochlear implants did not reveal any such treatment programmes. In this sense this programme can contribute to the

science of psychology as well as to other disciplines involved in cochlear implants.

1.3 DESIGN OF THE RESEARCH

There was a time when most researchers believed that the only phenomena that counted in the social sciences were those that could be measured. To make that perfectly clear, they called any phenomenon they intended to study a 'variable', indicating that the phenomenon could vary in size, length, amount, or any other quantity (Tesch, 1990). Unfortunately, not many phenomena in the human world come naturally in measurable quantities. Sigmund Freud discovered a wide variety of individual characteristics about the way human beings function and so did Jean Piaget. Neither of them tested hypotheses or used large and representative enough samples of people to satisfy the rules of statistics. Yet both made important assertions about human beings and created many psychological constructs for use in the description of their theories.

Qualitative research indicates any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known (Tesch, 1990). Qualitative methods can give intricate details of phenomena that are difficult to convey with quantitative methods. Qualitative research is more discovery-oriented and provides wide descriptions and a holistic perspective of the topic of inquiry. For the purpose of this study and the description of the phenomenon of cochlear implants and hearing impairment, the qualitative method of research was chosen. The nature of qualitative research as opposed to quantitative research will be explicated in Chapter 6. Purposive sampling will be used to select the case study participants in the research.

1.4 CHAPTER REVIEW

This study contains a literature survey as well as theoretical and practical components. The chapter content can be summarised as follows:

Chapter 2 discusses hearing impairment. It explains the mechanism of hearing and sound. It gives a classification of the different types of hearing impairments, the causes and the way hearing impairment is diagnosed. It also focuses on the impact of hearing impairment and the diagnosis of hearing impairment on the development of the child and the child's family and in the case of an adult, the impact of hearing impairment on the functioning of the adult and on his/her family.

Chapter 3 describes cochlear implantation, the functioning of the implant, the criteria for considering cochlear implantation and the evaluation process for having an implant. It also includes a description of the surgical procedure, the risks and the MAPping procedures once the device has been implanted surgically. The limitations and the benefits of the implant are described and expectations surrounding the implant are mentioned.

Chapter 4 explores the systemic perspective – it suggests that human behaviour is always context-based and is a function of the interaction within and between systems levels across time. It also posits that human behaviour can only be properly understood by perceiving all the systems of which the person is a part in interaction with each other. The qualities of systems from an intersystemic and intrasystemic perspective are described. The systemic perspective forms the lens through which the researcher observed the data.

Chapter 5 contains descriptions of the different therapeutic interventions incorporated in this specific treatment programme. The

descriptions include the basic concepts/theoretical constructs of the different approaches. These include Structural Family Therapy; Theraplay with a child and Spontaneous Healing Intrasystemic Process (SHIP®) with and adult.

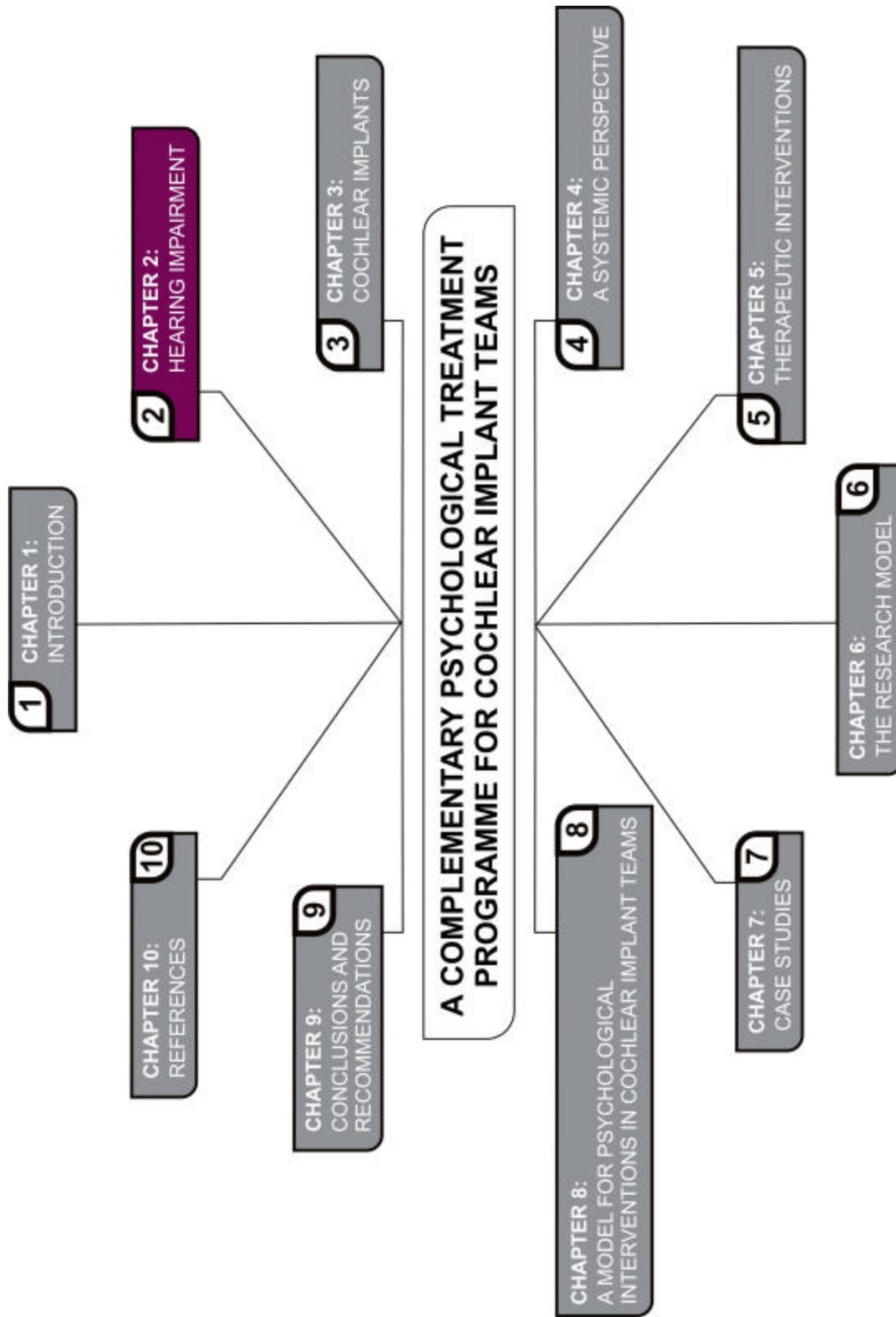
Chapter 6 describes the method of research and the research design used in this study. The naturalistic paradigm and qualitative research as opposed to the positivist paradigm and quantitative research are discussed. The choice of the naturalistic paradigm and qualitative research as the preferred method of inquiry is substantiated. The legitimisation and validity of qualitative research and its congruency with the systemic perspective is highlighted.

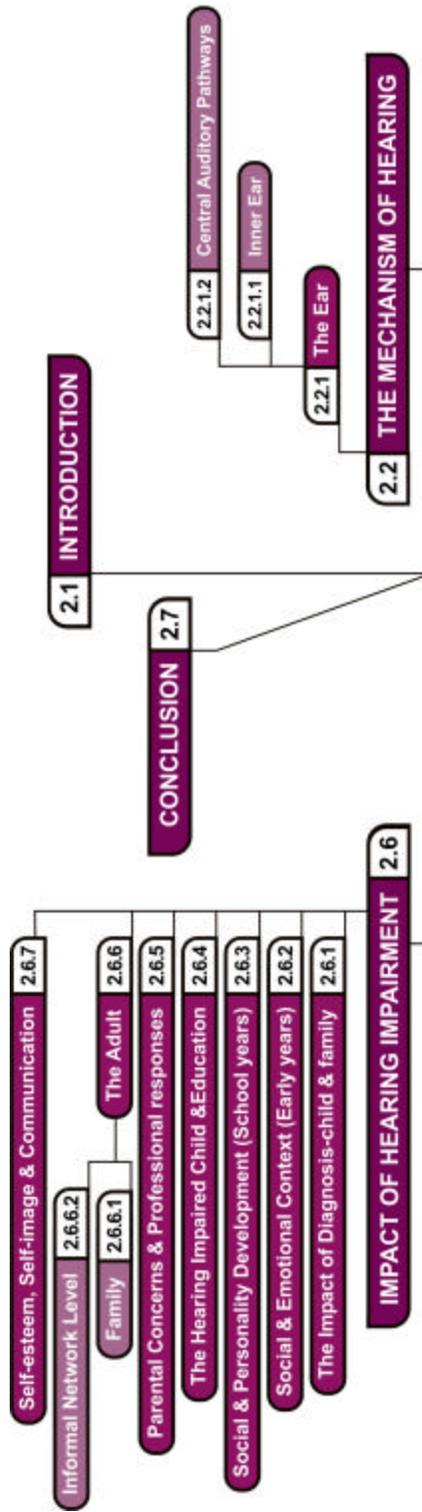
Chapter 7 contains three case descriptions where the application of the three therapeutic interventions is shown. This chapter also illustrates how different theories account for the data.

Chapter 8 puts all the information gathered from the previous chapters regarding the need for psychological interventions into a practical treatment model. This model shows the role of the psychologist and where and how psychological interventions can take place in the process of cochlear implants.

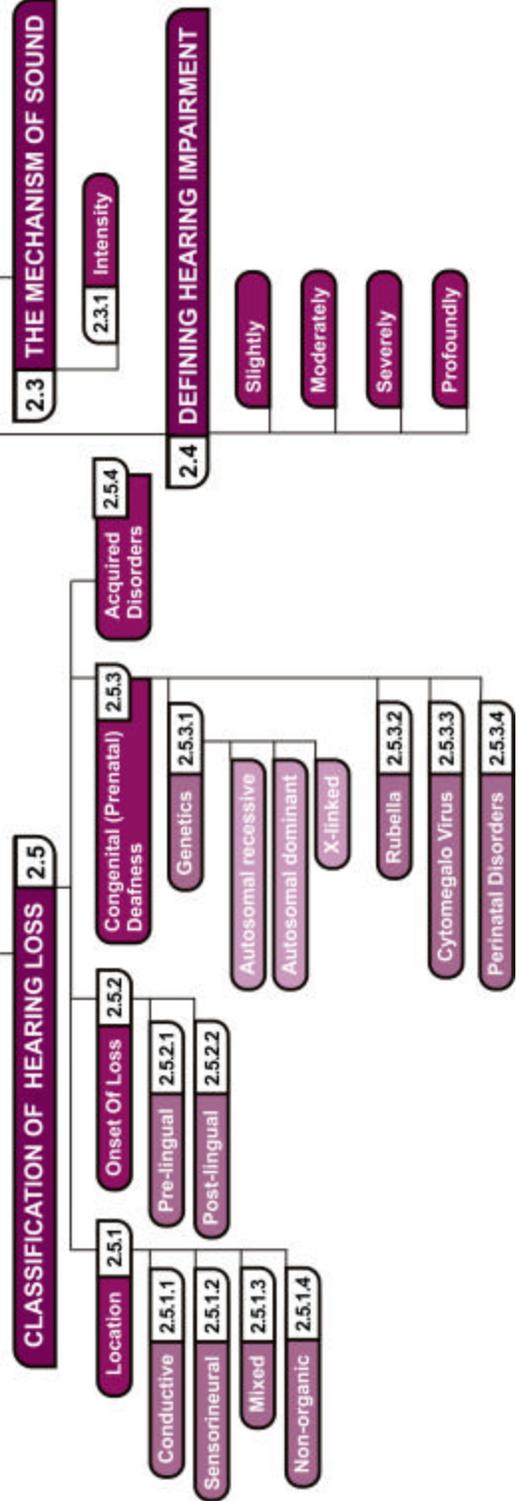
Chapter 9 is the concluding chapter. The treatment programme, its strengths and limitations are discussed. Recommendations for future research are also made.

The next chapter describes hearing impairment and all its surrounding factors.





CHAPTER 2 : HEARING IMPAIRMENT



CHAPTER 2

HEARING IMPAIRMENT

2.1 INTRODUCTION

This chapter deals with hearing, hearing impairment and the psychobiosocial impact of hearing impairment. The mechanisms of hearing and sound are described briefly in order to understand the description of the cochlear implant in Chapter 4. The different types of hearing loss and the causes of hearing loss will be explained. The impact of hearing loss and the way it contributes to the functioning and developing of the personality of the person with hearing impairment will be described. This knowledge will influence psychological interventions and is of importance for the psychologist.

2.2 THE MECHANISM OF HEARING

The human ear is a detector capable of recording incredibly minute sounds. It acts as an early warning mechanism, and the two ears working together enable the brain to localise the source of a sound (Pickles, 1982).

2.2.1 The Ear

The ear is divided into the outer, middle and inner compartments (figure 2.1). The cochlear implant involves the inner ear and the working of the inner ear. The anatomy and physiology of the inner ear can be described as follows:

2.2.1.1 The inner ear.

The inner ear has a bony, coiled tube of two-and-a-half turns, called the cochlea, which is divided into three parallel canals. These are called the scala vestibuli, the scala media or cochlea duct, and the scala tympani. The inner ear is filled with fluid. The scala vestibuli and scala tympani are filled with perilymph, while the cochlear duct is

filled with endolymph. Two membranes separate the cochlear duct from the other canals. The upper scala vestibuli is separated by Reissner's membrane, and the lower scala tympani by the basilar membrane.

A round window is set into the wall of the scala tympani. When the stapes (from the middle ear) is pushed into the oval window, a wave is conducted along the scala vestibuli, through the Reissner's membrane to the cochlear duct. The basilar membrane is depressed and the round window bulges out into the middle ear, where sound energy is dissipated into the air. Sound receptors are found in the organ of Corti, which lies on the basilar membrane. It is made up of hair cells (Corti cells), arranged into inner and outer groups, with supporting cells. Each hair cell is anchored on the basilar membrane and has a bundle of hairs projecting upwards. The hair cells make contact at their base with fibres from the auditory nerve (the eighth cranial nerve).

Individual hair cells vary in length and stiffness. The short, stiff hair cells are more sensitive to high frequencies than the longer, more flexible ones.

When a wave travels along the basilar membrane the hair cells are mechanically stimulated. Bending of the hairs triggers the release of a chemical transmitter, which in turn activates the cochlear fibres.

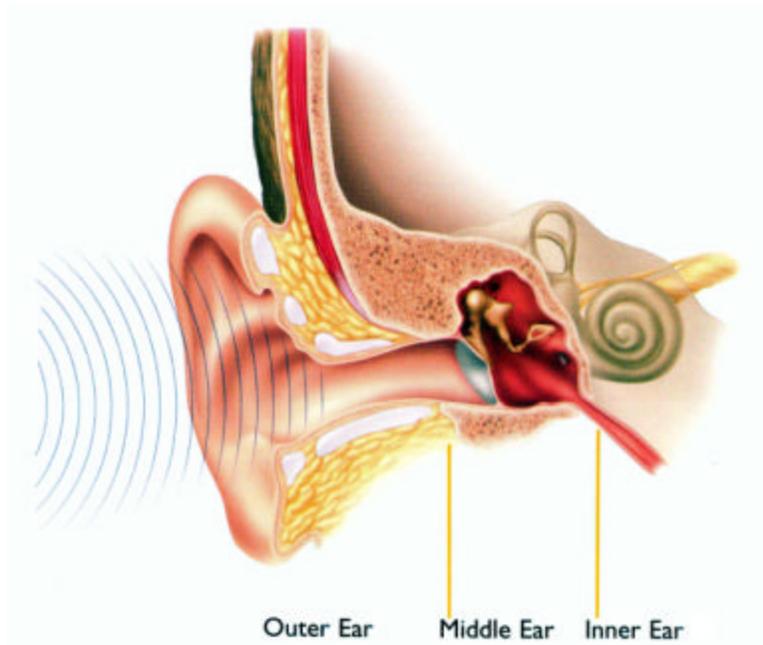


Figure 2.1 (The Nucleus® Cochlear Implant System, 2001, p.2.)

2.2.1.2 *Central auditory pathways.*

The auditory pathways lead from the cochlea to the primary auditory cortex, which lies deep in the brain, and has several relay stations along the route (Martin, 1986). The brain has centres, which are specialised for analysing individual sounds to work out their direction of origin. It also has higher centres, which are able to recognise the source and nature of sounds and the content of speech. The ascending system provides stimulation from one ear to both sides of the brain, while descending fibres from each side of the brain provide inhibition to both cochleae. The relay stations process the incoming nerve impulses, so that recording and processing of information takes place all the way up through the system (Martin, 1986).

2.3 THE MECHANISM OF SOUND

Sound can be defined in terms of either psychological or physical phenomena. In the psychological sense, sound is an auditory experience – the act of hearing something, connecting and being in touch with the environment. It allows in part for a relation between the self with the self and the self with others. In the physical sense, it is a series of disturbances of molecules within an elastic medium (Martin, 1986).

Sound is caused by variation in air pressure within a specified range of frequencies and intensities. Outside this range the sensations produced are described as vibration, flutter, tickle and pain (Bray, Cragg, Macknight, Mills & Taylor, 1989).

The human ear is capable of perceiving frequencies from as low as 20 Hz to 20 000 Hz, which is nearly ten octaves of pitch range. Most speech is in the range of 500 Hz to 2 000 Hz and is a mixture of these frequencies (Alpiner, 1970). Pure tone sound is a sound of only one frequency, but sounds rarely consist of one pure tone; they are usually complex, comprising a combination of tones of different frequencies.

2.3.1 Intensity

The concept 'loudness' is subjective and therefore difficult to measure, so the intensity of sound is measured instead.

The intensity of sound is measured in decibels (dB or db). The range of intensities that the human ear can detect is extremely wide. The loudest sound we can hear without damaging our ears has a level of about 120 dB above the faintest sound we can detect (Moore, 1982).

2.4 DEFINING HEARING IMPAIRMENT

The term 'hearing impairment' is defined as: "loss of hearing that is severe enough to produce disorders of communication requiring remedial or educational treatment" (Rodda & Grove, 1987; p.1).

Myklebust (1960) defined the term "deaf" as referring to a more restricted group of hearing impaired people: those in whom the sense of hearing is non-functional for the ordinary purposes of life. Hearing impairment is divided into four categories:

- ***slightly hearing impaired*** – a person whose average hearing loss, regardless of age of onset, does not exceed 40 dB;
- ***moderately hearing impaired*** – a person whose average hearing loss, regardless of age of onset, is from 41dB to 70 dB;
- ***severely hearing impaired*** – a person whose average hearing loss is from 71dB to 95 dB and greater, who acquired their hearing impairment after the age of 18 months;
- ***profoundly hearing impaired*** – a person who was born with, or acquired before the age of 18 months, an average loss of 90 dB or greater (Densham, 1995).

2.5 CLASSIFICATION OF HEARING LOSS

There are three different ways to classify the hearing loss (Schwartz, 1999):

- Based on the location of the disease in the ear.
- Based on the onset of the hearing loss in relation to the language and speech development.
- Based on the cause of the problem within the ear.

2.5.1 The Location of the Disease in the Ear

Hearing loss can be classified according to the location of the disease in the ear into three basic types:

2.5.1.1 Conductive impairment.

Conductive impairment is caused by interference with the passage of sound waves through the outer and middle ear (Adams, 1987). Conductive deafness is often treatable, either medically or with hearing aids. Conductive deafness mainly tends to affect low notes, which in speech terms means the vowels. Temporary forms of conductive impairment can occur - for example, the drum membrane can become strongly retracted by a negative pressure in the middle ear; as can be caused when an aircraft is descending, so that air is absorbed and the middle ear rapidly fills with fluid (Best & Taylor, 1966). This condition reverses once the pressure equalises and the fluid is absorbed.

2.5.1.2 Sensorineural impairment.

Sensorineural impairment is caused by damage to the cochlea mechanism and/or to the auditory nerve (Adams, 1987). Sensorineural deafness is usually medically irreversible and is only partly helped by amplification with hearing aids (Quigley & Paul, 1984). Sensorineural deafness is particularly liable to affect high notes that define some consonants, although it may affect all tones equally. Sensorineural hearing loss associated with injury to the hair cells in the cochlea may be accompanied by "recruitment", where there is a more rapid growth of loudness than normal (that is, a person may suddenly hear a loud sound with no prior build-up towards it). This can cause problems for someone wearing hearing aids that are adjusted for everyday speech, as some sounds may be uncomfortably loud (West, 1985).

Temporary sensorineural impairment can occur from continuous exposure to sound (Rosenberg, 1982). Continuous exposure to sound of intensity 75-85 dB causes temporary impairment known as 'auditory fatigue'. There is an increase in the threshold of hearing (that is, the quietest sound that can be detected), referred to as a 'temporary threshold shift'. When a person enters a noisy place and stays there, that person's hearing threshold starts to rise and continues rising for several hours until it reaches a plateau level (the level will depend on the intensity of the noise). When the person leaves the noisy environment the threshold begins to fall, but it may take 24 hours or so to return to 'normal'. The noise does not have to be continuous – intermittent sounds of minutes' or even seconds' duration has a cumulative effect (Densham, 1995). If there is continuous or intense exposure to very loud noise, the change causes irreversible damage to hearing (Rosenberg, 1982). Sensorineural impairment can occur at any age. Presbycusis (hearing impairment due to advancing age) can cause a conductive impairment in the middle ear as well as a sensorineural hearing loss. Congenitally deaf children also have a sensorineural hearing loss.

2.5.1.3 Mixed deafness.

It is possible to have a mixed deafness, with both conductive and sensorineural loss in the same ear (Adams, 1987). When treated, the conductive element disappears, but hearing is still not within normal limits due to the presence of the sensorineural element.

2.5.1.4 Non-organic deafness.

Non-organic deafness can occur in three forms: hysterical deafness, malingering or where organic disease is present in a mild form (Adams, 1987). Hysterical deafness is not very common in children under five years, and is often stress-related. There may be psychological problems, such as aggressive or withdrawn behaviour. With malingering there is intention on the part of the person to

deceive and in most instances, for financial gain. It is rare in children, because most cannot keep up the pretence for long.

2.5.2 The Onset of the Hearing Loss in Relation to Language and Speech Development

2.5.2.1 Pre-lingual hearing loss.

This is when the hearing loss is present before language and speech have developed.

2.5.2.2 Post-lingual hearing loss.

This refers to a hearing loss that develops after the development of speech and language has started or has been completed.

2.5.3 Based on the Cause of the Problem within the Ear (Congenital/ Pre-natal Deafness)

2.5.3.1 Genetics and deafness.

Autosomes are the 22 pairs of chromosomes, which are not the sex chromosomes (that is, X and Y), while genes are units of hereditary information present on the chromosomes. Autosomes pair according to their shape, so every gene occurs twice in every cell of the body. In every pregnancy one of the genes for hearing will be passed to the child from each parent (Fraser, 1987).

a) Autosomal recessive deafness.

This is the commonest form of inherited deafness. In its simplest form, the gene for hearing exists in both a normal and abnormal form in the parents. There is a 25% chance that any child will inherit two abnormal genes and so be deaf. There is a 50% chance that they will inherit one abnormal gene and so become a carrier. This condition is not usually passed from a deaf parent to child unless both parents happen to be carriers (Fraser, 1987).

b) *Autosomal dominant deafness.*

With this condition a single abnormal gene causes deafness, even when a normal gene is also present. The deafness may vary from mild to profound, and can be bilateral or unilateral. There is a 50% chance of each child receiving the abnormal gene (Fraser, 1987).

c) *X-linked deafness.*

This form of deafness occurs in males, having been passed on by unaffected females. It is extremely rare. There are also rare X-linked syndromes, which include deafness.

Inherited deafness can be present at birth or may appear later in childhood and can cause either conductive or sensorineural loss. A wide range of syndromes which can be autosomal recessive, autosomal dominant or X-linked, can cause varying degrees of deafness from birth, including a rare group where hearing appears to be normal with a gradual onset of deafness (Fraser, 1987).

2.5.3.2 *Rubella.*

Rubella is the most common identifiable cause of congenital sensorineural deafness in children (Martin, 1982). Deafness occurs in about one-third of rubella children, and Hardy (1973) has shown that infection with the virus at any stage in pregnancy can cause deafness and not just if infection occurs in the first trimester, which is a common mistaken belief.

2.5.3.3 *Cytomegalovirus.*

Congenital cytomegalovirus (CMV) is the most common congenital infection in the UK, affecting three to four infants per 1 000 births. Most infants who are affected do not show any symptoms, and often the virus is unrecognised. Nevertheless, many unexplained cases of sensorineural deafness may be due to this infection, and could account for approximately 12% of all children with

sensorineural loss (Peckham, Coleman, Hurley, Chin & Henderson, 1983).

2.5.3.4 Perinatal disorders.

There are three major causes of sensorineural deafness in the perinatal period: hypoxia (insufficient oxygen), disorders associated with raised bilirubin levels (jaundice), and problems associated with prematurity and low birth weight (Adams, 1987).

Pre-term delivery (before the 37th week of pregnancy) and low birth weight (weighing less than 2 500g) are very closely linked, and infants in these groups have a higher incidence of hearing loss than normal (Minoli & Moro, 1985), although the causes are varied. Pre-term babies are more likely to suffer episodes of hypoxia, and are generally at risk because of their immaturity. They are very prone to life-threatening infections, and may well be given antibiotics, which are potentially harmful to the auditory system (ototoxic).

2.5.4 Acquired Disorders

Meningitis is the most frequent cause of acquired sensorineural deafness in childhood, and about 10% of children with meningitis will develop some degree of hearing loss (Martin, 1982). In some children with bacterial meningitis the initial loss will recover in six months (Munoz, Benitez-Diaz & Guiscafne, 1983). Certain drugs may be ototoxic. These include a particular group of antibiotics and cytotoxic drugs, which are used in the treatment of childhood cancers (Adams, 1987).

Other causes include certain rare diseases of the immune system, tumours, cancers such as leukaemia, and trauma. A blow on the head that is severe enough to render a child unconscious can damage the cochlea.

2.6 THE IMPACT OF HEARING IMPAIRMENT

2.6.1 The Impact of Diagnosis on the Child and Family

In the UK, 90% of deaf children are born to hearing parents (Kyle & Woll, 1988). For the majority of these parents the discovery that their child is deaf comes as a devastating shock. In contrast, deaf parents do not tend to experience the diagnosis of deafness in their child as the same kind of disaster, particularly if the household communicates in sign language (Grant, 1987; Schlesinger, 1985).

The birth of a baby is a profound and deeply moving experience for most parents, and the discovery – or even suspicion – that a new infant is not perfect can be shattering (Powell, Finito-Hieber, Friel-Patti & Henderson, 1985). If there has been some abnormality surrounding the birth (for example, prematurity or birth trauma), or an obvious cause such as maternal rubella or meningitis in the child, parents may have some preparation for the possibility of there being something wrong with their child. Even so, any abnormality, no matter how apparently insignificant to others, can cause distress, and parents may take a long time to come to terms with a potentially serious diagnosis such as deafness (Densham, 1995). Because of complicating factors such as delays in getting appointments and disappointing results of hearing screening (Bellman, 1987; Martin & Moore, 1979; Newton, 1985) as well as difficulties in diagnosing the level of loss of hearing in young infants, parents may remain in a state of anxiety about the degree of impairment their child possesses for a prolonged period of time (Graham, 1986; Ross, 1990; Schlesinger & Meadow, 1972).

Professionals have a vital role to play during this period. Whether a child is born deaf or becomes deaf, no matter how well hearing parents may eventually come to accept the diagnosis, initially there will always be a crisis to overcome (Densham, 1995). How parents feel about, and act towards their children will affect the way those

children come to view themselves. This view may cause life-long effects on later social relationships, career decisions or lifestyles for the child.

The time of diagnosis is perhaps the most critical period, when decisions are made which can have far-reaching consequences for the rest of a child's life. It is a time when professionals need to be at their most sensitive to the needs and feelings of the family (Densham, 1995). A study by Woolley, Stein, Forrest and Baum (1989) on imparting the diagnosis of life threatening illness found that all parents remembered vividly the manner in which the diagnosis was imparted, and some parents were still preoccupied with this many years later. Although the diagnosis of deafness is less serious than diagnosis of life threatening illness, similar reactions were found among parents who were interviewed in the study done by Densham (1995). For example, the father of a profoundly deaf nine-year-old boy had tears in his eyes as he related his memories of being given the diagnosis:

It was eight years ago nearly. It never leaves you – never leaves your mind.....They don't prepare people beforehand. It was so cold....just.....a miserable.....sort or place really. Just me and me wife and John and there was nobody.....else, nobody else in this backwater of a place. It didn't seem as if we was.....going somewhere that you'd expect to go to...to be told that sort of stuff that.....you just was hope...hopefully thinking might not be. It just seemed....sort of.....like backwater type place to be told really bad news.....We have never seen anybody else. There was only the doctor there and I.....think the receptionist type of nurse. If I could have chosen how to have been told it would have been a bit more – bit more important. It was.....as if you should just understand it straightaway and be cool like. I had to take it back – I didn't understand....I asked if they might be able to do an operation.....Oh no, he's deaf and

that's the end. If we'd been told "You're going to have a problem. You need to come to terms with it." But not all could like that (Densham,1995; p.2-3).

It is well known that parents go through a process of grieving the loss of a 'perfect' child in order to be able to accept a 'new' child with a disability (Buscaglia, 1975; Gordon, 1975; Kubler-Ross, 1969; Moses, 1977). The stages of grief include denial, guilt, depression, anger and anxiety, before acceptance. Moses (1985) has specifically set out the grieving process as it relates to parents whose child is diagnosed as deaf, stressing the importance of early psychosocial intervention in order to help parents work through the process effectively. He reminds us that disability in a child shatters cherished and significant dreams (which require an unimpaired child), and that it is the dream that must be grieved for. Because this is such a personal and illusory loss, few people understand that it is a dream that has been lost, and that they are therefore frequently confused by the grief process that follows. Furthermore, successful grieving seems to depend on significant human interactions, yet those wishing to offer support may fail to recognise that each of the affective states in the grieving process serves a specific function that allows the parents to separate from the cherished dream.

Parental reactions during the grieving process (particularly the expression of negative feelings such as anger or rage) may affect professional workers, especially if they do not understand the process and its importance (Densham 1995).

Moses (1985) states the following:

Professionals who have negative opinions or difficulty with the affective states are likely to inhibit the grief process and be detrimental to the habilitation of the child. The professional who is able to convey an attitude of acceptance toward the affective states will have a positive effect upon the parents and help to

create a sense of security for the child. Without this, children cannot go on to develop in other areas, such as language development, that are seen as tantamount to the successful habilitation of the deaf (p.99).

Professionals sometimes tend to distract the parents from their spontaneously activated feelings of loss of a normal child. According to JOS (2002) that which is denied through the act of distracting, will linger on in the system and be projected onto the external world, it 'lives' on until allowed to speak.

Meadow (1980) has also argued that, until parents have the opportunity to examine their feelings and to express anger, guilt and sorrow, these negative feelings can interfere with the parents' relationship with their child, and reduce energy and coping strengths necessary to overcome the consequences of deafness; and that there are some families who continue to relive the diagnostic trauma throughout the life of the child.

The lack of support by professionals during the diagnostic crisis, followed by professional advice that is seen as overwhelming, conflicting and incompatible, can contribute to stress, and often lead to a crisis in parenting (Schlesinger, 1976).

Research done by Densham (1995) suggests that a sense of powerlessness may be evoked in the parents by the professionals with whom they have initial contact. Professionals create a sense of powerlessness when they assume that parents know the implications of the diagnosis and that parents have the knowledge to make the right decisions for their children. Professionals have a responsibility to parents and their children. The impact of deafness on hearing parents can affect the whole life outcomes of their children, embracing their self-esteem, ability to communicate, their education and integration into society. By their attitudes professionals influence parents, who influence their children. In turn those children become

adults and influence future generations, and so a dynamic process is set up which has begun with the professional. Therefore, insightful and caring professionals can have a profound and positive effect on this whole interactive cycle (Densham, 1995) (Figure 2.2)

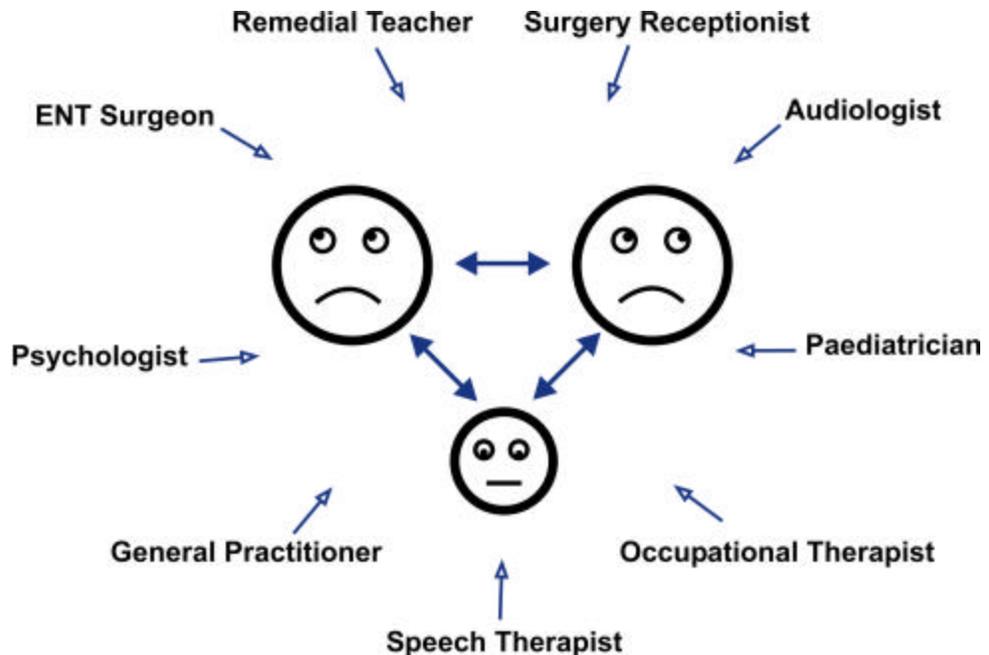


Figure 2.2 Caring professionals can have a profound effect on the hearing-impaired and his/her family systems

2.6.2 Social-emotional Context of Development in the Early Years

“He’s only 2. He doesn’t understand why his toys don’t make a noise any more” (Densham, 1995; p.2). Normal babies come into the world with the potential for hearing a universal set of language sounds and contrasts, some of which are maintained and some of which disappear as the child matures and experiences language input (Marshark, 1993). Even before birth, however, it appears that the sounds in a hearing child’s pre-natal environment may indirectly affect the course of psychological and intellectual development. During the last trimester of pregnancy, the fetus turns from its former position and now rests with its head against the mother’s pelvis. At this point in development, normal fetuses already have considerable

responsiveness to sound, especially human speech (Eisenberg, 1976). For those mothers who speak and are carrying babies who can hear, this period presents the opportunity for the fetus to hear its mother's voice and heartbeat through bone conduction (Als, Lester & Brazelton, 1979). That the foetus experiences its mother's voice before birth is not a matter of dispute. How the effects of that experience are interpreted has important implications for our understanding of children who are born deaf and those hearing infants who are born to deaf parents (Marshark, 1993). A variety of studies has shown that pre-natal auditory experience can exert powerful effects on post-natal learning and perception in humans. The results of these studies suggest that for normal mother-infant dyads pre-natal and early post-natal maternal speech can play a role in initial mother-child bonding. This conclusion does not mean that there are no other cues that would be available to deaf babies or hearing babies of deaf mothers. Balogh and Porter (1986), for example, have shown that maternal odours are preferred stimuli for day-old infants who are breast-fed. Moreover, both deaf and hearing infants probably engage in additive cue strategies using diverse sources of information for identifying familiar people.

What is important here is that the early physiologically based "regulators" of interaction can influence developing systems throughout their formative stages and contribute to attachment and early mother-child relationships. During the earliest stages of mother-child interaction, it is essential that the mother and child become attuned to each other through the development of synchrony and reciprocity. Synchrony here refers to the intertwining of the behaviour patterns of mother and infant as they converge on a common routine of interaction. Reciprocity refers to the development of mutual cuing systems that result in complementary behaviours – a kind of symbiosis between mother and child. These early interactions provide the roots for later attachment and emotional bonding between mother and child (Marshark, 1993).

Bell and Ainsworth (1972) use the following example to illustrate the importance of these reciprocal patterns. Consider a typical and almost universal routine: the infant cries or fusses, the mother attends to it, touching and caressing it, talking to it, and perhaps picking it up. The infant temporarily ceases to fuss, looks at the mother, who is now speaking or smiling, produces some vocalisation, and is “answered” by the mother with more vocalisation, more handling, and so on. It is important to note here that, although relatively inexperienced at such things, the infant is playing a vital, reciprocal role in this interaction. Unwittingly the child is giving the mother cues that in part determine her behaviour, including the passing of cues back to the child. Over time both sides become better at the socialisation game, and these reciprocal patterns or interaction develop greater synchrony and complexity.

The deaf neonate thus lacks at least one component of the earliest social context available to hearing neonates. Marshark (1993) notes that evidence available from work with other species suggests that the absence of the vocal-auditory linkage between mother and infant may be a significant one with distinct behavioural and emotional consequences. In the case of children with parents who are deaf or who are aware of their child’s deafness, it may be that increased rates of touching, visual stimulation and facial expression can compensate for the absence of auditory stimulation in mother-child interactions. In other cases, where parents do not realise that their child is deaf, such compensation may not occur, and there could well be a disruption or lag in the establishment of behavioural synchrony between mother and child. This anomaly is likely to increase with the passage of time until the infant’s handicap is discovered and parental child-orientated behaviour patterns are adjusted. In the meantime the infant not only receives less of the social experience available to hearing infants, but what experience is available may be less than ideal. In extreme circumstances, one can

imagine a scenario in which the only time a hearing-impaired child hears the mother's voice is when she raises it in anger or frustration.

2.6.3 Social and Personality Development During the School Years

Marshark (1993) recognises here that in the case of deaf children, particularly those with hearing parents, the rules, customs, and social behaviours learned in the home may not generalise to social situations outside the home. As young children develop into more social organisms, the variety of their relationships with family, peers, and other adults (e.g., teachers) increases far beyond that established with the mother and other care-givers within the home. Most children exhibit an affinity toward others, displaying both instrumental and emotional (or person-oriented) dependence. Marshark (1993) defines instrumental dependence as dependence to seeking attention from others to satisfy needs or wants, whereas emotional dependence refers to the extension of attachment-like bonds as children strive for proximity, approval, and affection from others. The child who is independent still displays appropriate instrumental and emotional dependence but blends such behaviour with self-reliance, assertiveness, and a need for achievement. Handicapped children, in general, are likely to encounter difficulty establishing their independence. In part, the relatively greater need for instrumental assistance is a real one, the qualities and extent of which vary with the nature of the child's handicap. However, the frequent overprotection of handicapped children by their parents creates further impediments to social independence, as those children are often able to perform a variety of tasks that others typically do for them.

Harris (1978), has suggested that the lack of effective communication with parents and peers is frequently a major impediment to social adjustment for deaf children. Because they typically receive fewer explanations for the causes of social and

emotional behaviours in others, deaf children experience more difficulty in self-regulation and a reduced ability to learn from social interactions. Less understanding of others' reactions to their behaviours results in less accurate self-images and, possibly, low self-esteem. Ultimately, these qualities can lead to less social independence and may negatively impact on the quality of relationships in the school setting.

Greenberg and Kuschè (1987) argued that although many deaf children are relatively impulsive and egocentric, these characteristics could be attributed only partially to linguistic or sociocultural sources. More pertinently, deaf children and adolescents frequently have significant deficits in knowledge and skills that impede their independence in both the social and academic domains (Marshark, 1993). Greenberg and Kuschè (1987), like Schlesinger and Meadow (1972), observed that deaf children tend to be more emotionally immature than their hearing peers. In the case of deaf children of hearing parents, one could argue that lags in social and emotional development result in part from the lack of appropriate social models with which they can identify and communicate.

Luterman further (1987) suggests that hearing parents of deaf children often become emotionally "stiff" in their interactions with their children after hearing loss is diagnosed. According to Marshark (1993) such behaviour derives at least partially from the unresolved guilt and vulnerability felt by parents, and they lead children to develop external loci of control and lack of autonomy.

The Gregory (1976) and Schlesinger and Meadow (1972) studies painted a picture of deaf children learning about social interactions in contexts characterised by maternal behaviours that, compared to mothers of hearing children, are less flexible, less imaginative, less encouraging, and less permissive while being more didactic, more

intrusive, and more physically punishing. At the same time, those mothers are more responsive in some ways.

The latter finding may be somewhat surprising because of the expectation that hearing mothers would tend to be less synchronised with their deaf infants than would be the case with hearing infants. By the time deaf children are in pre-school, however, there is a marked tendency for hearing mothers to be more responsive, perhaps even over-responsive, to them. Schlesinger and Meadow (1972) observed that mothers of deaf children were almost three times more likely than mothers of hearing children to report being comfortable spanking their children (71% vs. 25%). Gregory (1976) reported a similar finding and concluded that many mothers of deaf children find physical punishment simpler than a verbal explanation when linguistic communication ability is low. Most likely, maternal frustration also plays a role there, as deaf children are likely to be less responsive and more disruptive than hearing siblings (Marshark, 1993).

Both Rodda (1966) and Gregory (1976) have pointed out that deaf children are less likely than hearing children to receive explanations from parents concerning emotions, reasons for actions, expected roles, and the consequences of various behaviours.

Marshark (1993) links deaf children's poor scholastic performance, at least in part, with their tendency towards impulsive behaviour. Impulsivity has a generic definition that frequently is applied to deaf individuals who are perceived as not behaving in a way that indicates "careful, coherent, advance planning.....(who are) unable to plan a course of action and adhere to it.... (or who) may make rash choices based on a desire for immediate gratification rather than on the expectation of long-term goals" (Meadow, 1980; p.4).

Considering the generic brand of impulsivity, several investigators have attributed deaf individual's "rash" behaviour to the

lack of early language interaction with parents, who are generally unable to explain delays in gratification (e.g., Gregory, 1976). Hearing parents of deaf children frequently yield to demands for attention, assistance, and objects rather than risk the possibility of temper tantrums, which cannot be stopped with linguistic intervention. Without sufficient communicative fluency to relate the present to the past and the future, these parents unwittingly may be teaching their children that emotional and instrumental dependence is immediately rewarded. This attitude is then carried over into the school environment, where deaf children are three times more likely to demonstrate emotional difficulties than their hearing peers (Harris, 1978). Various investigators have described deaf individuals (and deaf children in particular) as unable to take the affective perspective of others, thus making them emotionally egocentric, lacking in empathy, and insensitive to the needs of those around them (e.g., Altshuler, 1974; Bachara, Raphael & Phelan, 1980; Myklebust, 1960). Bachara et al. (1980) found that deaf nine- to 14 year-olds were more egocentric than their hearing age-mates, lagging behind as much as five years, as assessed by a role-taking task. According to Marshark (1993), these findings might be interpreted in two ways. One possibility is that language flexibility is intimately related to social and cognitive maturity, so that children who have the benefits of early linguistic interactions with parents and others are better able to consider the perspectives of others in social situations. Another possibility is that deaf children generally might be able to assume the perspectives of others but are unable to interpret or evaluate the consequences of those perspectives with regard to their own actions.

To conclude: When considering the emotional context of deaf children's development, it is important to avoid over-generalising from the relatively sparse data that is available. There are, however, some fairly well documented social-emotional problems of deaf children that appear to be rooted in early socialisation and intertwined with impairments in hearing and language competence.

2.6.4 The Hearing-impaired Child and Education

According to Hodgson (1953), until the 17th century, when technology advanced understanding of the nature of sound, the attitude towards deafness was one of fatalism. The view Aristotle (384-322 BC) put forward – that the deaf could not learn to speak because their tongues were tied, and ‘those who are born deaf all become senseless and incapable of reason’ (Hodgson, 1953, p.32 in Marshark, 1993), lasted for more than 2 000 years. Deaf people became outcasts and were ill-treated.

Debates regarding which mode of communication should be used with deaf children for teaching purposes are deeply entrenched in the history of deaf education. Although the arguments are less intense than a decade ago, the oral/manual controversy has not yet ended. Two opposing views are expressed within the oral/manual debate with one extreme advocating oral/manual methods only, and the other arguing totally for sign language without the use of any form of oral/aural input. An oral method implies that the hearing-impaired child must learn to speak without the use of any signs.

The extreme oralist argument suggests that if deaf children learn to use sign language or gesture, they will fall back on this easier method of communication and never learn to speak. Without speech they will be unable to communicate with hearing people, and so will be unable to live full lives in the hearing community. At the other end of the spectrum are exponents who recognise British Sign Language (BSL) as a fundamental aspect of deaf culture, and within that culture the deaf do not need speech (Marshark, 1993).

A national survey of all schools for the deaf and partial-hearing in the UK in the 1980-81 year showed an increasing trend away from oral methods to Total Communication (Densham, 1995).

Oral methods as methods of education are used for children who received **cochlear implants** and natural body language is used in the same way as in the communication of a normal hearing person.

The trend towards integrating deaf children into mainstream schooling has increased steadily throughout the second half of the 20th century. Holsgrove (1987) has argued that the literature takes for granted that integration is highly desirable and advantageous, although he has found that this is not necessarily the case. Implicit in the idea of mainstreaming is the assumption that deaf children will model themselves on hearing children and adjust to a “normal” lifestyle. By mixing with hearing people they will assimilate the language, values and culture of hearing people so that eventually they will become fully integrated members of the wider normal-hearing society. Without mainstreaming, they remain isolated and segregated, and are deprived of a “normal” environment. There is an assumption that handicapped children need experience with normally developing peers, and that this is essential for “normal” socialisation (Ladd, G.W., Munson, H.L. & Miller, J.K., 1984).

Not everyone considers mainstreaming to be of benefit to very deaf children. For example, Dimmock (1981) cited a “catastrophic run of events” that occurred in British Columbia, Canada, where a school for the deaf was closed against protests from the deaf, parents and teachers, and the pupils transferred into mainstream schooling. After 10 years, educational attainments in reading, writing and spelling of a number of the pupils were so low that the school had to be re-opened. Dimmock (1981) pointed out that, although the school was improved and expanded to deal with the reversed flow of children coming back from mainstream schooling, the victims of the blunder may never be able to read or write for the rest of their lives. From this experience the authorities realised with humility that deaf children have a unique handicap. They need centralisation of educational resources and highly trained teaching personnel.

Stewart (1984) has argued that education is dependent upon interaction between the teacher and the pupil, and pupils with their peers. When the communication pathway is blocked, learning suffers. Therefore integration must have a purpose. There needs to be meaningful interaction in order for integration to be successful. That which may be appropriate for the hard of hearing, depending on their oral skills, it is much less likely to be appropriate for deaf children. The most appropriate educational setting depends on the individual (Densham, 1995).

Children spend a large proportion of their lives in school. If they are unhappy in their educational environment they are likely to suffer socially and emotionally. Geers (1985) concludes that the most important ingredient in effective education of the deaf child is “well structured educational programmes that are based on the realisation that most deaf children require extremely careful, intensive, individualised instruction in order to realise their potential” (p.81).

2.6.5 Parental Concerns and Professional Responses

From all the studies that have been undertaken in the literature, there appear to be three main areas where parents of deaf children may be in need of particular professional expertise. These include:

counselling in relation to the deafness;

communication;

education (Densham, 1995).

According to Rogers (1942), “Effective counselling consists of a definitely structured, permissive relationship which allows the client to gain an understanding of himself to a degree, which enables him to take positive steps in the light of his new orientation” (p, 18). Rogers cautioned that counselling might sometimes be used as a means of advising or persuading people (sometimes called ‘intervention’), and

that, in order for counselling to be successful, there must be an awareness of both self and other on the part of the counsellor. In a situation where there is the basic assumption that the counsellor is the one most competent to decide what are to be the goals of the individual and what are the values by which the situation is seen to be judged (that is, “the counsellor knows best”), very little is likely to be achieved. The aim of counselling is to assist the individual to grow, so that he or she can cope with the present problem and with later problems in a better-integrated fashion. Denmark, Rodda, Abel, Skelton, Elridge, Warren and Gordon (1979) set out the differences between counselling, guidance and support as they relate to the handicap of deafness. They argued that **counselling** is the process by which the counselled person is helped, gradually, to understand what the problem means. It is simultaneously the art and skill of listening to people, and allowing them to express themselves in order that they may see their problems more clearly.

Workers who practice counselling in the area of deafness must have a thorough knowledge of human growth and behaviour as well as of the dynamics of interpersonal interaction and family structures.

Guidance differs from counselling in that the person receiving the guidance is given a number of options and, through discussion, comes to decide upon certain modes of action. It also requires knowledge of both statutory and voluntary helping services. Denmark et al. (1979) claim that guidance is often confused with the giving of advice, which is a more directive form of help; the giving of advice does not offer a choice of options.

Luterman (1979) has argued that parents go to professionals with many expectations, some of which may not be met. Professionals need to be able to work with feelings. If parents feel that they do not have enough **support**, this may not reflect the actual physical amount of support being given or offered. If a professional appears

“cold” or tries to remain detached and objective, and does not reach the emotional side of parents, then change within those parents is unlikely to take place.

Cumming (1982) argues that the outcome of counselling is acceptance. It is through the process of acceptance that change is facilitated. It is the mutual, empathic “touching”, on an emotional level, of two people which facilitates a process that enables change to come about, so that change actually occurs through acceptance: being accepted by another, and accepting the present situation.

To be able to handle emotions in their clients, professionals need to be able to cope with emotions themselves. They need to learn how to handle the negative reactions of parents without taking the guilt or blame onto themselves. This requires training and experience. There is a need for a team approach to give support to all its members, so that parents themselves may be supported. Densham (1995) describes the need for a separate specialist person to take on the role of facilitator, trained in both counselling and aspects of hearing impairment, who would function as part of the multidisciplinary team, liaising with other members as necessary, and whose main purpose would be to work with the family through the diagnostic crisis, aiming to gradually withdraw as the family regains their own power and control. This person should not be an “advisor”, or a “guider”, or a “hidden manipulator”, but a facilitator who can help parents regain their self-respect and self-esteem and realise the full potential of their child, instead of the present situation where many parents are left with unresolved feelings of anger and grief, and a sense of failure, which may then be passed on to the child.

Each member of the team – for example, the audiologist, teacher of the deaf, speech therapist, **psychologist**, etc., – has his/her own specific role and his/her own expertise to offer a family with a deaf child. The facilitator could be seen by parents to have a distinct role,

separate from other members of the team (yet also part of the team). This person would be someone to whom parents could also release their emotions of anger, hurt, fear, etc., so that these emotions could be skilfully directed away from other personnel who are working with the child. If parents are left with negative emotions towards a particular professional – whether from real or imagined cause – it is the child, ultimately, who is going to suffer. JOS (2002) does not distinguish between a psychologist and a facilitator. He uses the concept of facilitator for a person performing the task of allowing a client to connect, to heal and to self-actualise. The psychologist, trained to work with people's emotions, is obviously the most suitable person to take on the role of facilitator.

2.6.6 The Adult

Because pre-lingually deaf and hard-of-hearing persons have never experienced first the presence and then the attenuation of sound, hearing impairment often becomes an integral facet of their identity. In contrast, persons who have experienced traumatic hearing loss, experience a loss of sensory capacity from which they had defined themselves (Glass, 1985; Ramsdell, 1978). Ashley (1985), who became deaf as an adult, emphasised “the born deaf are denied the advantages gained by the deafened before their hearing loss, yet they are spared the desolating sense of loss” (p.61). As Elliot (1983) said pre-lingual deafness is a sensory deficit. Acquired deafness is a sensory deprivation. Consequently, whereas many congenitally or pre-lingually deaf persons may consider their deafness a “difference to be accepted” and part of a cultural phenomenon, deafened people may consider their deafness as a deficit, a disease or an affliction (Luterman, 1979).

Meadow-Orlans (1985) suggested that the variables of age (particularly whether the onset of hearing loss occurred before or after the development of speech), severity and rapidity of loss, and the amount of residual hearing are important biological influences

toward shaping the functioning of the particular individual. In addition, Schlesinger (1985) described the myriad of possible psychological reactions to acquired hearing loss as related less to the nature of the disability than to its meaning to the individual. As an example, coping with a major life crisis, such as an acquired hearing loss, frequently includes revising one's view of how life is and/or should be. One meaning of the traumatic loss may be that life is not necessarily fair. Life need not conform to the axiom that good things happen to good people, and bad things happen to bad people, a sentiment that is echoed by Kushner (1981) in his book entitled When Bad Things Happen to Good People. Life also need not follow the rule that rewards are divided up in accordance with how much work one puts in. The sorting out of these and other beliefs and feelings occur during the process of grieving (Elliot, 1986; Moses, 1986). Similarly, Humphrey, Gilhoma-Herbst, and Faurqi (1981) stated that a person's attitudes to a disorder suffered at a stage in life when it was felt to be untimely and exceptional are different from the response to the same disorder encountered at a stage where it is conventionally expected as part of a normal running down process. Becoming deaf or significantly hearing impaired at the age of 30 is phenomenologically distinct from becoming deaf or hearing impaired at the age of 70, secondary to presbycusis, a loss of hearing associated with ageing.

The emotional trauma or grieving associated with untimely deafness also varies widely. Ashley's (1985) descriptions of his own progressive 90dB hearing loss included "thunderbolt of deafness", "tortured months," "shattering beyond belief," "plummeting of my happiness, aspirations, and hope for the future," and "existing in misery" (In Harvey, 1989; p.109).

Given the intensity of affective reactions to acquired hearing loss, it comes as no surprise that denial holds a pivotal role in shielding one from that realisation (Harvey, 1989). Denial plays an important and adaptive function towards preserving the intrapsychic sense of

self (Kyle, Jones & Wood, 1985). This period of initial adjustment through denial prior to or following the actual diagnosis may vary from a period of a few days to 20 or 30 years or more! Kyle et al. (1985) further observed that it is easier for one to deny hearing loss with stimuli over which volume control can be exercised, such as watching television or using a telephone. In contrast, it is usually in situations when such control cannot be exercised, that is, when telling people to speak up is socially unacceptable, that awareness of hearing loss rises. Although it is common for one to initially accuse others of “mumbling” or of “talking too softly”, such rationalisations, after repeated confrontations by others, eventually succumb to a realisation of hearing loss. This accentuates the feeling of loss, which is also experienced as a loss of control. The variables of control and information are useful in conceptualising how to assess psychologically and assist deafened persons. Schlesinger (1985) defined lack of control or powerlessness as “an individual’s self perception as not having the cognitive competence, psychological skills, instrumental resources, and support systems needed to influence his or her environment successfully” (p.105). Receiving information from the environment can be conceptualised as occurring on three levels, as delineated by Ramsdell’s (1978), tri-level description of the psychological functions of normal hearing: a) the symbolic level, which encompasses understanding language; b) the signal or warning level, which encompasses having access to direct signals of events to which one makes constant adjustments in daily living; and c) the primitive level, which encompasses what is loosely described as the auditory background or “rumble” of daily living. Clearly, all of these “levels of information” are affected by loss of hearing.

Kyle et al. (1985) described the process of an individual coming to terms with acquired hearing loss as a function of these variables of control and information. They listed eight axioms:

Individuals live and work in information environments governed by social and personal norms as well as access features such as speed, intensity, and density of information.

Individuals, through personal and social adjustment, attempt to control the access features of the information they receive. In normal circumstances, most people have adjusted to a specific level of control of these features, which varies from one individual to another but is negotiated and agreed upon in any social circumstances.

The onset of hearing loss disturbs the control that the individual can exert. In terms of access, the individual's initial response is to increase the intensity, the reception, or the concentration level to maximise the information being received.

This overt additional control may be unacceptable to others in social situations and produces a realisation of 'hearing loss'.

There are at least three solutions: a) increase the level of control at all costs; b) accept or expect a reduced level of control and flow of information; and c) reject or avoid situations in which the level of control is threatened. All three can be adopted by any individual. The degree to which an individual can tolerate the reduced and varying access to information at home and work will determine the degree of adjustment (p.122).

It is important to note that one typical reaction to hearing loss is a pervasive feeling of helplessness. The helplessness literature initiated by Seligman (1975) suggests that sustained inability to avoid negative outcomes prompts an individual to give up and become passive, to habitually operate from an illusion of incompetence. JOS (2002) states that the long term experience of helplessness by an individual in a particular situation, causes the individual eventually to adapt to the situation but at the cost of the part of the self that cannot function as spontaneously as before. This results in an imbalance in

the self that should be addressed professionally or else the individual will suffer the psychobiological consequences of living at the cost of the spontaneous self (e.g. depression).

2.6.6.1 Effects of acquired hearing loss on the family.

In terms of how a person who has recently sustained a hearing loss affects his or her family, Orleans (1985) suggested that the impact is similar to other significant stressors and is related to the severity of hearing loss, the characteristics of the individual, the family's integrity, and the family's stage of the life cycle, such as the age of the children. As an example of the latter influence, in a family with both old and young children, the hearing loss of one parent represents more of a loss for the older children rather than for very young children. Therefore, greater effects of loss, such as depression, would be predictable with older children. However, this will be mitigated by the extent to which they receive support from within the family, from outside the family, and by the extent of their individuation from the family.

Kyle et al. (1985) also noted that families frequently come to view the manifestations of anger and frustration by the deafened family member as being indicative of self-centredness and as failure to adjust or adapt to the loss of hearing. Consequently, members of the family might be apt not only to avoid the deafened parent but also to manifest anger toward him or her. Schein and Stone (1986) noted that "the disability (of hard-of-hearing or late-deafened persons) often generates hostility within their own family. Family members, including spouses, sometimes become annoyed when their requests are ignored or their conversation misunderstood. Anger and resentment, loneliness and bitterness, can build to barely tolerable limits" (p.13). It becomes apparent that these common reactions of avoidance within families may support dysfunctional intergenerational affiliations and/or coalitions that include the family feeling victimised and antagonistic toward the deafened member.

The other direction of the punctuation – how family affects the deafened individual – is illustrated by frequent comments that “my family just doesn’t understand my plight” (Kyle et al., 1985). Many such individuals, frustrated in their attempts to gain support from their spouses and, to a different extent, from their children, often withdraw and may become clinically depressed or may abuse alcohol and/or drugs. The more an individual does not feel understood, the more he or she withdraws, and the more the family comes to view him or her as egocentric and angry, the more that individual does not feel understood and so on.

The circularity or reciprocity of causation is also relevant to examining dependency issues that arise in the marital relationship. The following therapy segment provided by Harvey (1989, p.117 - 118) illustrates the effect of the hearing loss on the marital relationship. The couple consists of “Tom” (35 years old), who recently became hearing impaired, and his hearing wife “Sue” (33 years old):

Therapist: What has changed between you two since you (Tom) lost your hearing?

Tom: We never seem to go out and socialise like we used to.

Sue: That’s right. Most of our previous friends lose patience.

Therapist: With whom?

Sue: With Tom. He can’t lip-read some of them, particularly when he gets tired and when it is noisy.

Therapist: And then what do you do?

Sue: I help interpreting.

Therapist: And what's that like for you (to Tom)?

Tom: Well, I appreciate it, of course, except when my friends say to Sue, 'tell him that'.

Therapist: And what do you then do?

Tom: Nothing, except sometimes Sue says to them, 'tell him yourself.'

Therapist: And do they?

Sue: Sometimes, but it reverts back after a while.

Therapist: (to Sue) It must be hard to try to be the link between Tom and potential friends.

Sue: It sure is! I wish people would be more considerate. That's why it's tough for Tom at parties.

Therapist: And for you, too?

Sue: Of course, it's tough for me, too.

Therapist: Are they related? I mean, when Tom and people aren't connecting easily and Tom looks as if he's having a lousy time, you sort of feel obliged to give up your good time and help him out, and you have a lousy time?

Sue: Yeh. I can't enjoy myself unless Tom is.

Therapist: (to Tom) And what's that like for you?

Tom: I didn't know that until now. I only knew that Sue was having a lousy time.

Therapist: So given this new information, what are your thoughts or feelings?

Tom: I don't want that arrangement! I don't want Sue to be so busy interpreting for me and helping me have a good time that she has a miserable time herself. I guess though she usually knows when I'm having a tough time of it, lip reading, feeling lonely, and so on. Ugh – And then we'd go home, and it would be tense. And I couldn't figure it out.

Therapist: And you (to Sue)? Do you want to continue this arrangement between you two?

Sue: No, I'm tired of it.

Their friends' losing patience was one of several factors that contributed to Tom and Sue becoming socially isolated. However, what was of greater systemic significance, in terms of their marital relationship, was that Tom and Sue together had established implicit rules that: a) Sue is to intercede when there are linguistic communication problems between Tom and another person, b) the reason for social isolation is to be attributed to other insensitive, impatient hearing persons, and c) Sue cannot enjoy herself socially unless Tom is also enjoying himself.

2.6.6.2 Acquired hearing loss and the informal network level.

Luey (1980) deemed it almost inevitable that the newly deafened person would lose some hearing friends who will not submit to laboured communication and/or who are threatened or repelled by the sheer intensity of the deafened person's feelings. Sam (Harvey, 1989), for example, prior to the age of 28 when his hearing loss became quite severe, recalled having "several informal buddies with whom I could get together and 'chew the fat'" (p118). Now he schedules meetings; friends do not drop in as they had done in the

past. Moreover, social encounters become tests to measure how long the conversation could last and remain comfortable. Ashley (1985) described a similar kind of social encounter:

“I took my cup of tea to a table to join friends. When one of them asked me a question, which I could not understand, the others repeated it for me but I was still unable to lip-read it. They paused while one of them wrote it down and I was aware that the easy-going conversation they had been enjoying before my arrival was now disrupted. Within a few minutes two of them left and after a brief pause the others explained that they had to go because of pressing engagements. They were genuinely sorry and I understood, but it was small solace as I sat alone drinking my tea” (p149).

2.6.7 Hearing Impairment, Self-esteem, Self-image and Communication

Coopersmith (1967, pp. 4-5) defines self-esteem as “the evaluation which the individual makes and customarily maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgement of worthiness that is expressed in the attitudes the individual holds towards himself. It is a subjective experience, which the individual conveys to others by verbal reports and other overt expressive behaviours. People view the world through their own perspective and create their own reality from the information they receive and transmit. Communication is the essence of human relationships and an integral part of this information input. Without a shared understanding, confusion, frustration and isolation may result. Misunderstandings can occur between people for a multitude of reasons. Confidence and self-esteem play a major part in interactions, and can affect a person’s whole way of communicating, including posture, expression of thoughts and feelings, tone of voice, etc. (Densham, 1995).

For example, when someone is feeling negative or depressed he/she tends to receive a negative response, and this can be a reinforcing phenomenon. Mood can affect the way people perceive and are perceived. An innocent comment or joke may be taken light-heartedly on one occasion, or experienced as a hurtful insult on another, depending on the mood of the people interacting at the time. Equally, an intentionally hurtful or sarcastic comment may be found to be amusing, or may be brushed off, ignored or 'taken to heart', depending on mood (Densham, 1995). Even in everyday communication, signals can easily be misread because of differences in the use of words, accents, ways of expressing the self, etc. For people who are deaf, the chances of misunderstandings occurring during everyday interactions are far greater than for normal hearing people. When people interact they expect the other to conform to particular forms of behaviour, and they use information obtained in the initial interaction to make predictions about future behaviour (Berger, 1975). Conversations between the deaf and normal hearing people can be fraught with difficulties.

Higgins (1980) argued that the assumptions and practices of those who hear have a profound impact on the lives of those who do not hear. He found that hearing people are reluctant to repeat spoken messages to deaf people, even though deaf people often do not understand a spoken message the first time. Higgins cites Furfey and Harte (1964), who demonstrated that encounters between the deaf and the hearing are often strained, awkward and confusing, and that increased contact between the deaf and the hearing does not necessarily increase communication or understanding.

It has been suggested by Gergen and Gergen (1981), that, for people who have problems with managing relationships effectively, one reason could be an inability to read the cues given out by other people. This is certainly a problem in many encounters between deaf and hearing people, and was highlighted by Meyerson (1948), in his

study on the dynamics of disability, in which he created experimental deafness in a number of children and adults by plugging their ears with a cotton and wax preparation for 24 hours. The reduction in acuity, as measured by a pure-tone audiometer, was approximately 30 dB in speech range, which is a relatively slight handicap. It was recognised that this was not a “natural” situation. The subjects knew that it was an experiment, and also knew that the plugs would be removed in 24 hours, or sooner if wished. Nevertheless, Meyerson (1948) found that it was possible to observe practically all of the behavioural phenomena that have been ascribed to hard-of-hearing persons. Introspections of college students included withdrawal from social situations, aggression and irritability, suspiciousness, bluffing, inappropriate behaviour, misunderstanding and restlessness.

Observation of the behaviour of primary school children who wore plugs for a day at school revealed that there was definite avoidance or less active seeking of social contacts, increase in tension or restlessness, delayed reaction or non-reaction to verbal cues, greater alertness to non-verbal clues, increase in “bored”, “stupid” or “inappropriate” behaviour, increase in evidence of fatigue and irritability, changes in quality and intensity of voice and attempts at concealment of the hearing loss by “preoccupations”.

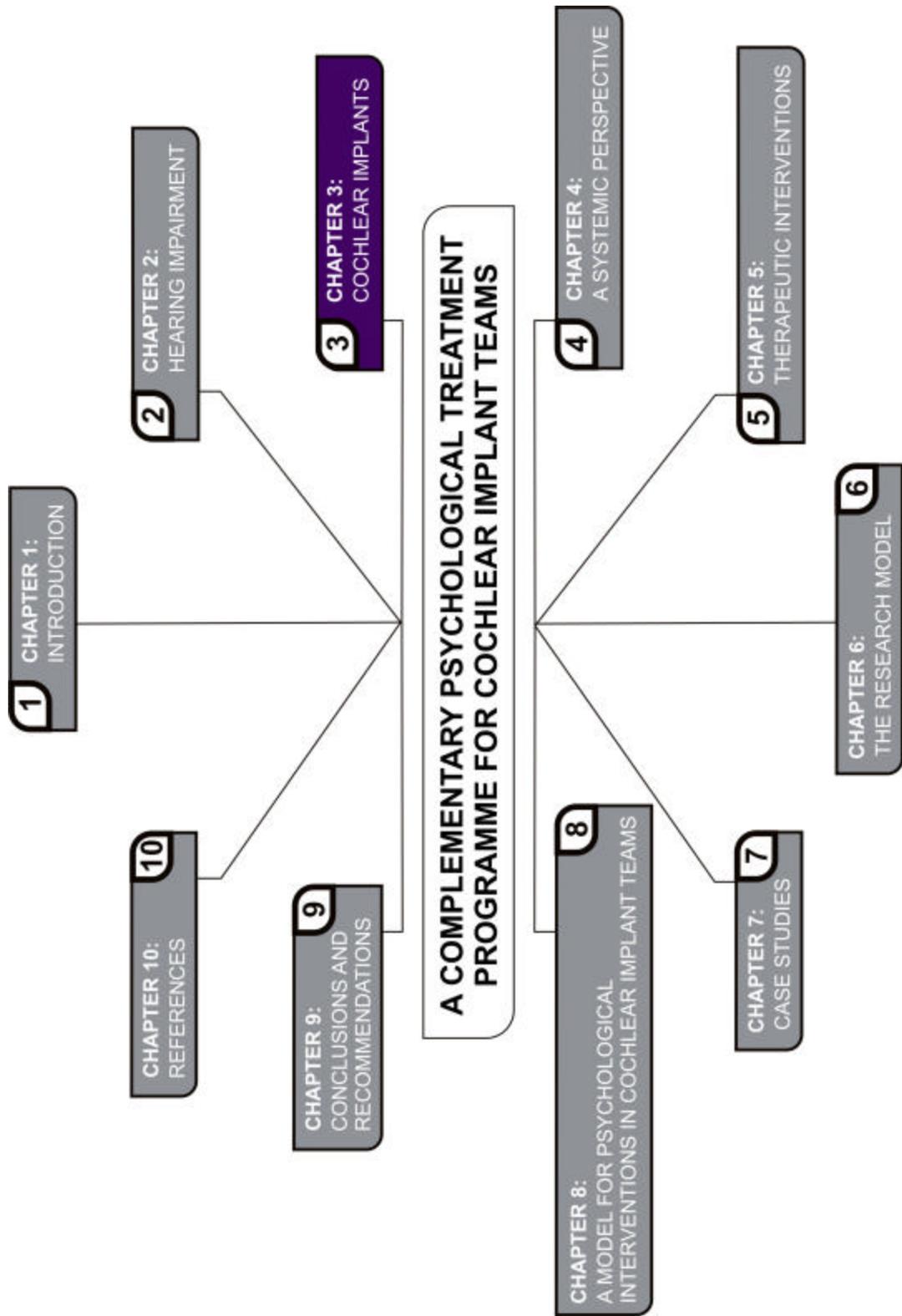
Meyerson concluded that “The socially and psychologically undesirable behaviour that has been reported for physically handicapped persons does not arise because the disabled are different kinds of people, but because they have been subjected to different kinds of life experiences” (Meyerson, 1948, p.71 in Densham, 1995).

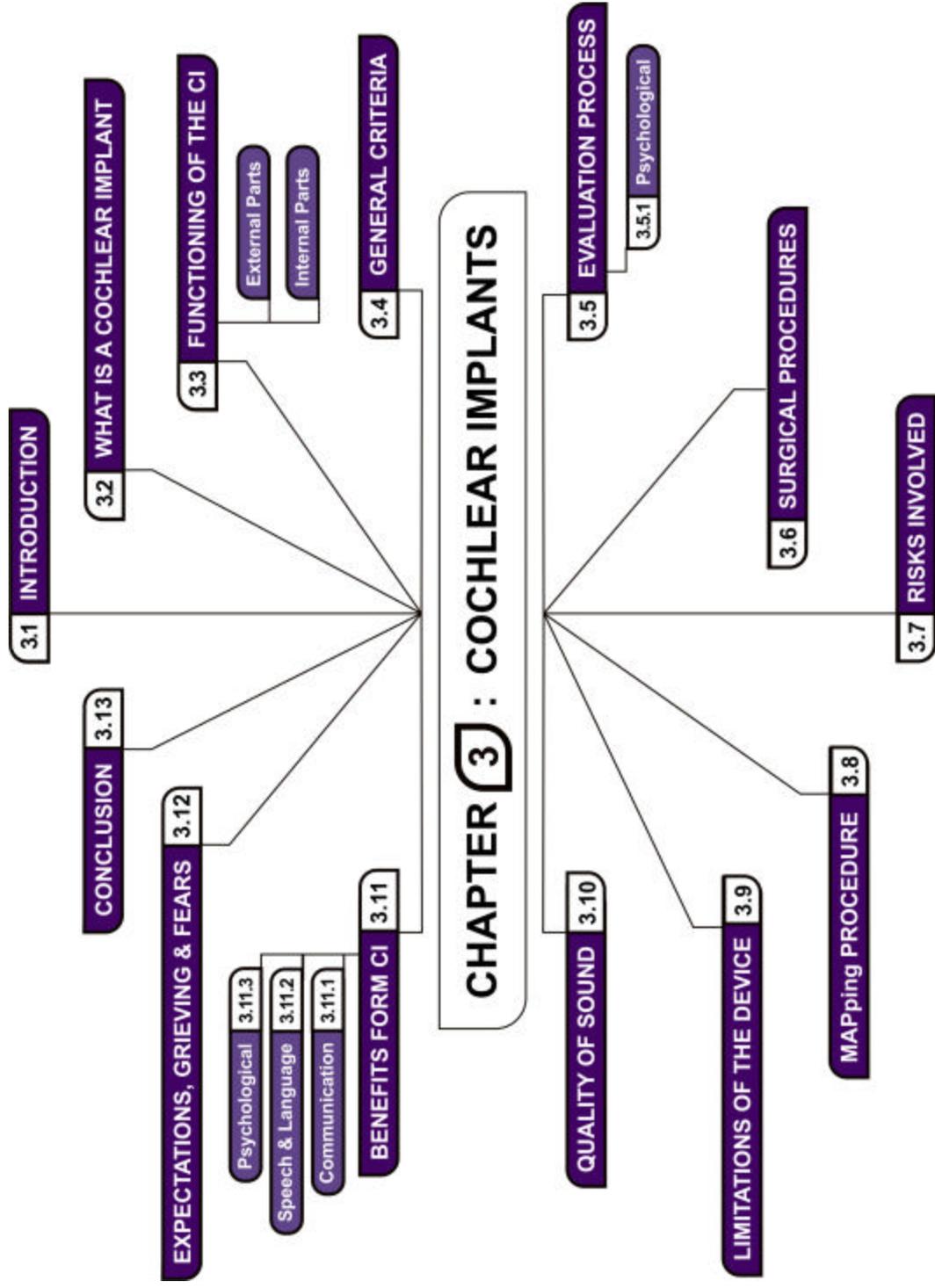
Berger and Bradac (1982) argued that language is used to exert control in relationships, and may also be a way of reducing our uncertainties, both about the other person and ourselves. Scherer (1979) suggested that, in some contexts, vocal qualities are more

critical for forming impressions about the speaker than either the actual content of what is said or visual clues. If this is true for hearing people, then how much more serious are the implications for profoundly deaf people, many of whom have difficulty in pronouncing words. Studies, such as the one by Meyerson (1948), and Goffman's (1976) work on stigma, have serious implications for deaf people. There is nothing outwardly unusual or odd about a deaf person until he/she attempts to communicate with a hearing person, when areas of complication are set up. Often assumptions are made about a person from initial interaction. Deaf people may be wrongly assumed to be mentally handicapped or even drunk.

2.7 CONCLUSION

In developing a sense of self we take into account the view of others. Some people will affect our self-identity and self-esteem more than others. It is the people with whom we identify and with whom we feel we are similar, or want to be like that most affect our self-feelings. Initially, with a young child, these people are generally the parents and other close family members. Children with very secure home backgrounds and high self-esteem may cope very well with a hearing impairment, but for children with low self-esteem, the risk of social isolation, depression and frustration, as well as possible behavioural difficulties, is higher than for normal-hearing children (Densham, 1995). This chapter showed that deafness and the diagnosis of deafness could have a complicated and far-reaching effect on the individual as well as the family of the individual. The next chapter deals with a cochlear implant, how it works, selection criteria and the possible impact on the individual and his or her family.





CHAPTER 3

COCHLEAR IMPLANTS

3.1 INTRODUCTION

In this chapter the focus is on cochlear implants, the history and need for implants and the different types of implants. The criteria for an implant and the evaluation process will be described. The risk involved in the surgical process and the MAPping process after the operation will be summarised. The process of cochlear implantation is surrounded by expectations. These expectations, specifically parental expectations, and the underlying grieving process will be discussed. Lastly a summary is given to show the profound effect of the cochlear implant on the systems of which the person is a part of, as well as the way the person as a system can be affected by a cochlear implant. The necessity of allowing for psychological interventions in the cochlear implant procedure as a life-changing event, is implicated.

3.2 WHAT IS A COCHLEAR IMPLANT?

In recent years many advances have been made in the rehabilitation of patients with a hearing impairment. For the past few decades hearing aids have been the only possible solution for an individual who has diminished hearing ranging from mild to profound (Parkins & Houde, 1982).

Hearing-aids and other hearing devices are designed to amplify sound. There exists, however a small group of hearing-impaired individuals for whom no conventional amplification device can provide any demonstrable communication benefits. According to Cummings (1993) there are three reasons for this: Firstly, when a hearing loss is so severe, resulting in little or no usable residual

hearing, the patient is unable to derive any benefit from the aid. Secondly, a certain percentage of these patients are unable to tolerate the vibrotactile sensations of the hearing-aid, and thirdly, severe recruitment (build-up of noise) makes the use of a hearing-aid intolerable. These reasons are also mentioned by Tong, Clark, Seligman and Patrick (1980) as well as Rosen (1990).

A major problem which remains is related to those people with bilateral profound sensorineural hearing loss who receive no benefit from hearing-aids (Cohen, Waltzman & Shapiro, 1985). With a sensorineural hearing loss, the cochlea is dysfunctional. Sensorineural hearing loss differs from conductive loss where the bony ossicles in the middle ear are damaged. Sensorineural loss is irreversible. A bilateral sensorineural loss refers to a sensorineural loss in both ears (See Chapter 2). In the USA alone, there are an estimated 300 000 people who cannot hear anything with a conventional hearing-aid, because of a sensorineural loss (Hanekom, 1990).

Research involving cochlear implants originated in an attempt to provide these patients with an alternative sensory device (Millar, Tong & Clark, 1984). The first reports of electric stimulation of the acoustic nerve in man go back to the late 1930s. It took another 20 years until 1957 when the French group of Djourno, Eyries and Vallancien were able to publish their results of successful electric stimulation of the cochlear nerve in two human subjects (Clark, G.M. Blamey, A.M., Brown, A.M., Gusby, P.A., Dowell, R.C., Franz, B.K.-H., Pyman, B.C., Shepard, R.K., Tong Y.C., Webb, R.L., 1987).

Interest in this phenomenon has increased in recent years as technological ability has developed through advances in surgical method, technique, electrode manufacture and miniaturisation of electronic circuitry (Cummings, 1993). Research therefore no longer

addresses the basic question of “will it work?” but is now at the stage of “how well can it be made to work?” (ASHA, 1992)

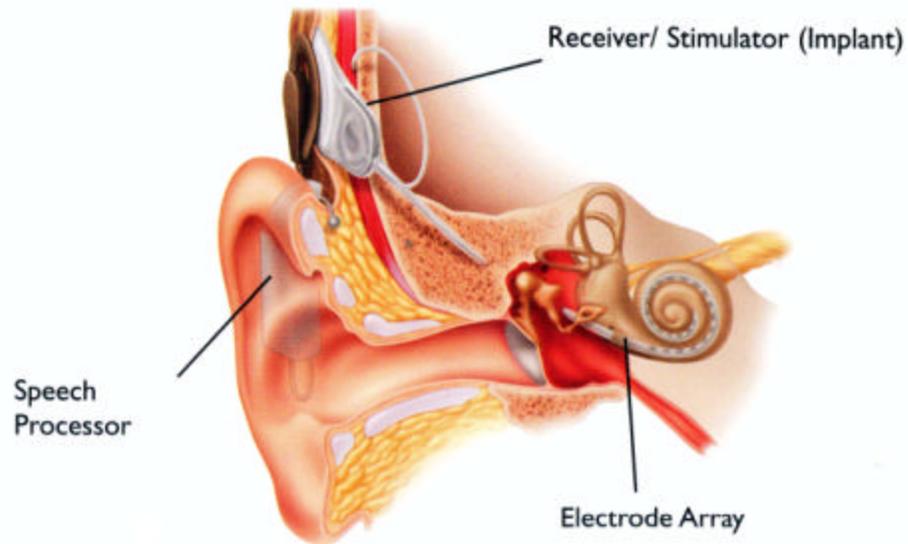
A cochlear implant is a device that provides electrical stimulation of the auditory nerve in order to elicit the patterns of neural activity that the brain requires to understand speech (Eddington, 1983). People with sensorineural hearing loss, or nerve deafness, have hair cells or nerve fibres that are undeveloped, damaged or destroyed. However, there are usually some intact nerve fibres. In order to be able to elicit a sound-like sensation, some residual nerve fibres must have remained in the cochlea. A cochlear implant bypasses some of the damaged parts of the inner ear, directly stimulating the auditory (hearing) nerve. Cochlear implants are composed of three basic elements: a microphone that receives the acoustic signal, a speech processor that transforms the output of the microphone to the desired electrical stimuli by selecting the most important acoustic information from the speech signal and discarding the rest, and lastly the pairs of stimulating electrodes which deliver the stimuli to the neural tissue (Cummings, 1993). There are various types of cochlear implants commercially available. The categories which distinguish the various types of cochlear implants from one another are cochlear implants varying in terms of the number of electrodes, electrode placement, i.e. intra- or extra cochlear, single- or multichannel as well as the speech processing strategies utilised.

3.3 THE FUNCTIONING OF THE COCHLEAR IMPLANT

- **The external parts**

The microphone is similar to the behind the ear hearing-aid in appearance as well as functioning. It receives the sound stimuli in the same way as the hearing-aid. It is important to note that the sound in the hearing aid is simply amplified, whereas in the cochlear implant, the sound is being sent to the speech processor. The speech

processor selects and codes the sounds that are useful for understanding speech. Different frequencies are allocated to different electrodes. These electronic codes are then sent back to the external coil up the thin cord. The external coil (transmitter) is held in place by magnets directly over the implanted receiver stimulator underneath the scalp. The codes are then sent as radio signals to the receiver stimulator, which is situated beneath the skin behind the ear. Figure 3.1 shows the cochlear implant system:



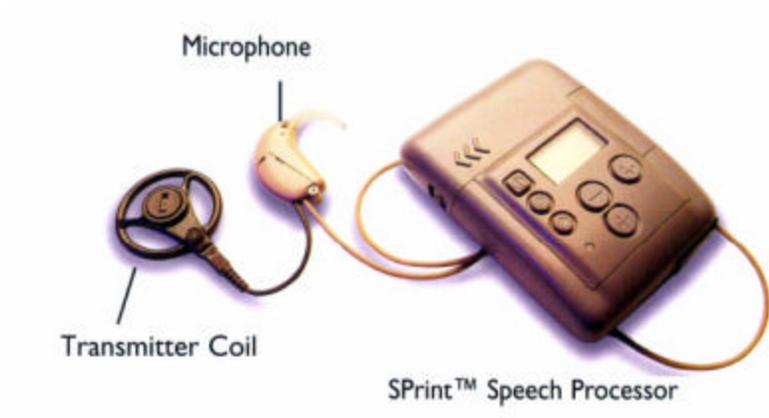
*Figure 3.1 The Cochlear Implant System
(The Nucleus® Cochlear Implant System, 2001, p. 3)*

There are two different versions of the cochlear implant of which the “Behind the ear” version is the most recent development. In the “Behind the ear” version all the electronic hardware (the microphone and the processor) is fitted into a small headpiece looking very much like an ordinary hearing-aid. In the previous version of the cochlear implant, the processor is separated from the headpiece (Bezuidenhout, 2001). Figure 3.2 shows the “Behind the ear” version of the cochlear implant:



*Figure 3.2 The behind the ear version of the Cochlear Implant
(Cochlear Partners in life, 2001, p.1)*

The next figure shows the cochlear implant system where the processor is separated from the headpiece and worn against the body instead of behind the ear. This implant system is sometimes chosen for small children.



*Figure 3.3 The Implant with the Body-worn Processor
(The Nucleus® Cochlear Implant System, 2001, p.4)*

- **The internal parts**

The internal component of the receiver stimulator is about three inches long and implanted in the mastoid bone (part of the temporal bone) underneath the scalp. This receiver stimulator converts the sound codes to electrical signals, which are sent to the electrodes (Schwartz, 1999). The electrodes (which are distributed along a wire-like structure) are implanted in the cochlea. The number of electrodes that are implanted depends on the model of the cochlear implant. These arrangements of multiple electrodes give a number of independent channels of stimulation (Schwartz, 1999). The cochlea is stimulated at different frequencies. This correlates with the function of the inner hair cells of a normally functioning ear. The stimulation is picked up by the auditory nerve, sent to the brain and is recognised as sound. The following figure shows the placement of the implant and summarises the working of the implant:



*Figure 3.4 How does the Cochlear Implant work
(The Nucleus® Cochlear Implant System, 2001, p.5)*

1. Sound is received by the microphone at the top of the speech processor.
2. Sound is coded or processed into digital signals.
3. Digital signals are then sent to the transmitter coil.
4. The transmitter coil sends the signals through the skin to the implant (receiver/stimulator) where it is converted to electronic signals.
5. The signals are sent to the electrode array to stimulate the hearing nerve fibres in the cochlea.
6. The signals are sent via the hearing nerve fibres to the hearing centres of the brain where they are recognised as sounds. (The Nucleus® Cochlear Implant System, 2001, p.5).

3.4 GENERAL CRITERIA FOR CONSIDERING COCHLEAR IMPLANTS

The following criteria are used to determine suitable candidacy for a cochlear implant:

- Profound sensorineural hearing loss in both ears. A person with normal middle ear functioning can be classified as being profoundly deaf when auditory responses can only be elicited at intensities larger than 90dB HL in the frequency region 500 Hz – 4 000 Hz (Silman & Silverman, 1991).
- Age two years or older. This criterion is changing; currently there is a tendency to implant babies from the age of six months (Larky, 2000). Miyamoto (1995) and Osberger (1993) state that a shorter duration of the deafness leads to

better performance of the hearing-impaired child with a cochlear implant. Children who receive an implant before the age of five years may show greater benefit in terms of speech production measures than children who receive cochlear implants after five years (Tye-Murray, Spencer & Woodworth, 1995). In the case of adults, the hearing loss is required to be post-lingual, in other words, the hearing loss must have occurred subsequent to the development of speech and language abilities (Clark, Black, Forster, Patrick & Tong, 1978). According to Dowell, Clark, Seligman and Brown (1986) and Allum (1993) a clear correlation exists between period of post-lingual deafness and implantation and the individual success achieved with the implant.

- Little or no benefit in understanding speech through hearing aids or a vibrotactile device.
- No contra-indications to implant surgery or post-implant training.
- A feeling that being able to understand sounds would enhance their life.
- A high degree of motivation and appropriate expectations.
- For children, an educational setting that emphasises development of auditory skills.

Cummings (1993) adds to these criteria:

- Good general health.
- Exclusion of otologic (ear) pathology. A full otologic examination prior to the operation should exclude external

or middle ear disease, asepsis in the upper respiratory tract, perforations of the tympanic membrane and previous middle ear or mastoid surgery (Clark, et al., 1987).

- Presence of residual VIIIth nerve functioning.

3.5 THE EVALUATION PROCESS FOR HAVING AN IMPLANT

The implant centre conducts a careful evaluation to determine whether the potential user is an appropriate cochlear implant candidate. Several evaluations are conducted including audiological, medical and psychological tests. Audiological tests establish or verify the level of hearing loss; medical tests include X-rays to determine if the cochlea is suitable for an implant. The surgeon determines whether the individual can successfully undergo general anaesthesia and surgery, and whether other medical conditions exist that would preclude use of an implant.

Children require additional evaluations: A vibrotactile aid may be fitted, again to determine if an adequate level of benefit is obtained using this device.

Some of the other procedures include evaluating and teaching the listening concepts necessary to programme the speech processor after surgery and to obtain baseline information for comparison after implantation. There is a test that can be conducted prior to surgery to determine whether an adult has enough remaining nerve fibres to receive sound information from the implant. The number of functioning nerves remaining in the inner ear is one of the several factors that influence the benefits received from an implant. This test cannot be conducted on children less than 12 years of age. In children, memory of sound appears to be an important factor. Children who have had some hearing and a short period of deafness may learn to use the sound information provided by the implant more

quickly and effectively than children who are born with profound hearing loss or lose their hearing very early in life.

3.5.1 Psychological Evaluation

The psychological assessment involves the individual with the hearing impairment but also the family system of which he/she is part.

According to Ouellet and Cohen (1999) exclusionary factors that the psychologist might diagnose are undetected psychosis, organic brain dysfunction or mental retardation. The psychological intervention and assessment will be described in more detail in Chapter 9 where the model for psychological interventions is discussed.

3.6 THE SURGICAL PROCEDURE FOR THE COCHLEAR IMPLANT

Bezuidenhout (2001) describes the procedure as follows: This operation is a major surgical procedure. It takes about four hours and is performed under general anaesthesia. It is the receiver stimulator that is implanted.

The first part of the operation

An incision is made behind the ear in the skin. The bone of the skull is exposed. The mastoid bone is prepared to form a bed in the skull for the receiver. The receiver is laid in this bed and sealed underneath the skin (Schwartz, 1999).

The second part of the operation

The mastoid air cell system behind the ear is exposed. Through this mastoid cavity the surgeon exposes the middle ear cavity and the first turn of the cochlea. The electrodes or stimulator are then carefully placed directly in the cochlea (Schwartz, 1999).

After the operation

Firstly the wound must have enough time to heal. As the external and internal parts are not connected at this stage, the child will not be able to hear. After approximately four weeks, the child will return for the “MAPping” procedure (this will be described shortly).

3.7 RISKS INVOLVED WITH THE COCHLEAR IMPLANT

While it is important to be aware of potential risks, few significant side effects have been reported in children or adults who have received a cochlear implant. The procedure is not considered dangerous or particularly painful. Complications that have been seen include those associated with any surgical procedure – anaesthetic risks, the possibility of inflammation, infection and bleeding, as well as those particular to this type of ear surgery – numbness or stiffness about the ear, taste disturbance, facial weakness, neck pain, dizziness or increased tinnitus (ringing sound in the ears). Although these risks exist, they are usually only temporary and in most cases would be expected to resolve completely with time and healing of the incision. Other possible risks may occur after surgery, e.g. a perilymph leak from the cochlea that can be repaired surgically, facial twitching can be caused by electrical current escaping from the cochlea and stimulating the facial nerve, but this is usually alleviated by programming the speech processor. Generally the implant system can be worn while participating in most activities if a few simple precautions are observed. The external components of the device must be protected from breakage and moisture, and the implant site

should also be protected from a direct blow. Like any sophisticated medical device, cochlear implant is expensive. Some of the medical aid organisations in South Africa pay for the implant but some of them only pay a certain amount of the total. The financial aspect to purchase the implant and to keep the implant in working order can create stress for parents of hearing-impaired children and adult recipients.

3.8 'MAPping' PROCEDURE

After the healing process has occurred, the adult or child returns to the clinic for initial fitting of the external parts of the device. At this time the audiologist activates and programmes the speech processor, setting the appropriate levels of stimulation for each electrode from soft to comfortably loud. This process is called "MAPping" and takes a few sessions. The clinician changes the programme or MAP as the person adjusts to the sound (McKinley & Warren, 2000). In rare cases, it may not have been possible to surgically place the entire electrode array in the cochlea or place them accurately. In this situation, the audiologist can select only those electrodes that provide a comfortable auditory sensation. Once the device has been programmed the adult or child embarks on a rehabilitation programme to interpret the sound sensation. The rehabilitation programme is specific to individual needs and may take weeks in the case of adults and children who have been post-lingually deafened for months, or even years in the case of pre-lingually or congenitally deafened children, and some younger post-lingually deafened children. The support of family and friends is a very important factor in any individual's success with an implant. Such support ranges from the practical help that all surgery patients appreciate during recuperation, to spending time helping the recipient adjust to the device to recognise sounds and improve communication. Other professionals may also be part of the evaluation rehabilitation team for children. Teachers, rehabilitation

specialists, speech pathologists, psychologists and other audiologists may participate in the evaluation process. Following surgery, many or them will work with the implantee's family and members of the implant team to develop auditory, speech-language, and academic skills to achieve optimal success in learning and social activities. These professionals can help furnish the practical, educational and emotional support that the implantees need as they learn to communicate, using the sound provided by the implant. An educational programme that focuses on developing the child's listening and speech production skills with the implant is most important for children. To facilitate a child's use of the auditory information provided by the implant, a training programme that provides the child with appropriate listening models and material for the development of auditory skills is advisable. Ideally, this programme involves an implant team member working with the child's teacher(s) and other rehabilitation specialists.

3.9 THE LIMITATIONS OF THE DEVICE

The implant does not restore hearing to normal hearing levels and, therefore, the sound the implant gives will be different to normal hearing. Furthermore, the implant operation alone does not ensure satisfactory use and benefit of the device. Children and adults will need training to help them learn to effectively interpret the sounds from the implant. Although many implant users are able to use the telephone, there are others who will still need to lip-read in conjunction with the implant to understand conversation (Cohen, Waltzman & Shapiro, 1989). As has been mentioned previously, motivation, support of family and friends and the necessary intervention by the psychologist, play an important role in how successful an implant user will be and if these are missing, success may be compromised.

3.10 QUALITY OF SOUND

The perceived sound from the implant is different for every implant user. Describing a sound is difficult for anyone, including a hearing person. Many factors affect the type of sound and quality of sounds perceived by an implant user. However, many implant users have described the sounds as being electronic, like a computer-generated voice. Some have said the sound is muffled, as if the person was speaking under water. Others described the sound as very natural, just like they remembered sound before going deaf.

3.11 BENEFITS FROM A COCHLEAR IMPLANT

3.11.1 Communication Benefits

There exists widespread evidence at present of the benefits that cochlear implants may provide (more than the initial expectations in terms of improved communication reception predicted) for the profoundly deaf, namely: improved lip-reading ability; increased awareness of environmental sounds; improved speech production and voice monitoring; improved speech perception skills and tinnitus suppression (Fraser, Cooper, Hazell, Phelps & Lloyd, 1986). Most implant users report that they are able to understand speech more easily and some can follow and participate in a normal conversation.

Clinical trials have shown that most adults show improvements in speech recognition when listening is combined with lip-reading. In fact 70% of users can understand some speech through the implant alone, without lip-reading. In Australia most of the children implanted, who were deafened after developing speech and language, are now attending their local schools with little or no additional support. For those children who were born deaf or went deaf before learning speech and language, progress is slower but with training they can learn to use the implant very effectively to develop speech and

language. In fact, an increasing number of these children are being integrated into their local school with minimal support (Cochlear Corporation, 1994). This implies a saving in educational costs. A cost-utility analysis done in England provides evidence, based on conservative assumptions, to support the view that paediatric cochlear implantation is a cost-effective health care intervention in profoundly hearing-impaired young children (O'Neill, O'Donoghue, FRCS, Archbold, & Normand, 2000). Another cost-utility analysis done in the United States concludes that cochlear implants in profoundly deaf children have a positive effect on quality of life at reasonable direct costs and appear to result in a net saving to society (Cheng et al., 2000). This accounts for children whose functioning does not allow them to be mainstreamed as well as children who are able to attend a normal hearing school.

3.11.2 Benefits in Speech and Language

Research done by Cunningham (1990) showed the following:

- The implant has a greater effect on awareness of sound than on discrimination of sound.
- The implant's effect on speech production was greater than its effect on speech perception. In a study to analyse the longitudinal speech perception performance of pre-lingually deafened children who have used their implants for three to four years, Fryauff-Bertschy, Tyler, Kelsay, Gantz and Woodworth (1997) report the following:
 - Regardless of age at implant and amount of daily device use, use of cochlear implants affords improved pattern reception.
 - Children who are consistent users of their cochlear implant device show improvement over time in their abilities to

recognise words from a closed set (the choice of words is limited and more clues are given). This suggests that pre-lingually deafened children can develop improved understanding of speech with consistent use of a cochlear implant.

- Open-set word understanding (choice of words are unlimited and no clues are given) is a measure frequently used to assess the benefit of cochlear implantation in adult cochlear implant users, but it must be interpreted somewhat differently in children. Unlike post-lingually deafened adults, pre-lingually deafened children do not have the auditory memory of spoken language to help them interpret the electrical signal of the cochlear implant. The development of speech production occurs hand-in-hand with the development of auditory perception. However, acquisition of meaningful, intelligible speech and language only occurs after development of basic auditory perceptual skills. Brackett and Zara (1998) and Fryauf-Bertschy et al., (1997) agree that these both occur at a faster rate when the child is implanted before the age of five years. Kiefer, Gall, Desloovere, Knecht, Mikowski and Von Ilberg (1996) have reported that, after cochlear implantation, the acquisition of auditory processing skills seems to follow a pattern similar to that found in normal hearing children, starting with sound detection and pattern perception, and then progressing over various levels of speech identification up to speech recognition. They stressed that the time course of this pattern may take several years. Open-set word testing can help us understand what elements of speech can be processed and delivered electrically to a congenitally deaf ear. Interpretation of speech depends upon the child's linguistic skills, his or her willingness to guess, and his or her ability to fill in missing bits of auditory information. Most

children, regardless of when they received the cochlear implant, can repeat some phonemes from a list of presented words. Paired with lip-reading, this can be a significant contribution to communication.

- The differences in performance between the full-time users and the minimal users were significant.
- Less than full-time use of cochlear implants by children occurred primarily in children implanted after the age of five years. This supports the notion that longer duration of deafness in a pre-lingually deafened child may result in less functional benefit and more difficulty adjusting to a cochlear implant.
- Children who do not achieve test scores may still benefit from cochlear implants by demonstrating pragmatic use of audition, awareness of communication by others, and awareness of environmental sounds.
- Each child's functional use of a cochlear implant depends upon his or her social and educational environment, as well as the consistent use of the device. Some critics claim that the published literature does not document even a single case of a child who has developed a linguistic system based on input from an implant. Research done by Svirsky, Robbins, Kirk, Pisone and Miyamoto (2000) found that the rate of language development after implantation exceeded that expected from unimplanted deaf children and was similar to that of children with normal hearing. Despite a large amount of individual variability, the best performers in the implanted group seem to be developing an oral linguistic system based largely on auditory input obtained from a cochlear implant.

3.11.3 Psychological Benefits

Many adult users report an increased level of self-confidence and greater willingness to be more socially active and involved. Some have reported increases in job opportunities and improvements in relationships with family and friends (Cochlear Implants, 1994). In children, the ability to hear sound and interact with the hearing world can have a positive effect on a child's development and feeling of involvement in daily and family life. Auditory information about speech can assist the child in increasing the ease of communication in the home and in the classroom. According to Lansing and Seyfried (1990), the acquisition and first month of use of an implant may have a greater impact on perceived communication performance than the additional experience with the implant device and formal training. It may produce a fairly immediate reduction of negative attitudes and feelings towards hearing loss and ease of communication. Tyler and Kelsay (1990), report improvements in all aspects of lifestyle, including social interactions with families and individuals, restoration of confidence, improvement in speech-reading and the hearing of warning sounds. The findings of Karinen, Sorri, Välimaa, Huttunen and Löppönen (2001) indicated somewhat contradictory changes in the implantees' quality of life. Problems with energy, sleep and social isolation seem to be more common among the implantees than in the age-matched average population. It is the writer's opinion that although the psychological advantage of the cochlear implant implies a feeling of more control, less helplessness and a minimising sense of loss of self in relation to the world, there maybe certain deep-rooted emotional problems that will not be solved by the cochlear implant and will persist. According to JOS (2002) the chemistry in the body that has been affected by interferences will not change when the conditions change. The person needs to resolve these issues 'stored' in the body, so that it will not be projected onto and into the 'now'. Only when the person has resolved the effect of the interferences of the past, only then can there be full appreciation of

living in the 'now' and possible changes in the conditions of the 'now'. Psychological interventions that can be helpful in this process will be discussed in detail in Chapter 6.

3.12 EXPECTATIONS, GRIEVING AND FEARS

The set of expectations that the implantee and the family of the implantee have developed prior to implantations will have an important impact on post-implant satisfaction levels. These expectations are often formed around the media hype about the "miracle of the bionic ear" and are often responsible for inappropriately high expectations. It is essential that, prior to implantation, and indeed as an integral part of post-implant counselling, candidates and their parents (in the case of children), are well prepared in terms of what to expect from the implant. Inappropriate expectations may lead to disappointment, frustration, and perhaps a loss of trust in the clinical programme (Downs, Campos, Firemark, Martin, & Myers, 1986; Tye-Murray, 1993).

Hogan (1998) found that over a period of time, expectations in adults drop off steadily over the first year of implantation, before beginning to steadily climb again. He obtained qualitative information from a series of subjects whom he interviewed, and was able to obtain detailed and insightful information about their changing expectations with regards to implant performance in a wide range of areas. Particularly useful and personal information was obtained about psychosocial issues, which often tend to be neglected in the management of implantees. Hogan (1998) stressed that the information acquired through these means demonstrated the high expectations and differing needs adults have when they approach implantation. These expectations and needs must be addressed within the rehabilitation process in order to optimise satisfaction and achieve the best possible outcomes. Parents' expectations of a cochlear device might be influenced by their emotional status

regarding the child's deafness. Hearing parents undergo a mourning process during which they experience a variety of emotional states or stages in reaction to a diagnosis of deafness (Kampfe, 1989). Although these states and stages are discussed in Chapter 2 (Hearing Impairments), it is important to note how these stages influence the expectations regarding the cochlear implant. Not all parents experience this process, and each parent experiences it differently. Mourning typically begins with a period of *shock*, a time when parents feel numb (Luterman, 1979; Mithell, 1981; Schlesinger & Meadow, 1972; Schontz, 1965). Kampfe, Tambry, Ludington, McDonald-Bell, Pillsbury III, (1993), describe another stage of mourning as *recognition*, a time when parents begin to recognise the severity and permanence of the deafness. It is during this state that parents feel one or all of many emotions such as frustration, impotence, disappointment, confusion, guilt, anger and depression (Luterman, 1979; 1984; Mindel & Feldman, 1987; Mindel & Vernon, 1971; Moses, 1985; Seligman, 1985). This stage may be followed by *denial* when parents do not recognise the deafness or do not wish to recognise it (Luterman, 1979; Schontz, 1965). They may know that their child is deaf, but are unable to recognise the permanence or the implications or the condition (Mitchell, 1981). Denial is often characterised by moving from doctor to doctor or from implant team to implant team.

These stages are thought to be followed by acknowledgment and constructive action, a time when parents display a willingness to discuss the deafness openly, to assess the reality of the situation, to assimilate information regarding the condition, and then take reasonable action toward intervention (Luterman, 1979; Schontz, 1965). These states or stages are not necessarily experienced in a particular order and they are often re-experienced at important milestones in the child's life.

Downs et al., (1986) suggested that families considering cochlear implants be assessed according to their stage in the grieving process as well as their methods of coping with the deafness. These factors may influence parents' reasons for wanting the cochlear implant and will likely influence their expectations of the device. Parents who are experiencing recognition or denial are quite likely to seek the implant for very different reasons than parents who are engaging in constructive action. Since recognition is characterised by emotional turmoil, they may be feeling so many emotions that they cannot focus on or understand the potentials and limitations of the device. They may, for example, be unable to understand that for maximum benefit long-term aural (re)habilitation must follow surgical implantation of the device. Parents who are experiencing recognition may be so overwhelmed by the prospect of parenting a profoundly deaf child, that they feel the need for someone else (the cochlear implant team) to assume responsibility for the (re)habilitation programme (Kampfe, Tambry, Ludington, McDonald-Bell, Pillsbury III, 1993).

Parents in denial might be seeking a miracle cure, hoping that the implant will remove the deafness from their lives. Seeking the cochlear implant may be another attempt to find a doctor or specialist who 'can make it all go away'. Additionally, parents who are experiencing a state of denial might feel uncomfortable about the appearance of the implant, which will, in turn, influence their enthusiasm for encouraging consistent wearing of the device (Downs et al., 1986). As Luterman (1979) stated, one of the best indicators that parents are beginning to adjust to the deafness is their willingness to maintain the hearing aid and encourage their child to wear it.

According to Kampfe et al., (1993) parents who are engaged in constructive action may recognise that the implant will not erase the deafness but that it can provide additional auditory input. With additional auditory stimulation, children are likely to be more attuned

to the environment and be able to improve their oral communication and speech-reading skills. Parents in this stage or state are more likely to be realistic about the possibility that the device will ameliorate the effects of deafness by providing some auditory stimulation but that it will not be a miracle cure.

From an investigation done by Perold (1999) into the expectations of mothers of children with cochlear implants, two types of expectations emerged:

- Hope-based expectations were those expectations based on mothers' more hidden wishes for performance outcomes. These hope-based expectations were generally emotionally driven. An example of a hope-based expectation was that the child would be switched-on and would hear normally, and that the development of speech would occur soon thereafter.
- Knowledge-based expectations were those that were as a result of counselling from the cochlear implant team members, speaking to mothers of implanted children, and from observing other children who used cochlear implants.

During periods of anxiety, where outcomes were not as expected or as hoped for, these hope-based expectations superseded knowledge-based expectations. The extent of hope-based expectations seemed to depend on the mother's stage of grieving. The less they had to adjust to the loss (i.e. the greater the denial), the more hope-based expectations predominated over knowledge-based expectations. It became apparent that the influence of the grieving process was an important factor to consider when providing a child with a cochlear implant. Kluwin and Stewart (2000) studied the parental decision process and outcomes of cochlear implants for younger children and concluded that parents sometimes make the decision during the grieving process where there is the clear pairing

of a medical problem with a medical solution. The hearing loss is put in the same context as any other bodily anomaly that can be “repaired” through surgery. The parents make the choice at a time when they are not fully cognisant of all the implications or the condition and much less of alternative solutions. Even if the demands of the post-implant regimen were explained to the parents, it is doubtful many would appreciate the time commitment. The pairing of the two events – diagnosis and remediation without sufficient information – has implications for later ‘success’ rate.

Mothers who were still in denial about their child’s loss became more anxious when expectations were not met, and this led to less reliance on their knowledge about performance outcomes. In her investigation, Perold (1999) found that there were two distinct periods, which appeared to be driven by hope as opposed to knowledge-based expectations. These were during the ‘switch-on’ period, and after what has been termed the ‘honeymoon’ period, namely the ‘despondency’ period. Hogan (1998), in a study examining expectations and the adjustment process to a cochlear implant in adults, found that the feelings of excitement and anticipation associated with the switch-on are usually met with disappointment when the new sound is not as expected, and there is a variable period of adjustment to the quality of the sound.

Perold (1999) suggests that the same principle could be applied to parents of newly switched-on children when their expectations of outcomes are not satisfactorily met. Because of the extent of the negative reactions usually associated with the switch-on by pre-lingually deafened children, the sense of disappointment may be even more severe. Although mothers knew that a negative reaction was likely, some of them still felt emotionally unprepared for a negative reaction. One mother described her feelings on the day of the switch-on: “You know, with the switch-on we expected to see weird and wonderful things... and when they switch them on and they

do nothing and you think, huh, what a let down” (Perold, 1999, p.50). In certain cases, no amount of counselling about expected outcomes prior to switch-on can change a certain type of mindset. According to Perold (1999) a possible implication that can be drawn from this is that the mothers may still be in denial about their child’s hearing loss.

The honeymoon period occurred after the switch-on period, where the child’s performance improved markedly, more in terms of listening skills. During this time, levels of anxiety dropped, satisfaction levels were high, and expectations about performance outcomes were based on knowledge. This period occurred soon after the switch-on, when the child began to respond to a variety of new sounds, and often became more vocal. This improvement was particularly noticeable as the performance with a cochlear implant was so much better than with a hearing-aid. The primary focus during this stage is on auditory responsiveness rather than the development of speech skills. After a period of time, as performance outcomes appeared to reach a plateau, mothers became despondent about this apparent slowing down of performance. There was a shift in expectations towards the onset of intelligible speech.

Perold (1999) names the next phase the ‘despondency’ period. A sense of despondency about the non-appearance of meaningful speech gave rise to increasing levels of anxiety. This resulted in an increase in unrealistic high hope-based expectations. These feelings may have been partly the result of poor insight into the importance of the development of adequate auditory skills as a precursor for speech development. New fears arose during this time. Some mothers began to doubt the wisdom of having to put their child through implantation. With this rise in new fears and concerns, emotional states clouded knowledge-based expectations.

Although the mothers in Perold’s investigation (1999), had knowledge about the time it takes for the normal course of

development of perceptual skills, reliance on this knowledge diminished when hope-based expectations for faster progress were not met. O'Donoghue (1996) states that parental disillusionment is common after the rapid restoration of hearing after implantation because the acquisition of intelligible speech is frustratingly slow. In the study of Perold (1999), the trend emerged that mothers became despondent about having to "start all over again". This raises the issue as to whether they felt emotionally drained after the build-up to the switch-on, and the excitement of the switch-on process. Support structures like psychological counselling during this difficult time play a very important role in assisting in reducing emotional distress (Dunst & Trivett, 1990). Support structures could also play an important role in expanding knowledge of outcomes during different time periods and recognition of parental fears through psychological intervention may release 'blockages' that might build up in the parents, causing them to be more receptive to the cochlear implant and degrees of improvement that the child might experience.

Perold (1999) identified the final phase in her investigation as the 'breakthrough', which was linked to the onset of intelligible, meaningful speech. This resulted in a marked reduction in anxiety about performance outcomes, which was replaced by high levels of satisfaction. Knowledge-based expectations increased sharply and hope-based expectations did not seem to be a feature of this period. Other factors that played an important role in reducing stress and anxiety were improvements in the behaviour of and the relationship with their child, as well as improved communication between mother and child. Mothers no longer felt so anxious about performance outcomes, and felt reinvigorated to continue.

This model of Perold (1999) suggests that there are critical times where counselling assumes more importance than perhaps MAPpings and evaluations. The fluidity of the adaptation process to deafness was demonstrated by the re-emergence of the stages of

grief over time. A further implication that can be drawn from the model of Perold (1999) is that before a mother is able to assimilate information and incorporate information into her knowledge-based expectations, her anxieties and emotions need to be addressed. It is essential for the cochlear implant team to understand these emotions, particularly during times of disillusionment, as ongoing cooperation and commitment from parents is essential for the continued success and progress of the child.

A final theme that emerged from the research of Perold (1999) was related to counselling needs. This counselling can be divided into two primary areas – informational and adjustment or supportive counselling (Kaplan, 1996). Support groups are an extremely valuable adjunct to the therapeutic process (Luterman, 1987). They provide an effective forum for discussion of common concerns, and mothers can share strategies they may have developed for coping with common problems (Maxon & Brackett, 1992).

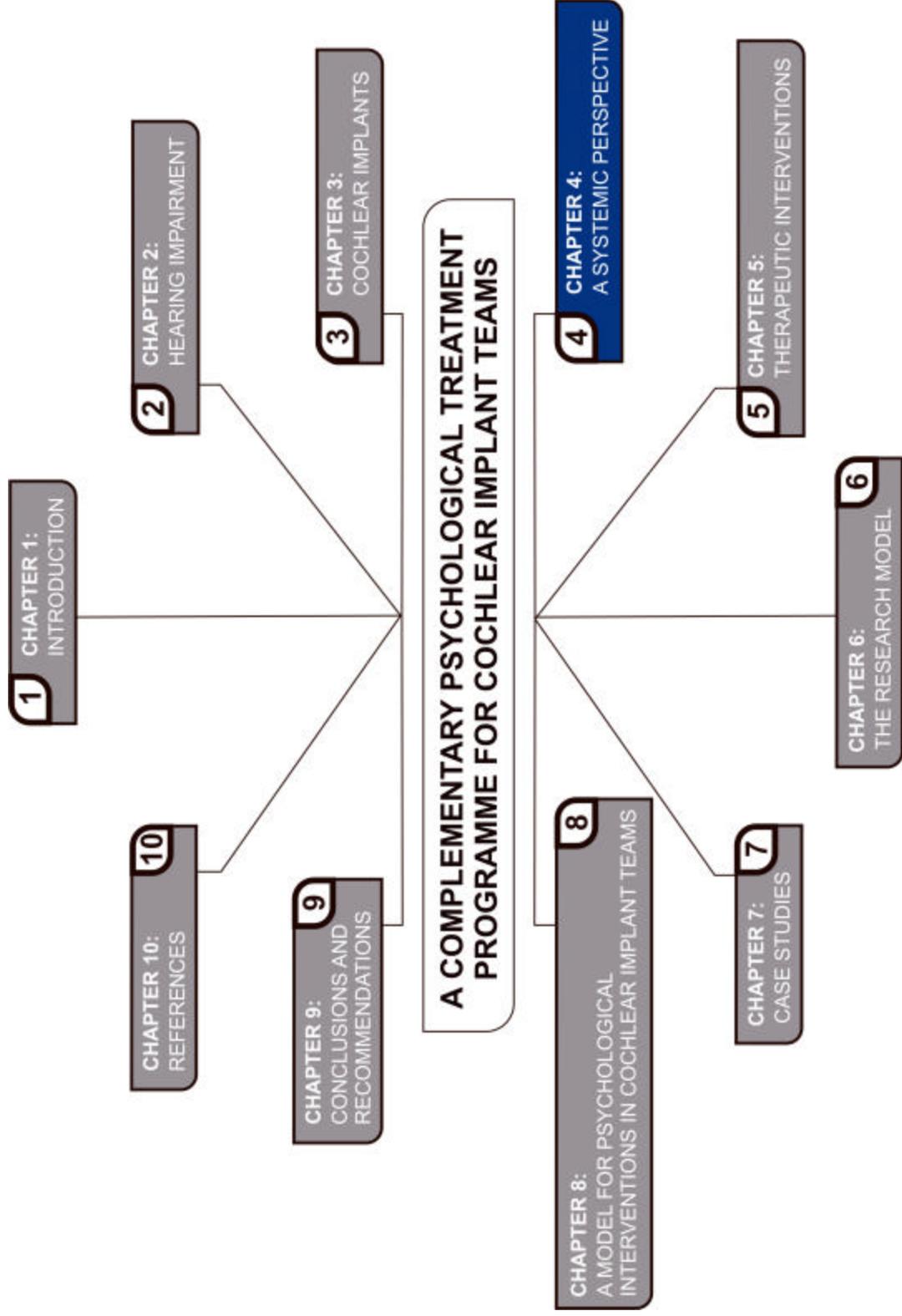
3.13 CONCLUSION

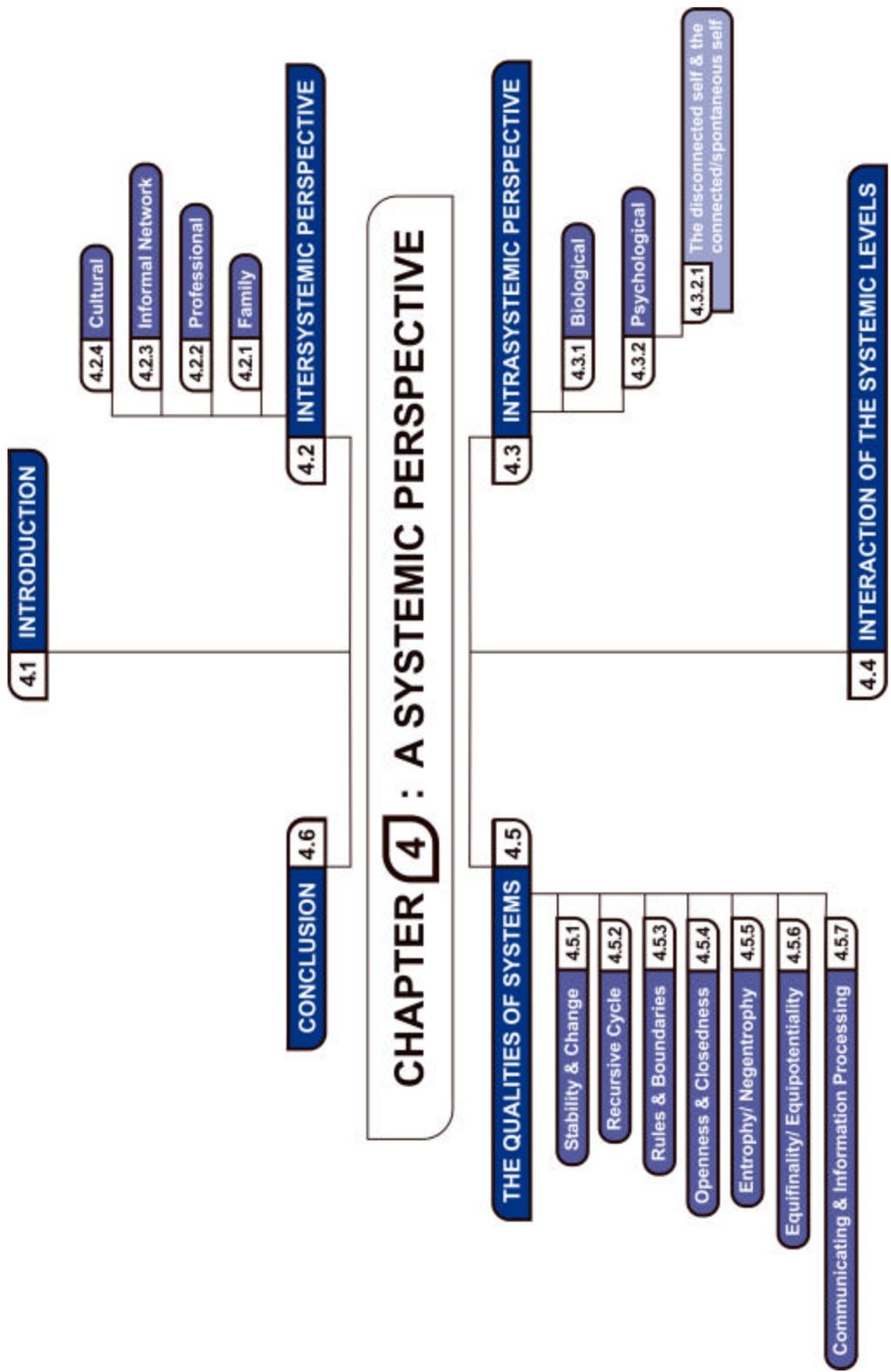
According to the medical/audiological perspective deafness is a disease-based hearing problem and the focus is on the degree and level of hearing impairment. The purpose of this perspective is to find a cure that will enable the hearing person to function according to the norms of hearing people. In contrast, the functional perspective depathologises deafness by suggesting that deaf persons must be seen as a bicultural and bilingual group – that is, as a minority group within a hearing society. In short, the medical/audiological perspective labels deafness as a “deficit to be corrected” and the functional perspective labels it as “deafness to be accepted” (Freeman, Carbin and Boese, 1981). The technology of a cochlear implant opened up a new world of possibilities for the hearing impaired. Although the implant enables the hearing-impaired person to hear better, it does not cure the hearing loss. The process of cochlear implantation is a

complex one. Human qualities like emotions, anxieties and expectations influence the process and can determine the success of the implant. Hearing and hearing impairment play a major role in the intrasystemic as well as the intersystemic functioning of a person. A person consists of systems and is always part of a system. This chapter shows that the cochlear implant not only concerns a person's hearing, but that it has a profound effect on, and is profoundly affected by the systems of which the person is part. It can be summarised as follows:

- 1) The client: pre and post the cochlear implant (C.I.) concerning expectations, fears and effect of the C.I.
- 2) The client: other psychological interferences/traumas, irrespective of the C.I. that should be worked through, so that the C.I. may be more effective.
- 3) The environment/parents/spouse of the C.I. candidate pre and post the C.I. concerning expectations, fears and the effect of the C.I.
- 4) The parents/spouse of the C.I. candidate: psychological traumas/interferences in the parents/spouse that might have been activated by the C.I./deafness and that should be addressed so that it does not impound negatively on the C.I. and the client's adaptation thereof.
- 5) The role of the psychologist concerning the above four points. JOS (2002) sees any activation as precursors for growth and the ignition of spontaneous healing. He notes moments such as political upheaval, sickness, age, divorce, the loss of a loved one, retrenchment and many more, as activators that can allow growth in a person. Similarly the C.I. procedure may become, more often than not, an activator for growth and the psychologist should define the healing potential as it unfolds and create/select the necessary psychotherapeutic complement to allow that process to unfold.

It is because of the importance of these interactions and the importance for the development of a suitable psychotherapeutic model/intervention dealing with the cochlear implant clients that the next chapter will look at human functioning from a systemic point of view.





CHAPTER 4

A SYSTEMIC PERSPECTIVE

4.1 INTRODUCTION

The systemic perspective refers to the cybernetic theory of systems that provides an abstract framework for the observation of human behaviour (Simon, Stierlin & Wynne, 1985). It teaches us that natural systems or groups or persons, such as an individual, family, or a larger social network, are always part of larger systems. These systems also consist, or are made up, of smaller systems called subsystems. Thus, any system containing an individual or group of individuals is simultaneously a whole unto itself and a part of a larger whole. Harvey (1989) illustrates this with the following example: Depending on our frame of reference, an individual can be viewed as a complete entity, as the sole object in our perceptual field, or as one part of a family; a family can be viewed as a complete entity, as part of a neighbourhood, or as part of an informal network system. There are thus many levels of organisation in human experience, from the subatomic particle and living cell, to complex organs and organ systems, to whole persons, to families, to communities, to cultures, and to larger societies. We speak of a hierarchy of biopsychosocial systems to refer to systems that are both a 'whole' and a 'part'. According to Bronfenbrenner (1979) these differing system levels appear to be arranged hierarchically, with each level more complex than the one before and encompassing all those that come before it. He has depicted his hierarchy as "a set of nested structures, like a set of Russian dolls" that are inextricably linked with one another (Figure 4.1).

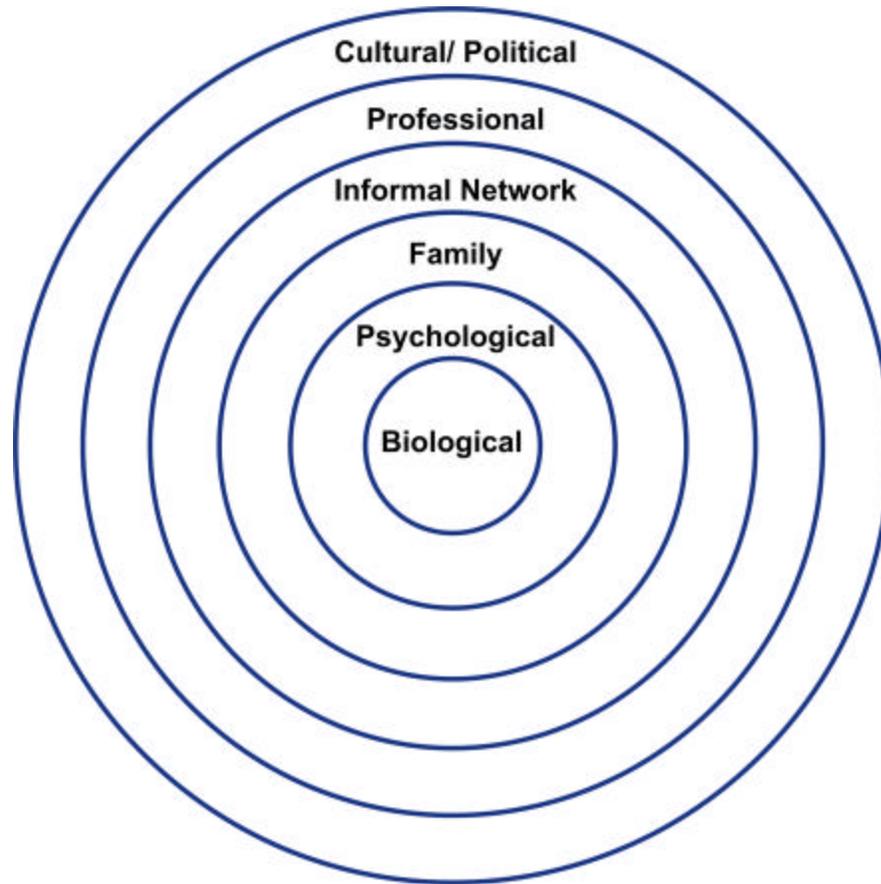


Figure 4.1. Nested Systems Levels (Harvey, 1989, p.7)

Stated more technically, an individual and family, or family and informal network, are seen as systems of differing logical types within the biopsychosocial hierarchy (Keeny, 1983). Consequently one can properly understand the behaviour of any given system only by tracking changes that occur within that system and its subsystems and by tracking changes between that system and the larger whole. One must obviously 'step back' and perceive all systems interacting with each other. One cannot infer the functioning of the larger system by hearsay or by simply observing each of its members (subsystems) separately; the whole (gestalt) is qualitatively and 'behaviourally' different from the sum of the system's individual elements (Harvey, 1989). This wider framework views behaviour as the product of reciprocal, circular interplays between environmental conditions and

intrapsychic processes. This is referred to as the circular nature of causation (Hoffman, 1981): environmental change leads to intrapsychic change that in turn, leads to environmental change. This is in contrast to a linear idea of causation, which focuses on one direction of change; either the environment causing individual change, or individual change causing environmental change (Harvey, 1989) Figure 4.2.

LINEAR CAUSATION



CIRCULAR CAUSATION

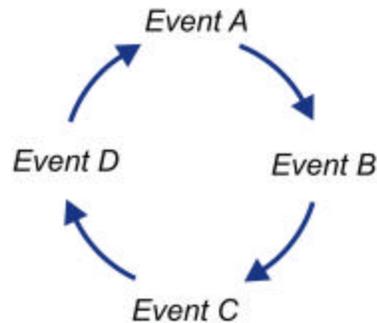


Figure 4.2 Linear causation and circular causation.

Organisms relate on inter- and intrasystemic levels and the hearing impaired are no exception. If a person is diagnosed with a profound hearing loss, it will not only affect the diagnosed person, but also the family and friends who form part of the systems of the hearing-impaired person. The previous chapters showed that the parents of a hearing-impaired child will be severely affected by the diagnosis. A treatment programme must always take into account that an individual (part) is part of a bigger system (whole). The foci of systemic interventions may include a wide range of procedures, such as: modifying individual biological factors via medication or diet; modifying individual cognitive, emotional, behavioural, or motivational factors via individual psychotherapy; and modifying the family, peers,

professional systems, and/or components of increasingly wider contexts (Harvey, 1989).

In this chapter the nature and qualities of the systems involved with the hearing impaired will be discussed and it will also focus on the inter- and intrasystemic relations and the implications thereof for the hearing impaired.

4.2 THE INTERSYSTEMIC PERSPECTIVE

Systemic epistemology (or lens) simply widens our vision and offers the clinician a humbled appreciation of the complex series of biological, psychological, and social interactions within the spatial systems hierarchy – the biopsychosocial field – in which individual symptomatic behaviour is embedded. It serves as the framework for the systemic diagnosis from which the clinician bases his or her interventions. The following is a brief discussion of those intersystemic levels, or nested structures, which are most relevant to the study of deaf and hard-of-hearing people as described in Harvey (1989).

4.2.1 Family

The family is the main environment for the developing child, particularly the young child. Its behavioural patterns, concepts about hearing loss, emotional responses to the loss, interactions with the child, and so on, all exert powerful influences on development. Furthermore, family development is powerfully influenced by the child and by the demands of raising a deaf child. In this sense, the child influences everything from the use of time and space to financial arrangements, travel patterns, patterns of communication among all family members, and even the family's image of itself – as well or not well, competent or incompetent, nurturing or not nurturing. In this

circular causation the deaf child influences, and is influenced by, hearing siblings, grandparents, and extended family members.

4.2.2 Professional

As with disabled or chronically ill people, many deaf clients have extensive and often intense relationships with a number of professional systems, including school, medical, audiological and other service agencies. For each ramification of hearing loss, there is often a corresponding professional system that can be more or less relevant at the different stages of the deaf client's life. For example, physicians tend to be important early on, with school systems later becoming the most influential forces. Harvey (1989) pointed out that professional systems and their relationships with family members may become patterned and rigidified over time and thereby exert an ongoing influence on the family. For example, parents often differ in their attitudes toward plans for their deaf child. A particular professional's advice can tip the scales. Continued support for one parent's position can exacerbate the split between the parents. Alternately, continued support and guidance toward the child can undermine parental authority, as when a professional exclusively meets with the child, while covertly assuming that he or she does a better job at parenting than the child's actual parents. The undermining of parental authority also may emerge in the relationship among schools, parents, and children when the school and parents compete about who is in charge of the child (Bodner-Johnson, 1986). The interpersonal patterns that emerge between parents and professionals may become so powerful that the boundary between these two systems virtually disappears. Therapeutic efforts to help the deaf child and his or her family are frequently impossible unless the way that professional systems reinforce family patterns, and vice versa, are also addressed.

4.2.3 Informal Networks.

Informal networks made up of friends and acquaintances of both the child and parents can exert strong influences on family development and thereby on the development of the individual child. The simple amount of support parents receive may determine how well they cope with the extra demands a deaf child may place on them. Informal networks, like professionals, reinforce functional and family patterns. Informal networks play an increasingly major role in the development of such individuals, particularly during adolescence, since this is the time the developing child associates with those who demonstrate the identity traits the child longs to live out.

4.2.4 Cultural

The way that a particular culture or subculture views being deaf through its political process, the way that a culture provides for such persons, exerts a major influence on the development of each child (Higgs, 1980; Lane, 1984; Sussman, 1976). With reference to deafness, Moores (1982) reported, "most of deaf people's problems are caused by the dominant society. Deaf people have survived and endured in the face of an indifferent world that must be dealt with daily" (p.141).

People who received cochlear implants and parents who have children with implants can provide a vital supportive network for diverse human needs, such as exchange of information and social/emotional support. With reference to cultural issues of deaf children in hearing families, Schlesinger (1986) stated:

Many of the parallels drawn between deaf children and other minority children are accurate and helpful in conceptualising developmental, psychological, linguistic, and academic issues. Deaf children are like minority children however, deaf children are

different from other minority children in that they do not share that minority status with their hearing parents (p.109).

4.3 INTRASYSTEMIC PERSPECTIVE

A characteristic of the systems world is theoretical relativity. According to this concept, embracing one theory does not require or imply the rejection of an opposite theory. Each theory gives meaning to the other and each has utility relative to a given context (Becvar & Becvar, 1996). Thus entry into the systems world does not require rejection of the world of individual psychology. Just as light and darkness are contrasted to each other and enable us to observe difference, so the individual psychology world and the systems theory world are intricately connected as each gives meaning to the other (Becvar & Becvar, 1996). The systems theory provides us with a passport to travel freely back and forth between both worlds. Through the intrasystemic perspective the individual is seen as a whole unto itself, a complete entity, but an entity that also consists of system levels in itself. The same systemic principles apply whereas the behaviour of an individual is properly understood by tracking changes in the person's intrapsychic systems. Becvar & Becvar (1996) describe the levels of organisation in systems hierarchy as consisting of two parts, namely the social hierarchy (aspects already described e.g. society, culture-subculture, community, family) and the organismic hierarchy such as the nervous system, organ system, tissues, cells, organelles, molecules, atoms and subatomic particles. In the middle of the two halves are the person and his/her experience and behaviour. The intrasystemic perspective mainly focuses on the person's experience and behaviour and the intra-effect on the organismic hierarchy. (Figure 4.3.)

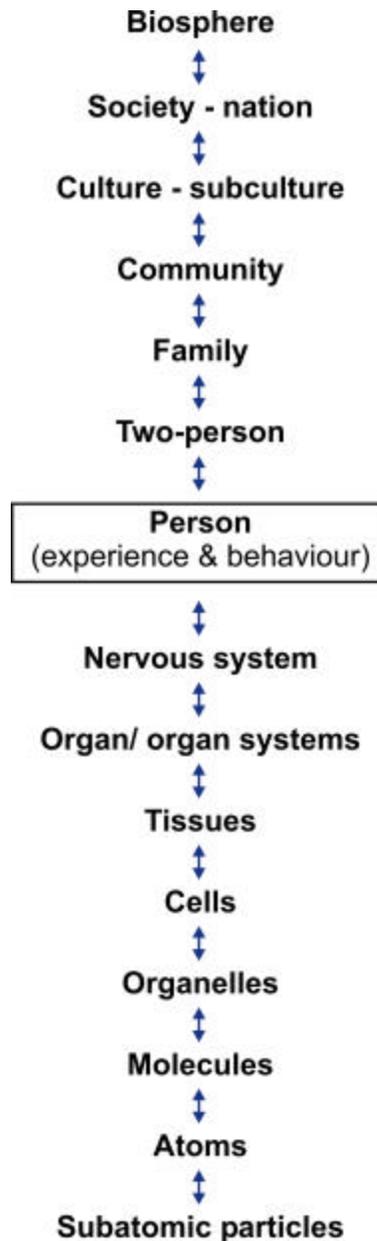


Figure 4.3. Levels of organisation in a systems hierarchy (Becvar & Becvar, 1996, p.366)

4.3.1 Biological

Biological factors are important, including the etiology of the hearing loss, the age of onset, the degree of hearing loss, the rate of loss, prognosis for continued hearing loss or gain, the configuration of the audiogram across the speech range, and the amount of residual hearing. There may be related medical conditions in addition

to hearing loss, depending on etiologic factors. (These factors are discussed in Chapter 2).

4.3.2 Psychological

The particular characteristics of an individual have a great influence on how he or she adapts to being deaf and on how the hearing loss is treated by his/her family, school and greater society. Although such children may well pass through some common and identifiable stages of development, each will do so in a unique way that is determined by his or her personality (Palmer, 1970). It is what Christie and Cullen (1983) refer to as a reaction of the individual to under-stimulation or over-stimulation that is peculiar to it.

4.3.2.1 The disconnected self and the connected or spontaneous self.

The intrasystemic perspective focuses on two concepts: the disconnected self and the connected or spontaneous self. This can be explained as follows: sometimes a person has to deal with physical or psychological pain that, at that specific point in time, seems to be life threatening. Sometimes this physical or psychological pain consists of long-term feelings of frustration and powerlessness in particular or similar recurring situations. The individual's system tries to protect it from these feelings of discomfort and in the process it leads to disconnectedness of that part/s of the spontaneous self that could not escape the discomfort of being bombarded with constant experiences of helplessness. The reason the self gets disconnected out of awareness is a direct result of the effort of the individual's system protecting it from further pain. The disconnected part is the spontaneous self that could not express itself while in the situation of the external interference; it is the healthy self that during the discomfort could not remain connected, because of the intensity of the helplessness (JOS, 2002). JOS (2002)

describes the body as the suitcase where we store the disconnected parts of the spontaneous self. The organismic hierarchy acts as a vehicle to convey the message of disconnectedness. Myss (2002, p.54) describes it so clearly:

The emotions of these experiences become encoded in our biological systems and contribute to the formation of our cell tissue, which then generates a quality of energy that reflects these emotions...and...our bodies contain our histories – every chapter, line, and verse of every event and relationship in our lives. As our lives unfold, our biological health becomes a living, breathing biographical statement that conveys our strengths, weaknesses, hopes, and fears.

JOS (2002) also notes the bodily suitcase as the disconnected memory imprint centre, which houses the disconnected self. For example, the stomach and the manifestation of chronic discomfort can be an indication of disconnected spontaneity. These physical manifestations are thus cantered in the involuntary system of the body, and it follows that the disconnected memory imprint centre is connected within the very same system - it also expresses itself involuntarily. Within the intrasystemic perspective the focus of therapy would be the connection and integration of these two subsystems of the disconnected self with the spontaneous or connected self. Physical manifestations indicating disconnectedness will then lose their 'message-value' and dissipate.

4.4 INTERACTION OF THE SYSTEMIC LEVELS

All of these systems levels comprise the context in which symptomatic behaviour may be embedded. It is not enough to say that "it is a problem" or "it is an individual problem", for, as was described earlier, a 'whole' is simultaneously a 'part'. Consequently, it is necessary to thoroughly understand the interactional patterns within and between each system level in order to provide effective treatment. As Bateson (1971) stated, "if you want to understand

some phenomenon or appearance, you must consider that phenomenon within the context of all completed circuits which are relevant to it" (p.244). The systemic perspective or cybernetic theory offers the clinician a more precise map of the interrelationship of symptoms and context.

4.5 THE QUALITIES OF SYSTEMS

4.5.1 Stability and Change

Cybernetics is based on the complementary relationship between stability and change (Keeney, 1983). Change is necessary for stability; stability is necessary for change. The theory posits that living systems maintain their form throughout processes of change. This ability of a system to remain stable in the context of change and to change in the context of stability is defined by the concepts known as morphostasis and morphogenesis. Morphostasis describes a system's tendency towards stability, a state of dynamic equilibrium. Morphogenesis refers to the system-enhancing behaviour that allows for growth, creativity, innovation, and change, all of which are characteristic of functional systems (Becvar & Becvar, 1996). Keeney (1983) illustrated this process by describing a tightrope walker who makes frequent adjustments to achieve balance on the high wire. Without these constant yet almost imperceptible changes, the acrobat could not maintain stability on the wire; without this stability, the acrobat could not perform the pattern of changes. The complementary nature of change and stability is also central to evolutionary processes and to the development of new structures in systems. For example, in order to maintain stability, a family must constantly adjust to internal and external changes, such as developmental changes of its members, diagnosed disabilities of a member, change of a job and other environmental changes. A family must constantly adjust to changes from within and between the systems levels of the biopsychosocial field in order to remain stable (Harvey, 1989). Using a cybernetic model, the dimension of time

must be added to the analysis. Changes in any level influence the other levels as a partial function of temporal factors or as Bronfenbrenner (1979) put it, by progressive, mutual accommodation. This process is properly described by the concept of co-evolution. According to Bateson (1972), co-evolution begins when one system levels adapts in reaction to disequilibrium within the same level or from another level. Internal and/or external forces may impose the disequilibrium. When a change in one system level affects, and is affected by changes in other levels, the systems are then said to co-evolve with each other. However, as Dym (1987, in Harvey, 1989) noted, there is no simple, cause and effect relationship in the idea of co-evolution. For example, a change in a child's physical symptoms (the biological level) is related to a change in how a child feels (the psychological level), which is related to a change in how the parents relate to each other (the family level), which is related to a change in how the professional helpers relate to the family and each other (the professional level), and so forth. All of these levels are said to co-evolve with each other (Harvey, 1989).

4.5.2 Recursive Cycle

Within the cybernetic theory, the concept of the recursive cycle helps us to track the co-evolutionary relationships occurring among the multiple levels of a complex ecological field (Dym, 1987; Harvey & Dym, 1987, 1988). A recursive cycle is a sequence of interactions that, like Keeny's tightrope walker, constantly adjusts to new conditions by processing new information in order to maintain an appearance of stability. The example of the acrobat on the tight rope previously noted illustrates this concept: the stability of the acrobat and his or her continual positional changes on the tightrope are complementary to each other; the acrobat makes constant adjustments to maintain balance. With each movement on the tightrope comes new sensory information allowing for better balance. Thus intersecting and constantly changing feedback loops occur.

Each feedback loop carries “news of a difference” (Bateson, 1979) – the sensory feedback of each loop is different than the one before, although the differences are usually slight, almost imperceptible. Thus, the feedback loops appear recursive, that is, repeating and unchanging. Nevertheless, both the system itself (in this case, the acrobat) and the complementary feedback loops continually change as a function of time and motion. In systemic analysis the *modus operandi* of making sense out of complex human behaviour, and of diagnosing the presenting problem, consists of the clinician continually and selectively perceiving certain variables within the biopsychosocial field as *figural* and thereby perceiving other variables as the *ground*. At any given time, the clinician may focus on a specific system’s level to the temporary exclusion of other levels. For example, at one particular time, the clinician may perceive psychological and communication factors of the hearing loss as *figural* and thereby perceiving other variables as the *ground*, or vice versa (Harvey, 1989). There are many options. The clinician not only continually shifts his or her perception within the ecological field, but also generates hypotheses about the relationships among several variables and systems levels, which include the presenting problem. These relationships are conceptualised by the recursive cycle. The identification of the recursive cycle serves as the clinician’s basic diagnostic unit. It represents a concise portrait of a complex field and locates symptomatic behaviour in an ecological context (Harvey, 1989).

4.5.3 Rules and Boundaries

The rules according to which a system operates are comprised of the characteristic relationship patterns within the system. These rules express the values of the system as well as the roles appropriate to behaviour within the system (Becvar & Becvar, 1996). A system’s rules are what distinguish it from other systems, and therefore rules may be said to form the boundaries of a system. However, according

to Becvar & Becvar (1996), such rules or boundaries, are not visible but must be inferred from the repeated patterns of behaviour of a system. A system exists only in the eye of the beholder. In other words, a system exists only as I, the observer, chooses to define it as such and form its boundary. The rules of a system are implicit for the most part, existing outside the conscious awareness of the members of the system.

4.5.4 Openness and Closedness

The extent to which a system screens out or permits the input of new information into the system refers to the openness or closedness of that system. All living systems are open to some extent, so openness and closedness refer to a matter of degree. An appropriate balance between the two is desirable for healthy functioning (Becvar & Becvar, 1996).

4.5.5 Entropy/Negentropy

Becvar and Becvar (1996), have the following view of systems: If the balance between openness and closedness is appropriate, then conversely, being either too open or too closed will probably be dysfunctional. At either extreme the system may said to be in a state of entropy, or is tending towards maximum disorder and disintegration. By allowing in either too much information or not enough information, the identity and thus the survival of the system is threatened. On the other hand, when the appropriate balance between openness and closedness is maintained, we may say that the system is in a state of negentropy, or negative entropy; it is tending towards maximum order. The system is allowing in information and permitting change as appropriate, while screening out information and avoiding changes that would threaten the survival of the system. Maier (1978) states the following:

The human being is an evolving system; in each moment of life development, the individual, in one sense, incorporates such opposites in order to create a new and unique life situation. In addition, this very solution generates different dilemmas with new opposing pulls and with promises and threats of syntheses (p.87).

4.5.6 Equifinality/Equipotentiality

All systems can be described according to the concept of equifinality. It does not matter whatever the particular balance is between morphogenesis and morphostasis, openness and closedness, or entropy and negentropy. That is, the system, as it is, is its own best explanation of itself, for regardless of where it begins, the end will be the same (Becvar & Becvar, 1996). These concepts can be explained in the following way: People in relationships tend to develop habitual ways of behaving and communicating with one another. We refer to these habits and characteristic processes as redundant patterns of interaction. Systems are comprised of patterns and these patterns tend to repeat themselves. Thus no matter what the topic, the way the members of a given relationship argue, solve problems, discuss issues, and so forth will generally be the same. These redundant patterns of interaction are the characteristic end state referred to by the term “equifinality”. In contrast, the concept of equipotentiality reminds us that different end states may be arrived at from the same initial conditions. The concept of equifinality/equipotentiality, therefore, directs our attention to the level of process and to a focus on what is going on (Becvar & Becvar, 1996).

4.5.7 Communicating and Information Processing

According to Becvar and Becvar (1996), communication and information processing is at the heart of the matter when thinking

systemically. Three basic principles form the foundation of this concept:

Principle 1: One cannot not behave.

Principle 2: One cannot not communicate.

Principle 3: The meaning of a given behaviour is not the true meaning of the behaviour; it is, however, the personal truth for the person who has given it a particular meaning.

According to Principle 1, we can never do nothing. Even so-called doing nothing is doing something.

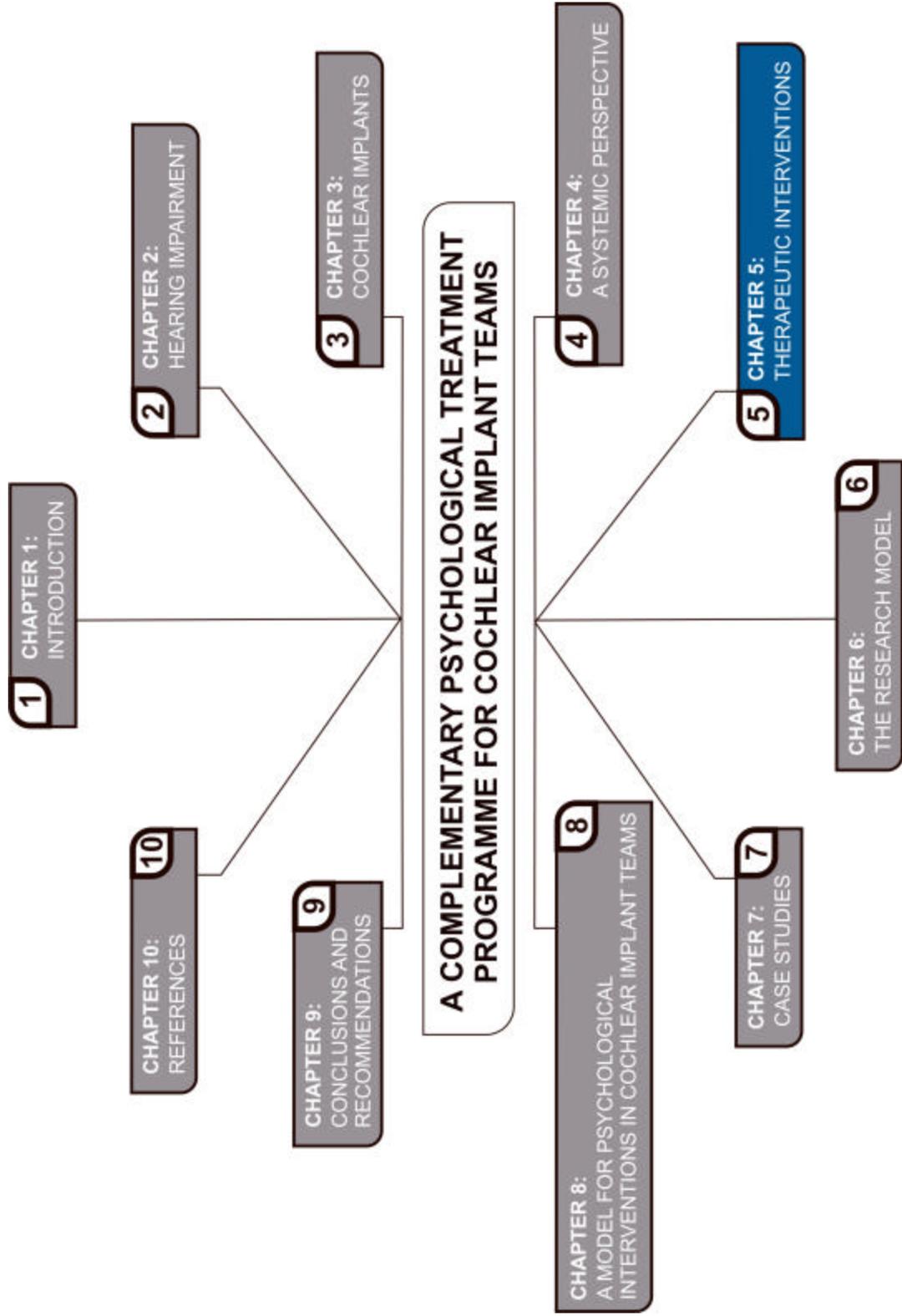
Principle 2 follows from Principle 1. What that means is that communication at the verbal level may be less than satisfactory, but at least at the non-verbal level, communication is taking place and meaning is given to behaviour even if the behaviour is silence.

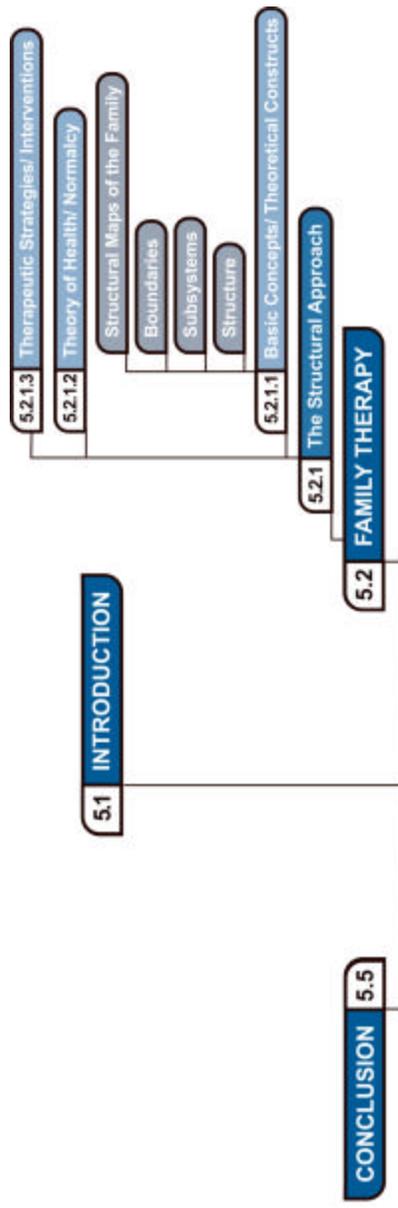
Principle 3 refers to the fact that a particular message or behaviour may be interpreted in many ways and no one interpretation is necessarily more correct than any other. All interpretations would be influenced by the 'assumptions' from the interpreter. Depending on the intrasystemic 'cloudedness' of the person, the more clouded the assumptions and interpretations would be.

4.6 CONCLUSION

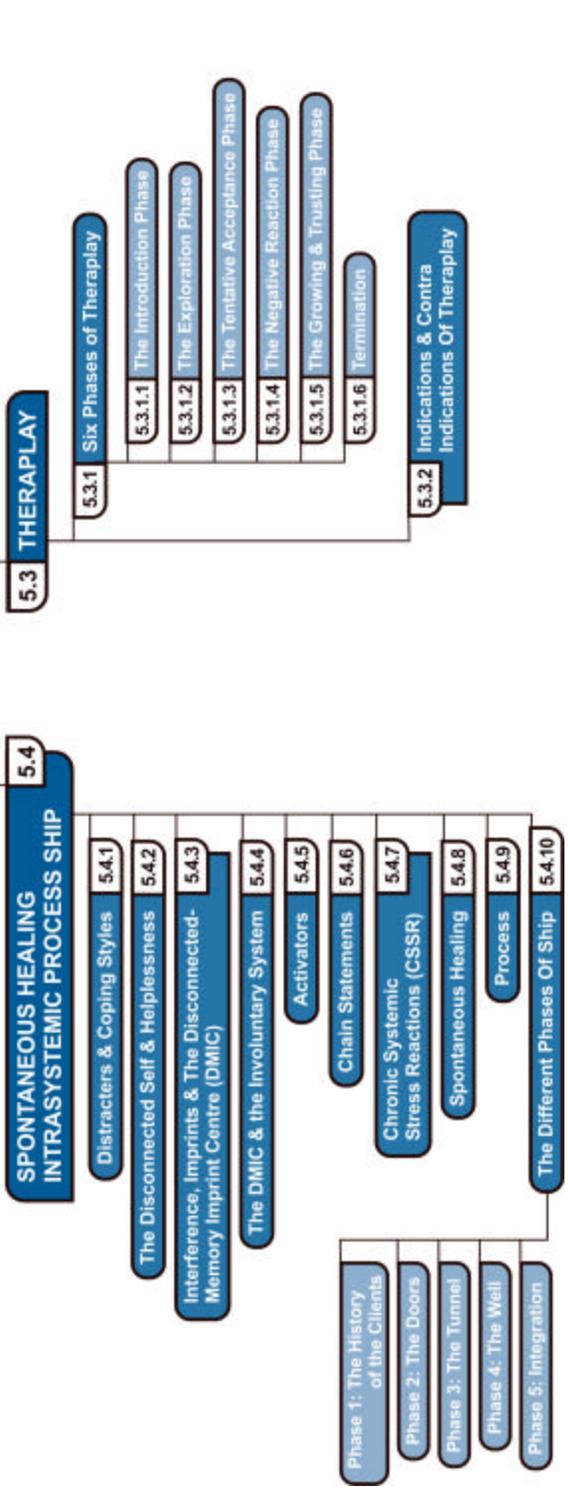
Myklebust (1960) and others posit that loss of hearing itself leads to an increasing number of atypical behavioural and emotional symptoms that are suggestive of emotional maladjustment. In contrast, the systemic model posits that the behavioural and emotional characteristics that may be presented by many hearing-impaired clients have come about, are supported, and are reified as a function of the interaction within and between systems levels across

time; they are context based. The systemic perspective offers the clinician several choices about how, when, and where to intervene in the context of the biopsychosocial field. Phenomena at different levels of the ecology involve biological, psychological, familial, informal network, professional, and cultural influences that co-evolve with each other. Therefore, modification in one level will influence, and be influenced by, all other levels to varying degrees. Intervention at one particular level may well exert a 'ripple effect' across several other levels, and therefore may be the optimal point of intervention. Alternately, all the systems levels may reinforce each other like glue to preclude effective intervention at any one level, and therefore may require simultaneous or sequential interventions at several levels. The next chapter deals with the different therapeutic interventions that have been selected to treat the cochlear implantee or the family/members of the family of the implantee.





CHAPTER 5 : THERAPEUTIC INTERVENTIONS



CHAPTER 5

THERAPEUTIC INTERVENTIONS

5.1 INTRODUCTION

This chapter describes the different psychotherapeutic interventions that will be incorporated to create the specific treatment model. The attempt of all the interventions is to create new meanings in the client's life which then logically lead to new actions. The different views of the problem formation, determine in every case the different interventions. According to Fourie (2002) there are many examples in the literature of how a particular conception of problem formation leads to specific modality of treatment. Whereas many proponents of specific approaches to treatment believe that their particular view of problem formation is the correct one, Fourie (2002) states that it is not really important whether the propounded explanation of problem formation is correct or not, but that it is the process of providing clients and other interested parties with a convincing explanation of the problem, followed by a coherent treatment ritual which brings about change.

Fourie (2002) describes reframing and action as two important aspects of the process of creating new meaning. Clients have certain ideas, attributions and conceptions about the particular circumstance, themselves, the presenting problem, and the expected mode, venue and agent of treatment. These ideas are presented in verbal and non-verbal ways to the therapist, who, in turn, has his/her own ideas and conceptions about all these and other concerns. After listening to the client's presentation of the problems, the therapist will give the client a full description or abbreviated understanding of the situation to bring across to the client and/or to other interested people

involved, an understanding of the therapist's conceptualisation of the problem. This might refute, confirm, extend or in some way modify the client's initial view of the situation. This process might involve the provision of a different explanation of a situation, problem or events and is known as the process of reframing or redefining the problem. Fourie (2002) describes reframing as the more or less deliberate attempt to influence the involved peoples' ideas about the particular occurrence of behaviour. From a meta-perspective it can be seen that reframing occurs in all forms of treatment, because these treatments all involve, explicitly or implicitly, the altering of perceptions and ideas. Different approaches to treatment use different types of reframing and it does not matter whether the reframing is "correct" or not. What matters is that the client and/or other people involved should be convinced of the "correctness" of the particular understanding.

Reframing can be done in many different ways and can, as such, bring about behaviour change. Reframing often leads to action which, in turn, confirms and strengthens the new understanding. This action can take different forms and would be coherent with the reframed understanding of the problem and would flow from the understanding. Fourie (2002) concludes that although all treatment agents do have and must have a commitment to a particular view, it is in their own and their clients' interests that they remind themselves that it is not the content of their theories that is important, but the conversational process of reframing. The more "open" the treatment agent is to other views, the more creative he/she can be in this process.

For the purpose of this treatment model, three different therapeutic interventions are used. The reframing in the different cases leads to different actions. Despite their differences, each of these therapies were constructed upon the same basic premise. In each case the therapist conceptualised and treated symptoms and problems as part of a more encompassing systemic pattern of

organisation. Each of the therapies has a unique way of constructing its own particular view of what constitutes a systemic pattern of organisation. Sometimes these patterns involve the immediate family system like in two of the interventions. On the other hand, the third intervention demonstrates that the pattern of organising problem behaviour need not include the family system.

In all three interventions a fundamental distinction will be made between two ways of looking at patterns that underlie therapeutic communication, namely: semantic frames of reference – looking in terms of meaning – and political frames of reference - looking in terms of organisational consequences. Keeney and Ross (1992) describe these two frames of reference as follows: When a therapist asks a client to explain why he has a problem, the therapist is asking for a semantic frame. The client may subsequently attempt to construct a particular meaning for his situation. He may point to traumatic experiences in his past, to character disorders, social constraints, or he may even construct an elaborate explanation as to why he has no explanation. Should the therapist shift to asking the client to describe what is actually happening, he is proposing a political frame of reference. The client may then specify who is doing what to whom. From these descriptions an overall view of the politics of his problem behaviour will begin to emerge. All therapists ask questions that interweave semantic and political frames of reference.

A troubled system (an individual or a family) comes to therapy with a request to alter the way it changes in order to stabilise itself. Keeney and Ross (1992) describe the role of the therapist as providing three communications to the troubled system: (1) a request for change; (2) a request for stability; and (3) some meaningful noise (reframing) from which an alternative pattern or structure for reorganising change and stability can be constructed.

Meaningful noise arises out of the analyses, stories, themes, historical interpretations, and hypotheses the therapist presents to the family or individual, regarding how the problem contributes to their being connected. The system itself brings all of these communication resources to therapy. The therapist's job is to use his/her sensory processes to discern how these communications are articulated and to mirror them back to the troubled system. In effect, the therapist's mirroring or articulation of the different communications of a troubled system enables the system to (re)calibrate how it maintains its organisation.

The cochlear implant concern adults as well as children. For the purpose of this study, Family Therapy, Theraplay and Spontaneous Healing Intrasystemic Process® (SHIP®) as therapeutic interventions will be described. Every person will be seen as a system, and interventions will be either intrasystemic, intersystemic or both.

5.2 FAMILY THERAPY

When family therapy is built on the assumptions of systems theory, a more appropriate label would probably be relationship therapy as relationships and patterns of interaction in the family are being studied (Becvar & Becvar, 1996). According to Keeney and Ross (1992) family therapy operates from the perspective that emphasises treating the patterns that connect the problem behaviour of one person with the behaviour of other people. There are many different models of family therapy. As will become clear in chapter seven, the reframing of the problem with this specific family as a system, showed that the family is lacking sufficient subsystem connection. Meaningful noise would imply the differentiation and connection of subsystems. A structural approach that focuses on restructuring the family would be the choice of intervention.

5.2.1 The Structural Approach

According to Becvar and Becvar (1996), the person most frequently associated with the development of the approach known as structural family therapy, is Salvador Minuchin. Although Minuchin and his colleagues are not regarded as originators of family therapy, the structural approach has been perhaps the most influential model in its popularisation. It is a clearly articulated theory that provides a useful tool for helping people see the patterns, processes, and transactions of the family as a system.

The structural approach gives the therapist a concrete, conceptual map about what should be happening in a family if it is to be functional; it also provides maps about what is awry in the family if it is dysfunctional. The structural approach gives definite ideas about how the process of therapy should be carried out (Becvar & Becvar, 1996). It is thus prescriptive and normative.

5.2.1.1 *Basic concepts/theoretical constructs.*

Minuchin suggests that the life history of a family is a series of experiments in living. Structural family therapy describes a delicate balance between stability and change, and between openness and closedness. While this model values a stable field for the family, the stability must be matched with appropriate transitions and changes in structure if it is to be a functional development context for its members. Structural family therapy sees the family as an integrated whole – as a system. Accordingly, it is also a subsystem in that its members belong to other agencies and organisations in the community of which it is a part and which affect its basic structure and pattern of organisation. In the language of the theory there are three key concepts/constructs: *structure*, *subsystems* and *boundaries* (Becvar & Becvar, 1996).

- **Structure**

Structural family therapy focuses on the patterns of interaction within the family, which give clues as to the basic structure, and organisation of the system. For Minuchin (1974), structure refers to the invisible set of functional demands that organises the way the family interacts, or the consistent, repetitive, organised, and predictable modes of family behaviour that allow us to consider that the family has structure in a functional sense. Thus, observations of patterns of interaction in the family provide information about how the family is organised or structured to maintain itself. A family operates through repeated transactional patterns that regulate the behaviour of family members. Such patterns describe the how, the when, and to whom family members relate. The concepts of patterns and structure therefore imply a set of covert rules of which family members may not be consciously aware but which consistently characterise and define their interactions.

- **Subsystems**

According to Becvar and Becvar (1996), structural theory defines three subsystems: the spouse subsystem, the parental subsystem, and the sibling subsystem. The rule among these subsystems for the functional family is that of hierarchy. The theory insists on appropriate boundaries between generations.

- *Spouse subsystem.*

The spouse subsystem is formed when two people marry or decide to build a future together and thus create a new family. The processes involved in forming the spouse subsystem are known as accommodation, which implies adjustment, and negotiation of roles between spouses.

Such accommodation can best be accomplished when the spouses have attained a certain degree of independence from their families of origin. While each brings the basic rules for being a spouse and parent from the families in which they were raised, spouses who remained enmeshed with their families of origin after marriage will have difficulty accommodating and negotiating their roles relative to each other. An important requirement of the spouse subsystem is that each spouse be mutually supportive of the other in the development of his or her unique or latent talents and interests. Accordingly, neither spouse is so totally accommodating of the other as to lose his or her own individuality. (Becvar & Becvar, 1996).

- *Parental subsystem.*

The birth of a child instantly transforms the system, and if accommodation and negotiation have been successfully developed in the spouse subsystem, these skills will be very useful in the evolution of the parental subsystem. With children, new issues arise which demand complementarity if the functions of the family are to be performed successfully. With the formation of the parental subsystem, the spouse subsystem must continue to exist as a system distinct from the roles of the participants as parents. In the parental subsystem, each spouse has the challenge of mutually supporting and accommodating the other in order to provide an appropriate balance of firmness and nurturance for the children. The parents are in charge and an important challenge is knowing how and when to be in charge about what issues. The children must get the message from the parental subsystem that the parents are in charge. A family is not a democracy, and the children are not equals or peers to the parents.

- *Sibling subsystem.*

By establishing the spouse and parental subsystems, structural theory also defines the sibling subsystem. The sibling subsystem allows children to be children and to experiment with peer relationships. Ideally, the parents respect the ability of the siblings to negotiate, to compete, to work out differences, and to support one another (Becvar & Becvar, 1996).

- **Boundaries**

Becvar and Becvar (1996) describe boundaries as invisible, but these boundaries nevertheless delineate individuals and subsystems and define the amount and kind of contact allowable between members of the family. For Minuchin (1974) the idea of boundaries implies rules, or certain preferred relationships between subsystems in the family. Each subsystem has its own identity, its own functions, and its own pattern or relationships within it. The identity, functions and patterns of relationships within a subsystem are governed by relationships between subsystems. Thus, what happens between subsystems affects what happens within subsystems and vice versa.

- *Clear boundaries.*

The ideal arrangement between subsystems is that defined by clear boundaries. Clear boundaries are contrasted with the less-than-ideal arrangement defined by rigid or diffuse boundaries. Clear boundaries are firm and yet flexible. Where clear boundaries exist, the members of a family are supported and nurtured and yet are allowed a certain degree of autonomy. Clear boundaries also imply access across subsystems to negotiate and accommodate situational and developmental challenges that confront the

family. Clear boundaries represent an appropriate combination of rigid and diffuse characteristics.

- *Rigid boundaries.*

The term “rigid boundaries” refers to the arrangement both between subsystems and with systems outside the family. Rigid boundaries imply disengagement within and between systems. Family members in that instance are relatively isolated from one another and from systems in the community of which the family is part. In the context of rigid boundaries, children have to learn to fight their own battles and to negotiate without the involvement of their parents. That is, parents are parents and children are children with little or no room for negotiation and accommodation, and access between subsystems is very restricted.

- *Diffuse boundaries.*

The family defined by diffuse boundaries is characterised by enmeshed relationships. This is the polar opposite or the rigid-boundary family. In this case everybody is into everybody else’s business and there is an extreme of hovering and providing support even when not needed. The parents are too accessible and the necessary distinctions between subsystems are missing. There is too much negotiation and accommodation. The cost to both the developing child and the parents is a loss of independence, autonomy, and experimentation.

- **Structural maps of the family**

Minuchin (1974), provides a method for mapping the structure of the family. The symbols used for mapping involve punctuating boundaries as clear, diffuse, or rigid, and transactional styles as enmeshed or disengaged. The following symbols are used: (Fig.5.1.)

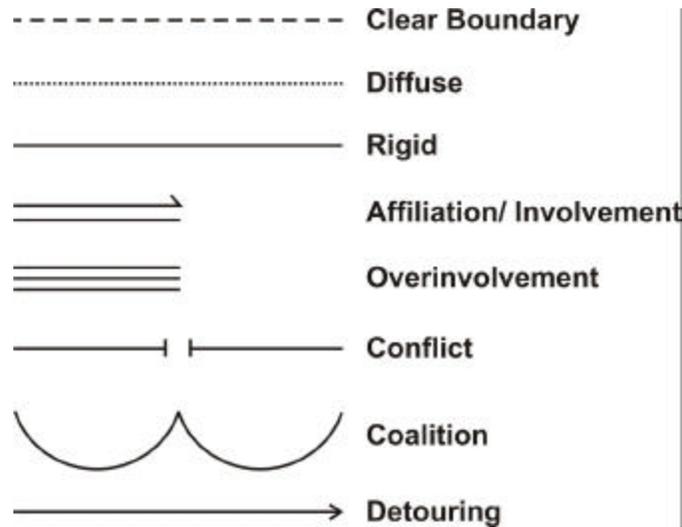


Figure 5.1 Symbols for structural mapping (Minuchin, 1974, p.53.)

5.2.1.2 Theory of health/normalcy.

For Minuchin the ideal family builds on a spouse subsystem in which each accommodates, nurtures, and supports the uniqueness of the other (clear boundaries). The spouses have attained a measure of autonomy from their families of origin. Ideally, in the family of origin each spouse felt supported and nurtured and yet experienced a degree of autonomy, independence, and responsibility. Similarly, spouses need to be able to maintain a delicate balance between proximity and distance. On this basis the couple negotiates complementary roles that are stable but flexible and, through a process of negotiation and accommodation, evolves different structures and role complements to deal with changing circumstances. The spouse subsystem maintains itself even when children are born and the parental/executive and sibling subsystems come into experience (Becvar & Becvar, 1996).

The ideal family will face expected and unexpected crises appropriately by recognising and facilitating necessary changes in structure. Such behaviour requires a great deal of patience and wisdom. In the ideal family the sibling subsystem feels the security and strength of both spouse and parental subsystems. This strength

provides the grounding for increasing levels of experimentation in independence and responsibility (Becvar & Becvar, 1996).

5.2.1.3 Therapeutic strategies/interventions.

According to Becvar and Becvar (1996), few families are ideal in the sense of being problem free and handling all challenges and transitions smoothly and without growing pains. All families experience stress from situational challenges at transition points in their evolution. The key to the success of the family is its ability to make adaptive changes in structure relative to family circumstances and the developmental stages of its members.

Structural theory suggests that the therapist should observe the transactions of the family and get a sense of its pattern and structure. There seem to be certain characteristic structures associated with certain kinds of presenting problems relative to the membership of the family. Therefore, hypotheses regarding existing structures can be developed before the first interview. Answers to key questions about the family can provide clues to the structure and to probable problems often accompanying a given structure. Among the questions that might be posed are:

1. How many people are in the family?
2. What kind of people is in the family?
3. What are the ages of family members?
4. What is the presenting problem?
5. What are the sexes of family members?
6. What is the religion of the family?
7. What is the family's socio-economic status? (Becvar & Becvar, 1996, p. 202)

The therapist must not rigidly hold to the patterns and structures suggested, but rather must be willing to rely on his/her observations as the most valid source of data in family assessment. This is an important part of the diagnostic process. Hypotheses regarding structures are formulated and revised as the therapist observes different patterns in subsequent sessions that were not evident in the initial observations of family transactions (Becvar & Becvar, 1996).

Once a pattern or structure is ascertained, the challenge becomes one of breaking the pattern. There are no specific techniques for doing this. According to Becvar and Becvar (1996) the therapist must know what he/she wants to say and must say it in a manner that will get the family's attention. The analogic mode of communication; that is, voice tone, pacing, volume, repetition, and word selection are used to achieve intensity. Intensity in delivery is what enables family members to hear a message about what is going on and thus sets the stage for structural change. Shaping competence is another important tool in structural family therapy. Shaping competence helps develop the positive, functional alternatives that the family members may already know. For example, praise for performing a difficult action (difficult relative to the existing structure) may help family members feel confident in themselves. A part of structural family therapy is the therapist's insistence that the family members are capable and can do what needs to be done. Becvar and Becvar (1996) suggest a list of other specific activities the structural therapist might do in therapy:

- Realign boundaries by physically altering the proximity or distance between family subsystems. This can also be accomplished by meeting separately with the subsystems or individuals in order to firmly establish or acknowledge boundaries.
- Help members of disengaged families to increase the frequency of contact between them.

- Help specific dyads resolve their own issues without intrusion from other members of the family. This can be sibling-to-sibling, parent-to-parent, or parent to child. Such activities can be described as allowing each relationship to seek its own level.
- Teach aspects of structural theory to the family so the family can have its own cognitive map to understand the goals and the interventions of the therapist better.
- Change the way family members relate to one another so their perception of the other can change. Structural therapists believe that reality is only a perspective. The family members are acting on the validity of the perspective each has of the other. The therapist can also provide the family with other cognitive constructions and thereby provide family members with a different world or family view for its experience.
- Confuse the family by using paradoxes and thus help them evolve different structures.

Becvar and Becvar (1996) summarise the fundamental processes of structural family therapy as follows:

1. Learning and believing in the concept of structure in families.
2. Observing transactions and patterns characterising these processes, from which structure may be inferred.
3. Having a definite ideal structure for a family given its constituent members and circumstances.
4. Joining, accepting, and respecting the family in its efforts to organise itself to achieve its goals while assuming a leadership role.

5. Intervening in the family in respectful and yet firm ways to make happen in a session what the therapist wants to have happen, consistent with the structural map deemed more likely to help the family and its members move toward the model of health described by structural theory.
6. Supporting members, challenging them to try new methods in sessions, and praising them generously when they are successful.

5.3 THERAPLAY

The next therapeutic approach used in this study, is a form of play therapy done in a very specific and structured way and is called Theraplay. Theraplay can be seen as a reconstruction of the parental subsystem where the therapist works with a specific dyad, namely the mother-child dyad without the intrusion of the other family members. Although the therapist initially takes over the role of the mother in this dyad, the goal of Theraplay is to expose the mother to a relationship where there is a focus on the different needs of the child within a framework of rules and fun with the definite assumption that the mother will take over the role of the therapist when she and the child are ready. Ideally, another goal of Theraplay would be to expand the parental subsystem by including the other siblings in the family when the time is ready. As the principles of the systems theory teach us, the change in the parental subsystem will also have an effect on the rest of the family system and it will also change the way the family members relate to each other. Although the therapist initially works with the mother-child dyad, this small system is part of a larger system. Theraplay can be seen as an intervention to bring about a healthy mother-child dyad, with a resulting positive rippling effect on the rest of the family system.

Many of the techniques and theoretical positions on which the Theraplay method is fashioned were developed by Austin Des

Lauriers (1962). Theraplay, as it has evolved at the Theraplay Institute, has assimilated most of Des Lauriers's principles.

Fairbairn (1952; 1963) originally articulated the theory of object relations as a psychology of the individual based on the premise that the individual has a need to relate. Relating begins in utero and continues at birth within the matrix of the attachment to the mother or primary caretaker. According to object relations theory internal objects (past relations) represent unconscious memory traces of experience with someone (the object) who has or had significance for the person (Klein, 1946). These internal symbolic representations act as a template. Templates influence all future relationships. The infant's initial experience of the world is fluid, but slowly over time he/she builds up an internal working model of objects. Templates, through the process of projective identification, penetrate every level of psychological experience – the motivational, behavioural, cognitive, perceptual, experiential and affective (Klein, 1946).

The American school of object relations family therapists (e.g. Scharff, 1989; Scharff and Scharff, 1987; Slipp, 1988) have adopted Klein's concept of projective identification to move the theory of the individual's object relations into the interactive family context. Object relations theory addresses the quality of the relationship between the infant and caregiver in terms of whether this relationship is 'good enough' (Winnicott, 1976). 'Good enough' refers to a constellation of qualities of care. It includes an awareness of the psychological and physical needs of the infant and implies a consistent, reliable and predictable response to the infant's needs. 'Good enough' does not mean perfect. There will be occasions when the carer cannot meet the infant's needs (Winnicott, 1976, 1977).

Jernberg (1979) suggests that the best way to understand the principles underlying the Theraplay method is to rediscover the basics of the mother-infant relationship: What are the typical daily

pleasurable interactions in the nursery? How does the healthy baby respond? What characterises the cycle they thus set in motion between them? And what are the specific effects of their reciprocal behaviour on each of the partners involved?

Daily the mother in the nursery with her baby nuzzles his neck, blows on his tummy, sings in his ear, hides his eyes (or hides her face) when playing “peek-a-boo,” and nibbles his toes. She powders him, lotions him, combs him, washes him, pats him dry, and rubs him. She whispers, coos, giggles, hums, chatters and makes nonsense sounds. She peeks at him, pops out at him, peers from upside down at him, looks wide-eyed with surprise, and beams at him. In addition, she holds him, confines him, binds him, restrains him, protects him, defines his life space, his property, his relationships, his use of time and finally, by gently teasing, chasing, and eluding (and returning), she remains one step ahead of him, thus encouraging him both to learn the art of mastery and to enjoy the challenge (Jernberg, 1979).

Her baby, in turn, coos at his mother, smiles at her, reaches for her, strokes her, worships her, imitates her and enjoys being mirrored by her; he gurgles with her, and finally, he names her. Most of all, he welcomes the certainty, implied throughout, that there is reliability, empathy, and caring.

The cycle thus set into motion is a reciprocal one. “Once we consider the dyad, we must at once conclude that both actors actively and significantly influence each other” (Lewis & Lee-Painter, 1974, in Jernberg, 1979, p.46). Each is eager to please, protect, and cherish the other, and each one responds by showing pleasure and concern in turn. The gratitude at having been given so much pleasure leads to greater and greater efforts to please, protect, and cherish (Jernberg, 1979). The effect on each of the partners is, of course, to enhance and clarify the view of self each holds and to portray the

world as a fun, caring, and loving place. The baby comes to see him/herself as clearly differentiated, attractive, safe, enjoyable to be with, loveable, and capable of making an impact. In the process the mother comes to see herself as loveable, giving, and feminine, yet at the same time resourceful, strong, and competent. She finds in her new motherhood the confirmation of many qualities in herself that she may have doubted – including a capacity for intimacy and a firm sense of self.

Ideal as these Structuring, Challenging, Intruding, and Nurturing interactions obviously are, they are not always possible.

Various factors can hinder the forming of this relationship. Sometimes the environment precludes the establishing of a close bond. Reality pressures may hinder this relationship. There may be competing demands from the house, a job or other members of the family. Sometimes the relationship itself may be responsible. Reframing in a case like this would be as follows: when parents have to accept the diagnosis of a child with a hearing impairment, the mother can be so busy trying to work through her own feelings of grief and disillusionment, that these frivolous, fun, surprising, teasing and warm moments become fewer as she tends to the necessary, the routine, and serious problems of family survival. Sometimes the parents are so overwhelmed by the seriousness of raising a hearing-impaired child that they focus on stimulation of the hearing and language and in the process they also lose their spontaneous interaction with the child. Sometimes it is difficult for the mother and her child to tune into each other because of their different personalities. A vigorous, aggressive, demanding, unpredictable, physically robust infant, for example may have been boisterously catapulted into the soft, artistic, gentle routine of his frail, dreamy mother.

There is a definite manner in which Theraplay evolved to restore a healthy relationship between mother and child. The reframing of the situation will lead to the following action: the six phases are being described by Jernberg (1979) as follows:

5.3.1 The Six Phases of Theraplay

5.3.1.1 The introduction phase.

Although they are never spelled out as such, the ground rules are clearly set in the introduction phase:

- The Theraplay sessions will be fun.
- The Theraplay sessions will be clearly directed by the therapist.
- The Theraplay sessions will be action oriented, rather than talk and insight oriented.
- The Theraplay sessions will be clearly delineated as to time, space, and therapist and patient roles.

5.3.1.2 The exploration phase.

In the exploration phase, child and therapist actively get to know each other. They get to know who has the largest hands, the curliest hair, the longest toenails, and the strongest muscles. In this relationship or interactive process, the child comes to view him or herself in a new light. Even his or her negativistic behaviours are turned around to show a more loveable side of him or her.

5.3.1.3 The tentative acceptance phase.

During the tentative acceptance phase, the child pretends to or may actually attempt to “play the game”. It is often pseudo-involvement only. Tentativeness, even apprehension, is the underlying tone. During this phase the therapist continues to be intrusive and insistent, indulging or challenging, surprising, appealing and fun. The

child may appear bewildered, excited, reserved or interested. Even when he or she reacts with enthusiasm and apparent intimacy, this reaction is often too premature to be evidence of a genuine relaxed engagement. It may be a defensive, apprehensive manoeuvre whose purpose is to keep the intruding therapist at bay.

5.3.1.4 The negative reaction phase.

In this phase the child becomes clearly resistant to any further efforts at intimacy. The child may suddenly become negativistic, resistant, limp or mute. The therapist's implicit response continues to be insistent and matter-of-fact, conveying to the child that what they are about to do together would be fun for any normal child. The resistance may continue over a few more sessions in the same or varied form. In the face of the therapist's firm perseverance it will diminish in intensity and eventually disappear.

5.3.1.5 The growing and trusting phase.

During the growing and trusting phase, the child first experiences the pleasure of interacting with another human being in a "normal," reciprocally satisfying way. The child is now ready to move into growing and trusting. The child is ready to begin to develop confidence in him/herself and trust in the world. During this phase, a sibling or a parent may be invited to participate.

5.3.1.6 Termination.

The phase leading up to, and including, the termination of the Theraplay treatment course, although encompassing a short span of time relative to other therapies, consists of three distinct phases.

- **Preparation:** Teachers or parents report decrease or disappearance of symptoms. The child shows increasingly harmonious and enjoying behaviour with respect to himself and his world.

- **Announcement:** The therapist announces the termination plans within the context of gains the child has made. In the last few sessions, the child's parents, siblings or friends join the child and therapist. The object is to redirect his/her cathexis away from the therapist and onto people who will comprise his/her post-therapy environment (Jernberg, 1979). According to Des Lauriers (1962), the behaviour of the patients reflects more and more a feeling of independence and a need to belong to a family.
- **Parting:** At the end of the final session, the therapist acts as anyone would at the close of a meaningful relationship. He/she may give the child a big hug, tell him/her how much he/she has enjoyed playing with such a special person, and tell him/her he/she knows from now on the child will be having fun with his/her own friends and family.

In conclusion: Theraplay is a structured way of presenting the child with the type of interaction necessary for his/her emotional well-being. Different children will have different needs. A child from a very structured, disciplined environment might have a bigger need for Nurturing and Intruding activities. The child with an over-protective mother may need activities where the focus is more on Challenging than Nurturing. An interview with the parents and the child will reveal the imbalance in the relationship and the reframing process will determine the type of action. This can then be addressed through the choice of activities.

5.3.2 Indications and Contraindications of Theraplay

Theraplay is a useful form of treatment for many emotional, social, and developmental problems. Its usefulness is very likely a function of its supplying the very kinds of attachment fostering and autonomy-enhancing experiences that children who were referred for help, have so often missed.

According to Jernberg (1979) Theraplay is indicated for children who, probably as a result of these early deprivations, have low confidence in themselves and little trust in their own world. The child for whom Theraplay is recommended is one who behaves in ways that keep distance between him/herself and the kind of relationship his/her therapist, as parent surrogate knows he/she needs. Theraplay, in its purest form, is not indicated for every child, however. Jernberg (1979) excludes the following children:

- The sociopathic child - Theraplay has been found to be effective with only a very few sociopaths and then only if two conditions are met: 1) if the child is pre-adolescent and 2) if the parents are willing and able to give up passive acquiescence toward their child's behaviour. This degree of willingness is not often found in parents of delinquent children. The prospects are dim for the adolescent whose parents only give lip service to their wish for change. He/she may come to enjoy the attention, spontaneity, and limit setting of the sessions, but a change in real-world behaviour is unlikely.
- The traumatised child – children whose presenting problem has been the experience of a recent trauma. A child who has suffered a recent trauma has the following therapeutic needs: 1) the need to understand fully and factually just what happened to him/her; 2) the need to express the feelings the trauma has aroused in him/her; 3) the need for reassurance that he/she did not bring about the episode; 4) the need to become convinced that, whatever happened to the victim (if this is someone other than himself), it is not going to happen to him/her; and 5) the need to know that he/she is not going to be punished for what happened (Jernberg, 1979).

- The fragile child – those children who respond to even gentle approaches with panic or terror. For these children, the more vigorous and intrusive approaches may be inappropriate until a firm relationship has been established between child and therapist.
- The abused child – abused children need therapy that primarily provides crisis intervention - the kind of therapy that would be appropriate for a child who has suffered any other kind of recent trauma. The Nurturing aspect of Theraplay is appropriate for this kind of situation.

To summarise: The systemic perspective provides a useful framework to observe and intervene in human functioning. The first approach, the structural family therapy, showed us how to intervene in the larger family system, Theraplay, the second approach, provides a way to intervene with a smaller subsystem of the family. The third approach focuses on intrasystemic intervention with the client as an individual, in other words, to work with the “internal family” of the client. Sometimes the therapist sees a client who is separated from his/her family. Although the client is still part of a family system, the rest of the family lives in a different part of the country and the client lives on his/her own. Contact with the family is limited because of distance and practical reasons. This was the case with the third case study in this model. Individual psychotherapy was the choice of therapy and this was done through the process of spontaneous healing, called SHIP®. This intervention will be discussed within the context of a systemic approach.

5.4 SPONTANEOUS HEALING INTRASYSTEMIC PROCESS (SHIP®)

According to Schwartz, 1995, it is sometimes also necessary to address those smaller systems of interacting psychodynamics within us. When the reframing of the problem the client presents, shows

that the way the current problem presents itself, can be linked to specific incidents that happened in the client's past, the action the therapist takes will include certain rituals to address the incidents that happened in the past. SHIP® is a useful therapeutic intervention where certain rituals can be introduced as part of the action taken in the therapy and as a way to address the smaller systems in the self.

Some of the assumptions of SHIP® are that our personality styles develop out of our childhood and the different interactions in our family of origin. These personality styles comprise a coping style, which develops when one part of the personality becomes more dominant through trial and error. The coping style creates a mask or persona, the part that we show the world. Unfortunately this happens at the cost of the rest of the personality traits, since there is now less energy representing them. The mask or the coping style is the over-exaggerated part that helps us cope in life. The mask or coping style is a way of the individual to create stability in the face of change. This can be illustrated as follows:

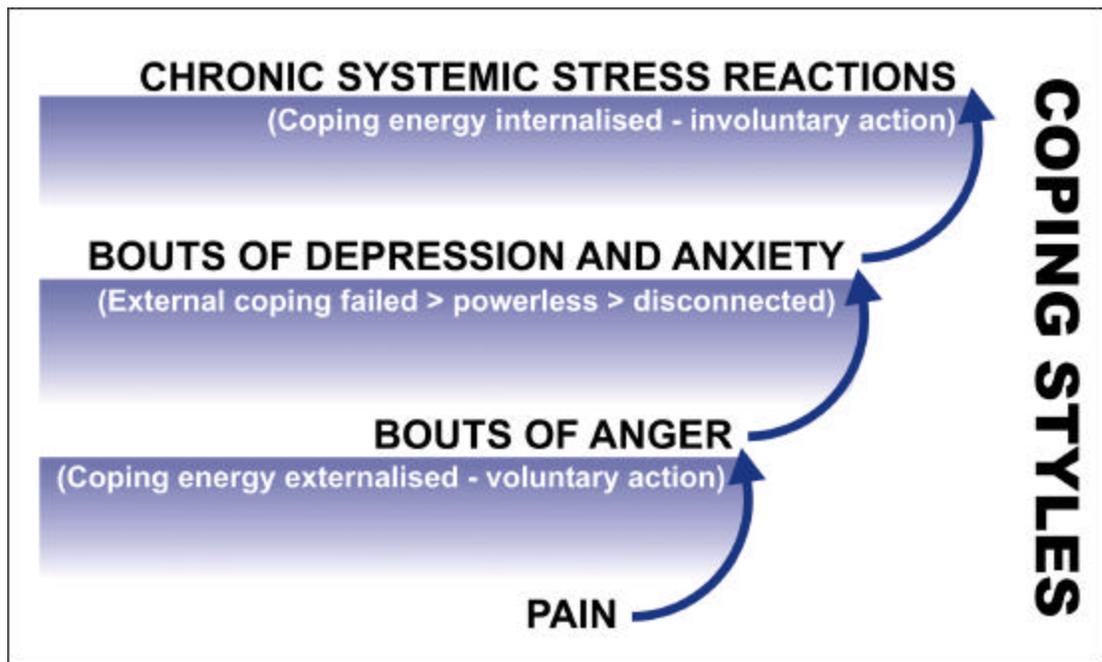


Figure 5.2 Coping Styles (JOS,2002, p.158).

The aim of SHIP® is to free the self. Freedom means you are in contact with all your faculties and are not inhibited from being you. According to JOS (2002) the author of SHIP®, we disconnect during youth from feelings he calls “the too-muchness”. As children we are at times powerless to retaliate against those people or events that cause us pain. In order to survive and cope, we disconnect from the “too-muchness” and store this pain in the different subsystems of our bodily suitcase (e.g. the respiratory system, the digestive system, endocrine system, etc.). This results in an absence of freedom of energy flow within those subsystems that also implies a loss of spontaneity. The experience of loss disturbs the spontaneous personal boundaries, which results in a confused sense of self, projection, intersystemic enmeshment with others, troubled interpersonal relationships, and chronic systemic stress reactions. Chronic stress reactions may include physical symptoms like migraines, ulcers, cancer, depression, anxiety, etc. In SHIP® an environment is created where the client can connect with his or her disconnected information, allowing for the spontaneous healing process that leads to full connectedness and intrasystemic balance.

In systemic language this spontaneous healing process can be associated with autopoiesis or the capacity of living organisms to reorganise themselves. The theory of autopoietic systems has taken important positions in different fields of knowledge such as in philosophy or sociology. In the psychodynamic field it was adopted by the Italian author Napolitani (noted in Laponi, 1996), in an application to the theory and therapy with groups. Autopoiesis of the individual is the condition through which the individual changes the world, transforming the “sense” of his relationship with it. The “sense” is the element that qualifies human knowledge, that is, a directional signal that makes one choice legitimate among many possible ways in which the human mind constructs experience. Relationships contain disturbances that set off conflicts, which in turn – in the context of circularity – are manifested both in relationships with

others and with the self. In autopoietic terms, therefore, we can say that the perturbations set off a self-reorganisation compensation that is directed in the “sense” of both internal conflict and conflict with the outside.

The viewpoint of SHIP® is that intrasystemic balance (or change) will cause a resonating ripple effect intersystemically – the spontaneous internal reorganising through SHIP®, will result in spontaneous external reorganising. The systems theory propagates this interactive process of reorganisation of change.

SHIP® starts with the client’s awareness that something is wrong, and the decision to do something about it. This feeling of “something is wrong” and the presenting chronic systemic stress reactions are seen as precious messengers that are trying to bring the client in contact with that which has been disconnected in the client. As has been said, disconnection mainly occurs during our childhood. JOS (2002) describes it as follows:

“Conditional acceptance by the current ‘culture’ causes the soft, sensitive and spontaneous self to disconnect. (See Figure 5.2.). By conforming, we make it easier to achieve the status of being accepted and loved. Unfortunately the expectations implicit in conformity deny the self and its spontaneity, and eventually lead to recurring moments of helplessness and periodic (or even continuous) disconnectedness from the spontaneous self. This train of events determines future coping styles, encapsulates the spontaneity and perpetuates further compliance with the expectations of others” (p.20). According to JOS (2002) the first ten years set the coping style used in adulthood during chronic stress. This coping style develops when one part of the personality becomes more dominant through trial and error. Unfortunately it happens at the cost of the rest of the personality traits, since there is now less energy representing them and this leads to imbalance (Figure 5.3.)

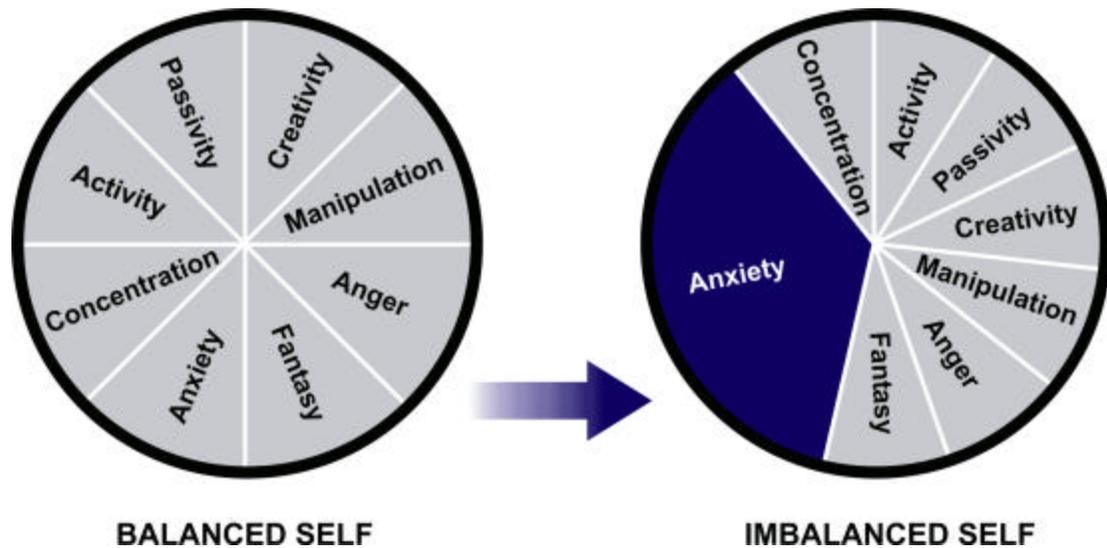


Figure 5.3 During our formative years coping styles develop when one (or more than one) part of the personality becomes more dominant through trial en error.

(JOS, 2002, p.6).

Bass and Davis (1997) mention a continuum of coping behaviours people make use of to survive. Due to limited resources available for taking care of the self at an early age, survival is hooked onto whatever seems most effective. For example a person may have become a super-achiever, excelling in school and taking care of brothers and sisters at home. Or the person may have forgotten what happened to him/her, withdraws into the self, or cut off from his/her feelings. Ford (1998) describes this coping process even stronger: “We are so fearful of being rejected that we sell out our most precious gifts just to fit in. We’re taught this as a means of survival, and we do it until we can’t stand ourselves anymore. Then the toxic emotions become so painful that we create situations in our lives to continually show us we’re unworthy, to prove that we are not deserving of our dreams” (p.129). According to the SHIP® theory this recreation of the discomfort is a spontaneous healing quality within the client with the aim of confronting the client with those

disconnected feelings or energies that need to connect (to be discussed in more detail further on).

5.4.1 Distracters and Coping Styles

Clients often express internal conflict, or even self-loathing, when they discuss their problems. They often identify this ambivalence or confusion as different internal perspectives of “parts” of themselves. Through listening to the ways that clients describe themselves, Schwartz (1995), devised a systems theory application to those “parts”. Schwartz asserted that these parts are separate sub-personalities and that family therapy methods may be used directly with these intrapsychic systems (i.e., the internal family of parts) to restore health. Schwartz describes an Internal Family Systems Therapy (IFS model) and this model allows therapists to use IFS with many different techniques (Deacon & Davis, 2001).

Schwartz (1995) asserts that each person possesses a Self, at times experienced as either a state of mind or an active entity. The Self is unlike a part in that it possesses a metaperspective of the internal system, is inherently compassionate and wise, and does not coerce the parts of the system into obedience (Goulding & Schwartz, 1995; Schwartz, 1995). The Self maintains leadership to allow proper internal development, balance, and harmony (Schwartz, 1995).

A client’s problems may be a reflection of parts overtaking leadership because he or she distrusts the Self’s abilities, other parts, or the external environment. The Self must then regain trust and leadership to recover control over the system by returning it to a state of balance and harmony. Rather than enter the power struggle, the Self demonstrates its inherent leadership qualities, so that the parts will trust the Self and become less reactive (Deacon & Davis, 2002).

Schwartz (1995) labels the parts in a low-functioning system according to how they act. He categorised the parts as “managers,” “firefighters,” or “exiles”. Managers allow the daily life or the individual to continue by generating competent and conforming behaviour to hide problems. Managers try to help the system to appear “normal” despite the person’s internal struggles. Firefighters attempt to distract the person’s Self from problems via extreme behaviour or thoughts. Exiles are those parts that embody the overwhelming fears, hurt, and burdens (such as childhood wounds) held within the person. Firefighters and managers typically work to isolate the exiles and prevent the Self from being overwhelmed by the exile’s intense emotions. In the case of binge eating, for example, a fire-fighter could create an insatiable desire to eat in response to certain environmental stressors. The eating could be a retaliation of parts toward external conditions, and also a way of comforting the hurt, exiled parts (Deacon & Davis, 2001).

According to Deacon and Davis (2001) it is necessary for therapists to remain theoretically grounded while applying techniques, it is not always necessary to adopt a theory wholeheartedly to use it. What is essential is that therapists respect clients’ beliefs and work collaboratively with them.

There are many similarities between SHIP® and the Internal Family Systems Theory. JOS (2002) gives other names to these parts and suggests that ‘distracters’ (fire-fighters) and ‘coping styles’ (managers) are closely linked and often seen as one and the same. They are fused into an interactive pattern with the outside world and not always easily distinguishable. He sees a coping style as a person’s long-term focus and way of being in, and relating to, the world. Distracters have a short-term purpose of deviating uncomfortable focus and come into being once the coping style is threatened by disconnected information wanting to connect, thereby allowing the coping style the necessary time and space to regroup

once more. Distracters have as their main aim the containment of the environment and thus the creation of a safe haven, by maintaining the status quo and inhibiting internal growth. A person does not experience growth that is activated by healing messages positively, but rather as a sense of pain or loss that one must avoid. Distracters become active to protect the vulnerability of the individual. They are voluntary and are activated by the fear of further losses (disconnectedness) of parts of the self. (JOS, 2002).

There are different layers of distracters. The first distracter we generally fall back on is anger, since that is our first order of defence at surviving. If the anger is disallowed or proves unsuitable (i.e. it fails), it becomes disconnected into the bodily suitcase and the next level of distracters is activated. The bodily suitcase now harbours the previous external anger internally, and the individual may react with bodily manipulations such as tics, obsessive traits, mannerisms, excessive talking, continuous swallowing, smoking, etc. These physical manifestations are still distracters that serve to divert attention, as well as to allow the individual some form of control, given that he or she is then doing (controlling) something. Within the human system spontaneous healing is on a continual quest to restore balance and if the system is not allowed this opportunity to grow and explore, the person has to keep on distracting because of internal fear or confrontation with the disconnected pain that might lead to change, but which is experienced as further potential losses of the spontaneous self. (See Figure 5.2 of coping styles).

5.4.2 The Disconnected Self and Helplessness

JOS (2002) sees a disconnected person as somebody who has a constant need to curb the powerless feelings by taking control. He or she may become angry because of the powerlessness: the anger is a way of taking control, retrieving power and thus ending the confusion created by helplessness. When such attempts to regain control fail

because of a discrepancy between the connected and disconnected needs, discontent is added to the helplessness (exiles) experienced by the individual.

From the above it follows that the person continues with life, but is living at the cost of the disconnected energy. 'At the cost' means without being allowed to express the self fully.

5.4.3 Interference, Imprints and the Disconnected-memory Imprint Centre ('DMIC')

At birth we function on a psychobiological level. Infants experience physically and soon also emotionally. When there is interference in our natural rhythm, i.e. a difficult birth, the imprint remains in our systems although the interference may be forgotten. The imprint is in our systems even if our connected selves do not remember that the spontaneous rhythm of birth was severely disturbed. The intensity of the discomfort pushed the spontaneity beyond awareness. "This is the pain, the first instance of spontaneity not being allowed to run its course – and it lives on in the disconnected-memory imprint centre (DMIC)" (JOS, 2002, p.40) (see Figure 5.4).

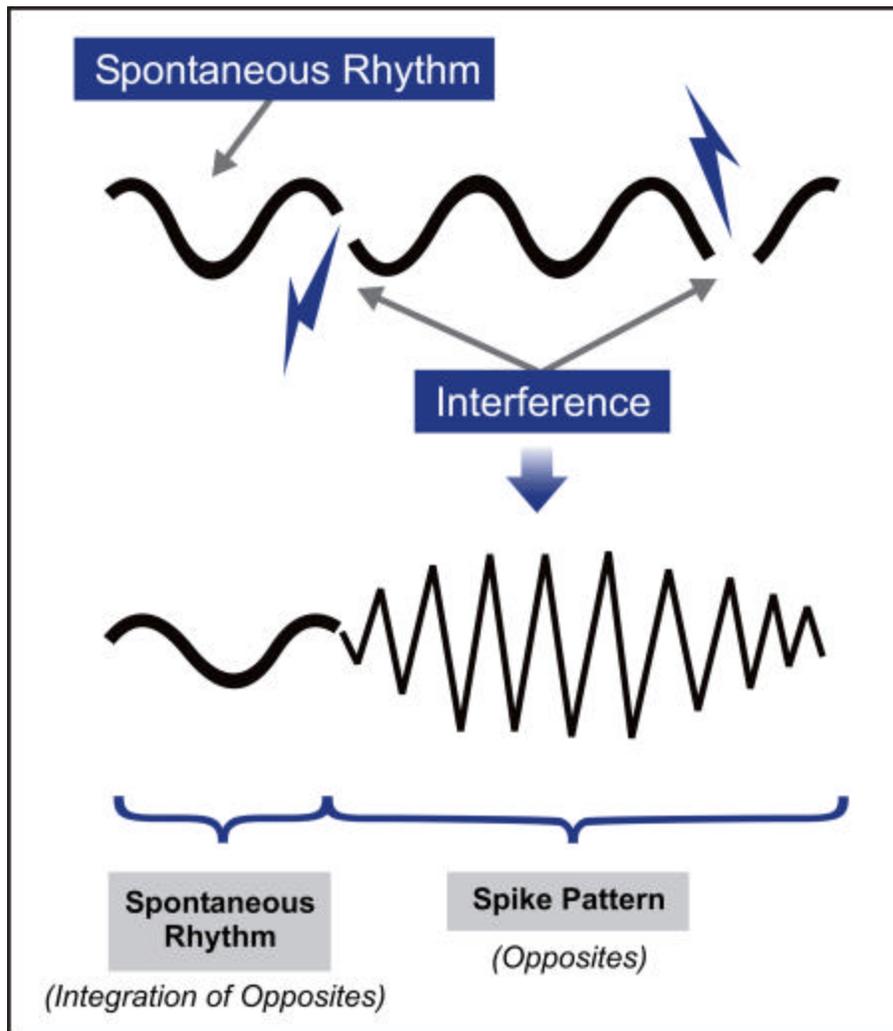


Figure 5.4 Interference interferes with the spontaneous rhythm, resulting in opposites (JOS, 2002, p.22).

The disconnected part is the spontaneous self that had no self-expression because it was in a situation of external interference. It is the healthy self that during the discomfort could not remain connected owing to the intensity of the helplessness/too muchness. Its natural rhythm was interrupted. The uncomfortable external incident interfered with the flow and denied natural expression. It is thus not the interference as such that caused pain, but the disconnection of the natural rhythm of the self during the interference. The denial of any part (once again the exiles according to Schwartz, 1995) means that part still needs to express its natural rhythm and

this need will continue until the opportunity for expression arises (JOS, 2002).

Schwartz, 1995, describes the forming of opposites in the system as polarisation. This is the process by which parts become reified in their roles out of fear that other parts will destroy the system. They, therefore, engage in repetitive and predictable actions out of desperation. Managers ignore or suppress the problem; fire-fighters engage in self-destructive behaviours; and exiles flood with intense emotions. Fearing system destruction, the parts vie for control of the internal family, which results in a vicious cycle as each part vainly tries to solve things from its own limited perspective.

According to the SHIP® theory, when interference disturbs the spontaneous flow, causing a part of the self to become disconnected, its opposite becomes part of the current coping style. A 'healthy' personality implies having a little bit of everything. The moment one pole of the opposite shows itself, i.e. being uncontrolled or too controlling; too domineering or subservient; too hyperactive or passive; it indicates an issue or projections and therefore disconnected pain. Spontaneity is inhibited because of the too-muchness/opposite, and the individual lives his or her life by compensating through symbolic action of some sort for the lack of the opposite in the connected self. Opposites are coping styles and can complement each other depending on the demands of the situation, but ultimately the balance should be restored. JOS (2002) illustrates this concept with the following Figure.

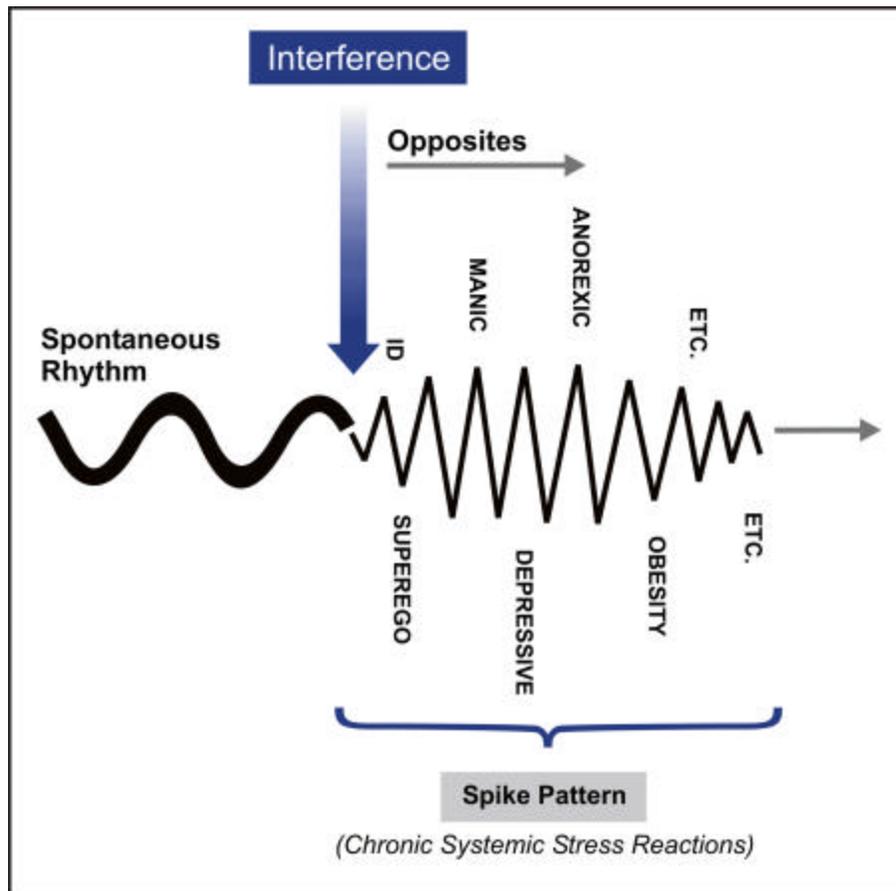


Figure 5.5. The spike pattern is seen as an effort to control, because the opposites are experienced as out of control. In the search for the boundary of the self, or the system's need for balance and integration, different processes, called chronic systemic stress reactions, are used (JOS, 2002, p.91).

5.4.4 The Disconnected-memory Imprint Centre and the Involuntary System

An emotion is often located as physical sensations in a specific part of the body. A feeling of fear might be a knot in the stomach, or heart palpitations. JOS (2002) views the body as the suitcase in which we store the disconnected parts of our spontaneous selves. Myss (1996) is in agreement with this viewpoint:

“The emotions of these experiences become encoded in our biological systems and contribute to the formation of our cell tissue,

which then generates a quality of energy that reflects these emotions.... Our bodies contain our histories – every chapter, line and verse of every event and relationship in our lives. As our lives unfold, our biological health becomes a living, breathing biographical statement that conveys our strengths, weaknesses, hopes, and fears” (p.54). The blotting-out of awareness during the formative years happens involuntarily, and the bodily suitcase is the disconnected-memory imprint centre housing the disconnected self. Physical manifestations (symptoms) are thus centred in the involuntary system of the body, and the disconnected-memory imprint centre is connected within the same system; it also expresses itself involuntarily. The events that caused the disconnected feelings to disconnect are called ‘chain-events’ and the disconnected feelings associated with them, link into an eventual ‘chain’ or theme. When the right activator presents itself, the energy surrounding these disconnected feelings gets activated.

5.4.5 Activators

An activator can be any internal (intrasystemic) or external (intersystemic) event and it is just a way of bringing the client in contact with an internal experience or experiences that have previously not been part of the psychobiological awareness, and therefore disconnected.

Three types of activators can be identified in SHIP®:

1. 1st order activators – where the client presents with an existing discomfort due to some recent interference;
2. 2nd order activators – these constitute the information of the life sketch and different images of the different phases of SHIP® that the facilitator initiates to activate the client;

3. Testing the limits – this is used in relation to images and/or feelings given by the client with the intent to further activate movement towards disconnected information. This is especially helpful when neutrality in feelings seem to serve as possible means of distracting from disconnected material (JOS, 2002).

5.4.6 Chain Statements

The emotional feelings that were pushed out of awareness into the disconnected self therefore group together according to these chains or themes, i.e. the feeling of “I am not good enough” or “there is nobody for me”. There can be one or many of these chains in the disconnected-memory imprint centre. In his description of SHIP®, JOS (2002) notes that chain statements verbalised by the client are the past interferences that are being projected onto the Now, indicating disconnected pain, which in turn is an indication of spontaneous healing potential. According to Schwartz (1995) this type of statement would represent an exile part in the client. Chain statements can be divided into three interlinking types:

- The repeat chain statement – this is the type of ‘here-I-go-again’ feeling, indicating a repeated pattern, for example *I’m always going to be alone, and..... there’s never going to be anyone for me.*
- The generalised chain statement – this also implies a repeated pattern but is expressed in a more generalised form, for example: *People don’t like me.* The wishful-thinking chain statement – this includes both of the above types of chain statements, but is expressed as a wish the individual believes will never be fulfilled, for example, *I wish/ if only I can also have friends and be popular.* The SHIP® facilitator should identify the chain statements in the course of what a client says and then focus the client’s attention on

the feeling/s attached to the chain statement. The feelings must be related to the client's youth and the times he/she had the same type of feeling. In this way the painful disconnected feeling can connect and heal.

5.4.7 Chronic Systemic Stress Reactions ('CSSR')

SHIP®, like the ecosystemical paradigm, steers away from making a diagnosis. Keeney (1979) observed that what is usually meant by diagnosis in the psychiatric nomenclature "is inseparable from the assumption that an individual is the site of pathology" (p.1180). The diagnostician employing the DSM-4 usually looks specifically for the pathology in the designated individual in an effort to name it. According to Combrinck-Graham (1987) using a nomenclature such as DSM-4 also organises the observations so that certain names are ruled in or ruled out according to inclusion or exclusion of critical factors. Thus, making a diagnosis is directed at the offending aspects of the individual's behaviour and may be seen as a form of name-calling. It is also an activity, which is not primarily concerned with the patient's system, but with the reporting, communicating, and decision-making system of the professional's operations on another system level. Combrinck-Graham (1987) strongly suggests that the concept of pathology, the notion that something is wrong, is inconsistent with ecosystemic thinking. Dell (1985) points out that malfunction is not intrinsic to a system but is attributed to it by the evaluation. System functioning can be characterised without judgements about what is right or healthy and what is wrong or sick. The SHIP® therapist, like the ecosystemically orientated clinician, does not feel obligated to judge or do social supervision, but rather focuses on how the system works – especially in relation to the issue that has brought the system to his or her attention.

According to JOS (2002), activators trigger psychobiological responses of discomfort and, depending on the severity of the external stress, they will cause 'chronic systemic stress reactions' that interfere with our daily routines. These reactions can differ widely in kind and intensity, and always impair the quality of our functioning in a certain area to some extent. They are signs of living chronically at the cost of parts of our spontaneous selves that have been disconnected in some way or another. As was mentioned earlier, these chronic systemic stress reactions are not regarded as psychological symptoms that need a diagnosis, but rather messengers trying to bring the client in contact with a disconnected part in him- or herself.

5.4.8 Spontaneous Healing

JOS (2002) suggests that our systems have an innate healing tendency, illustrating nature's process towards balance. The disconnected-memory imprint centre has this same quality; it leans towards balance in its effort to connect. The disconnected part in a person sends messages in the form of systemic stress reactions (symptoms). If these messages go unnoticed, stronger messages (chronic systemic stress reactions) must be sent. The moment the person comes in contact with and integrated his/her disconnected part, the symptoms lose their relevance and balance has been obtained. In SHIP®, therapy and symptoms are defined as a healing process, rather than pathology that needs diagnosis. Spontaneous healing is a process of an internal journey activated by intra- or intersystemic circumstances, and manifesting as chronic systemic stress reactions (JOS 2002).

This healing journey that the client and the therapist undertakes in SHIP® implies that the therapist is not seen as a healer but rather a facilitator of a healing process active within the client. Schwartz (1995), in his IFS model uses the client's Self in the role of the

therapist. The therapist becomes less important and the client directs his or her own therapy and internal system. In SHIP® the therapist or facilitator must trust the client's innate ability to heal. The role of the therapist is in the first place to create an atmosphere of total unconditional acceptance. The therapist will also present the activators from the client's past (obtained from the client's life history), guide the client to focus on his or her pain and in this process neutralise the distracters the client incorporates to steer away from his or her pain. Spontaneous healing can only take place in the here-and-now and requires that the client remains passive, activating yet again the involuntary processes. This is part of the role of the therapist, to promote this passivity so that healing can be allowed to run its course. Liberman (1995) argues that the natural impulse of all emotions is to move through us. It is only when we hold them within that they get stuck.

Healing can only take place through the involuntary system and the involuntary system can only make itself heard fully when control is relinquished. When painful feelings start to emerge, the client may feel exposed and therefore try to take control of these feelings by closing up in an act of distracting. When this happens, the therapist has to take the client back to the feeling experienced prior to the distraction and guide the client to remain passive so that the hurt emotions of past pain can move through the client's system. The task of the therapist is to always bring the client back to his or her healing process and to encourage the client to go into this abyss of pain. According to Cumes (1999) one should release control trusting the inner process to guide the way to healing. The therapist guides the client to the point of contact with his or her own natural healing process and keeps the client there - spontaneous healing does the rest. As in the IFS model of Schwartz (1995) progress in SHIP® occurs respectfully and at a pace at which all parts agree.

JOS (2002) states that the moment you make people feel good by means of an external source, you have distracted them from the spontaneous internal healing process. Facilitate the internal healing or the connectedness, and the outside balance will follow suit. The process of SHIP® can be illustrated as follows: (Figure 5.6).

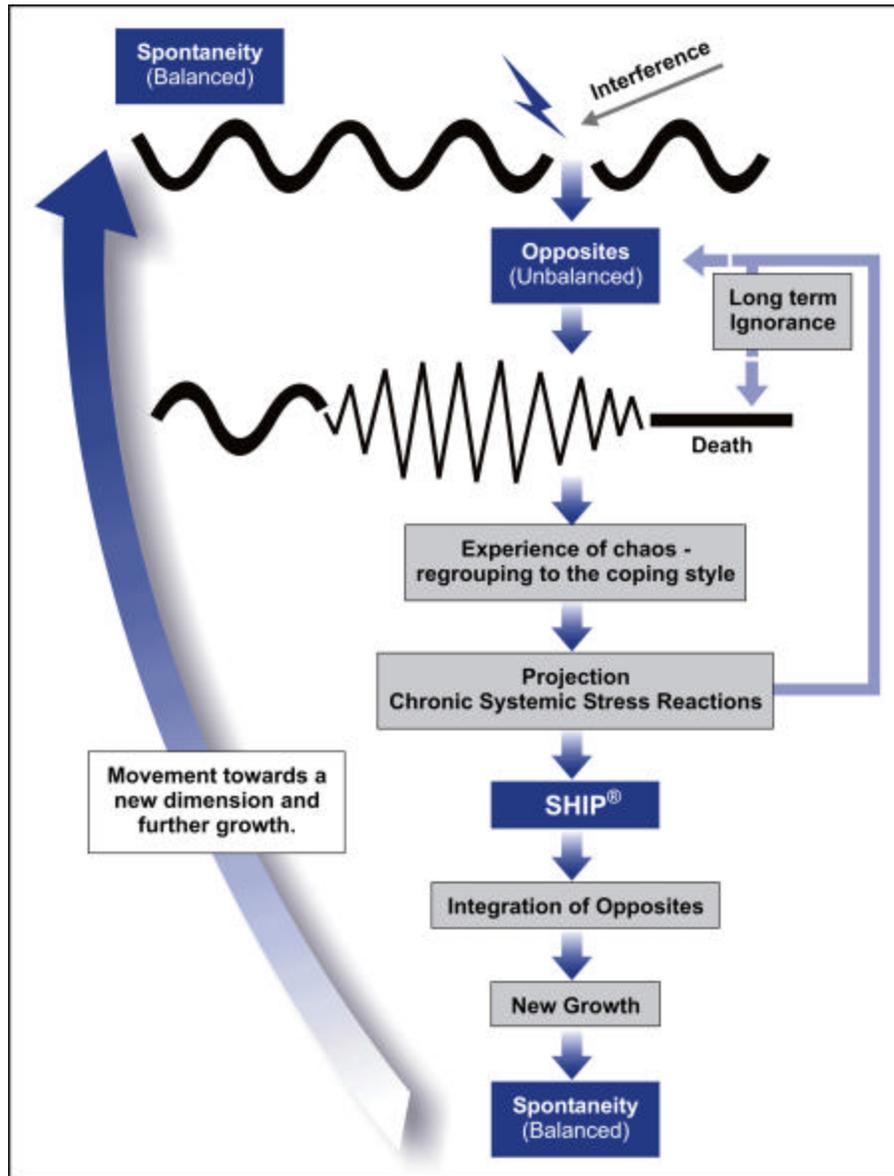


Figure 5.6. The effect of SHIP® on the results of interference and the outcome of long-term ignorance of the chronic systemic stress reaction (JOS, 2002, p.97).

5.4.9 Process

According to JOS (2002), in SHIP®, “process” refers to the granting of identity to every part or the journey towards health. Process is change, always in motion, expanding and contracting and located in the Now. All people are in process, and in the constant motion there is continual exposure, and nothing is regarded as fixed, or encapsulated. In SHIP® everything the client says is considered relevant and revealing. To illuminate this: if a client gets ‘stuck’, then being stuck is experienced as part of healing and is not viewed as something the psychotherapist must find a path around. Denying that which is presented causes the system to retaliate. There is never a ‘good’ or a ‘bad’ session in SHIP®, there is only the process.

5.4.10 The Different Phases of SHIP®

The different phases of SHIP® can be explained graphically by a frame in the form of a funnel comprising 5 phases. The following Figure illustrates it:

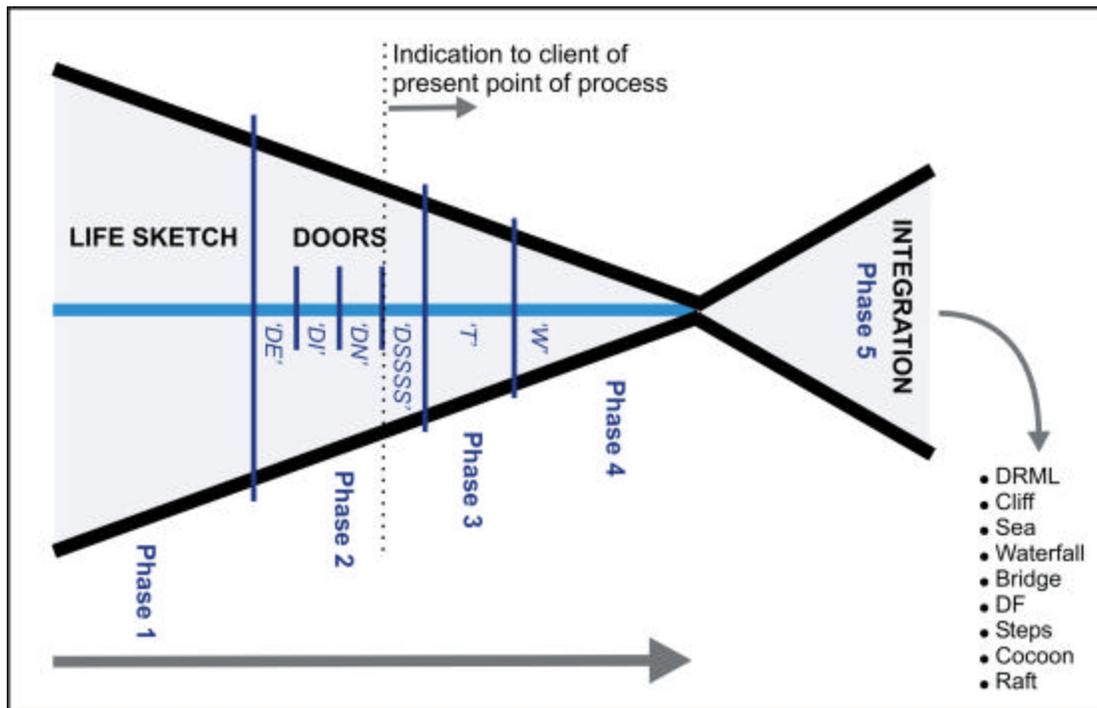


Figure 5.7. The Frame of SHIP® (JOS, 2002, p.205).

JOS (2002) describes the phases of SHIP® as follows:

Phase 1: The history of the client.

During the first interview, after the client discussed the reason for the consultation, the rationale of SHIP® is explained. Once the client commits to SHIP®, he or she is asked to write a life sketch on everything they can remember as having been distressing or unpleasant. The writing needs to cover all stages, from pre-school till present. This might bring already forgotten memories to the surface. It also presents the therapist with valuable data concerning potential chains. It very often also gives the client a sense of relief at the fact that something was written down that was never told to anyone before.

At the follow-up session the client is initiated into what to expect in the first SHIP® session. The client is requested to lie on the bed with his/her eyes closed and their arms next to their body or comfortably on their chest. The reason for the bed is to allow for

passivity. Sometimes they have the need to cover themselves with a blanket. The instructions are conveyed in the following way:

You may experience smells and sounds. You may also experience a range of emotions, like anger, sadness, guilt, frustration, irritation, or the like. You may experience different physical sensations in your body. Everything you experience is relevant and useful, so don't be alarmed by what you may experience. You might not experience everything I have described; these are just examples. The point is that it is OK to experience whatever arises; you should feel it and follow the process as it unfolds. SHIP® is not a form of hypnosis and throughout the experience you will be fully awake.

There are three important things to take notice of:

- 1) I will tell you what to do as we progress, so don't worry about that.
- 2) You must tell me everything that you experience, however trivial or difficult.
- 3) Don't do anything with your experience. For example, if you feel claustrophobic and you want to take a deep breath, express the desire but don't actually do it. Tell me about any physical need you feel compelled to act on, but stay passive. Passivity allows disconnected material to come into the Now. I'll remind you throughout this process not to do anything with your feelings, but to experience what the feelings are doing to you. I will guide you through the process (JOS, 2002, p211).

This is a new experience for the client and in the first session the effects of this unfamiliar situation is focused on. When the client expresses discomfort, he/she is requested to stay with the discomfort and inform the therapist whether the discomfort increases in intensity

(an indication of a chain with a definite interference from the past); whether it fades away (at which point an activator will be given); or whether the feeling simply remains constant (in which case the client should experience it as it is). Sometimes the initial activation can follow into a deep wound that culminates in spending the remainder of the session on that particular issue. The important thing is to follow the process as it unfolds.

Phase 2: The Doors.

During this phase, doors are used as activators and projected avenues into the disconnected-memory imprint centre (DMIC). There are four different doors in this phase. JOS (2002) describes them as follows:

- 1) A door with the word **Emotion** on it – allows for contact with projections related to emotions from which the client has disconnected.
- 2) A door with the word **Identity** on it – once emotions have been disconnected, there is a natural tendency in the system to search for those parts of the self that have been denied identity.
- 3) A door with **Your Name** on it – this projects an overall connectedness with the self, of how the client projects him or herself.
- 4) A door with the words **My Soft Sensitive Spontaneous Self** on it – the conditional acceptance and chronic feelings of helplessness during childhood caused a disconnection from this part. The words on the door create an opportunity to venture into the sacred area called the spontaneous self.
- 5) Any other name can be used on the door, depending on where the client is.

With all images, the client should “feel” each image as it expresses itself. The client is asked to go through the door once a neutral feeling is experienced in front of the door. Once on the other side, the client should describe the total image as it unfolds, as well as the feelings activated by the image. After this the client must walk towards the middle of the scene, and sit down in the middle of it with closed eyes so as to neutralise any form of control. The client is then asked to focus on the word on the door and to experience the effect if other people enter that area of the self (external projections originate internally). Next the focus should be on people entering the personal space of the client, since this implies exposure, which in turn takes the client back to the vulnerability of the initial imprints of not being good enough, isolated and helpless. Once this procedure culminates in a neutral feeling spontaneous healing has taken place and further exploration of the image, associations with the present and past occurrences/interactions, should be opened up. As long as the interference projected into the image is felt completely while the client remains totally passive, save for verbalising the process, the image will rectify itself (spontaneous healing) and the client can then experience it positively, for example, a dark, uncomfortable room will change into a peaceful, illuminated space.

Phase 3: The Tunnel.

The Tunnel signifies a journey towards life. It is the archetypal symbol of the birth canal, of travelling from one dimension to the next. During this phase the client is asked to visualise a naturally formed tunnel. All uncomfortable feelings are allowed to connect before the client is asked to move into the tunnel. Once again the client must describe everything seen and felt. Once in the centre of the tunnel, the client must sit down with eyes closed, and experience all potential discomforts. The following activators are given and allowed to connect until neutrality is reached:

isolation;
experiencing the tunnel as if it were the birth canal;
emotions within the self that block the spontaneous self from moving forward;
all other activators that had substantial psychobiological effects on the client during the previous phases of SHIP®.

The client is then asked to get up and walk toward the other side. Once on the outside, general feelings are verbalised and experienced.

Phase 4: The Well.

The well represents the prenatal/foetal phase, of being in the mother's womb.

According to Nortrup (1999), babies know what is going on in utero and can hear, feel and experience emotions long before they are born. If the mother is detached or emotionally distant, the baby will sense it. During this phase the client is asked to visualise a well and once this image has been verbalised, the next step is to look down into the well and describe the image and the feelings that are activated. The client is asked to imagine that he/she is floating down into the well. The journey must be described. The client is then asked to sit down at the bottom with his or her eyes closed and to experience the image fully. Should the water be above the client's head, he/she is assured that they can breathe under the water. Once all experiences have been felt, the following activators are presented to the client while he/she remains seated at the bottom of the well: prenatal phase – as if being in the womb and being surrounded by the mother; the therapist asks the client if he/she experiences the mother as near or far; all other activators that caused intense psychobiological discomfort when presented initially in the previous phases.

Phase 5: Integration.

This phase is an integration of the four previous phases. The images selected deal with closure and with testing of issues that might still be undone and disconnected. There are a few images that are used during this phase.

- **Door with inscription ‘the road of my life:** Clients are asked to visualise a door with the above inscription, and all the usual feelings are allowed until neutrality is achieved. Again the client proceeds to the other side of the door, and must experience everything along the way. The client is then asked to look back to the past, at the road they have travelled on and to focus on the concept of ‘emotions within myself concerning the past that might still inhibit me from being spontaneous’. Once these feelings have been experienced, the attention is drawn to the road ahead and a similar instruction is given – ‘emotions within myself that still inhibit me from continuing into the future spontaneously’.

The following images also deal with relinquishing control:

- **Cliff:** The client is asked to visualise him- or herself standing at the edge of a cliff, looking straight down and to describe all sensations. Once neutrality is reached (the result of spontaneous healing) the client is asked to fall forward, letting go completely.
- **Sea:** The client is asked to experience him- or herself descending in the middle of the sea, where he or she is able to breathe naturally. He or she must describe the journey and all that is experienced. Once on the seabed, he or she must sit down with eyes closed and must then experience being at the mercy of the sea.
- **Waterfall:** The client is told that he or she can breathe under water and that they are floating down a river towards

a waterfall. The complete journey should be verbalised and the facilitator must continually, as with the other images, ensure that the client does not take control. When the waterfall is reached, all forms of control should be neutralised until the client can pass through the waterfall with ease. Usually clients describe a deep tranquil pool awaiting them on the other side.

- **Bridge:** The client is asked to visualise a bridge and to describe it. Once the image is given, the client is asked to move to the centre and to look straight down. The client then has to sit in the middle of the bridge with eyes closed (relinquishing control) and once a neutral feeling is reached, the client must look back to the side of the bridge where he or she started out at and then view this part symbolically as the past. The client is then asked to focus on 'emotions within myself that might still hold me back'. Afterwards the client is asked to focus on the side towards which he or she is journeying, which symbolises the future. Again he or she must focus on emotions within him or her that might still inhibit movement into the future. The client is then asked to get up and walk to the other side, describing all images and feelings on the way.
- **Door with inscription 'Freedom':** Freedom means to be in full contact with the self. As with the images of the other doors, the client is asked to work with this image and to connect with all the feelings that arise.
- **Stairs leading down with an inscription at the top: 'My disconnected self':** In order to check for any residual disconnected information in the disconnected-memory imprint centre, the client is asked to go down the stairs and to enter the space, representing that part of the self.

- **Cocoon:** The cocoon is the archetypal silkworm projection, where metamorphosis has taken place. The client in SHIP® has gone through transformation changes from being disconnected with areas in the self, to being connected and open to a new definition. The client is asked to experience the self in the cocoon, and all feelings are felt until neutrality is achieved. The client is then asked to describe all the feelings experienced as he or she emerges from the cocoon.
- **Raft:** At this point, the client has opened the self to the world, and can begin exploring and utilising the released energy. The client is asked to see him or herself on a raft in the middle of the sea, and to describe the journey and the physical as well as emotional feelings that arise, without taking control.

Once this image has been completed and there are no recurring chronic systemic stress reactions, the images used during SHIP® are interpreted to the client and SHIP® is terminated. The Structural Approach, Theraplay and SHIP® show that the therapist can be grounded in theory and yet be creative in technique.

5.5 CONCLUSION

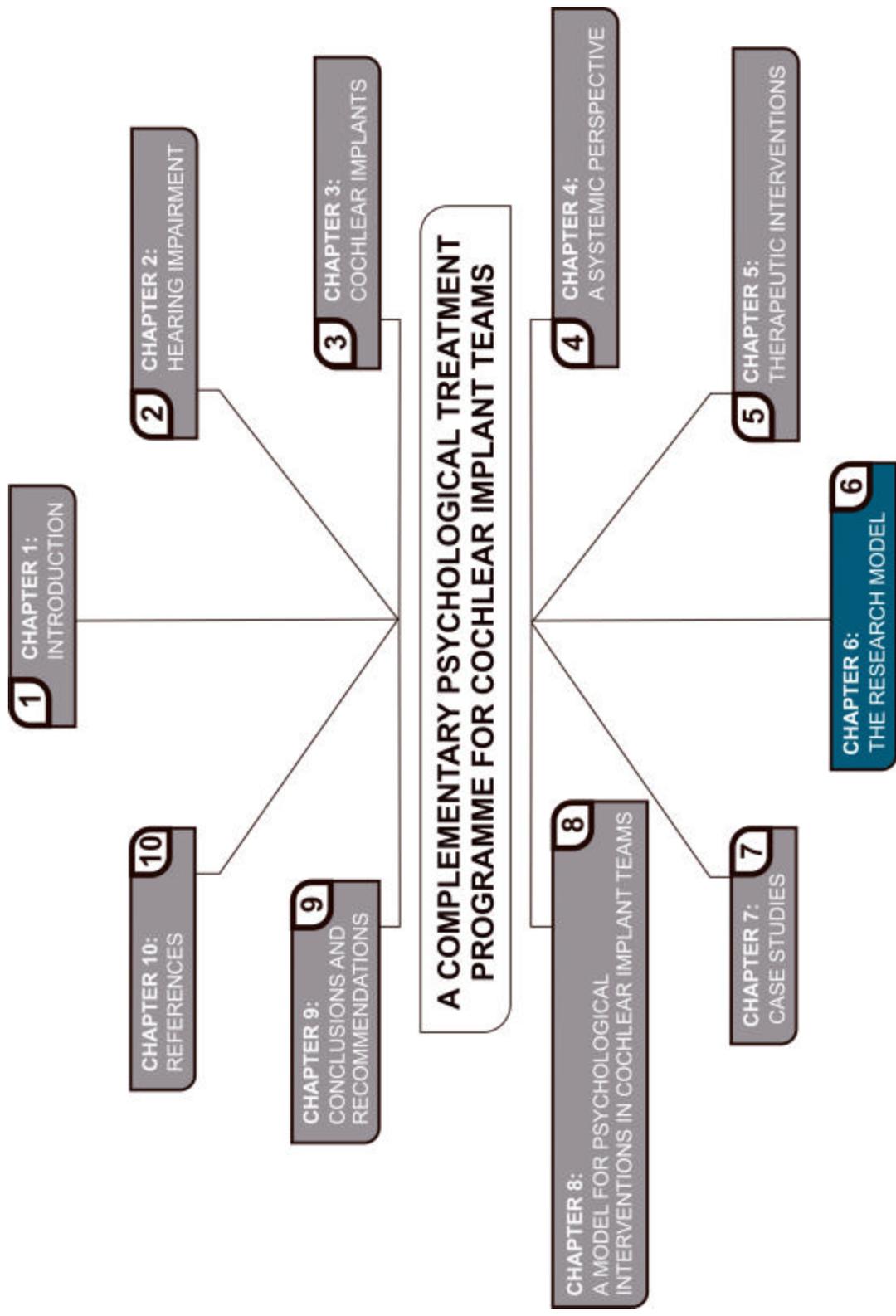
Nowhere in the literature is there any indication that the Structural Family Therapy, Theraplay and SHIP® have been implemented for the patient with a cochlear implant. The writer, through this study, will contribute by applying these methods for the cochlear implantee.

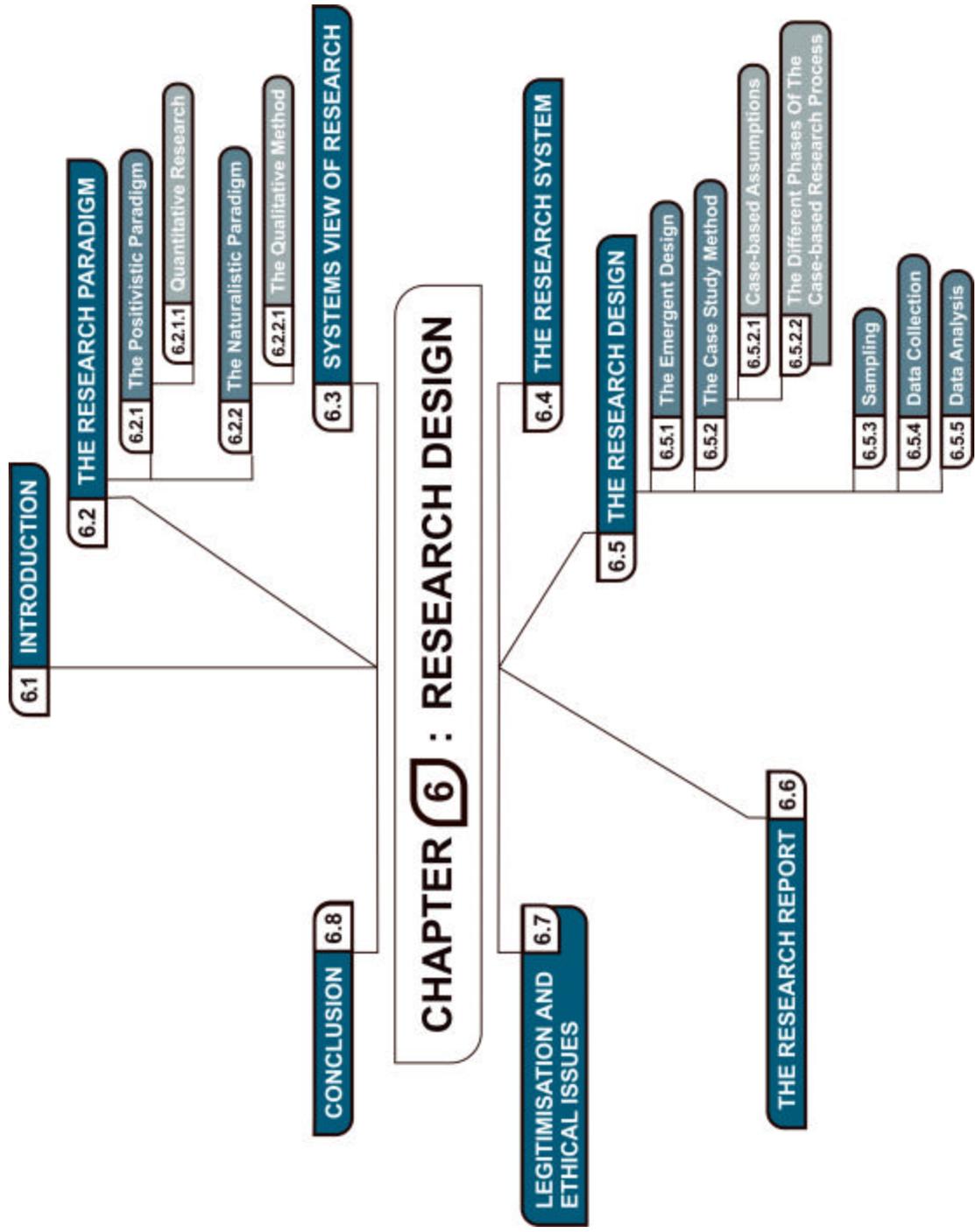
Case studies will be presented to indicate the different processes and where the necessary adaptations have been made. It is the writer's experience in working as part of the cochlear implant team, that the cochlear implant will not necessarily solve all the client's

problems. It is sometimes only after the implant that the hearing-impaired person becomes aware of that “something wrong” feeling.

Through the use of Structural Family Therapy, Theraplay and SHIP® this study aims to initiate these integrative approaches for the cochlear implantee.

The next chapter will describe and motivate the research model used in this study.





CHAPTER 6

RESEARCH DESIGN

6.1 INTRODUCTION

Research in the caring professions adds value to the field in different ways. De Vos (1998) summarises a few of these benefits in practice:

- Research provides a framework for practice activities. Although psychological work can be seen as an art, practitioners should make use of a scientific orientation in seeking to obtain the best outcomes possible.
- Research helps build knowledge for practice. It can generate and refine concepts, determine the evidence for generalisations and theories, and ascertain the effectiveness of practice methods. Research serves the practical function of providing situation-specific data to inform action, such as decisions about practice.

The direction of the research process and the research method is determined by the choice of the researcher between a quantitative or qualitative, or combined quantitative-qualitative approach. This chapter will explore the chosen qualitative approach. An explanation of this paradigm and method will be provided as well as an explanation of the research design. A legitimisation of the qualitative research will be provided in order to illustrate how this research will remain ethical and valid.

6.2 THE RESEARCH PARADIGM

Most dictionaries define the word “paradigm” merely as “an example or pattern”. In the human sciences this term finds its origin in

Thomas Kuhn's (1970) *"The structure of scientific revolutions"*. Kuhn uses this word with reference to the nature, growth and development of the sciences. Kuhn calls a 'paradigm' the model or pattern according to which a scientist views his/her objects of research within the particular discipline. Lincoln and Guba (1985) describe 'paradigm' as a systematic set of beliefs together with their accompanying methods. 'Paradigms' represent a distillation of what we think about the world (but cannot prove). Our actions in the world, including actions that we take as inquirers, cannot occur without reference to those paradigms: "As we think, so do we act."

Research paradigms influence the methods of research that are employed in any research and are seen both to enable and to constrain researchers by making research action possible (Lincoln & Guba, 1985).

Research can be done from a positivist or from a naturalistic paradigm. These two paradigms and their respective methods of inquiry will be discussed separately.

6.2.1 The Positivist Paradigm

Positivism departs from the assumption that the methods and basic assumptions of the Newtonian science are also applicable to the study of man (Riegel, 1973). Positivism is based on an early nineteenth-century philosophical school of thought founded by the father of sociology, Auguste Comte (1798-1857).

Positivism is associated with many specific social theories. It is best known for its linkage to the structural functional and exchange theory frameworks. Positivist researchers are likely to do quantitative social research and to use experiments, surveys, and statistics. They favour "objective" research, attempt to measure precisely things

about people, and test hypotheses by carefully analysing numbers from the measures (Neuman, 1994).

Critics say that positivism reduces people to numbers. Its concern with abstract laws and formulas is not relevant to the actual lives of real people. Positivism assumes that human behaviour is caused by social forces external to a person, and that the concept of 'free will' is largely a fiction and only describes aspects of human behaviour that science has not yet conquered. According to Neuman (1994), positivism defines social science as "an organized method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity" (p.58).

There are certain serious challenges to and critiques of positivism. Lincoln and Guba (1985) summarised these as follows:

- 1) Positivism leads to an inadequate conceptualisation of what science is. Positivism confuses two aspects of inquiry that have been called the "context of discovery" and the "context of justification" (p.25). The former deals with the genesis or origin of scientific theories and the latter with testing them. Positivism excludes the former and focuses on the latter. The process of theory conceptualisation is seen as non-cognitive or non-rational and hence not scientific. Verification has taken precedence over discovery.
- 2) Positivism is unable to deal adequately with two crucial and interacting aspects of the theory-fact relationship. These are:
 - The underdetermination of theory, sometimes also called the problem of induction. In deduction, given the validity of the premises, the conclusion must be true and it is the only

conclusion possible. In induction there are always many conclusions that can reasonably be related to certain premises. Deductions are closed but inductions are open.

- The theory-ladenness of facts – the apparent impossibility of having facts that are not themselves theory-determined.
- 3) Positivism is overly dependent on operationalism, which has itself been increasingly judged to be inadequate. Operationalism results in a meaningless splintering of the world. Nothing exists for the operationalist except through the instruments that measured it.
 - 4) Positivism has at least two consequences that are both hideous and unfounded:
 - Determinism is hideous because of its implications for human free will and unfounded because of recent findings in many fields that argue against it.
 - Reductionism is hideous because it would make all phenomena including human phenomena ultimately subject to a single set of laws, and it is unfounded because of recent findings in many fields.
 - 5) Positivism produced research with human respondents that ignore their humanness, a fact that has not only ethical but also validity implications.
 - 6) Positivism falls short of being able to deal with emergent conceptual/empirical formulations from a variety of fields.
 - 7) Positivism rests upon at least five assumptions that are increasingly difficult to maintain:

- An ontological assumption of a single, tangible reality “out there” that can be broken apart into pieces capable of being studied independently; the whole is simply the sum of the parts.
- An epistemological assumption about the possibility of separation of the observer from the observed.
- An assumption of the temporal and contextual independence of observations.
- An assumption of linear causality: there are no effects without causes and no causes without effects.
- An assumption of value freedom, that is that the methodology guarantees that the results of an inquiry are essentially free from the influence of any value system. However, this in itself embodies a particular value system.

The method of inquiry that is mostly used in positivism, is quantitative research and this will be discussed in the next section.

6.2.1.1 Quantitative research.

The main aims of quantitative research are to measure the social world objectively, to test hypotheses and to predict and control human behaviour (De Vos, 1998). The quantitative paradigm is based on positivism that takes scientific explanation to be nomothetic (i.e. based on universal laws). In contrast, the qualitative paradigm, which will be discussed later in this chapter, stems from an antipositivistic, interpretative approach, is idiographic, thus holistic in nature, and the main aim is to understand life and the meaning that people attach to it (Lincoln & Guba, 1985).

De Vos (1998) describes the following qualities of quantitative research in relation to qualitative research:

- In terms of ontology, the quantitative researcher believes in an objective reality that can be explained, controlled and predicted by means of natural (cause-effect) laws. Human behaviour can be explained in causal deterministic ways and people can be manipulated and controlled. In contrast, qualitative researchers discard the notion of an external, objective reality. They aim to understand reality by discovering the meanings that people in a specific setting attach to it. To them behaviour is intentional and creative, and it can be explained but not predicted.
- In terms of epistemology, the quantitative researcher sees him/herself as detached from, not as part of, the object that he/she studies. The researcher can therefore be objective – he/she does not influence the study object and is not influenced by it. In contrast, the qualitative researcher is subjective because he/she interacts with the subject (object of investigation).
- In terms of methodology the quantitative paradigm emulates the physical sciences in that questions or hypotheses are stated and subjected to empirical testing to verify them.
- According to Edwards (1998), quantitative multivariate methods have the advantage of allowing researchers to measure and control variables, but they have the disadvantage that the resulting theory often fails to take account of the unique characteristics of individual cases. In clinical psychology, it has long been recognised that the group-based research process failed to contribute the kind of knowledge base that is of direct application to much of clinical practice. In 1981, in a special issue of the *Journal of*

Consulting and Clinical Psychology, this concern was addressed (Barlow, 1981; Hayes, 1981; Kiesler, 1981; Strupp, 1981).

Research conducted within a positivist paradigm would include a hypothesis, which would then be researched in a specific manner to arrive at a stable and predictable truth. The research then aims to prove this hypothesis, preferably by using a large sample of participants who would provide quantifiable data that would be generalised to the wider population (Kagan, 2002). The naturalistic paradigm on the other hand, offers a different way of looking at research and this will be outlined in the next section.

6.2.2 The Naturalistic Paradigm

The following points are, according to Lincoln and Guba (1985), crucial to an understanding of the naturalistic paradigm and the ways in which it differs, contrasts, and even conflicts with the positivist paradigm.

- 1) The nature of the reality: There are multiple constructed realities that can be studied only holistically.
- 2) The relationship of knower to known (epistemology): The inquirer and the “object” of inquiry interact to influence one another; knower and known are inseparable.
- 3) The possibility of generalisation: The aim of inquiry is to develop an idiographic body of knowledge in the form of “working hypotheses” that describe the individual case.
- 4) The possibility of causal linkages: All entities are in a state of mutual simultaneous shaping so that it is impossible to distinguish causes from effects.

- 5) The role of values in inquiry: Inquiry is value-bound in at least five ways:
- Inquiries are influenced by inquirer values as expressed in the choice of a problem and framing.
 - Inquiry is influenced by the choice of the paradigm that guides the investigation into the problem.
 - Inquiry is influenced by the choice of the substantive theory utilised to guide the collection and analysis of data and in the interpretation of findings.
 - Inquiry is influenced by the values that inhere in the context.
 - Inquiry is either value-resonant (reinforcing or congruent) or value-dissonant (conflicting).

Following the naturalistic paradigm in research has enormous implications for the doing of research. Lincoln and Guba (1985) describe 14 characteristics of operational naturalistic inquiry. These are summarised as follows:

- 1) Research is carried out in the **natural setting** or context of the entity for which the study is proposed because naturalistic ontology suggests that realities are wholes that cannot be understood in isolation from their contexts, nor can they be fragmented for separate study of the parts (the whole is more than the sum of the parts).
- 2) The researcher uses him- or herself as well as other **humans** as the primary data-gathering **instruments**. This means that the researcher plays a fundamental role in eliciting and determining multiple meanings that emerge in a collaborative process of interaction (Kagan, 2002).

- 3) The naturalistic paradigm respects the **intuitive knowledge** of the researcher because often the nuances of the multiple realities can be appreciated only in this way.
- 4) **Qualitative methods** are chosen over quantitative methods (although not exclusively) because they are more adaptable to dealing with multiple realities. The qualitative method will be discussed in more detail shortly.
- 5) **Purposive sampling** instead of random or representative sampling is included because in this way the scope or range of data exposed is increased.
- 6) **Inductive data analysis** is preferred as the process is more likely to identify the multiple realities to be found in those data. Inductive data analysis is more likely to identify the mutually shaping influences that interact.
- 7) The naturalistic paradigm prefers to build a theory step by step based on well-substantiated observations. The theory emerges from the data rather than the data confirming already produced theories. This is **called grounded theory**. According to Strauss and Corbin (1990), a grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore data collection, analysis, and theory stand in reciprocal relationship with each other.
- 8) In the naturalistic paradigm, the **research design emerges** during the research process, what emerges is a function of the interaction between inquirer and phenomenon and is therefore unpredictable in advance.

- 9) The naturalistic paradigm prefers to **negotiate meanings and interpretations** with the human sources from which the data have chiefly been drawn, as it is their constructions of reality that the inquirer seeks to reconstruct.
- 10) The naturalistic paradigm is likely to prefer the **case study reporting mode** as this mode is more adapted to a description of the multiple realities encountered at any given site.
- 11) Data is **interpreted idiographically** (in terms of particulars of the case) rather than nomothetically (in terms of law-like generalisations) because different interpretations are likely to be meaningful for different realities.
- 12) The naturalist is **tentative** about making broad application of the findings because realities are multiple and different.
- 13) **Boundaries** are set to the inquiry on the basis of the emergent **focus**.
- 14) **Special criteria for trustworthiness** are incorporated.

Qualitative research methods are preferred, although not exclusively, by the naturalistic paradigm. The above reasons indicate to the more appropriateness of the qualitative method for this research. In the following section the qualitative method will be outlined.

6.2.2.1 The qualitative method.

Qualitative methods are stressed within the naturalistic paradigm not because the paradigm is antiquantitative but because qualitative methods come more easily to the human as instrument (Lincoln & Guba, 1985). There are many opportunities for the naturalistic

investigator to utilise quantitative data but the qualitative methods come more easily to hand as they are mere extensions of normal human activities: looking, listening, speaking, reading, etc.

The qualitative research paradigm, in its broadest sense, refers to research that elicits participant accounts of meaning, experience or perceptions. It also produces descriptive data in the participants' own written or spoken words. It thus involves identifying the participant's beliefs and values that underlie the phenomena. Like the quantitative paradigm, the qualitative paradigm is more than a set of data-gathering methods. It is a way of approaching the empirical world (Taylor & Bogdan, 1984). The qualitative researcher is concerned with:

- understanding rather than explanation;
- naturalistic observation rather than controlled measurement;
- the subjective exploration of reality from the perspective of an insider as opposed to the outsider perspective that is predominant in the quantitative paradigm (De Vos, 1998).

The qualitative researcher is on a voyage of discovery rather than one of verification, so that his or her research is likely to stimulate new leads and avenues of research that the quantitative researcher is unlikely to hit upon, but may be used as a basis for further research. The word 'qualitative' implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency" (Denzin & Lincoln, 2000, p.8).

The similarities between the qualitative researcher's aspirations and the naturalistic paradigm become evident in this regard. The work that qualitative research requires is time-consuming and often

difficult but it gives the researcher a way to bridge the gap between the abstraction of theory and the reality of everyday life. It is both liberating (in that it provides new perspectives from which to view human activity) and conserving (in that it gives insight into ultimate necessity of order and triviality).

Qualitative research offers a perspective from which to view the world; it is one mode of experience among many open to us. It is not a privileged mode, and it certainly does not provide ultimate truth or a picture of the whole experience. Every experience leaves things out in an effort to make experience coherent. In this way the researcher becomes constructors of knowledge as well as consumers (LeCompte, Millroy & Preissle, 1992).

Qualitative research moves us back to contemplation about the nature of human experience, the origins of human knowing and what it means to be human.

Neuman (1994, p.317) summarises the differences between quantitative and qualitative research in the following table:

QUANTITATIVE	2.1. QUALITATIVE
<ul style="list-style-type: none"> • Test hypothesis that the researcher begins with. • Concepts are in the form of distinct variables. • Measures are systematically created before data collection and are standardised. • Data are in the form of numbers from precise measurement. • Theory is largely causal and is deductive. • Procedures are standard, and replication is assumed. • Analysis proceeds by using statistics, tables, or charts and discussing how what they show relates to hypotheses. 	<ul style="list-style-type: none"> • Capture and discover meaning once the researcher becomes immersed in the data. • Concepts are in the form of themes, motifs, generalisations, taxonomies. • Measures are created in an ad hoc manner and are often specific to the individual setting or researcher. • Data are in the form of words from documents. • Theory can be causal or non-causal and is often inductive. • Research procedures are particular, and replication is very rare. • Analysis proceeds by extracting themes or generalisations from evidence and organising data to present a coherent, consistent picture.

Differences between Qualitative and Quantitative Research

(Neuman, 1994, p.317).

As this study makes use of the systemic point of view in its research, it is therefore necessary to note the systems view of research and the central concerns of systemic research.

6.3 SYSTEMS VIEW OF RESEARCH

The systemic perspective describes the meaning and validity of research in the tradition of logical positivism as inconsistent with systems thinking on many counts. Particular areas of concern include the following (Becvar & Becvar, 1996):

- It is more appropriate to speak of many viewpoints than of a single objective reality as implied in positivism;
- If it is necessary to speak of causes, it is also necessary to refer to the multiple causes that can be discerned relative to the frame of reference used in making observations;
- Rather than focusing on subunits, the whole system, or the larger context must be the unit of analysis;
- The concept of independent variables influencing and affecting dependant variables describes a linear notion of causality;
- The traditional research models offer little help in understanding the complexities of human systems.

The systemic perspective concurs with the principles of qualitative research within the naturalistic paradigm, for example:

- Subjects/clients should participate in inventing their own explanations and experiences of themselves and their relationships (Becvar & Becvar, 1996). Systemic research is thus reflexive where the process of knowing is embedded in a reflexive loop that includes the researcher as a participant in the interactional flow and construction of the research data (Steier, 1991).
- The observer and observed influence each other, and the activity of scientific study changes what is being studied (Becvar & Becvar, 1996).

- People are seen to construct their world through language and shared meanings. How a participant attributes meaning to the research context needs to be taken into account as this influences the outcome of the research (Fourie, 1998).
- A technique cannot cause change in a linear way regardless of the context, but rather a technique should be seen as one possible way to perturb the existing debilitating ecology of ideas in the specific situation (Fourie, 1996).
- Systemic research does not aim to prove law-like connections like in Newtonian thinking (Fourie, 1998). The research outcome is an interpretation rather than a reified fact about a phenomenon (Kagan, 2002).

The naturalistic paradigm and qualitative research methods are deemed suitable and fitting with systemic research and contextual issues. Multiple realities, holism, recursion and complexity are emphasised (Kagan, 2002). The aim of this study is to explore human experience. The naturalistic paradigm with the qualitative research are, as shown in the literature, best suited for this study and is also consistent with the systemic view of research.

6.4 THE RESEARCH SYSTEM

According to Kagan (2002) the involvement of all the participants in the research forms the research system. Everyone is a knower whose ideas deserve to be heard, thereby making it possible to learn from each other. The research ritual can be seen as a collaborative effort that influences the creation of data and the co-construction of a final product. As described earlier, the researcher and the client/s are the primary instruments of measurement in the process of qualitative research. They are all observers. The interaction between all the research participants is regarded as reflexive and circular. The research context becomes an observing system and one in which all observers' presence and influence on the emerging conversation

must be acknowledged (Kagan, 2002). In a very real sense, then, investigator and respondent(s) together create the data of the research. Each influences the other and of course the data of research is also influenced by the values of both the investigator and the respondent(s). The nature and quality of the interaction determines the negotiated and co-created meanings that emerge within the discovery process, or on the other hand, that which does not emerge (Kagan, 2002). The interaction and interventions do not imply that each participant will leave with the same knowledge, but possibly each will have learnt something from the other. This implies that the researcher too must be prepared to shift his or her own viewpoints (Kagan, 2002).

Evans (1998), in her research done with a deaf child, found the process of qualitative research inquiry an enriching experience, in her own words:

Qualitative methodology placed demands on me for different kinds of thinking and conceptualising, and in the process, led me to a rich and powerful array of information and insights that I may not otherwise have considered exploring. Engaging in qualitative methods of inquiry has made me aware of the value and rewards of becoming a more flexible and fluent thinker. I have begun to look around corners. (p. 25)

6.5 THE RESEARCH DESIGN

The research design in qualitative research is the part of a study which describes the flexible guidelines that connect the theory to the strategies of inquiry and to the methods of data collection and analysis (Denzin & Lincoln, 2000). In this section the research procedures that are applicable to this study will be described. This will include the method of inquiry; the sampling procedure; the data

collection, and the data analysis. This description is not set, nor is it the only means through which to investigate this research topic.

6.5.1 The Emergent Design

In the emergent design the research procedures unfold as the research ritual continues. A summary of the reasons why in the naturalistic paradigm the designs must emerge, can be found in Lincoln and Guba (1985) and can be described as follows:

- meaning is largely determined by context;
- the existence of multiple realities constrains the development of a design based on only one (the investigator's) construction;
- what will be learned at sight is always dependent on the interaction between investigator and context and the interaction is also not fully predictable. Evans (1998) notes that the qualitative researcher must learn to expect the unexpected;
- the nature of mutual shaping cannot be known until they are witnessed.

The above implies that a researcher has the freedom to interact with the research system in a way that allows for unique outcomes, rather than to be restricted by preordained prescriptions (Lincoln & Guba, 1985).

A researcher does not begin a study empty-handed. Prior knowledge obtained through readings will influence the course of the research. However, as the inquiry proceeds, the researcher will become more aware of the specific features that are particular to the cases he/she is exploring, which will further shape the research design (Lincoln & Guba, 1985).

The case study method is a preferred mode of naturalistic inquiry as will be evident from the following description:

6.5.2 The Case Study Method

Case-based studies are widely used in case study methodology as well as in a number of qualitative methodologies, including grounded theory development, phenomenological research method, and psychotherapy process research. The epistemological principles on which case-based research is based are fundamentally different from the principles on which positivistic research using quantitative multivariate statistics are based. In case-based research one or more cases of a phenomenon of interest are systematically examined with a view to achieving an understanding and developing or extending a theoretical framework. A case study is a case-based research project that examines a single case, usually in considerable depth. In a multiple case study, a series of cases are examined. However, the case-based approach is not limited to research that formally bears the title of “case study”. Many qualitative research approaches use case-based strategies.

Case studies have played a pivotal role in the evolution of humanistic and transpersonal clinical methods. Edward (1998) mentions the work of Robert White, *Lives in Progress* (1972), as a classic collection of pioneering and compelling psychological case studies in the personological tradition of Henry Murray and Gordon Allport. Carl Rogers (1942) published his first case study to promulgate a “person-centered” approach to therapy in contrast to the prevailing behavioural and psychoanalytic alternatives. His case of Herbert Bryan was particularly notable for incorporating an actual transcript from the session to illustrate the unique aspects of this approach. Rollo May’s (1972) case of Mercedes, a black woman of low socioeconomic status, established the applicability of a humanistic-existential approach to a broader range of clientele than

that addressed by psychoanalysis. Ever since Kraepelin's (1883) work, and even before, the process of developing a system of diagnostic categories has drawn extensively on case studies. The impact that case studies continue to have in this area is illustrated by the recent development and acceptance of the new diagnostic category of "religious or spiritual problem" (American Psychiatric Association, 1994, in Edwards, 1998, p. 39).

Historically, case-based research has always had a place in psychology (Bolgar, 1965). However, recognition of its value was increasingly lost as enthusiasm grew for the development of quantitative methodologies. In most social sciences, it came to be completely discredited, and it survived mainly in anthropology and psychoanalysis (Mitchell, 1983). Over the past three decades, there have been many independent moves to correct the balance and to legitimate case-based research models. Edwards (1998) suggests that the following aspects contributed:

- The recognition that many of the methods of clinical practice constitute a systematic, if informal, research method. The clinician is usually motivated to answer a specific question, analogous to a research question, and gathers data in a systematic manner that is designed to provide an answer to the question. This means that the principles by which conclusions are drawn from clinical assessments are of relevance when examining how conclusions are drawn from case studies in general.
- The development of single-case experimental designs, another has been the emergence of case-based qualitative research methodologies, and in particular, phenomenological research method, discovery-orientated psychotherapy research, grounded theory building, cooperative experiential enquiry or new paradigm research,

psychotherapy process research, action research and case study research.

6.5.2.1 *Case-based assumptions.*

Edwards (1998) mentions the following assumptions concerning case-based research:

1. The ultimate task of science is not to map human behaviour and experience on a vast matrix of variables from which predictions can be derived. Factor analysis models, for example, are based on the untested assumption that human behavior and experience can be modeled as a set of discrete variables that are mutually determined in a predictable way (Polkinghorne, 1986). As a result, the mathematical models on which factor analyses are based bear only a limited relationship to real psychological and interpersonal processes.
2. It follows, therefore, that although quantification may at times have a place in research, it can not be an end in itself. Individuals are not merely sources of scores from which the means and variances of population distributions of the slopes of regression lines can be estimated.
3. The quality of our science depends on the quality of our data. The limited value of factor analytic personality models is partly due to the fact that the database is quite impoverished compared to the in-depth case material that forms the foundation of case-based theories. Edwards (1998) quotes Josselson and Lieblich (1993) as follows: "Listening to people talk in their own terms about what had been significant in their lives seemed to us far more

valuable than studying preconceived psychometric scales or contrived experiments” (p.9).

4. Participants are encountered respectfully as persons and treated as individuals whose accounts of themselves call for exploration and understanding.
5. Data are contextualised. This means that a sufficient range of qualitative data is collected to enable meaningful relationships to be examined within a single case.
6. Research needs to be case based and case centred. This means that the material of each case is taken seriously and used as a basis for theory development. The resultant theory can, in turn, be profitably brought to bear in understanding and researching new cases.

Although case studies can use any form of relevant data, the focus in this research is largely on phenomenological case studies. These are the case studies in which the central research question focuses on participants’ experience. Observable behaviour can be treated as part of phenomenological data if it is viewed not as a mechanistic response but as a meaningful incarnation of an individual’s lived reality (Edwards, 1998).

6.5.2.2 The different phases of the case-based research process.

The research process can be usefully conceptualised as having three major phases: a descriptive phase, a theoretical-heuristic or theory-development phase, and a theory-testing phase.

Phase one: Descriptive work.

Edwards (1998) emphasises the importance of careful and unbiased description when investigating a new or little-

researched phenomenon. This task calls for detailed observation of the phenomenon and the identification of basic concepts and distinctions that will enable what has been observed to be described accurately. There are two types of descriptive work, namely:

- *Exploratory-descriptive work.*

In exploratory-descriptive work, a relatively unknown phenomenon is examined and investigated on its own terms in this kind of open-minded manner.

- *Focused-descriptive work.*

In focused-descriptive work, a phenomenon that has already been described is examined in more detail and researchers bring to bear specific questions about the nature of the phenomenon. Researchers ask a carefully phrased question that directs the respondent to the type of experience in which the researcher is interested.

Phase two: Theoretical-heuristic work.

In this phase, descriptions are used as the basis for the generation of or experimentation with theory (Edwards, 1998). Building a grounded theory is the main aim of this phase.

- *Grounded theory building.*

In grounded theory building, theory is built up step by step and is based on well-substantiated observations. The aim is, according to Edwards (1998), to develop a conceptualisation, or a framework of distinctions and relationships that opens up the essential qualities of the

type of case being investigated and whose value can be re-examined against further cases.

Edwards (1998), summarises the five components of grounded theory building as follows:

- *Categorisation*. This is the refining of categories for classification. This is the interface between focused-descriptive work and theoretical-heuristic work.
- *Statements of correlational relationship*. This is the identification of correlational relationships (i.e., What is associated with what?)
- *Definitions of psychological structure*. Psychological structure in this sense is a specialised kind of theorising, informed by a phenomenological perspective that goes beyond mere description. Giorgi (1985) sees this as a capacity for insight into the psychological dimensions of the data on the part of the researcher.
- *Propositions about process*. A fourth component of grounded theory is the identification of process (i.e., What follows from what and under what conditions?).
- *Propositions about causal relationships*. This means that the theory allows for predictability (i.e., in the limited sense that if elsewhere approximately similar conditions obtain, then approximately similar consequences should occur).

Phase three: Theory-testing work.

- According to Edwards (1998), a well-developed case law embodies distinctions and generalisations that can be

empirically tested against new cases. There are two ways of testing and can be described as follows:

- *Testing propositions within grounded theory.*

The careful examination of individual cases can be used to critically evaluate and strengthen or weaken the evidence for propositions relating to any of the five components of grounded theory discussed previously and to extend existing theory by achieving a more differentiated body of principles (Edwards, 1998).

- *Metatheoretical deconstruction.*

According to Edwards (1998) metatheoretical deconstruction involves using material from cases to expose the hidden assumptions on which a body of psychological theory is based. The consequence of this is not the refining of theory but a more radical reformulation.

6.5.3 Sampling

Sampling is a process of systematically selecting cases for inclusion in a research project. Naturalistic sampling is very different from positivistic sampling and its purpose is to maximise information rather than to facilitate generalisation (Kagan, 2002). In the naturalistic paradigm, large samples are not required as the goal is to produce in-depth information rather than quantifiable data (Lincoln & Guba, 1985).

In this study purposive sampling was chosen. Purposive sampling is appropriate in three situations. First, a researcher uses it to select unique cases that are especially informative. Second, a researcher may use purposive sampling to select members of a difficult-to-reach specialised population. Third, a researcher may

want to identify particular types of cases for in-depth investigation (Neuman, 1994). The purpose of this type of sampling is not so much to generalise to a larger population but rather to gain deeper understanding of types, to detail the many specifics that give the context its unique flavour. Lincoln and Guba (1985) state another purpose for this type of sampling, namely to generate the information on which the emergent design and grounded theory can be based.

In this study the first and third reasons mentioned for purposive sampling apply. The cochlear implant is a unique process and the cochlear implantees form a very unique group of people selected according to specific criteria as described in Chapter 3. The uniqueness of this group is further established in the sense that little research has been done, especially concerning the psychological impact of the implant. No research could be found where the experience of a cochlear implant was described from a systemic point of view.

The clients in this research presented with different problems and processes in therapy. These differences will be described in the next chapter in order to provide a description for each specific client. The clients were asked to sign a consent form before participating in this study in order to cover ethical concerns. The consent form is provided in Appendix I.

6.5.4 Data Collection

Although the major and sometimes only data collection instrument used in naturalistic inquiry is the inquirer him- or herself, the sources that the instrument utilises may be both human or non-human (Lincoln & Guba, 1985). Human sources are incorporated by interviews and observations, and by noting non-verbal clues. Non-human sources include documents and records. In this study both

human and non-human sources were used as a mean of collecting data.

An **interview** is a conversation with a purpose (Dexter, 1970). According to Lincoln and Guba (1985) the purpose of an interview includes, among others, obtaining here-and-now constructions of persons, events, activities, organisations, feelings, motivations, claims, concerns and other entities and reconstructions of such entities as experienced in the past; projections of such entities as they are expected to be experienced in the future. The interview is also a means by which information can be verified.

The human source of information gathering in this study was utilised by means of a **semi-structured interview**. The semi-structured interview allows the researcher to prepare a list of key topics or a schedule of open or closed questions. The data derived from these interviews were recorded by means of hand-written notes taken during the interview itself. The advantages of hand-written notes are remarkable, e.g. taking notes forces the interviewer to attend carefully to what is being said; the interviewer can interpolate questions or comments onto the paper without the client's awareness, the notes can be easily flagged for important items to which the interviewer wishes to return later; the interviewer need not to rely on his or her memory to compose a summary at the end of the interview (Lincoln & Guba, 1985).

Non-human sources of data collection are also useful sources of information. In this study the researcher made use of a life sketch that the client was asked to compose in one of the cases. In the same case the therapy sessions were documented by using running notes, straightforwardly anecdotal, with summaries from the researcher at the end of the session. In the other cases the researcher documented a summary of the therapy sessions and also made use of the drawings of the client as a source of information.

6.5.5 Data Analysis

The next step in the research involves the analysis of the data in such a way as to allow recurrent themes to emerge. The analysis phase should not be regarded as completely separate from the data collection as both phases recursively connect with each other in a continuous process (Kagan, 2002).

The aim of this study is not to explain human behaviour in terms of universally valid laws or generalisations, but rather to understand and interpret the meanings and intentions that underlie everyday human action. Therefore, the analysis conducted in this research took the form of **interpretative analysis** of the interviews. The interviews were regarded as narratives in order to produce themes that could be analysed. This **thematic analysis** is coherent with the naturalistic as well as the systemic epistemology as it allows for multiple realities to emerge as they were expressed by the participants themselves (Kagan, 2002).

The steps followed were as follows: After the initial interview the researcher went through her notes. She also read through the life sketch in one of the cases. This gave her the opportunity to immerse herself in the material. The researcher then went on to the interpretative level where underlying patterns and themes were recognised and described (phase one - exploratory-descriptive work as well as phase two – grounded theory building). The next step was a comparative analysis where the researcher compared that which emerged with the literature (phase three – testing propositions within the grounded theory). The context of the interview was taken into account throughout the process. The emergent design means that the evaluation of the data is a continuous process and the researcher remained open, also to her own changes.

6.6 THE RESEARCH REPORT

Compared to quantitative research, it is more difficult to write a report on qualitative research as with a case-based study. It has fewer rules and less structure. The purpose is the same as the purpose of the quantitative research report: to clearly communicate the research process and the data collected through the process.

Quantitative research reports present hypotheses and evidence in a logically tight and condensed style. By contrast, qualitative research reports tend to be longer. According to Neuman (1994), qualitative research requires greater length for the following five reasons:

1. The data in a qualitative report are more difficult to condense. Data are in the form of words, pictures, or sentences and include many quotes and examples. If there are charts, figures, and tables, they are to supplement, not replace, the qualitative data.
2. A qualitative researcher may want to create a subjective sense of empathy and understanding among readers in addition to presenting factual evidence and analytic interpretations. Detailed descriptions of specific settings and situations help readers better understand or get a feel for settings. The researcher attempts to transport the reader into the subjective world view and meaning system of a social setting.
3. Qualitative researchers use less standardised techniques of gathering data, creating analytic categories, and organising evidence. The techniques applied may be particular to individual researchers or unique settings. Thus researchers

explain what they did and why, because it has not been done before.

4. Exploring new settings or constructing new theory is a common goal in qualitative research. The development of new concepts and the examination of relationships among them adds to the length of reports. In addition, theory flows from evidence, and detailed descriptions demonstrate how the researcher created interpretations from evidence.
5. A qualitative researcher may use more varied and literary writing styles, which increases length. He/she has greater freedom to employ literary devices to tell a story or recount a tale when translating a meaning system for the reader.

6.7 LEGITIMISATION AND ETHICAL ISSUES

All research must meet with certain criteria against which the trustworthiness of the project can be evaluated. According to Lincoln and Guba (1985), these criteria can be phrased as questions to which all research must respond:

First, how credible are the particular findings of the study? By what criteria can we judge them?

Second, how transferable and applicable are these findings to another setting or group of people?

Third, how can we be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context?

Fourth, how can we be sure that the findings are reflective of the subjects and the inquiry itself rather than a creation of the

researcher's biases or prejudices? (Marshall & Rossman, 1995).

Lincoln and Guba (1985) propose four alternative constructs that more accurately reflect the assumptions of the qualitative paradigm as opposed to the quantitative paradigm:

The first is credibility, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described. The strength of the qualitative study that aims to explore a problem or describe a setting, a process, a social group, or a pattern of interaction will be its validity. An in-depth description showing the complexities of variables and interactions will be so embedded with data derived from the setting that it cannot help but be valid. Within the parameters of that setting, population and theoretical framework, the research will be valid. A qualitative researcher should therefore adequately state those parameters, thereby placing boundaries around the study (Marshall and Rossman, 1995). In this study, clear parameters were set. All the cases were profoundly deaf and all were selected to meet the criteria for a cochlear implant. All three the cases had already received the implant. All three the cases visit the cochlear team on a regular basis for the necessary 'MAPping' procedures.

The second construct Lincoln and Guba (1985) propose is transferability, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make that transfer than with the original investigator. A qualitative study's transferability or generalisability to other settings may be problematic. Positivistic researchers see the generalisation of qualitative findings to other populations, settings, and treatment arrangements – that is, its external validity – as a

weakness in the approach. Marshall and Rossman (1985) describe a counter challenge – the researcher can refer back to the original theoretical framework to show how data collection and analysis will be guided by concepts and models. By doing so, the researcher states the theoretical parameters of the research. Then those who make policy or design research studies within those same parameters can determine whether or not the cases described can be generalised for new research policy and transferred to other settings, while the reader or user of specific research can see how research ties into a body of theory.

Marshall and Rossman (1985) describe one additional strategic choice that can enhance a study's generalisability: triangulating multiple sources of data. Triangulation is the act of bringing more than one source of data to bear on a single point. Data from different sources can be used to corroborate, elaborate, or illuminate the research in question (Rossman & Wilson, 1985). Designing a study in which multiple informants, or more than one data gathering method are used can greatly strengthen the study's usefulness for other settings. In this study the researcher made use of triangulation in the sense that the other members of the cochlear implant team contribute data concerning the case studies. In one of the cases the researcher also made use of the school as a source of information.

The third construct Lincoln and Guba (1985) propose is dependability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by increasingly refined understanding of the setting. According to Marshall and Rossman (1995), this represents a set of assumptions very different from those shaping the concept of reliability. Positivist

notions of reliability assume an unchanging universe where inquiry could, quite logically, be replicated. This assumption of an unchanging social world is in direct contrast to the qualitative/interpretative assumption that the social world is always being constructed, and the concept of replication is itself problematic.

The final construct that Lincoln and Guba (1985) propose confirmability, captures the traditional concept of objectivity. Lincoln and Guba (1985), stress the need to ask whether another could confirm the findings of the study. By doing so, they remove evaluation from some inherent characteristic of the researcher (objectivity) and place it squarely on the data themselves. Thus the qualitative criterion is: Do the data help confirm the general findings and lead to the implications? This is the appropriate qualitative criterion (Marshall & Rossman, 1985).

Conventional science ignores the value that may emerge by knowing about the particular or unique (Kagan, 2002). Qualitative, and specifically case studies, are, quite essentially, about understanding a “particular” in the “all-together” (Sandelowski, 1996, p.525). When the existing culture imperative is to take things apart, putting things together is not an easy task to do or to describe in words that also tend to take things apart. Patton (2002) quotes Albert Einstein as follows: “Not everything that can be counted counts, and not everything that counts can be counted” (p.12).

Ethical issues are serious considerations for all qualitative researchers. They range from assessing the real impact of the researchers' presence on their subject population to examining the nature or the relationships that result from their research effort (LeCompte, Millroy & Preissle, 1992). Great care must be taken to ensure that no harm is done to any of the subjects in the research

project. A survey interview may, for example, create anxiety and discomfort among the subjects who are asked to recall unpleasant events. The ethical researcher is sensitive and always considers possible precautions and weighs potential harm against potential benefits. Ethics begins and ends with the researcher. According to Neuman (1994) a researcher's personal moral code is the strongest defence against unethical behaviour. Before, during, and after conducting a study, a researcher has opportunities to and should, reflect on research actions and consult his or her conscience. Ethical research depends on the integrity of the individual researcher and his or her deeply held values.

A fundamental ethical principle of social research is: Never coerce anyone into participating; participation must be voluntary. It is not enough to get permission from subjects; they need to know what they are being asked to participate in so that they can make an informed decision (Neuman, 1994).

Researchers protect privacy by not disclosing a subject's identity after information is gathered. The subject's identity is protected, and the individual is unknown or anonymous. Even if anonymity is not possible, researchers should protect confidentiality. According to Neuman (1994) confidentiality means information may have names attached to it, but the researcher holds it in confidence or keeps it secret to the public. The information is not released in a way that permits linking specific individuals to specific responses.

Sieber (1992) summarises the principles of ethical research as follows:

Beneficence: Maximising good outcomes for science, humanity, and the individual research participants while avoiding or minimising unnecessary harm, risk, or wrong.

Respect: protecting the autonomy of (autonomous) persons, with courtesy and respect for individuals as persons, including those who are not autonomous (e.g., infants, the mentally retarded, senile persons).

Justice: ensuring reasonable, non-exploitative, and carefully considered procedures and their fair distribution of costs and benefits among persons and groups (those who bear the risks of research should be those who benefit from it).

House (1990) also suggests three basic principles, only one overlapping with Sieber's:

Mutual respect: understanding others' aims and interests, not damaging self-esteem, not condescending.

Non-coercion and non-manipulation: not using force or threats or leading others to cooperate when it is against their interests.

Support for democratic values and institutions: commitment to equality and liberty, working against oppression and subjugation.

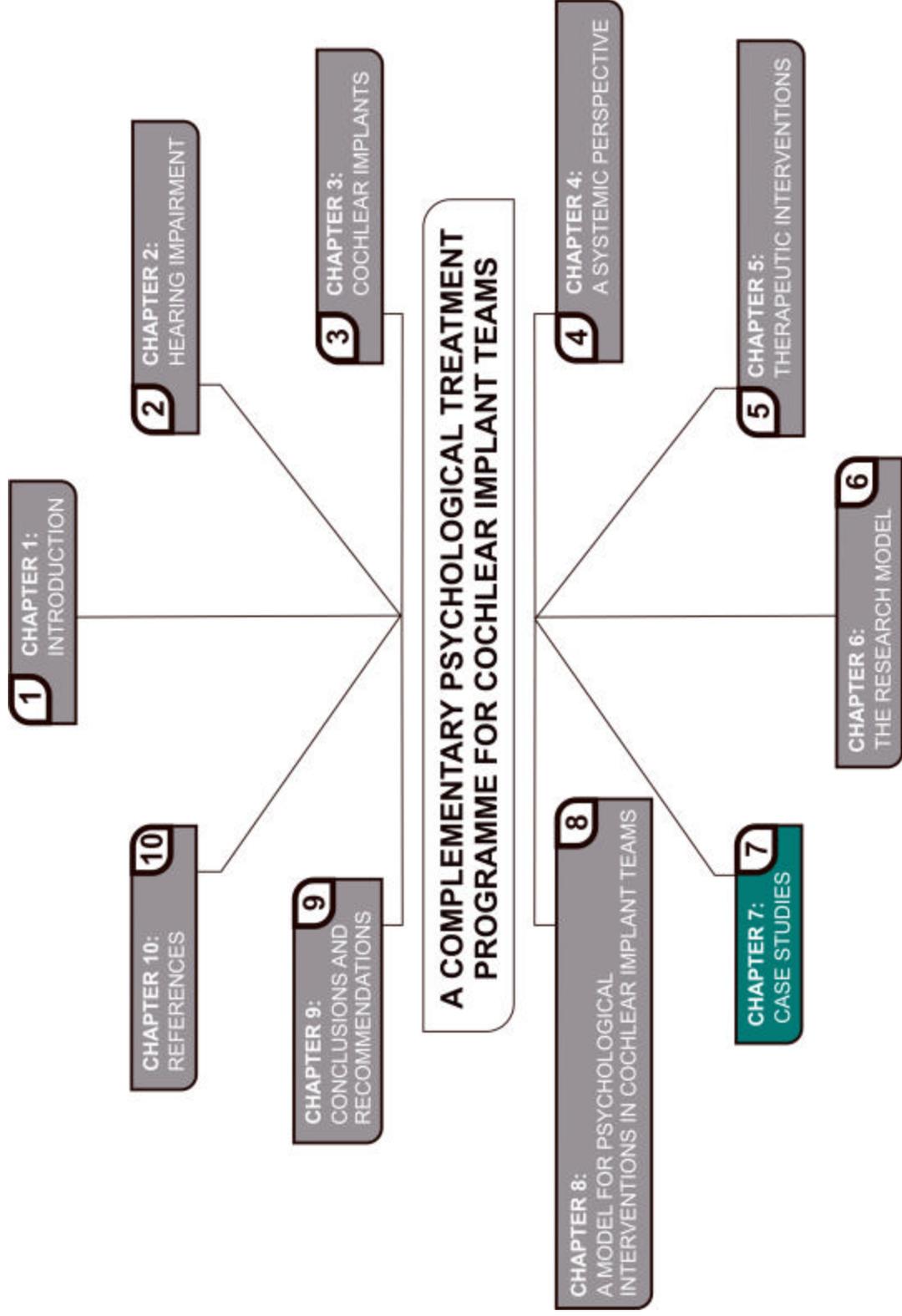
Although the researcher knows the names of the subjects, pseudonyms were used in this study in the written reports of the case studies. The research process, what it entails, and the length of the research process, were fully discussed with the participants. As mentioned earlier, they also signed a form of consent (Appendix 1).

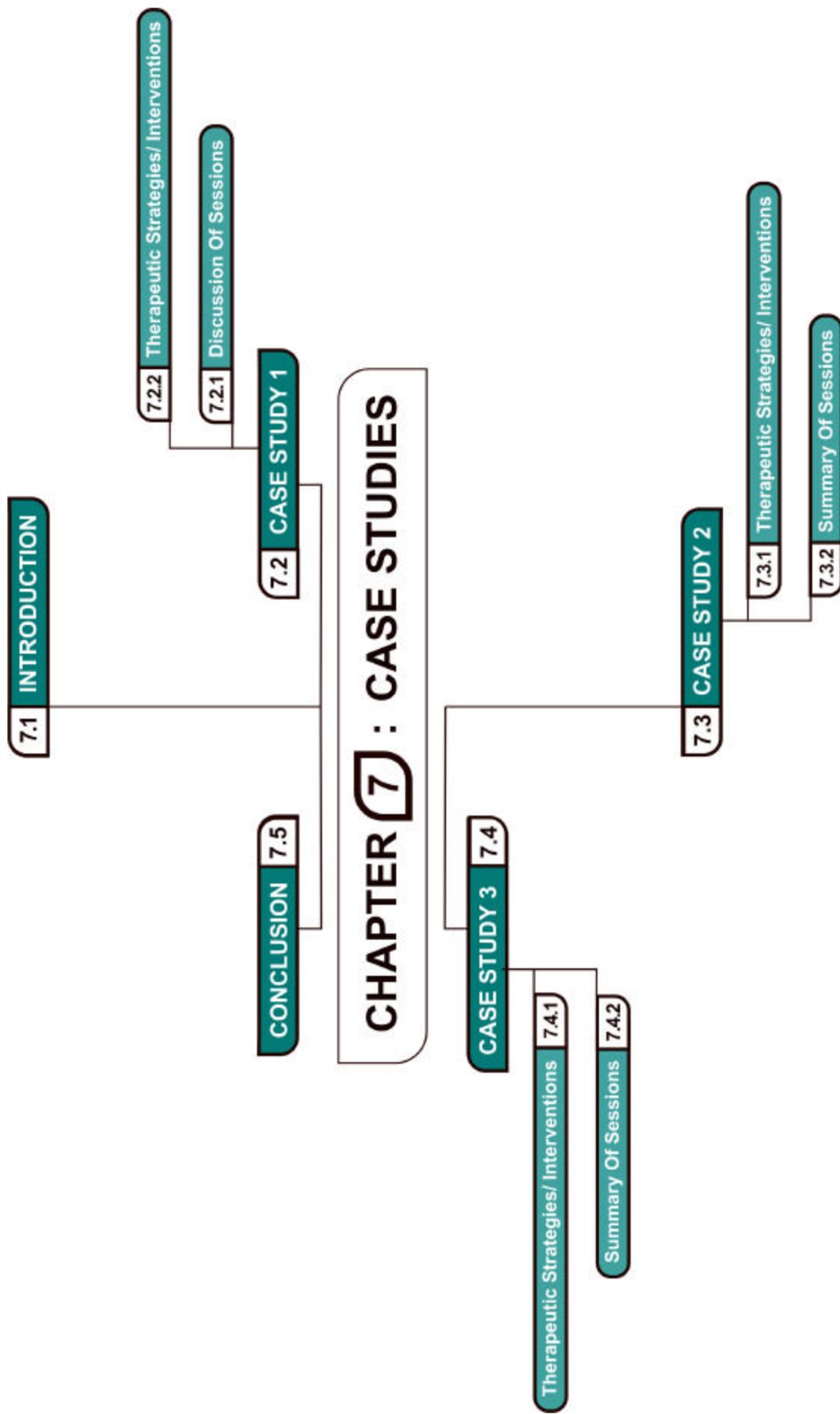
6.8 CONCLUSION

This chapter described the naturalistic paradigm and the qualitative research inquiry. The qualitative method of inquiry was chosen as the one that most enables the researcher to meet the objective of this research and one that was also coherent with the

systemic perspective described in Chapter 4. The emergent research design, the case study as method, data collection and data analysis were described in detail. Finally, the legitimisation and ethical issues of the research design were discussed.

The next chapter consists of the application of the research design in the form of the three case studies where the three different therapeutic interventions described in Chapter 5 will be applied.





CHAPTER 7

CASE STUDIES

7.1 INTRODUCTION

This chapter contains three case studies and will show how the three different therapeutic interventions described previously, were applied to the cochlear implantee and his or her family. The interventions were initiated by exploring the problem as stated by the client. The next step was to give a convincing explanation of the problem, followed by a coherent treatment ritual to bring about change.

The first case study involves a family where the brother of the cochlear implantee was identified by the family as the person with a problem. The reality constructed by the therapist and the family illustrated the circular nature of the systemic epistemology where the hearing-impaired child influenced the hearing sibling, parents and grandparents and was also influenced by the hearing sibling, parents and grandparents. A meaningful treatment in this troubled system was to see the presented problem as a request for change, but also a request for stability. The role of the therapist would be – through reframing – to construct an alternative pattern for reorganising change and stability. This was done using the structural approach to family therapy.

In the second case study the systemic perspective also offered a map of the interrelationship of symptoms. In the construction of the problem by the therapist and the mother, the mother-child relationship was chosen as the figural and the other variables as the ground. A meaningful ritual in this case was to reconstruct the parental subsystem, namely the mother-child dyad. This was done in a specific way as illustrated by Theraplay with the nine year old boy after he had received his cochlear implant.

In the third case study SHIP® (Spontaneous Healing Intrasytemic Process®) was chosen as ritual where the individual was seen as a whole unto itself, a complete entity, but an entity that also consisted of system levels in itself. This was done with a 33 year-old female a year after she had received a cochlear implant.

The names of the participants have been changed to ensure confidentiality and to ensure that the research study was ethical.

7.2 CASE STUDY 1

The therapist first saw the B. family to evaluate two year-old Mary for a possible cochlear implant. The mother (Luïsa), father (Gregory), brother (Sam) and maternal grandmother accompanied Mary. The following information was presented:

Luïsa (Mary's mother) had rubella while she was pregnant with Mary. It was a difficult pregnancy and Mary was born by means of a caesarean section. Mary had a poor immune system and easily contracted illnesses. At the age of one month, the family suspected that Mary was hearing impaired. They took her to a paediatrician and at the age of six months a serious sensorineural hearing loss was diagnosed. She received hearing aids at eight months. Because of financial reasons, Luïsa had to work fulltime. The maternal grandparents decided to move in with the family so that the grandmother could assist with the upbringing of the hearing-impaired Mary. At this stage Mary's brother, Sam, was six years of age.

During the interview Mary was quite active. Questions about her diet revealed that she had access to a lot of colourants and sugar. She was also put to bed with a bottle of coffee. She would sometimes wake up during the night, screaming, as if she experienced night terrors. The family had no other complaints and was highly motivated to give their hearing-impaired daughter the best they could, including

a cochlear implant. The parents acknowledged the diagnosis of hearing impairment in their child and also discussed constructive action. The only recommendation the therapist made at that stage was for the family to adapt their eating habits and to exclude stimulants like sugar, colourants and caffeine from the childrens' diets. The cochlear implant team approved the family and Mary, and she subsequently received an implant. Prior to the implant, there was an article about Mary in the local newspaper and the family put a lot of energy and time into fundraising to be able to afford the cochlear implant.

A year later, Luísa contacted the therapist and an appointment was scheduled. This time, it was not Mary who was seen as the patient, but her brother Sam. Luísa, Gregory, Mary, Sam and the maternal grandmother were present at this interview. Nobody mentioned the grandfather. On inquiry from the therapist, the grandfather was described as a quiet person and not very involved with the rest of the family. Luísa voiced most of the complaints while the grandmother contributed some of the time. Gregory – Sam's father - was, as in the previous interview, quiet and did not contribute much. Complaints relating to Sam were as follows:

Sam experienced problems at school; this was in contrast to the previous year when he seemed to have fared quite well. According to his mother, Sam showed signs of disobedience and cried often when he felt that the adults did not want to help him or attend to him. He was wilful and he told lies. He often verbalised that his parents did not love him. His sister did extremely well with her implant and the grandmother referred to her as 'brilliant' and a 'star'. During the session the two children were playing with toys that the therapist provided in the therapy room. On several occasions Mary would take a specific toy from Sam. If he complained or tried to retrieve it, his mother or grandmother would scold him and inform him to be good to

his sister because of her hearing impairment and therefore her lack of understanding at times.

The family situation was as in the previous session - the grandparents were living with the family, Luïsa was in full-time occupation and Gregory had begun to work after hours to extend his work to supplement the family's income.

One session a month covering a five-month period was scheduled as the family lived in the country and was not able to drive to the city more regularly. Another reason for this monthly arrangement was to allow the family time to regroup in between sessions.

During the first two sessions the interventions were mainly exploratory. Through observation and questioning, the therapist and the family tried to explore and describe the problem which seemed to be complex. Sam was the identified patient and there were definite behaviour problems on his side. Mary, the cochlear implantee, was the obvious favourite within the family and ignored any efforts of discipline towards her. There was more than one mother figure as well as an absent father figure. A definite daily routine seemed absent in the household.

During the second phase, the theoretical-heuristic work, a theory about the functioning of the family was formulated. Everybody involved constructed the following theory:

The boundaries within this family were diffuse. Involvement of the grandparents, and specifically the grandmother, complicated the boundaries between the mother and father, as well as between the parents and siblings. The way Luïsa and her mother spoke to one another and talked about Gregory instead of with him illustrated a coalition between the grandmother and her daughter.

Such coalition might undermine Gregory's authority, which could explain his reserved manner. Although the grandfather was absent, the therapist reflected on the possibility that a similar communication pattern existed between Luïsa, her mother and father. Of further interest was the particular order in which the members took their seats during the initial sessions. The grandmother and Luïsa sat next to each other, then there was an open space and then it was Gregory. The children moved in and out as they were playing on the side of the grandmother and Luïsa.

The metaphor of a hearing-impaired family took shape during the therapist's observations. All the attention and energy were focused on Mary, but Sam could not be "heard". In a symbolic way Sam was shouting for attention by creating all kinds of behaviour problems but nobody in the family seemed to "hear" him. His problem gave him some form of attention from the adults in his family and this supplied him with standing and identity. Furthermore, the voices of the male authority figures in the family were not heard, while the voices of the mother, grandmother and most of all that of Mary, could be heard loud and clear. Mary received constant attention, she received speech therapy, went for "MAPping" sessions at the University, all the friends asked about her well-being and people could even read about her in the local newspaper. In addition, the possibility existed that Sam sensed that his father's authority was being undermined. That could possibly underlie Sam's challenging behaviour towards authority – as was evident from his disobedience and wilfulness at home and at school. The picture he drew of the family showed the father figure as big and prominent with an open mouth shouting swear words. This was a total opposite of the impression the therapist formed about the father during the sessions. Sam could have expressed the father's underlying

aggression or he could have expressed his own aggression towards the father figure being absent.

The therapist reframed the problem by composing a structural map of the family. The map looked as follows: (Figure 7.1)

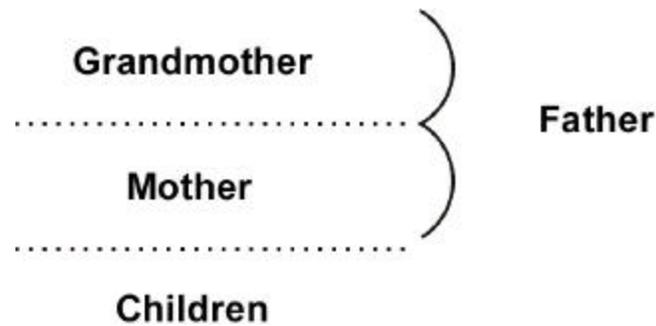


Figure 7.1. A structural map of the family

This is a three-generational family and the key issues were: who were the children's parents? Was the mother the grandmother's "child", and thus more of a peer and less of a parent to her own children? Were they competing for the role of primary parent to the children? Was there a parental coalition between grandmother and child at the cost of the father?

By the end of the second session, the therapist decided to intervene in a manner that would perturb the current family structure, to initiate change in the coalitions as described. This was done by means of asking Mary's father to bring his wife, son and daughter to the next session and to leave the grandmother at home, seeing that she was already working so hard during the week. The therapist reframed it as allowing the grandmother time-out from the family and thereby opening the possibility that she could spend more time with her husband. In doing this, the message implicated by the therapist was that Mary's father was the head of the family and that a change in definition of his role in the family was evident. The assumption made by the therapist was that should the father's "voice" again be

“heard”, it could contribute to a realignment of boundaries between the father, mother, Mary and Sam. In a non-threatening way it also sent a message to the grandmother that her children are able to care for themselves. Luisa needed support to care for the children and the grandmother it seemed, bestowed the necessary love and warmth. This kind of necessary energy spent by the grandmother in support of the mother was not defined as negative for it did serve a complementary role. Sam’s presenting problems indicated that the time had come for the family to redefine their roles.

In the third session, Mary’s mother reported that there was an improvement in Sam’s schoolwork but that he still told lies. He also wanted to sleep between his mother and father and he did not want his sister, Mary, to attend the family therapy session. This was a good example where the change in the family’s function was also followed by stability, in the sense that although Sam’s behaviour changed, there were still “hearing” problems in the family. It also indicated the symptoms as an expression of ambivalence. Sam “shouted” but in such a way that he was still not “heard”.

The therapist enquired from the parents their explanation for the behaviour of their son. This was a way of recognising the parents as the experts in the upbringing of their children. It also relieved the therapist of the expectation to heal the family. This was also congruent with the structural viewpoint of the need for the parents to form a strong subsystem.

In response to the therapist’s question, Gregory proposed he might not have spent enough time with Sam. The opportunity for the therapist to discuss the “hearing impairment” in the family had opened up. It also presented the opportunity to gain clarity on how the parents perceived their different roles. Luisa responded by expressing the need to be more of a mother figure to the children, not only to nurture, but also to spend more fun time with them. Her

response was an expression of change in the family. She also said that she knew it would be better if her parents could live in their own place, instead of living with them in the same house. Gregory suggested activities where he could involve Sam, e.g. Sam could spend time with him some of the evenings while he was working. His evening job was fixing cars in his garage at home. The therapist continued to ask him more about his own activities and interests and also about his perception of Sam and his interests. This was once again done to confirm the father's role as an important figure in Sam's life and a person who had the knowledge to give his son what he needed.

During the conversation Sam stopped playing and came to sit on his father's lap. He expressed his love for cars and motorbikes, just like his father. The therapist encouraged the father to explore more possibilities for quality time between him and Sam. It further reinforced the role of the father as authority figure. Sam's non-verbal and verbal behaviour expressed his need to be closer to his father.

The focus then shifted to the mother and to the suggestions of change by asking her to explain the reason for her wish that her parents live on their own. She reacted by stating that she was aware of the fact that she, her husband and two children did not spend enough time together as a family. She also mentioned that Gregory might sometimes feel overwhelmed by the presence of his mother-in-law. When she mentioned this, she looked at Gregory and said she knew that sometimes she and her mother tended to make decisions without consulting him. Through her reaction she indicated an awareness of the need for change concerning their situation, as well as a readiness to realign the boundaries within the family.

In responding to this it was clear that Gregory was cautious not to hurt his wife's feelings. He realised that his mother-in-law was a big help to them in their situation but that he also had a need for them to

spend time on their own. The therapist asked Luísa what alternatives she could see for the present situation. According to her they had considered building a granny flat on their premises for the grandparents. They could then still look after the children till five o' clock in the afternoon. When she arrived home from work, the family could spend time together without the grandparents. Luísa and Gregory continued to discuss the possibilities of being involved in more family activities bar the grandparents. This was a confirmation of the roles that they as parents have in their childrens' lives. The parents and the therapist then went on to explore other possibilities of spending time with Sam. Luísa suggested that she sat with Sam in the evenings while he took his bath. Thereafter she could also read him a bedtime story while Gregory spends time with Mary. The therapist reinforced this idea by reassuring them that the activities would also lead to a bedtime routine that was necessary in creating a secure atmosphere at home.

The therapist ended the session by commenting in a positive way on the parents' need to be involved with their children and the ways they care for the family.

Only Sam and Gregory attended the fourth session. Luísa had to work and was unable to attend. Gregory said he felt it was an opportunity for him and his son to be together and that they left Mary at home with the grandmother. They were also planning to attend an air show after the session. The change in Gregory was remarkable. He talked much more than in any of the other sessions. Sam too, was different. He seemed excited and energetic. He would alternate between playing with the toys and sitting on his father's lap. The therapist asked him to draw a picture of the family (the same task she gave him during the first session). He drew a picture of the family but with his grandmother and grandfather separate in the top part of the house.

Gregory told the therapist that they had started building a flat for the in-laws and that they were all very excited about that. He also mentioned that he and Sam managed to spend more time together. Sam did not display the earlier wilful and disobedient behaviour. He still liked to tell fantasy stories – where he played the main character – as the truth.



Figure 7.3. Sam's picture of the family

The task of the therapist during this session was mainly to confirm and reinforce the new behaviour patterns between father and son. This is part of the structural family therapy where praise was used for performing an action in order to help family members feel confident in themselves and for family members to realise that they are capable of doing what needs to be done. The therapist also gave Sam and Gregory an assignment to do together in the therapy session. Another appointment was scheduled for two months' time.

In the follow-up session two months later the strong bond between Sam and Gregory was clear. Gregory was more outspoken than earlier. The family was still in the process of building a granny flat for the grandparents. Luisa, Gregory, Sam and Mary attended

this session. Gregory announced that the grandparents went to visit their other children in another city. Sam seemed to be happy and relaxed and his parents mentioned that they did not experience any of the earlier behaviour problems with Sam. The boundaries and the communication in the family seemed to be clear and an effective hierarchical structure seemed to be in place.

7.2.1 Discussion of the Sessions

With the discussion of the sessions, phase three of the case-based research model is entered. Various theories proposed in the previous chapters will be illustrated. The theory about the family that was constructed after the first two sessions will also be further investigated.

During the first two sessions it was already clear that the diagnosis of deafness in the daughter affected the whole family. The parents would go to extremes to try to restore her hearing (through a cochlear implant). Possible guilt feelings manifested in the way they handled the other sibling, Sam. He had to accommodate the hearing impairment in his sister at the cost of his own needs. The grandmother was involving Mary in all kinds of therapies in order for her to be 'normal'. Luisa left more and more of her responsibilities to Sam's grandmother, as if she did not have the energy to face the reality. This illustrates the theories presented in Chapter 2, where the impact of the diagnosis of hearing impairment on the family and the social and personality development during the early years of the hearing-impaired child, are discussed.

The family showed a tendency to over-protect the hearing-impaired child at the cost of the other sibling. The importance of the psychological aspect of the cochlear implant was highlighted. The other members of the cochlear implant team perceived the implant as a huge success, as Mary is doing so well with the implant. They

focused on their role, namely the hearing and the performance of the little girl according to measurable standards of hearing. This was the positive side – on the other hand, the cochlear implant and all the aspects surrounding it, contributed in causing changes in the family's situation. The presence of the grandparents and the way of communication in the family complemented the specific situation in the family where the voice of Mary was heard but the voice of Sam was not heard.

This is also an example where the change in one member of the family, through a hearing impairment or a cochlear implant, had an effect on the rest of the family system. This is an illustration of the qualities of systems stated in Chapter 4. In this case the behaviour of Sam could only be fully understood when the therapist “stepped back” and perceived all the subsystems interacting with each other. The circular interplay is clear where the diagnosis of hearing impairment and the cochlear implant in the one sibling affected the family, which affected the behaviour of Sam, which in turn again affected the family's behaviour. The intervention of other professionals, like speech therapists and audiologists, affected the family system and contributed to Sam's feelings of being ostracised. Even the informal networks, like the friends and acquaintances reinforced the focus on the implanted child, thus in a way excluding the other sibling.

This intervention of other professionals underlines the importance of the suggestion of Perold (1999) mentioned in Chapter 3, where she states that there are critical times where counselling assumes more importance than MAPpings and evaluations. The circular interaction between these factors is also in agreement with the conclusion in Chapter 3 that the cochlear implant does not only concerns a person's hearing, but that it has a profound effect on, and is profoundly affected by the systems of which the person is a part.

7.2.2 Therapeutic Strategies/Interventions

The first two interviews showed that this family indeed experienced stress from situational challenges and at transitional points in their evolution. The key to the success of the family is its ability to make adaptive changes in structure relative to family circumstances and the developmental stages of its members (Becvar & Becvar, 1996).

The goals of the therapy for this specific family were as follows:

1. To have an effective hierarchical structure. Parents must be in charge.
2. To have a parental/executive coalition. Parents must support and accommodate each other to provide a united front to their children.
3. To increase the frequency of interaction while the family is moved to clear boundaries.
4. To foster differentiation of individuals and subsystems (because of the enmeshment in the family). This must reflect a respect for differences in developmental stages of the children and permission for age-appropriate experimentation with independent activity.
5. To establish a spouse subsystem as an entity distinct from the parental subsystem.

The first two sessions showed the first two phases of structural therapy where the therapist joined the family, assumed a leadership position and where the therapist in conjunction with the family, ascertained the family's underlying structure. The other sessions were utilised to change the structure of the family. The therapist indicated respect for the hierarchy of the family by asking for the parents' observations first.

An attempt to realign the boundaries in the family was made at the end of the second session where the therapist asked the father to leave the grandmother at home for the next appointment. Asking them to discuss the possibilities of moving the grandparents out of the house and to explore other activities that they as a family can participate in, was an attempt to strengthen the spouse subsystem. Asking father and son to make time which they can spend together, reinforced the father-son subsystem. By meeting separately with Sam and Gregory, their subsystem was once again reinforced. The focus on Mary as the favourite was changed. The mother-son subsystem was established by confirming Luísa's idea of spending bath-time with Sam and reading him a bedtime story. The therapist also attempted to change the way the family members related to Gregory and thereby changed the perspective of the father and his role in the family.

This family system showed morphogenesis in the sense that it was able to change, grow, be creative and innovative. The system also showed morphostasis in the sense that there was stability and equilibrium during the final session. The initial problems were dissolved and Sam was no longer the identified patient. The family was also made aware of the ideal structure for the family where all the individuals are equally respected. Boundaries were clear and communication open. Subsystems were functional. The parental dyad was able to resolve their issues without the intrusion of other members (in this case the grandparents). A structural map of the family is as follows:

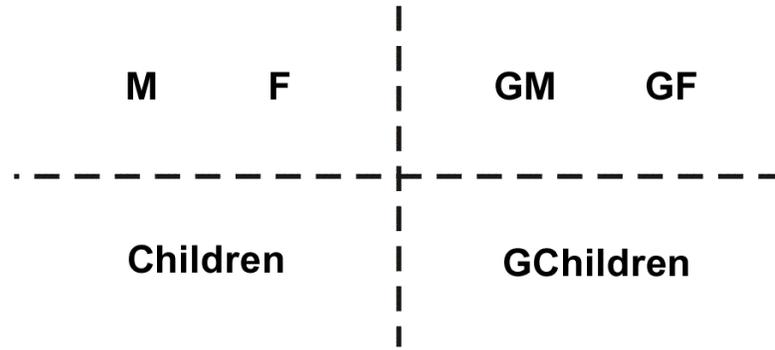


Figure 7.3 A structural map of the family after therapy

The next case study studies the mother-child dyad through Theraplay as a therapeutic intervention.

7.4 CASE STUDY 2

Jason (seven years old), and his family were initially seen by the therapist as part of the evaluation procedure to determine if Jason and his family were suited for a cochlear implant. His family consisted of a mother and father, Jack and Yvonne, and a sister (Lee-Ann), two years younger than himself. His family history was as follows:

Jason was born with a hearing impairment caused by the cytomegalovirus. He was born at 37 weeks, the birth process was difficult, forceps were used and Jason experienced hypoxia (oxygen deficiency). He was an allergic baby. He had a sensorineural loss in both ears. Although the parents suspected that he was hearing impaired at an early age, it was – as is often the case – difficult to determine the nature of his hearing impairment. He was diagnosed with a severe hearing loss at the age of 18 months. He was fitted with hearing aids at this stage. He attended speech and hearing classes at a nursery school for the hearing impaired. His progress was not adequate and because of the severity of his hearing loss no conventional amplification device could provide any demonstrable communication benefits.

He attended a primary school for the hearing impaired. The communication mode at his school was aural-oral, in other words, a normal communication pattern was followed where children learn to use their residual hearing and to lip-read with gestures – as one would find in a normal conversation. He adapted well in the school although his reports showed that he did not progress enough, because of his hearing impairment. He also received occupational and speech therapy. These reports showed a low muscle tone, deficiencies in certain aspects of visual-motor co-ordination and a tendency to be attention deficit. On an emotional level the therapists involved described him as a sensitive child who sometimes lacked self-confidence and who steered away from challenges. Yvonne reported episodes of enuresis and encopresis during his early school days, but the problem did not occur at the time the family visited the therapist.

Yvonne described Jason as easy going and calm. He showed a lack of perseverance especially when the task at hand challenged his abilities. He had a good relationship with the other family members.

The family seemed to be functioning well with clear communication patterns and boundaries. Jason qualified to be implanted and he was approved for an implant.

A couple of years later Yvonne contacted the therapist. Her main complaint was that Jason's sleeping pattern was very restless. He would sleepwalk every night and would sometimes get up seven times during the night. He seemed to be calm during the day although she could detect anxiety whenever there was an evaluation situation at school. The school did not report any problems but mentioned a lack of self-confidence - it was as if Jason lacked the confidence to meet challenges. The audiologists in the cochlear implant team reported that Jason's progress with his cochlear implant was good. They observed that he would sit on Yvonne's lap during

the early MAPping sessions, even though he was seven years old. This was in contrast with other children of the same age who are quite happy to sit at a little table with their mother next to them.

From the history, interviews, school reports, and different helping professions, the following theory was constructed:

There was a lot of caring and involvement in the family. Although Jason had many positive aspects in his life, it was as if he lacked the self-confidence to face challenges. Yvonne played a supportive role in his life but she could not help him to overcome certain obstacles. A possible reason for this might be found in the nature of the relationship between Jason and Yvonne in the sense that there might have been too much nurturing and too little room for challenging and structuring. This could be because Jason was the first born, had a difficult birth and was hearing impaired. He also experienced health problems as a baby. These are factors that could lead to overprotection from the mother's side. As was previously mentioned in Chapter 5, sometimes the parents are so overwhelmed by the seriousness of raising a hearing-impaired child that they focus on stimulation of the hearing and language and in the process lose their spontaneous interaction with the child. Jason's mother wanted the best for her son and she did not hesitate to ask for help.

A therapeutic approach where a relationship could be created which would allow Jason to feel safe and protected, but would also allow him to face challenges, seemed appropriate. Theraplay, as described in Chapter 6, met these requirements.

7.3.1 Therapeutic Strategies/Interventions

During the second interview, when Yvonne discussed his current problems, the therapist suggested individual therapy with Jason. Theraplay and its underlying principles were discussed. Yvonne and the therapist agreed on seven sessions of therapy over a seven-week period (one session per week). The therapist explained to Jason that they would meet once a week for 45 minutes of fun and laughter and 15 minutes of information sharing with his mother. Based on the information obtained from Yvonne, certain assumptions were made about Jason, his functioning, and the nature of his relationship with his parents. In terms of the research model, this is part of the exploratory-descriptive work, where this relatively unknown phenomenon is examined. Theraplay had been done with hearing-impaired people before, but was apparently never done with a child with a cochlear implant (no evidence could be found in the literature).

Although all the sessions would have aspects of nurturing, challenging, intruding and structuring, in this case it was decided to put more emphasis on challenging and structuring activities to address that specific need in Jason.

The first therapy session will be discussed in more detail to explain the procedure and the mood created in the sessions. Thereafter each therapy session will be noted shortly and after each session a discussion of the session will follow. At the end of the last session a summary of the themes that emerged will be done. All the scheduled Theraplay sessions form part of phase two – the theoretical-heuristic work where a theory is built up step by step and is based on well-substantiated observations.

First session

Activities.

Fingerboard competition, paper-bashing, washing of hands.

The therapist greeted Jason in a cheerful way, reassuring him that she was looking forward to spending time with him. The fingerboard activity was explained in the following way:

We are going to play a few games of fingerboard. I must just warn you that I am a regular player and very good at playing fingerboard. It may be difficult for you to beat me.

After a few games of fingerboard, the therapist announced the next activity as follows:

We are now going to play a game of war. We are going to take turns to bash these newspaper pages to pieces. You can bash first while I am holding it up for you (Therapist keeps the page firmly up in front of Jason). Then you must hold a page for me to bash. We are going to finish off this whole newspaper.

The activity proceeded and after completion the therapist explained further:

Now we are going to create big bombs out of these pieces of newspaper. You are going to sit in that corner and I will be sitting here. Let's see how hard we can throw these bombs at each other.

This activity usually leaves the participants with dirty hands, because of the printer's ink on the newspaper. This creates the ideal opportunity – in a natural way – to switch over to nurturing and intruding by washing each other's hands.

Discussion.

Jason was intrigued by the nature of the session. Initially he was cautious about getting involved, but that changed into keenness and a fighting spirit with the fingerboard activity. He verbalised that he was going to beat the therapist. The results were even; this was on purpose, to keep Jason's goal alive of winning but also to show Jason that in real life it sometimes takes effort and willpower to reach a goal.

The paper-bashing evoked an interesting response from Jason. At first he was cautious and uncertain. As the activity proceeded he became very spontaneous and verbalised a lot of aggression. He switched over from a fist to karate gestures in the hitting of the paper. He even used his head to hit the paper. With the bombing there was a lot of spontaneous laughter and enjoyment. He did not show any problem in obeying the rules.

The washing of the hands gave the opportunity to compare the size of hands. By asking Jason also to wash the therapist's hands, it allowed Jason to view himself as a contributing team member. The similarities but also the differences in hands were emphasised. The therapist also asked to feel Jason's bicep muscles and commented on his strength. These 'touching' activities reinforced to Jason that he had a special and unique identity as an individual.

The first session is very important as it sets the tone for the rest of the sessions. In this session the message was conveyed that the sessions would be fun, but structured. The sessions would be action oriented, rather than talk and insight oriented. Jason's initial reaction was representative of his attitude towards demands in general. He was cautious to become involved. His reaction later in the session showed that he was able to become involved and enjoy it. It was also practical interaction for Jason where he could experience the results of handling new and uncertain situations. It also made him aware of

his own physical strength and possibilities. The focus on his physical appearance was a way of showing him his uniqueness and hidden power. That way he had the opportunity to see himself as clearly differentiated, attractive, safe, enjoyable to be with, loveable, and capable of making an impact.

In the 15-minute discussion session with the mother a summary of the session and Jason's reaction was given. As a homework assignment Yvonne was requested to repeat the paper bashing activity with Jason a few times and also to ask Jack (Jason's father) to participate in this activity. This was important, as it is a goal of Theraplay to assist in changing the mother's perception of herself. This change gave the mother the opportunity to relate to Jason in a different way. In the process, as described in Chapter 5, the mother could come to see herself as loveable, giving, and feminine, yet at the same time resourceful, strong, and competent. She could find in her new motherhood the confirmation of many qualities in herself that she might have doubted – including a capacity for intimacy and a firm sense of self. This illustrates the recursive cycle of the systemic perspective. The change in one person of the dyad reverberated change in the other person of the dyad and vice versa.

Other tasks included games where problem situations were created and the family was challenged to get solutions for these situations. This was a way to stimulate Jason in seeing himself as able to solve problems.

Second session

Activities.

Fingerboard competition and pillow push (On the count of 'three', the child and therapist push hard against one another, trying to push the other off 'base'). Pillow fight and arm wrestling followed.

Discussion.

The fingerboard activity was repeated to allow a sense of continuity and thereby created a safe and known previously conquered platform to cultivate further challenges. The other activities were chosen to focus on Jason's physical strength. He is well built and quite tall for his age. The opportunity to measure himself against an adult in a safe and fun situation was once again a way of showing him his uniqueness and hidden power.

This time Jason's reaction was different from the previous time. He immediately showed his willingness to participate and also verbalised that he was going to beat the therapist in all the activities. Except for the arm wrestling activity, he did win, which gave him a sense of accomplishment. His daring thus paid dividends, securing yet another victory on his way to building his self-confidence.

Yvonne gave some interesting feedback: The previous week Jason volunteered to enrol in a competition for Mr. Valentine at his school. Although he did not win, he felt good about the experience. He also wrote a letter to a girl friend in his class – something he previously would never have considered. At home he enjoyed doing the paper bashing activity and even involved Lee-Ann (his sister) to participate. Yvonne tested his problem solving skills one afternoon by taking the wrong way home. He took control by correcting her and taking charge in showing her the correct way home. He also did very well in a school test.

Homework for the following week was to continue with the paper bashing activity and also to include pillow push and arm wrestling.

Third session

Activities.

Fingerboard activity, tracing of hands and feet, measuring and comparing with one another. Comparing and drawing of each other's eyes. War activity where war figures are rolled over with a golf ball.

Discussion.

Jason seemed enthusiastic about all the activities. He was definitely more spontaneous than the previous times although he did not initiate any conversation.

Fourth session

Activities.

The use of paint to draw patterns on hands and feet that were traced on paper (Figure 7.4). Shoot-'n-Win – a competition game where each participant must try to get the ball into a goalpost. Life-size portrait (child on his back – arms and legs outstretched – on a large piece of paper. The therapist kneels alongside and traces the outline of child's body with crayons. After completion of this, the therapist and child together fill in facial features, buttons, cuffs, belts, collars, buckles, shoes and socks). This portrait was put up against the wall in the therapy room.

Discussion.

Jason spontaneously initiated activities, e.g. with the painting of the hands and feet he also started to paint the therapist's face. This behaviour indicated the improvement in his self-confidence in that he could venture from his personal space into the therapist's boundary and react spontaneously and creatively. The therapist did the same to complement his process of sharing. He offered information about his week – his class went on an outing to the botanical gardens. He also asked a lot of questions about the therapist, e.g. about her children and their ages. These were answered but then the therapist

brought the focus back to activities in the therapy session. Jason was pleased to see the image of himself against the wall.

Feedback from Yvonne revealed the following information: Jason was now much more spontaneous at home. His sleeping pattern was undisturbed. The previous night he woke up once and discussed with Yvonne his anxiety over a test he was writing the following day. He was also appointed as captain of his class. The therapist recommended an activity for the family, e.g. something like table tennis where Jason could experience success (he has good ball sense). This type of activity would serve to further reinforce his success at connecting with his external world.



Figure 7.4.1 Jason's hands.



Figure 7.4.2 Therapist's hands.

Fifth session

Activities.

Paint and paper; clay and pieces of material to build and dress a clay man; leg wrestling (therapist and child lie on the floor, heads in opposite directions, legs touching and raised off floor, hooked to one another. On count of 'three', therapist and child proceed to try to roll each other off balance). Elbow and face trophies (Therapist wraps sheets of double-thickness foil around child's elbow and moulds it carefully to fit snugly around the elbow. Then she removes it cautiously and compares wrinkles and indentations in 'impression' with wrinkles and protrusions in child's elbow. The same procedure is followed for the face trophy).

Discussion.

Jason's first reaction was to go and have a look at the image of himself that was done the previous week. The therapist and Jason painted a picture together and took turns to start to draw something which the other person must then complete. It was a cold winter's day, which gave the therapist and Jason the opportunity to build a 'snowman' out of clay and also to dress this man using pieces of material. A very energetic leg wrestling activity followed, filled with lots of laughter. The trophies focused on illuminating the uniqueness of Jason's characteristics.

During the discussion with Yvonne she mentioned that Jason had to write a speech the previous evening about an accident. He stated that he wanted to write about the accident in which his grandfather was killed. He got emotional and showed reluctance to complete the task. This was new information and the therapist decided to do something different in the next session. She asked Jason to bring his favourite toy cars and trucks to the session; the therapist assumed that Jason might be ready to integrate feelings relating to his grandfather's death.

Sixth session

Activities.

Fingerboard competition; unstructured play with toy cars and trucks. Chocolate sweets to throw into each other's mouths.

Discussion.

The fingerboard activity was repeated once again to give a sense of continuity and to create a feeling of safety and familiarity. The new information was important as it showed the presence of repressed feelings surfacing in Jason. The therapist decided to use this session and to see if some of these feelings could be voiced. They first

started by just playing with the different cars and trucks. Then the therapist asked Jason to show her what happened in his grandfather's accident. He reconstructed the situation and gave a lot of detail on what happened. He also talked about the funeral.

When he finished talking about this, he asked the therapist what game they were going to play next. This was an indication for the therapist that Jason was ready to move on. They proceeded with the next activity that was the throwing of chocolate sweets into each other's mouths. He enjoyed this tremendously. At the end of the session he asked the therapist if Lee-Ann could join them for the next session. Wanting to share his special place (the therapist's office) with his sister meant that Jason had indeed overcome his initial fear of venturing beyond his mother's boundary. According to the writer, fear is the result of a sense of loss of self and therefore it inhibits further spontaneity because of the fear of additional losses. If Jason could start sharing so freely, it indicated a lack of a too intense need to control and thus a freedom to open up, to release and to share.

Seventh session

Activities.

Fingerboard, table tennis.

Discussion.

The fingerboard and table tennis activities required two or four contestants. The therapist asked Yvonne and Lee-Ann to join them in this session. Jason took the lead by explaining the rules of the games to them. He and Lee-Ann played on one side while the therapist and Yvonne were their opponents.

This was the last of the seven sessions initially scheduled. The therapist felt that one more session was needed to make sure Jason was ready to end the therapy. Another session was scheduled in two

week's time. The therapist ended the session by telling Jason that they had such a wonderful time playing together and that he could teach a lot of the activities to his dad, sister and friends. She also informed him that the next session would be the last. His birthday was due within the next two weeks and the last session could be an extra birthday party for him.

Last session

Activities.

All kinds of snacks, cool drinks, party gifts with a small birthday gift for Jason; arm wrestling.

Discussion.

The last session was a real party where everybody had fun and enjoyed each other's company. Jason informed Lee-Ann and Yvonne about some of the other activities that were done during the therapy. Jason looked happy and relaxed. Yvonne reported that even his teachers commented on the change in him. He was keen to volunteer for tasks and had much more self-confidence.

7.3.2 Summary of all the Sessions

In the first session the therapist clearly challenged Jason. The activities chosen were not difficult, but fun. This initiated Jason in exploring some of his abilities. These activities also provided the possibilities for Jason to experience himself as an individual and to teach him that combat, competition and confrontation can release and focus pent-up tension and anger in a safe, direct, controlled and playful way. The continuity of the activities at home was important because it kept Jason linked to the therapy between sessions. One of the assumptions in Theraplay – discussed in Chapter 5 – is that the mother will take over the role of the therapist when she and the child

are ready. Most of all, it gave the mother the opportunity to relate to Jason in a different way.

The first three sessions can be perceived as the exploratory and also the tentative acceptance phase of Theraplay. During this phase the therapist and Jason got to know who had the largest hands, the longest toenails, and the strongest muscles.

Although some changes had already occurred in Jason's behaviour at home and at school, this could be part of the tentative acceptance phase and although he reacted with enthusiasm and apparent intimacy, this reaction could be premature and was not necessarily evidence of a genuine relaxed engagement.

There was no apparent negative phase during the course of the therapy. The reason for this might be the family's involvement at home. The activities done during therapy were repeated at home, involving Yvonne, Jack and Lee-Ann. This supportive environment could have given Jason the self-confidence to stay involved with the therapeutic process. With the fourth session the change in Jason's reaction was evident that he now was in the growing and trusting phase. The type of questions he asked showed a confidence in himself and a trust in the world (the therapist became a representative of the world outside). Jason's initiative to paint the therapist's face showed that they had become partners in a plan to try out new variations on old themes. The feedback from the mother about his need to prepare a speech about his grandfather's accident and the emotions he displayed, could be his way of expressing his need to face and connect with repressed feelings. In Chapter 5 in the discussion of the Spontaneous Healing Intrasystemic Process (SHIP®), JOS (2002) the author of SHIP®, states that we disconnect during youth from feelings he calls "the too-muchness". As children we are at times powerless to retaliate against those people or events that cause us pain. In order to survive and cope, we disconnect from

the “too-muchness” and store this pain in the different subsystems of our bodies. Jason’s symptom of sleepwalking could have been a way of this disconnected information attempted to express itself. When we sleep, we do not have our regular defence mechanisms or coping styles active and the disconnected information can more easily make itself known (JOS, 2002).

In the Theraplay sessions prior to this episode, the focus was strongly on Jason and his hidden power. This is one of the underlying principles of Theraplay – discussed in Chapter 5 – to enhance and clarify the view the participants have of themselves. This positive message conveyed by this principle, enabled Jason to allow that which was not healed or connected, to heal and connect.

Although the incorporation of play, where the child is allowed to express and voice feelings, and where the therapist reacts to it, is not part of the theory of Theraplay, the therapist felt that in this specific context it was indicated. The structure was maintained as the therapist decided on the activity. The trusting relationship allowed Jason to express repressed feelings and to also relive the painful event. When Jason asked about the next activity, it might be that spontaneous healing took place and that he was ready to move on. Jason’s request to include his sister was also an indication that he was in a trusting and growing phase and was ready for the termination of the therapy. His internal growth rippled externally.

The last session showed Jason as a confident pre-adolescent who no longer steered away from challenges. This was confirmed by Yvonne – he slept well at night without waking up. He did not show any outstanding signs of stress when he had to write a test and he was more spontaneous at home and at school than before.

The Theraplay process with Jason is in agreement with the conclusion in Chapter 4. There it was stated that although the loss of

hearing can lead to emotional symptoms and can contribute to certain personality traits, the systemic interaction within the family can support or reinforce these behavioural and emotional symptoms and/or personality traits. The systemic perspective thus offered several choices – to intervene intersystemically through Theraplay, or intrasystemically within the structure of Theraplay. The last session was a confirmation of the theory proposed at the beginning of Jason's therapy and is thus part of phase 3 as described in the research model, namely theory testing. The cochlear implant gave Jason a better quality of life, but the psychological intervention enabled him to benefit even more from his implant and to develop his personality without fear.

The last case study will focus on the person as a system, in other words intrasystemically.

7.4 CASE STUDY 3

The therapist first saw the person of the third case study, Becky, as part of the evaluation process before she received her cochlear implant. Becky was 33 years old and congenitally deaf. She became hearing impaired in the perinatal period, as she had raised bilirubin levels (jaundice). The possibility of hypoxia also existed. She was seriously ill. After she recovered from this illness, she was not only hearing impaired but also showed symptoms of cerebral palsy.

During the evaluation Becky did not have any other complaints except handling the challenging situations emanating from her deafness. She presented herself as an outgoing and optimistic type of person. She met all the selection criteria and was approved for a cochlear implant. She was able to make use of her implant from the start and progressed well in this regard. During her MAPping sessions, the audiologists would comment on her sometimes socially inappropriate behaviour, e.g. inappropriate laughing. They also

observed that Becky would sometimes look depressed and that she said things were not well at work. They suggested a follow-up appointment with the psychologist. This only materialised a year after Becky received her implant, when she made an appointment to see the therapist.

In this interview Becky had several complaints. She had an eating disorder; she would constantly overeat and would then go for a frantic gym session of an hour-and-a-half every day, sometimes twice a day. She had a sleeping disorder in the sense that she had bad dreams and then could not get herself out of bed the next morning. As a result of that she would constantly be late for work. She experienced intense religious conflict. She was incompetent at interpersonal relationships and experienced herself as a failure in her work situation.

As part of the exploratory-descriptive work the therapist used the first two sessions – through observation and questions – to explore and describe the problem together with the client. Becky lived on her own. Her brother worked in a city nearby and would visit her occasionally. Her father and other brother lived in the countryside. Her mother was deceased. Becky seldom visited them because of the long distance. During this phase, Becky described a few incidents from her past that were very hurtful to her. From these sessions the theory emerged that the way the current problem presented itself, may be linked to specific incidents from her past.

This theory was reframed in the following way: The symptoms Becky experienced made it necessary to address those smaller systems of interacting psychodynamics within herself. Our systems have an innate healing tendency, illustrating that systems progress towards balance. Symptoms and chain statements (explained in Chapter 5) surface to make us aware of the need to look at repressed feelings and pain and to allow these feelings and pain to

heal. Becky's experience of "something wrong" and presenting chronic systemic stress reactions can be seen as psychobiological messengers trying to bring her in contact with that which had been disconnected in her. The problem was thus reframed not as pathology, but as a process of healing that was activated.

Becky understood this reframing. The actions following from this reframing included certain rituals and these were explained to her. The rationale of SHIP® as a ritual, the terms and certain Figures were explained to Becky. Becky and the therapist agreed on individual SHIP® sessions once a week. Becky mentioned that she had regular unsettling dreams (part of her sleeping problem). The therapist decided to use these dreams as part of the therapeutic ritual and also as a monitor of what was happening in her and that she could not always express on a conscious level. She was asked to write down these dreams and to bring them to the therapy sessions. One of the rituals in SHIP® is to write a life sketch of everything that the person can remember that was distressing or unpleasant. This is also the first phase of SHIP® as described in Chapter 5. Becky presented a life sketch and from the life sketch the following chain statements became evident: (Appendix 2 contains the life sketch).

Feelings of *I am not good enough;*
I am responsible;
being isolated and not part of;
helplessness and humiliation
aggression – especially towards God and men in
general.

It also became clear that there were other significant people in the client's life who triggered the above mentioned feelings in her.

These were: *Mother*
Father

Teacher B.

Grandfather

Grandmother

Teacher R.

Scholar C.

Aunt W.

Uncle J.

People involved in three different places of work.

7.4.1 Psychotherapeutic Strategies/ Interventions

Every session was written down verbatim. Because of the volume of written texts only the first session is recorded in this study. A discussion follows after the first session. For the purpose of this study only parts of the other sessions from the different phases of SHIP® were recorded with discussions afterwards.

Phase 1: The Life Sketch.

First session.

Therapist: During most of this therapy you will be lying on the bed with your eyes closed. The reason for the bed is, it allows for passivity – giving in totally to your experiences as their memory opens up in your bodily suitcase. The reason for keeping your eyes closed is so that you can keep visual contact with the images we will be using. You may experience smells and sounds. You may experience a range of emotions, like anger, irritation, guilt, sadness, frustration or any other emotions. You may experience different physical sensations in your body. Everything you feel is relevant and useful. It is OK to experience whatever arises, just feel it and follow the process as it unfolds. There are three important things to remember:

1. *I will tell you what to do as we progress, so don't worry about that.*
2. *You must tell me everything that you experience, however trivial or difficult.*
3. *Don't do anything with your experiences. Tell me about any physical need you feel compelled to act on, but stay passive. Passivity allows disconnected material to remain in the NOW. I will guide you through the process. I am going to sit right next to you. I know you need to read my lips when I talk so I will touch your arm if I want you to open your eyes." (Although Becky can hear very well with the cochlear implant, she is still dependant on lip-reading to assist her in understanding conversations).*

Becky lay down on the bed. The therapist moved her chair to sit right next to her.

Therapist: *This is a new and unfamiliar experience for you, so I want you to focus on being in this position for the first time. Focus on you feelings about lying on the bed with you eyes closed, and not really knowing what to expect. Go through your whole body and tell me exactly what you are feeling, however difficult that may be.*

Becky: *It feels all right. I'm comfortable.*

Therapist: *I am going to read you something from the life sketch you wrote. Just listen and experience the effect of my words on you:*

'I try to play with the other kids, but they just get up and walk away.'

What do you experience?

Becky: *No effect*

Therapist: *Francine and I must sing together".*

Becky: *I get this pain on my tummy, a kind of a paralysing feeling.*

Therapist: *Just stay with the feeling. Don't do anything to try and make it better. Just allow the feeling to be there. When you keep focusing on the feeling you will find that it can become stronger, weaker or remain the same.*

Becky: *The feeling makes waves where it is strong and then weak and strong again.*

Therapist: *Just be with it and allow the feeling to do whatever it wants to.*

Becky: *The feeling has moved up into my throat like a choking feeling in my throat. There is also this aching feeling in my uterus and colon area.*

Therapist: *Just stay with the feelings and tell me what you see, hear or smell.*

Becky: *I remember the passes that Uncle J. made at me. I felt the same when he put his arm around me. I feel oppressed. He is too close to me. I am feeling nauseous. The pain in my stomach is worse now.*

Therapist: *Stay with the feeling.*

Becky: *After a few minutes – It just stays the same now.*

Therapist: *Were there other times when you had this same feeling?*

Becky: *I always get the feeling that I am wrong and that I am responsible. My grandmother stayed in an old-age home in Pretoria. She became ill and I didn't want to visit her. I had nothing to say to her. She got bedsores and I felt guilty, as if it was my fault. Always my fault.*

[She starts to cry badly.]

Therapist: *I know this is a terrible feeling, but I just want you to go with that feeling of, "always my fault".*

Therapist after a few minutes: *Is the feeling still the same?*

Becky nods her head to indicate yes: *The grade two teacher who lost her job due to me. My throat is tight.*

Therapist: *Stay with the feelings.*

Becky: *I see the garden boy laughing at me.*

Therapist: *What effect does the image have on you?*

Becky: *I just want to die.*

Therapist: *Where do you feel that feeling in your body, which part of it?*

Becky: *Still in my throat – as if I am choking. The feeling is also in my tummy.*

Therapist: *Just stay with it, it is a spontaneous healing reaction that is taking place. It could not complete at the time of the interference because of the too-muchness of the feeling and the fact that you had to cope. In this context now we are providing an environment where in it is given the opportunity to release and complete.*

Becky after a few minutes of intense visible pain: *The feeling is slowly getting weaker.*

Therapist: *Just allow it.*

Becky: *It's gone know.*

Therapist: *We are going to stop our session now. Just lie here for a while and take your time to get used to your external environment and when you're ready you can sit up.*

The rest of the time was allocated to talk about Becky's reactions during SHIP® and to reassure her that all these emerging feelings played an important role in her healing process. Reassurance was also given about her co-operation during therapy. Becky expressed feelings of being tired but relieved after the session. The complete session lasted approximately an hour.

Discussion.

The first two sessions prior to the SHIP® session created a secure atmosphere wherein the client felt safe. This became clear in her reactions which were quite intense from the start of the SHIP® session, indicating her willingness for this type of ritual. The introduction of the SHIP® session where the client lay down and the therapist verbalised potential discomfort, allowed the client to

participate from the outset in the process. It was also an acknowledgement of where the client was at that point. The activators in the form of incidents drawn from the life sketch brought her in contact with experiences that had not previously been part of her psychobiological awareness. These painful experiences were stored in the disconnected-memory imprint centre (the involuntary system in the body). Already in this first SHIP® session, the client made two repeat chain statements:

I always get the feeling that I am wrong;

“Always my fault.

These recurring phrases imply a repetition of some kind and indicate a chain in the disconnected-memory imprint centre that needs to be experienced and completed. By staying with the feeling attached to the chain statements, the client could return to the incidents in her youth and could allow the painful feelings to connect by remaining passive and giving room for the involuntary system to release. The feeling of not being good enough and humiliation in one situation (singing with a schoolmate) unlocked a similar feeling in another situation (the perceived rejection by the gardener), the feeling of being responsible (teacher losing her job) linked up with the same kind of feeling in yet another situation (blaming herself for her grandmother’s bedsores).

The neutralised feeling (feeling calm) at the end of the session indicated that spontaneous healing had taken place and that that it could be said that part of the disconnected information had connected. The chain is not necessarily emptied by this one session and future sessions would probably address these feelings again where it links to other situations. The following Figure illustrates the emptying of the chain:

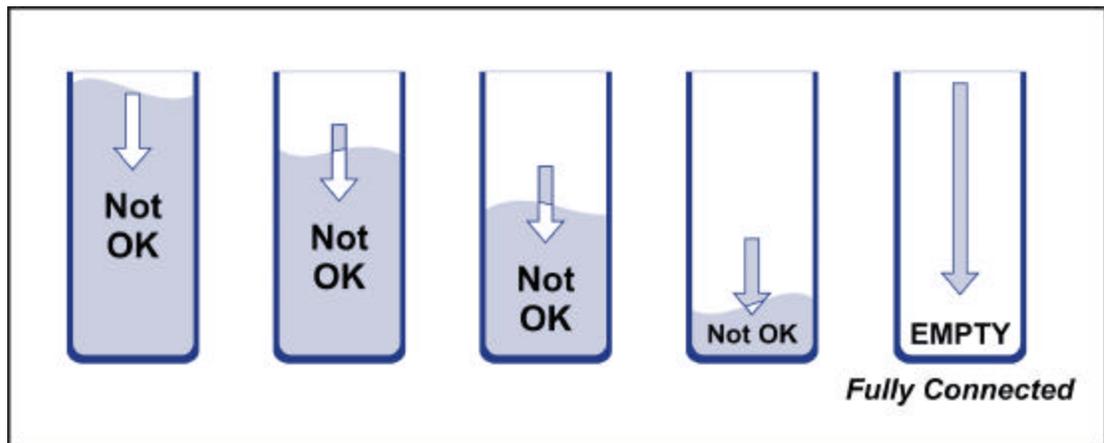


Figure 7.5. The emptying of the chain.

The session was terminated with the reassurance that Becky did well during this first session. Although it was difficult for her to experience all the discomfort, it was a healing process that took place and would ultimately result in a release of distracter energy and therefore a higher sense of freedom to enjoy life to the full. No explaining of the images was done as this could potentially contaminate a client's spontaneous reactions in future sessions.

During the rest of the first phase Becky and the therapist went through the other events described in the life sketch. Although this was done systematically, the reactions of the client sometimes took the client and the therapist from one event to the other in a non-systematic way as the different emotions were linked to each other (as was clear from the first session).

Phase 2: The Doors.

During this phase doors are used as activators.

From the life sketch it was clear that Becky's mother played a prominent role in her life. During the first phase, her mother was used as an activator but the therapist felt that there were still unresolved

feelings concerning the mother figure. The second phase was initiated with a door with the name "Mother" on it.

Therapist: *I want to you see a door with the word 'Mother' on it. Look at it and describe it to me.*

Becky: *It is a nice door, a polished door. 'Mother' is written in silver letters.*

Therapist: *How does this image make you feel?*

Becky: *I get a knot in my tummy.*

Therapist: *Focus on this feeling in your tummy. Let's see where it takes you.*

Becky: *It becomes stronger. I remember once when I was little we went to Durban for shopping. My mother was very fond of shopping. I felt ill. I couldn't stand waiting for her. She said I was being difficult and that I was just full of whims. It turned out that I had tick bite fever and was really ill.*

Therapist: *See yourself in that situation again and feel the effect on you.*

Becky: *The feeling remains the same. It is the same feeling I get when I realise that I cannot change anything.*

Therapist: *Focus on it.*

Becky: *My dad used to get these moods – my oldest brother as well – where they just become quiet. They don't talk. It would create this atmosphere in the house where you don't know what to do. Especially when mom and dad fought - it was like that.*

Therapist: *You felt helpless then?*

Becky: *Yes.*

Therapist: *The feeling on you tummy, is it still the same? Is it worse or better - did it move to other areas in your body?*

Becky: *Feeling is gone now.*

Therapist: *Let's return to the door with the word 'Mother' on it. I want you to open that door and go inside. Tell me what you see?*

Becky: *It is a nice room, filled with sunshine. Nice couch and curtains.*

Therapist: *Walk into the room and sit down in the middle of the room. Just experience what it feels like to be there.*

Becky: *It is a little bit stuffy. I am glad my mother isn't here. It is not comfortable; I don't want to be here. The feeling is back in my tummy.*

Therapist: *Go with the feeling. Allow the feeling to do with you what it wants.*

[Therapist could see discomfort on the client's face. After a while her face relaxed.]

Becky: *The feeling is gone know.*

Therapist: *I want you to see your mother there with you in the room.*

Becky: *I see myself as a little girl. It is nice to see her. She is a beautiful woman.*

Therapist: *See yourself as you are now and look at her.*

Becky: *I get that feeling again on my tummy.*

Therapist: *Focus on it.*

Becky: *The feeling is better now but I get a tight feeling in my chest.*

Therapist: *Go with the feeling.*

Becky: *I want to cry now. I want to tell her that I love her.*

Therapist: *Tell her that.*

Becky [cried for a few minutes]: *Sometimes she was so nasty. Most of the time I don't miss her.*

Therapist: *Tell her that.*

Becky cried intensely for a few minutes. The therapist just remained by her side, allowing the feelings to run their course.

Becky: *The feeling is gone know.*

Therapist: *Is there anything in the room you would like to change?*

Becky: *No, its fine.*

Therapist: *Leave the room and close the door behind you. How do you feel when you look back at the door?*

Becky: *No feeling, a kind of quietness in me.*

The session was ended and the other doors were addressed during the following sessions.

Discussion.

Although the mother figure was used as an activator for disconnected feelings during the first phase, the emotions shown were not very intense. During the second phase however, the client experienced a deeper level of emotions. This is in agreement with the theory of SHIP® where the journey of psychotherapy is seen as a gradual movement into deeper layers of the disconnected-memory imprint centre.

In a similar way, the other doors were addressed. Doors with the following headings were given:

My eating habits

Helplessness/humiliation

God

Emotions

Identity

Becky

My Soft Sensitive Spontaneous Self

I am deaf

Some of the doors triggered such intense emotion that several sessions were spent on that particular door. For example, the door with the word *helplessness* on it extended over five sessions. During this phase the client sometimes spontaneously returned to events documented in her life sketch and time was allocated to relive those events and to connect with the disconnected feelings. The client presented the feeling (helplessness) that needed to connect; the

therapist was the facilitator who guided the client to make contact with the feeling and to experience it until the eventual non-threatening image conveyed that that particular part of the feeling connected and integrated fully.

During this phase the client reported that she did not experience her sleeping problem anymore. She was able to get up in the morning on time and did not have the usual nightmares. She would still occasionally have a bad dream. Her eating habits improved dramatically. She did not experience cravings and she reduced her gym sessions to three times a week. She still experienced relationship problems. She found it difficult to be assertive and was scared to induce any conflict situation. Unhappiness at work remained and she was considering applying for another job. From this information it was gathered that although a lot of healing had already taken place, there were still some deeply embedded issues that needed to be addressed. This is once again in agreement with the SHIP® theory that SHIP® is not a quick fix, but a gradual process where the pain that presents itself heals according to the different layers in the disconnected-memory imprint centre. This was explained to the client by means of the following two Figures.

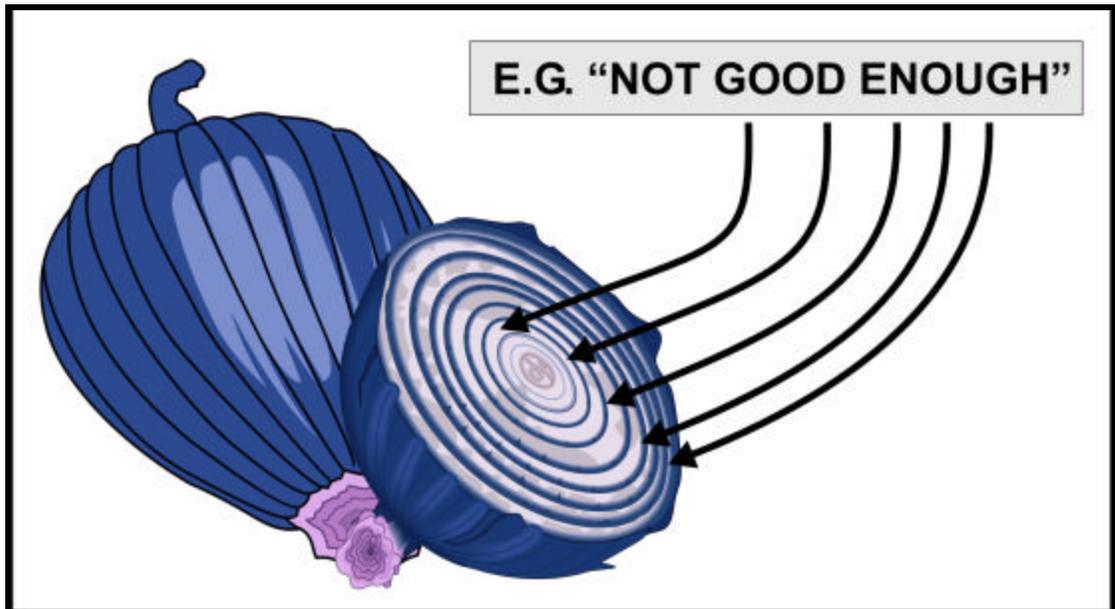


Figure 7.6. Peeling away the layers of the onion releases the self – even though all layers may activate the same emotional discomfort (e.g. ‘not good enough’), since it is of the same chain, each layer peeled away means one less in the journey towards the self.

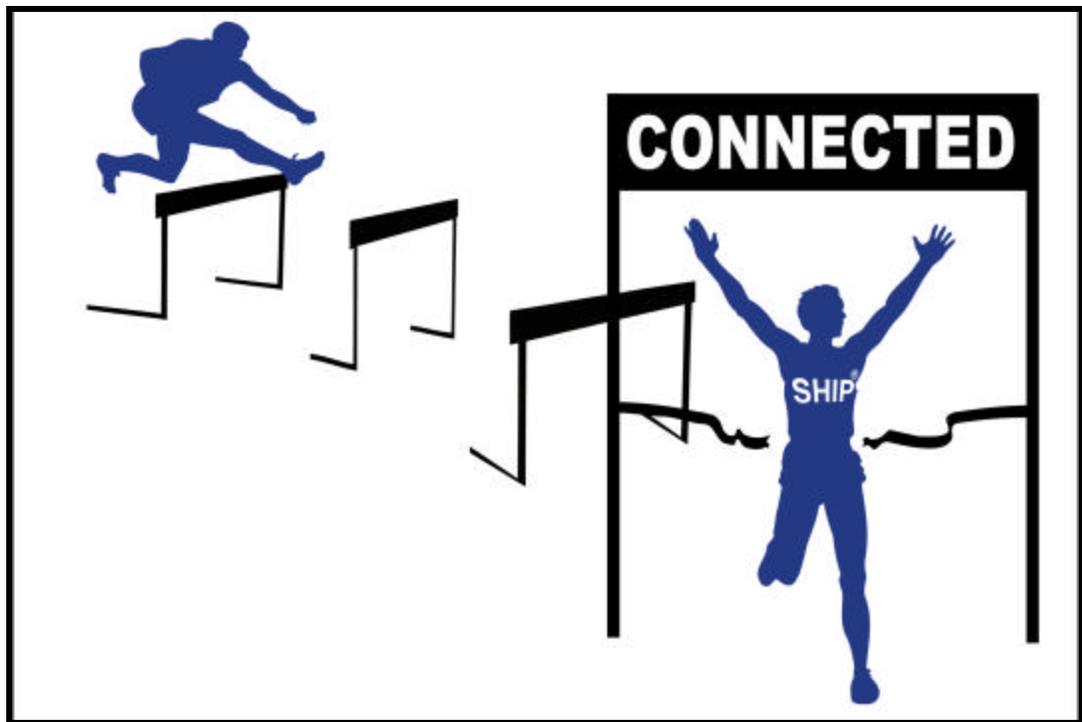


Figure 7.7. Each hurdle is one less obstacle towards the finishing line, not one more.

Phase 3 The Tunnel.

As mentioned in Chapter 5, the tunnel signifies the archetypal symbol of the birth canal and of travelling from one dimension to the next.

The session started with the therapist instructing the client as follows:

Therapist: *I want you to visualise a tunnel. It is not a man made tunnel but a naturally formed tunnel. See yourself in front of the tunnel and describe the image to me.*

Becky: *I am standing behind a waterfall in front of a tunnel. It is cold and I don't like it here.*

Therapist: *Focus on the feeling and tell me in which part of your body you feel the discomfort.*

Becky: *There is a slight feeling of discomfort on my tummy but it is not prominent. Now the feeling is gone.*

Therapist: *Walk into the tunnel and sit down. Get in touch with the effect it has on you.*

Becky: *I can't see much but it feels OK.*

Therapist: *While you are sitting there I am going to say something. Experience the effect on you: 'My future'.*

Becky: *There is that familiar feeling on my tummy again. Two thoughts spring to mind – the first one is the knowledge that things will be all right for me – things will work out for the best. The second thought is I can't help but to think of all the mistakes I have made in the past.*

Therapist: *Focus on the second thought and feel the effect on you.*

Becky: *My tummy again.*

After a short while the feeling dissolved and the other activators were presented to Becky. After the activators were

given and the repressed feelings were allowed to connect, the therapist initiated the following activator:

Therapist: *I now want you to get up and walk deeper into the tunnel.*

Becky: *I can see a bright light like dazzling sunlight.*

Therapist: *Walk towards the light.*

Becky: *It is a waterfall again and I am looking down.*

Therapist: *What effect does it have on you?*

Becky: *It's not my favourite but its OK.*

Therapist: *Move to the edge and fall towards the waterfall. The assumption is that you can breathe under water. Just give yourself to the waterfall.*

Becky: *It is a cold muddy pool. It feels as if I am going to drown.*

Therapist: *Go into that feeling. I know it is scary but go into that drowning feeling.*

Becky: *I am freezing. I am under a slab of ice. I am dead. I want to get out. I want to break the ice.*

Therapist: *Don't do it. Just feel it.*

Becky: *My tummy is aching and it feels as if I am trembling on the inside.*

Therapist: *Stay with the feeling.*

After a while the feeling started to abate but was not totally gone. The hour for the session had run out and an extra time was scheduled, as the therapist did not want the client to wait a week in an activated state.

In the follow-up session the client did not experience the same intensity of feeling as in the aforementioned session. It could be that there was still some disconnected information that wanted to heal but that the connected self of the client was not ready to face these feelings or that the remaining feelings had

washed out similarly to a wave washing itself onto the beach. The therapist made a note to test this specific image again during the integration phase.

Phase 4 The Well.

The well is used as an activator of the prenatal/foetal phase of being in the mother's womb. After the therapist had asked the client to see a well, she responded as follows:

Becky: *I see an old fashioned well with a small red brick wall surrounding it. There is water in the well. I can see it shines.*

Therapist: *You are able to breathe under water so I want you to see yourself at the bottom of the well. You are sitting there.*

Becky: *The water is a nice blue colour and there are some fishes.*

Therapist: *Close your eyes and experience the effect of the word 'mother' on you.*

Becky: *Its dark and I have an oppressed feeling.*

Therapist: *Where in your body do you feel these feelings?*

Becky: *Low down in my stomach. I want to get out or curl up.*

Therapist: *Just keep focusing on the feeling and go with it.*

Becky: *It becomes worse, I can't breathe!*

Therapist: *This is a terrible feeling but just stay with it. Allow it to do with you what it wants to.*

Becky: *Its slightly better but still there.*

Therapist: *What other time in your life did you have the same feeling?*

Becky: *I always got this feeling when I knew my mother was going to scold me. I always knew when she was going to be angry. Whatever you did it was never good enough. She was a perfectionist.*

Therapist: *How does that make you feel to say those words?*

Becky: *I just want to curl up and never get up again.*

Therapist: *Go into that hurtful feeling.*

Becky: *Its worse now, my tummy. She never thanked you for your efforts. It never was good enough.*

Therapist: *Stay with that feeling.*

Becky: *Ria (friend) also has this effect on me – I am never good enough.*

During this session a few repeat chain statements surfaced again. This proved that this particular feeling (*I'm not good enough*) was well-known to the client. Chain statements verbalised by the client are seen as the past interferences that are being projected onto the Now. She was forever trying to get rid of this feeling. She would start a new job or new friendships as a way of getting rid of this feeling. The feeling was embedded (disconnected – never completed) in her early developmental years and kept on popping up as a way to connect and heal. In return, she did not want to be reminded of this feeling or feel it, so she tried to ignore or repress it and tried something new – in the hope that this time she would succeed and be good enough. These distracters underline the theory of SHIP® that distracters are used to deny and replace the repetitive uncomfortable experience. It is seen as a way of controlling and manipulating the effect of the activator in order to minimise the activated internal discomfort. The client had experienced this uncomfortable feeling in relation with a significant other, namely her mother – it has disconnected because of too much pain and resurfaced again during intimacy and close interpersonal encounters - it therefore affects her other relationships as well. The friend she referred to in the session is a woman older than herself and could easily represent a mother figure. This illustration of the mother-child relationship serves also as a confirmation of the literature mentioned in the description of Theraplay and also in Chapter 2 - where the effect of the diagnosis of deafness is discussed. How parents feel about, and act towards, their children will affect the way those children come to view themselves, and may have long-lasting effects

on later social relationships as well as on career decisions, and future lifestyles, possibly throughout life.

Phase 5 Integration.

This phase is an integration of the previous four phases. The images used in phase five represent closure of previous issues and indicated the need to test whether there are still disconnected feelings that need to connect.

Door with inscription ‘The road of my life’, the Cliff, the Sea, the Waterfall and the Raft did not activate any further spontaneous healing reactions in the client.

Stairs leading down with an inscription at the top ‘My disconnected self’

This activator presented the client with a few people she used to work with. She did not mention these people in her life sketch. Her reaction was not prominent and the feelings abated fairly rapidly.

The Cocoon

This image was a severe activator for the client. Her reaction was as follows:

Becky: I don't like this. I can't breathe. I want to hit this off me.

Therapist: Don't do anything, just allow the healing process to take place.

Becky: I am trapped. There is a contracting feeling in my lower stomach. It is bad and it becomes worse. All that I can see....it is as if I am in my mother's womb. I want to get out but I can't. It is too enclosed. I can't breathe.

Therapist: Go with the feeling

Becky: I kick and kick.

Therapist: *Stop kicking and just experience everything.* (The therapist neutralised the client from taking control and distracting from the awareness of surfacing disconnected pain).

[Client's body presented with muscle cramps, her neck pulled backwards while she gasped for breath.]

Becky: *I can't get air, it feels as if there is something against my skin. Something is pulled over my face and I can't breathe.*

[Client kept on gasping for breath – this went on for a couple of minutes].

Therapist: *Stay with the feeling.*

Becky: *It feels as if I am inhaling plastic. I see Danny. (client's brother), he has a plastic bag over his head and I want to pull it off.*

Therapist: *Don't do anything, just allow the image and the feeling to do with you what it wants to.*

[Client looked distressed, she was still gasping for air.]

Becky: *I still see Danny, he is fading away now. It feels as if I am about to faint. Everything is spinning. My breast is burning. It feels as if I am falling.*

It feels as if I am being pushed on a trolley into a theatre everything is blurry and confused. My tummy aches. The feeling in my tummy takes me back to the cocoon. It looks different. It is kind of a wet skin all over me. I am curled up.

[The client kept on gasping for breath in a very distressed state.]

Becky: *I get a picture where I was trapped in a lift. The lift got stuck between 2 floors. I was still small. It was one of those older types of lifts where you could see through the glass door.*

Therapist: *Stay with the image.*

[Client still battled to breathe.]

Becky: *I see how I banged against the doors, I kept on screaming they must bring an axe and break the door open. The people try to calm me down but I can't hear them.*

Therapist: *Don't do anything to try and make it better, just allow the image to take you wherever it does.*

Becky: *I can't breathe! I remember when I got the asthma attack at my grandparent's house. My grandpa got angry when I was like that. He yelled at meHe shouted that I must stop crying... I was so scared...I am so tired now, so tired.*

Therapist: *How does your body feel now?*

Becky: *It's gone now but I don't know if I am just tired.*

Therapist: *We will return to this image. For now I just want you to lie here for a while and rest. When you are ready you can get up slowly and return to the chair.*

Discussion.

This was the most intense of all the sessions. It was as if there was a deep-rooted emotion that was concealed under various other feelings and incidents and it took a long time to uncover. A variation of explanations is possible about the images and feelings. According to the philosophy of SHIP® the explanation is, however, not as important as the fact that these feelings need to connect. The possibility exists that the client did experience a process of birth where there could have been a situation of hypoxia. This could also be the explanation of her deafness. The image of her brother is realistic (client told therapist she observed her brother playing with a plastic bag). Her own disconnected feeling of suffocation was activated by the image of her brother playing with a plastic bag. The memory of her being stuck in an elevator also reflected a real encounter (client got stuck in an elevator during a holiday at the coast). Once again the feeling of being stuck was intensified by the memory of a previous event of being stuck, and of oxygen deficiency. These incidents linked with each other to form a chain of events with the same type of feeling: "I am stuck, can't breathe." It can be

conceptualised that her body cells still carried the memory of the pain and discomfort and when the SHIP® ritual complemented her internal healing process, the feelings emerged and were allowed to start the spontaneous integrating process.

The cocoon and the feelings triggered by this image were spread over two sessions. Eventually the therapy session ended with an image of an open field and a peaceful feeling. Spontaneous healing had taken place and was reflected accordingly in the image.

7.4.2 Summary of all the Sessions

The first phase where activators from the life sketch were given, took the longest. As the therapy progressed, the client was able to move along quicker with the healing process more quickly. The reason for this might be that she felt safer and that she did not find it necessary to distract within the session. The healing in the client is also not limited to the session only. The session is just a structured way of facilitating healing and to initiate the healing process.

During the therapy the client's symptoms dissolved. She mentioned that she experienced more energy and did not suffer further from any eating problems. At the end of the therapy, she was working for a company and ran a part-time practice. She was successful and happy in her work with the company and was even asked to be a guest speaker at a business convention. She shared her life experience in a motivational talk that provided her with a lot of positive feedback about herself. In this speech she mentioned that when she looked back on her life, she could see that everything that happened to her provided her with an opportunity to grow. She was happy and projected an image of health and energy. She had a few friends whom she visited on a regular basis. She had made peace with the fact that she was deaf. During the therapy Becky recorded her experience of the therapy. After the completion of SHIP® these

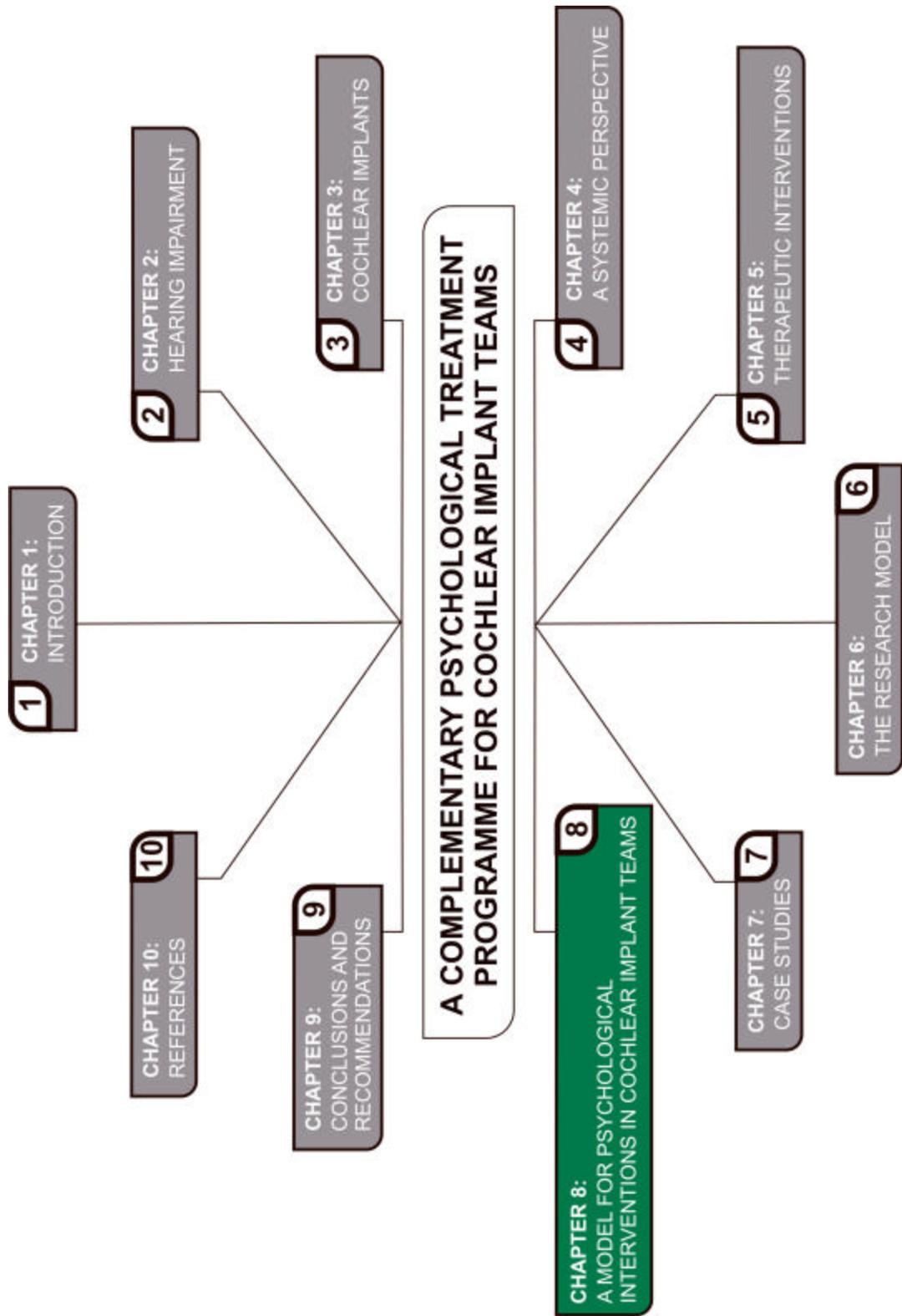
notes were compared with the notes of the therapist as a means of validating the information of the therapist.

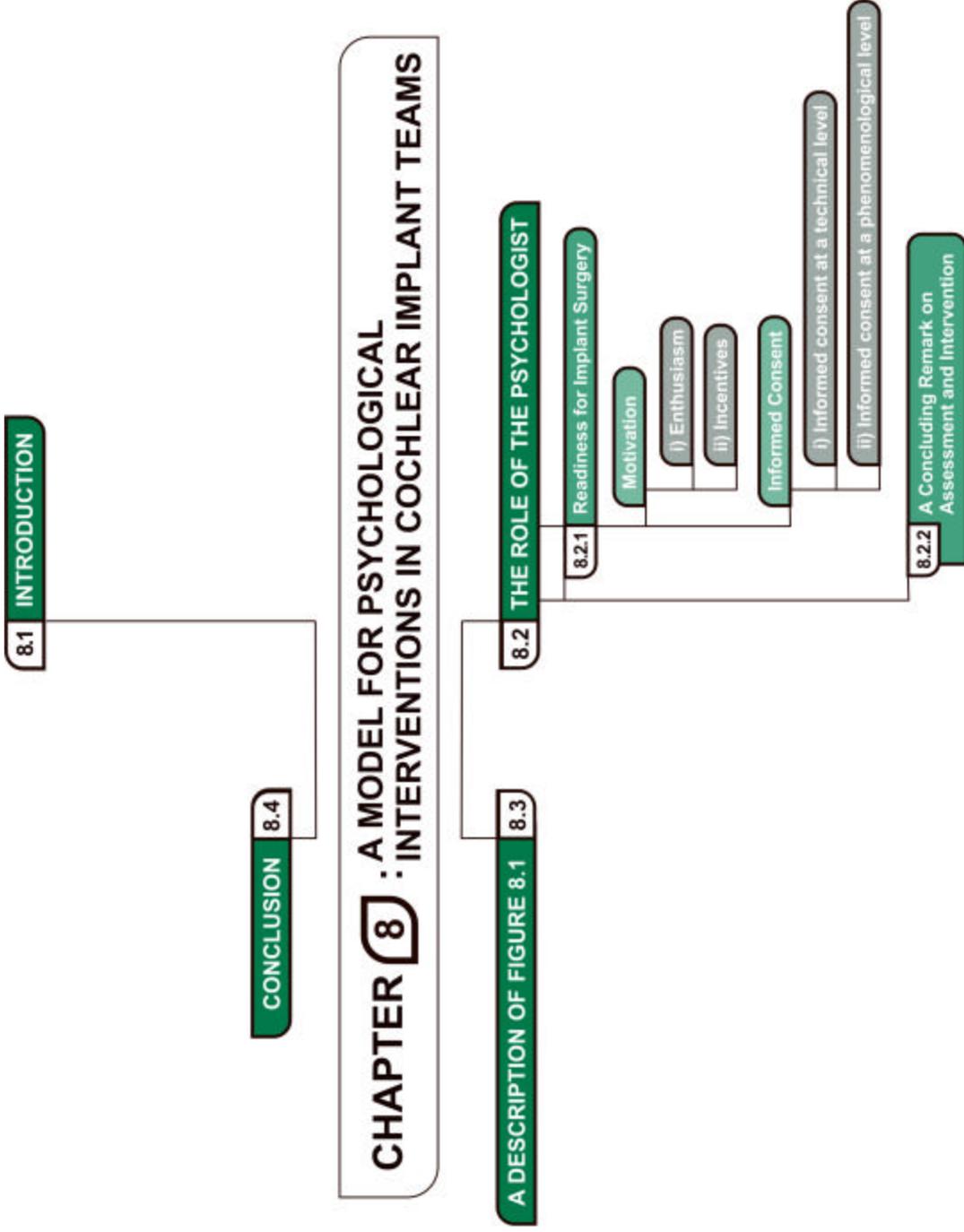
7.5 CONCLUSION

This chapter indicates how three different clients were treated in three different ways. Hearing impairment can occur at any age. Someone may also be part of a family system, like a child, but sometimes an immediate family system could be absent. These situations offer opportunities to utilise different therapeutic approaches and interventions. This chapter also showed that although the cochlear implant, as an intervention, can be very successful, it can sometimes also have an effect on the family, this, in turn, could create other problems, which can influence the family's functioning, or someone's functioning with the implant. The effect of a disabled child on the mother-child relationship became clear – also the fact that it is never too late to alter a mother-child relationship. The effect and importance of the parent-child relationship were evident in all three cases. The final case described the intrasystemic healing process through the SHIP® philosophy. In this case study the focus was on connecting and healing of repressed feelings that were seen as affecting the client's functioning. This chapter illustrated the viewpoint posited in Chapter 4 – the systemic perspective - where it is suggested that the behavioural and emotional characteristics that may be presented by many hearing-impaired clients have come about, are supported, and are reified as a function of the interaction within and between systems levels across time. The systemic perspective offers the clinician several choices about how, when, and where to intervene in the context of the biopsychosocial field.

This chapter illustrated how three different therapeutic approaches can be utilised in practice. The case studies highlighted treatment models that could benefit and complement any existing treatment modalities of any cochlear implant team.

The next chapter discusses the role of the psychologist and the place of psychological interventions. A Figure and a brief discussion of the Figure is used to illustrate the process the hearing impaired-person follows when cochlear implants are considered.





CHAPTER 8

A MODEL FOR PSYCHOLOGICAL INTERVENTIONS IN COCHLEAR IMPLANT TEAMS

8.1 INTRODUCTION

In the previous chapters the need for focus on psychological adaptation was stipulated and carried through during the discussion and application of the case studies. In this chapter the role of the psychologist in the implant team is summarised. A route is suggested in the future treatment of cochlear implant candidates as the most applicable interventions necessary to complement the process holistically. Figure 8.3 summarises the whole process.

8.2 THE ROLE OF THE PSYCHOLOGIST

The role of the psychologist varies between assessment and intervention. Whether considering adult or child candidates, functions of the pre-operative psychological assessment could include:

- a) identifying psychopathology that may exclude individuals from implant candidacy;
- b) collecting cognitive skills data relevant to predicting post-operative outcomes (someone must be able to function on a cognitive level that will enable him/her to understand what is expected from him/her during the 'MAPping' procedure). There is an on-going debate regarding mental retardation and cochlear implants. While the NIH (National Institutes of Health, 1995) statement excludes those with severe forms of retardation from implant candidacy, Gantz (1989) argues that the device may be helpful to deaf persons with milder degrees of retardation, a finding already reported with one

individual who had an IQ of 63 (Fritze & Eisenwort, 1989). At present, most studies exclude persons with any degree of mental retardation, even some with higher “borderline” IQ levels. Although this restriction of range makes it difficult to know how intellectual limitations may impact on post-operative outcomes, several studies have demonstrated that IQ does predict post-operative audiological and communication outcomes for persons with average or above intelligence (Fritze & Eisenwort, 1989; Gantz, 1989; Knutson, Hinrichs, Tyler, Gantz, Schartz & Woodworth, 1991);

- c) collecting psychological data relevant to formulating judgements of candidates’ readiness for implant surgery, including motivational and informed consent information (this will be described below);
- d) evaluating the family functioning and support system of the potential cochlear implant patient;
- e) providing assistance, as needed, when problems are identified in these areas (Pollard, 1996).

8.2.1 Readiness for Implant Surgery

Readiness for implant surgery is conceptualised by Pollard (1996) as a multidimensional psychological concept that embodies two broad factors. The first is **motivation**, in terms of both enthusiasm and incentives (motives) for seeking the implant. The second is **informed consent**, which subsumes knowledge of “reasonable expectations” about cochlear implantation but also includes more. This conceptualisation of readiness is consistent with NIH’s (1995) recognition that “determining candidacy requires consideration of ... the subjective needs and wishes of individual

candidates (p.10)” as well as with the more traditional, objective aspects of readiness commonly stressed in the implant literature.

Motivation.

i) Enthusiasm

There is general consensus in the literature that implant candidacy and post-operative outcomes depend on persons' motivation (enthusiasm) about undergoing the operation and active participation in the 'MAPping' (as described in Chapter 3) and training that follows (Pollard, 1996).

ii) Incentives

The second aspect of motivation deals with the reasons why someone is seeking an implant. Although infrequently discussed in the literature, the incentives or motives are a different but equally important matter to investigate in pre-operative assessment (Pollard, 1996). Knutson, et al. (1991) point out that psychological distress in the face of hearing loss may be the primary motivating factor for some candidates.

Informed consent.

i) Informed consent at a technical level.

According to Pollard (1996) this aspect of informed consent consists of knowledge of the device itself (its components, placement and function), the surgery and recovery process, the MAPping and training period, and the range and frequency of various audiological and communication outcomes. Knowledge pertaining to surgical risks, the MRI prohibition (due to the magnet inside the C.I., Magnetic Resonance Imaging should be avoided), and alternatives to cochlear implantation is also necessary (NIH, 1995). The psychological

assessment should verify that the candidate and relevant others have understood and retained the aforementioned information.

ii) Informed consent at a phenomenological level.

Pollard (1996) describes informed consent conceived at a phenomenological level as freedom from undue bias based on ignorance or unfounded beliefs about life with deafness or, more specifically, life without a cochlear implant. Such biases are at times revealed in discussions of the motives of candidates' families but more commonly must be elicited through direct inquiry regarding individuals' knowledge base, beliefs, and attitudes about deafness and different adaptations to it. It is common to meet candidates or families of candidates who have never met a deaf adult or learned how different types of deaf adults successfully adapt to hearing loss. When persons do not possess such knowledge, there is considerable danger that their images of life with or without the implant will be influenced by fantasy or other sensational portrayals of deaf people. Brauer (1993) used Erickson's concept of *pseudospeciation* to describe the inappropriate dichotomisation of life in the "deaf world" versus life in the "hearing world" that some individuals characterise as the essential choice underlying the implant decision. Cochlear Corporation (1994a) lists "a desire to be part of the hearing world" (p.3) as a criterion for implantation. A balanced, informed decision about pursuing cochlear implantation must be predicated on knowledge not just about the implant and the range of adaptations to it, but also about life without the implant and the range of adaptations to it. Such information is consistent with NIH's (1995) recommendation that "all candidates require in-depth counselling of alternatives to cochlear implantation" (p.10).

8.2.2 A Concluding Remark on Assessment and Intervention

Given these complex considerations regarding readiness for cochlear implantation and the multidimensional nature of motivation and informed consent, it follows that few implant candidates “walk through the door” fully prepared for the procedure from a psychological perspective (Pollard, 1996). However, the majority of candidates present in some earlier stage of readiness.

The implant team, and especially the psychologist, must initiate a partnership with the individual and his or her significant others, where it is understood that there is more to learn, consider and evaluate before the final decision about candidacy can be made. Pollard (1996) describes assessment in this context as both an evaluation and an intervention procedure. Shea and Domico (1993) discuss the importance of pre-operative sessions with the psychologist in establishing informed consent with parents of child candidates, while Evans (1989) discusses the psychologist’s role in preparing the child. Spitzer (1993) describes the utility of psychosocial measures in fostering pre-implant counselling. In practice, psychological assessments often move back and forth between objectives related to data collection and objectives related to education or counselling.

The role of the psychologist does not stop when the decision for implantation is made. The assessment and interventions proceed throughout the period of rehabilitation. If assessment of the situation shows that further interventions are necessary, psychological interventions can take place.

Further interventions by the psychologist are to optimise the functioning of the team as a system and also to make the other professionals in the team aware of the impact the team as a system has on the client and his/her systems and vice versa. The qualities of

systems as described in Chapter 4 illustrate this reciprocal nature of systems.

The following Figure illustrates the practical implementation of the psychological interventions. This Figure also represents the manner in which the cochlear implant team of the University of Pretoria functions.

8.3 A DESCRIPTION OF FIGURE 8.1

Step 1.

The hearing-impaired patient, usually desperate about his/her hearing impairment, inquires about a cochlear implant. In the case of a child, the desperate parents decide to find out more about this unique process. The hearing-impaired patient or parents of the hearing-impaired child, usually referred by an ear, nose and throat surgeon or audiologist or sometimes by a friend or family member, make an appointment to see the audiologist and other professionals involved with cochlear implants.

Step 2.

This first interview consists of the exchange of information. The medical/audiological history of the patient is important to the audiologist. This interview serves as a screening of the patient before any other evaluations take place. In the case of a child, his/her educational placement is evaluated and referrals made if necessary. During this interview the expectations of the patient will surface and can be addressed. For the patient it is important to get as much information as possible on cochlear implants.

Step 3.

If the screening evaluation shows that the hearing-impaired patient is a potential cochlear implant candidate, an appointment is made to see the ear, nose and throat surgeon involved with cochlear implants. The surgeon performs an ear, nose and throat examination and a C.T. scan of the inner ear is requested to determine the status of the cochlea.

Sometimes the patient will start the process by visiting the ear nose and throat surgeon first. In that case the next step is an appointment with the audiologist (step 2).

Step 4.

The hearing-impaired patient visits the psychologist for a psychological assessment as described. Another purpose of this assessment is to determine if the client and his/her family have accepted the diagnosis of hearing impairment. It also serves as a means to observe the family functioning. The psychologist can make use of a variety of psychological tests to assist him/her with the evaluation process. At this stage the expectations of the patient, or that of the parents of the patient, already indicate possible candidacy and/or the success of the outcome of the implant.

Step 5.

This step includes another visit to the audiologist where further audiological evaluations are done. These evaluations are described in Chapter 3. This is very important as they can give an indication whether the audiological information the hearing-impaired patient will receive from the implant exceeds the information he/she currently receives from hearing aids.

Sometimes the patient visits the audiologist before seeing the psychologist. This is not important, as long as both these professionals are consulted. In specific cases a trial period of three to six months with hearing aids and rehabilitation, or proper educational placement (a more appropriate school) is recommended before a final decision on candidacy is made.

Step 6.

A cochlear implant team meeting takes place where all the information gathered, is discussed. The members of the team each give his/her feedback on the evaluations done.

A mutual agreement about the suitability of the patient for a cochlear implant is reached. The decision is always in the best interest of the patient. The audiologist who co-ordinates the process, informs the patient or his/her parents about the team's decision. If the patient seems to be a suitable candidate he/she proceeds with A1. If not, B1 applies (Figure 8.1).

Step A1.

The patient goes into a preparation period where funds are raised and negotiations with medical aids take place. This period can sometimes be very stressful and the patient or family members are always advised to visit the psychologist on the team should they have the need.

Step A2.

Just before the implant the client and his/her family visit the psychologist again. During this visit the focus is on the expectations the client and his/her family have regarding the implant and the switch-on. Sometimes the client and his/her family are fearful of the surgical procedures awaiting them,

e.g. the choice of ear that should be implanted. These fears are addressed.

During the four-week period when healing of the wound takes place, the client will have no hearing in the implanted ear. Although they know that there is not much hearing left before the implant, this is still a frightening time for some of the implant candidates. During this period the patient can find it more difficult than usual to communicate. All these aspects are discussed with the patient and the feelings surrounding it are worked through. In the case of a child these fears of the parents are attended to.

Step A3.

The patient is admitted to hospital and the chosen ear is implanted. Depending on the state of mind of the patient/parents during the previous session, the psychologist may pay the patient/parents a visit during the hospital stay.

Step A4.

- The four weeks healing of the wound period has expired and the patient is ready for the switch-on of the electrodes. The patient is usually accompanied by significant others such as spouses, family and/or friends. These people can project their expectations onto the patient, which can lead to a stressful situation. It is therefore a better option if these people are seated in an adjoining room from where they may observe the procedure through a one-way mirror. It is also helpful to have a team member with them to inform them about the process and to answer their questions. This is an excellent opportunity for the psychologist to observe the interaction between the patient and his/her family. These observations

usually play an important role when further psychological interventions are necessary.

Step A5.

The initial 'MAP' that was obtained with the switch-on changes as the patient gets accustomed to the sound of the electrodes. Regular 'MAPping' sessions are necessary to obtain optimum performance from the implant.

Step A6.

Several weeks have passed since the implant. The patient has experienced the implant and the new sounds. The initial excitement of the implant and switch-on has passed and the reality of the new situation becomes clear. Sometimes this also evokes certain feelings in the patient/parents of the patient. The psychologist spends time discussing expectations surrounding the implant. The importance and effect of these expectations are discussed in Chapter 3. If necessary, psychological interventions as discussed in Chapter 5 follow.

These steps complete the initial cycle of professional interventions. From here on the patient proceeds with step 2, 3, 4, 5, and 6 to continue into the second cycle of the treatment process: The audiologist does the 'MAPping' (**step 2**) and, where necessary, also refers the patient to another audiologist who does a rehabilitation programme with the client. The surgeon does a follow-up examination when indicated (**step 3**). These visits usually reveal any psychological discomfort in the family or individual. If this is the case, the surgeon and/or audiologist refer the client back to the psychologist. Sometimes the patient or the family contact the psychologist spontaneously as a trust-based relationship with the psychologist has already been established (**step 4**). Interventions

can be in the form of Family Therapy, Theraplay, SHIP® or other forms of psychological interventions.

Not all the cochlear implantees or their families need psychological support or interventions, but this service should be available for them when needed to complement the whole process of cochlear implants. Eventually the visits to the surgeon decrease and only materialise when necessary. 'MAPping' and rehabilitation with the audiologists continue but with longer intervals between visits.

The cochlear implant team has monthly meetings where the progress of the different patients is discussed and where follow-up interventions are recommended if necessary. These interventions include school visits and contact by other professionals involved with the client.

Step B1.

If the candidate does not qualify for an implant there are usually a few other options available e.g. to enrol the child in a school for the deaf where signing is the primary mode of communication or in some cases different/stronger hearing aids are a possibility (step **B2**). In many of these cases candidates have a preconceived idea that the cochlear implant is not an option but they still pursue the possibility in the hope of an improvement in their quality of life. The decision of the team is then a confirmation of their own ideas. Sometimes when candidates or parents of candidates learn that the cochlear implant is not a possibility, the grieving process about the hearing loss is triggered and psychological interventions may be necessary. In some cases where the hearing of candidates is still too good for implants they are kept on the list of evaluations and when their hearing deteriorates they proceed with the rest of the steps in the evaluation process, starting again with **step 2**.

As mentioned earlier, this is a dynamic and fluid process and may be altered where necessary.

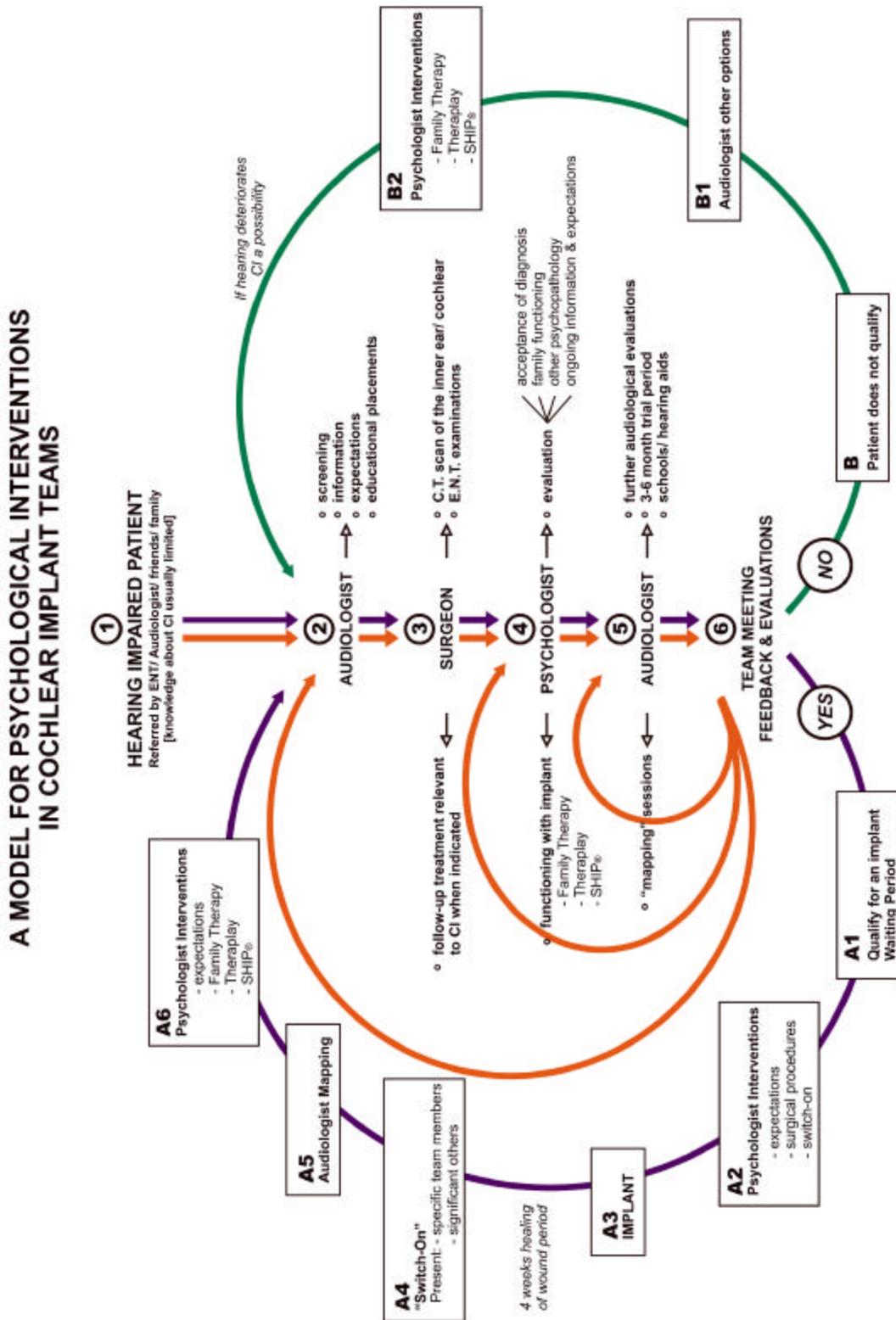
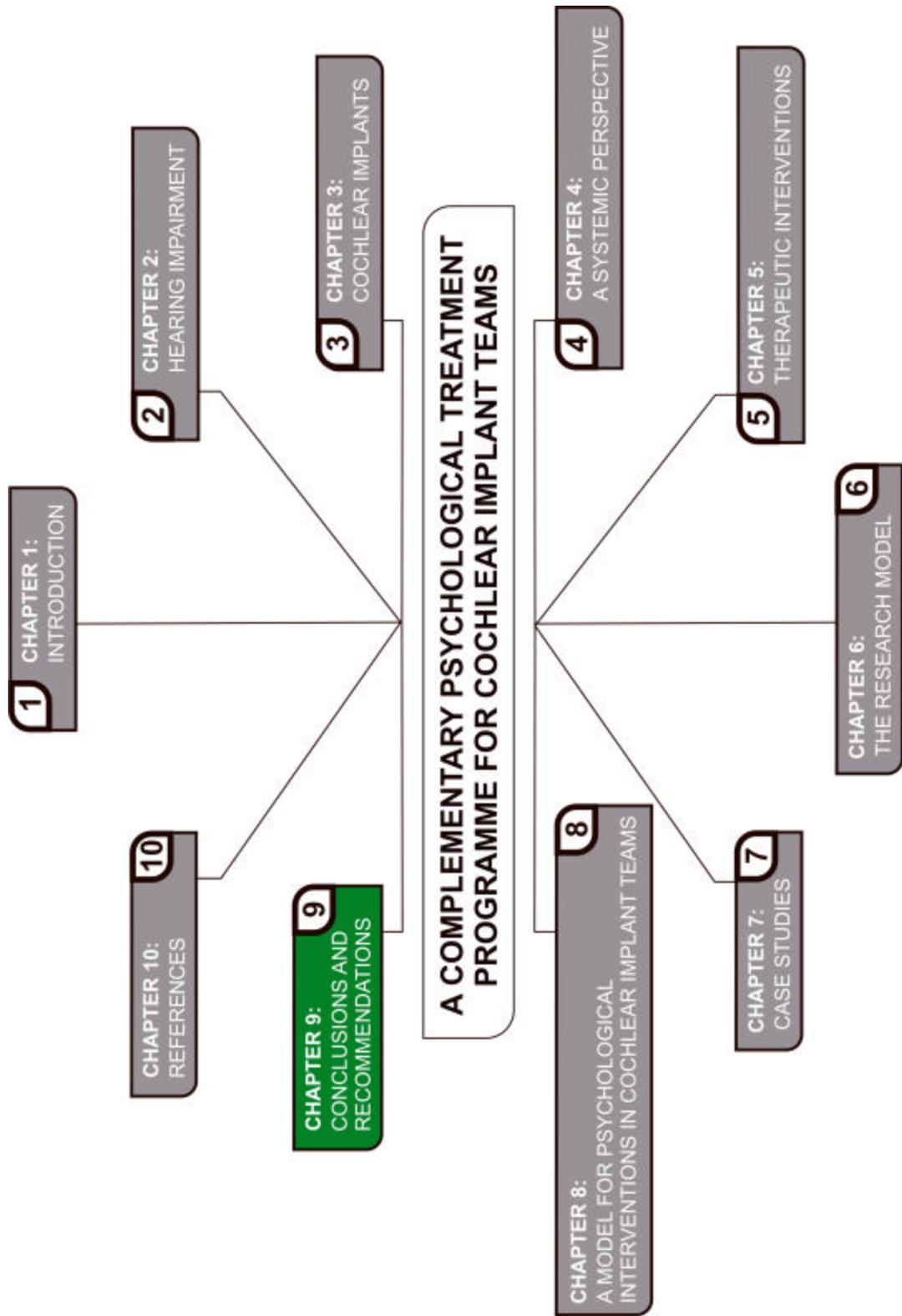


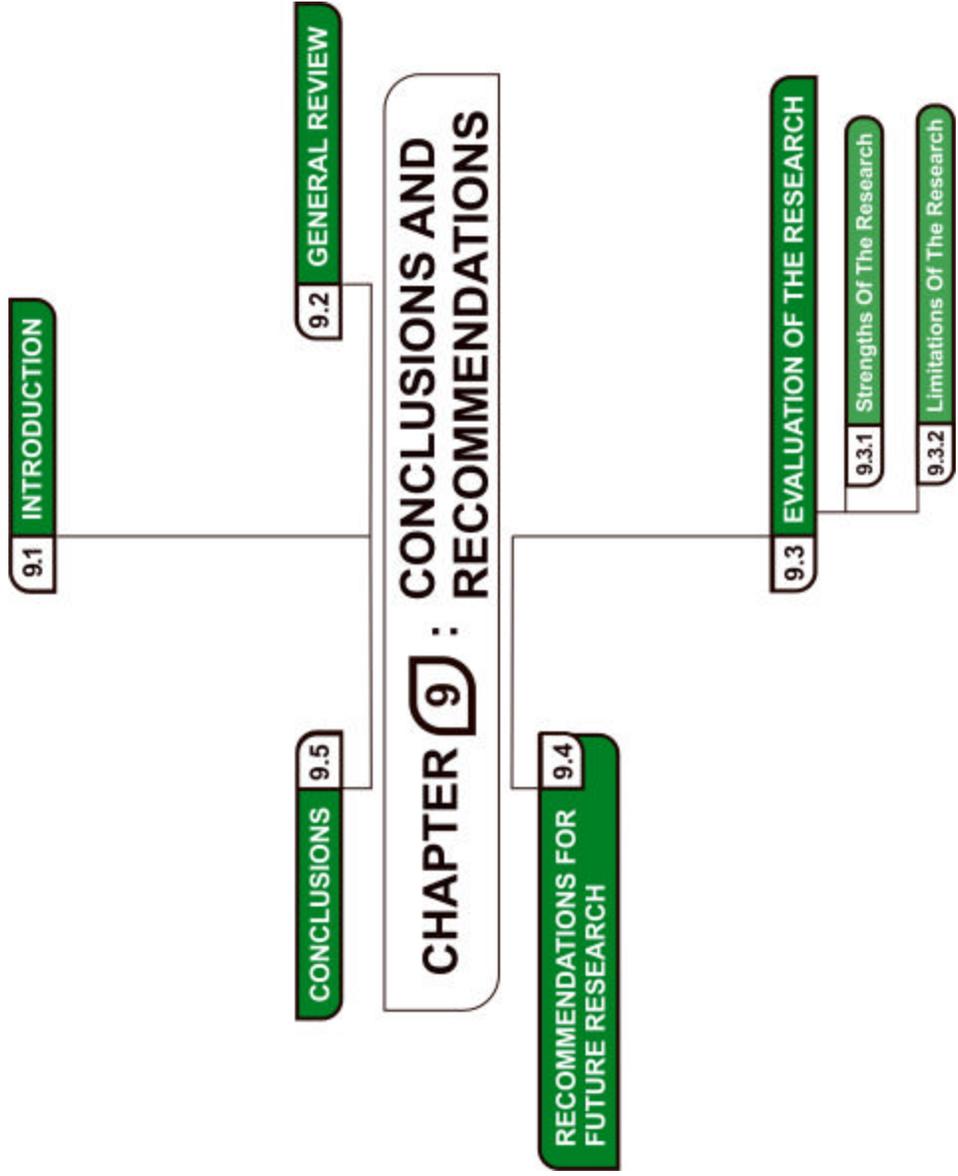
Figure 8.1 A Model for Psychological Interventions

8.4 CONCLUSION

This described model and psychological involvement developed from practical experience and, in the case of the University of Pretoria Cochlear Implant Team, proved to be successful. This Chapter illustrates the comprehensive and important role of the psychologist, not only in terms of pre-operative assessment and interventions but also as an ongoing process throughout the implant- and rehabilitation period.

- The final chapter is a concluding discussion on the value of this research and its possible contribution to other cochlear implant teams, the cochlear implantee and the interrelating systems involved. Recommendations are made for future research.





CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

This concluding chapter presents a general review of the present study. The aim of the study and the outcomes are noted. The strengths and limitations of the study will be discussed and recommendations for future research will be made.

9.2 GENERAL REVIEW

The aim of the research was to create a psychological treatment programme for cochlear implant teams. Working towards this aim unlocked a holistic and rich account of the experience of deafness and a cochlear implant from a systemic perspective. Research done on hearing impairment as mentioned in Chapter 2 indicated that deafness and the diagnosis of deafness can have a multifaceted and far-reaching effect on the individual and the family of the individual. The reality of being hearing impaired must be addressed from several perspectives. This creates various opportunities where the psychologist could intervene. With the cochlear implant, the emotions associated with hearing impairment will still be a reality as the implant does not heal the emotions underlying hearing impairment. When necessary psychological interventions could assist the client during this process.

The process of cochlear implants could also bring about other challenges into the client's life. As noted in Chapter 3, human qualities like emotions, anxieties and expectations play a major role and should be addressed throughout the process of implantation and rehabilitation. The cochlear implant not only concerns a person's hearing, but has an intense effect on, and is deeply affected by the

systems of which the person is a part. This is another opportunity for the psychologist to intervene.

The research highlighted a particular role for the psychologist. Until recently not many cochlear implant teams had psychologists as part of their teams. If a psychologist was involved, it was mainly to evaluate and to determine if the cochlear implant candidate was psychologically balanced enough to be able to adjust to the implant and also to exclude any other potential psychopathology. This research showed that the role of the psychologist could be expanded not only to evaluate but also to define the cochlear implant procedure as an activator for growth and change and, accordingly to create or select the necessary psychotherapeutic complement to allow the process to unfold. The systemic perspective with all its qualities, as described in Chapter 4, provided an applicable framework to study hearing impairment and cochlear implants. This perspective acknowledges the reciprocal and circular interplay between hearing impairment, the process of cochlear implantation, and the individual and his/her systems. No other framework of observation would be as encompassing and appropriate for this specific research.

The therapeutic interventions described in Chapter 5 accommodate the three most common situations encountered in cochlear implantation, namely the family and change; the mother-child relationship and change and the individual and change. Through the use of Structural Family Therapy, Theraplay and SHIP®, this study contributes and applies to initiate integrative approaches for the cochlear implantee. In all three therapeutic interventions as discussed in Chapter 7, positive changes were evident. The case studies highlighted treatment models that could benefit and complement any existing treatment modalities of any cochlear implant team.

The naturalistic paradigm, the qualitative research inquiry and the case studies, unlocked a wealth of knowledge that enabled the researcher to meet the objective of the research. It was also coherent with the systemic perspective described in Chapter 4.

The treatment model as described in Chapter 8 gives a logical and workable explanation of how and where the psychologist may intervene in the process of cochlear implantation. The model illustrates the comprehensive and important role of the psychologist, not only in terms of pre-operative assessment and interventions but also as an ongoing process throughout the implant and rehabilitation period.

This model was tested and adapted in the cochlear implant team at the University of Pretoria over a period of ten years. The model could be applied or changed or used as a template for new teams. Intervening as described in the model, presents the opportunity to address various different needs as they occur. This was illustrated by Figure 8.1 in Chapter 8.

9.3 EVALUATION OF THE RESEARCH

9.3.1 Strengths of the Research

As far as is known, this study is the first of its kind and should be seen as a voyage of discovery rather than one of verification. The strength of this qualitative study lies therein that it managed to describe a specific situation and the processes surrounding it in depth. The in-depth description indicating the complexities of variables and interactions surrounding hearing impairment and cochlear implantation makes it a valid study within the described parameters. Unlike in quantitative studies about hearing impairment or cochlear implantation, attempts were not made to create lawful connections between particular variables. The descriptions did not

include cause-effect connections between techniques and therapeutic outcomes.

- The qualitative research design furthermore proved to be a fitting method to explore the experiences of the participants from their own viewpoints and this type of inquiry is congruent with a systemic perspective and emphasises social context, multiple perspectives, complexity, recursion and holism (Moon et al., 1990).

- This study aimed to create awareness within professionals working with hearing impairment of the complexity of systems and of the fact that one can only properly understand the behaviour of any given system by tracking changes that occur within that system and its subsystems and by tracking changes between that system and the larger whole.

Another strength of this study is that the therapist made use of different therapeutic interventions in the different case studies. This was a way of accommodating the multiple realities of the different systems. The model included interventions with two children from different age groups as well as with an adult. This covers the two groups usually addressed by the cochlear implant teams. The study did not aim to provide a fixed way of working with cochlear implantees and their families, but rather to stimulate new leads and avenues of enquiry that may be used as a basis for further research.

9.3.2 Limitations of the Study

In Chapter 2 the impact of the diagnosis of hearing impairment on the parents stands out quite significantly. The people who work with the parents when the diagnosis is made are mostly audiologists and surgeons. It could be helpful if studies could also include guidelines for audiologists on how to convey the diagnosis of hearing impairment in an empathic manner and also how to guide parents

through the grieving process. The same theme also features in Chapter 3 where the expectations of parents about the cochlear implant are addressed. Once again it could be helpful if the audiologists who work with the parents had some form of guidelines to ease this process. Most cochlear implant teams do not have a fulltime psychologist on their team. This is further reason why the audiologists in the teams need some assistance.

Only three case studies were described in this study and this could be regarded as a narrow scope of research. This is criticised from a quantitative viewpoint as being a limited sample. Quantitative research emphasises large research samples in order to create the opportunity for generalisation of the research findings, which is in line with the ontological assumptions of realism and linear causality (Kagan, 2002). The choice of the research paradigm and design and the use of only three case studies makes replication in order to test validity and reliability difficult. The data could not be reduced into quantifiable statistics for the purpose of normative analysis and can therefore be criticised from a quantitative stance. A further limitation from a quantitative perspective is that objectivity and neutrality were not achieved in this study. The researcher did not try to control extraneous variables in order to create a homogeneous sample. This could be a limitation in that other researchers could find it difficult to replicate the same research in the same manner.

However, the qualitative research and in-depth descriptions done in this research contain a wealth of information which can supplement the field of hearing impairment and open up new ideas of research into cochlear implantation. In this research an attempt was made to understand the experience of hearing impairment and cochlear implantation and not to explain it. This understanding was described from the subjective perspective of the researcher, therefore the qualitative design was the ideal option for this research.

9.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The hearing-impaired child grows up and becomes a teenager as do normal hearing children. However, the hearing impairment places a further burden on this process which is often difficult enough for the growing child. According to Kolod (1994) the process of forming one's own identity in adolescence involves a response to and sometimes a rejection of the parents' values and ideals. The adolescent accepts some of the parental values and integrates them into his or her own separate identity. Some of the parents' values and ideals are rejected with the implicit statement, "That is not who I am". Erikson (1950) writes of adolescence, "In their search for a new sense of continuity and sameness, adolescents have to refight many of the battles of earlier years even though to do so they must artificially appoint perfectly well-meaning people to play the roles of enemies" (p. 229).

Hearing-impaired adolescents can be seen as facing even more difficult hurdles of normal growth and development than their hearing counterparts. Psychological intervention in the form of group therapy can be an effective medium and an opportunity for developing communication tools and skills helpful in negotiating these hurdles more quickly and more smoothly for hearing-impaired adolescents. Helping the hearing-impaired adolescent master tasks of normal growth and development can often alleviate adjustment problems and prevent further problems of adjustment in the hearing world.

Another area where a substantial amount of necessary research can be undertaken with hearing-impaired children is psychotherapy in the form of SHIP®. Some hearing-impaired children might have experienced a number of interferences in their young lives. If the reframing of the problem shows that there are certain intrasystemic aspects that need to be addressed, SHIP® can be a useful form of psychotherapy with these children. SHIP® is still a developing model

and research into the images useful for children has not been addressed.

A further area of research is the ethics and culture in the deaf community and the response to cochlear implants. The deaf community calls for recognition of its identity, and respect for its knowledge of the educational and life experience of being deaf. According to Ramsey (2000), there are cultural narratives about cochlear implants and they reflect two phenomena. One set of narratives elaborates on the frightening “science fiction” aspect of implant surgery; the second on the unknown outcome for implanted deaf children. The most common example of the first type of narrative is based on the act of invasive surgery, and its potential outcomes. Accordingly, deaf people will report cases of deaf children whose facial nerves, vision, or cognitive capacity were destroyed as a result of surgery. The most extreme case reported in this category of legend is the deaf child who received an implant that caused his brain to explode when, after recovery, the device was “plugged in”. A second type of cultural narrative centres on a theme that is also familiar to all of us, that is, the unknown long-term effects of new medical treatments and drugs. One account questions the safety of long-term exposure to batteries, magnets, chips, and other unnamed hi-tech components of implants so near the brain. It is worth noting that this concern is rarely expressed about hearing aids.

Cochlear implants are on the increase and the results seem to be more and more positive. An increase in the number of cases where hearing-impaired parents wanted and obtained a cochlear implant for their hearing-impaired children is noted. It would be valuable to determine how these hearing-impaired people perceive the cochlear implant and how the deaf community as a system responds to the change in the system due to cochlear implantation. This type of research can contribute to the change of perception of cochlear implants and the way information is conveyed.

The application of cochlear implants with people who are deaf-blind continues to be explored. Currently, children who have been diagnosed with Usher syndrome seem to be the most likely candidates for implants (Chute & Nevins, 1995). Cochlear implants may provide the necessary auditory cues to increase the ability of people who are deaf-blind to communicate and to have auditory contact with the environment (Martin, Burnett, Himelick, Philips, & Over, 1999). This auditory stimulation may allow for increased social interaction and reinforce individual safety. Continued research on the use of cochlear implants in patients with Usher syndrome may yield additional information on how best to meet their psychological needs.

9.5 CONCLUSION

This study and the time spent on compiling this complementary treatment programme have enriched the researcher and the cochlear team of which the researcher is a member. Although the method of research was time-consuming, it was also the most appropriate way to present a rich account of the experience of deafness and cochlear implantation from a systemic point of view. The researcher described her conceptual framework and research methodology and the congruence between the two. The accounts of therapies in the case studies indicated that this treatment programme made a difference to the lives of the people involved. The psychological interventions were put into a practical model that was tested in practice and which is duplicable for other teams. The strengths and limitations that this study identified highlighted different issues, which could be elaborated on in future. The recommendations for future research open up fields of interest that could enrich the field of hearing-impairment and cochlear implantation.

Appendix 1

I,....., herewith agree to give my consent to participate in this research project. I agree that the clinical information generated during the process may be utilized for research purposes.

The information obtained will be treated with strict confidentiality.

Your participation in this Doctorate's research project is greatly appreciated. The aim of this study is to inquire about your experience of hearing impairment and cochlear implants.

Thank you for agreeing to participate.

Name:

Date:.....

Signature:.....

Appendix 2

Case Study 3

LIFE SKETCH

A summary of me

- I dislike children INTENSELY – I want to lash out at them if they so much as approach me. I become anxious if a child comes near me. I don't feel this way about infants – they're adorable.
- I DISLIKE old or sick people INTENSELY, and if it weren't for societal pressure, I wouldn't bestir myself to help or spend time with them.
- I have a thing about humiliation and I make a point of not humiliating others. I also find it tremendously upsetting to witness another's humiliation.
- I'm ALWAYS angry and often FURIOUS. Rage kickstarts me but it's not a good feeling. It's very tiring.
- I always feel stupid, as if I'm short of a good few IQ points.
- I constantly compromise myself – I struggle to feel valid and to say how I really feel about things. People mostly don't agree with me and almost never want to do what I want – if I insist on having my way, the other person looks sour and then I feel like an ogre out to spoil everyone else's day. Sometimes it gets so bad that I can't distinguish between what I want and like and what others want and like.
- I operate primarily on the basis of self-discipline: it's never a question of whether I want to do something, but rather of whether it ought to be done. This is the only way I can be happy. Enforcing this kind of discipline is what keeps me from falling apart.
- I despise men. And even that doesn't fully describe the degree of my contempt for them. I don't trust them AT ALL.
- I jeopardise myself, time after time.
- I have a helluva inferiority complex.
- I'm constantly struggling with my weight; I seldom feel in control.
- One of my biggest fears in life is that I won't achieve anything, and that's exactly what happens: I achieve nothing. I also have a great

fear of mediocrity, of being just like millions of others who don't achieve anything either. Oddly enough, I don't see myself as mediocre.

- I consider God a fairly sick, autocratic bastard. He's already made his decisions and stuff you if you don't get it. I can't relate to him. The bugger is a man and then he had the audacity to create the weaker sex, the little wife and mother, to serve men dutifully. And I have to be CONTENT with that? What's more, he owes me. Religion is humiliating: you're a zero and you've got to be humble and do humiliating shit like confessing your sins and being eternally grateful if he so much as deigns to do something for you.

1. SANDPIT

There was a sandpit at nursery school at White River. One day during playtime, I saw some other kids having fun with buckets and spades and thought I'd like to join in. I climbed in and went to help fill the nearest kid's bucket with sand. They all got out and left me there on my own. I was desperately upset and close to tears, momentarily unsure of what to do next. Should I carry on playing and pretend nothing had happened, or should I get out, with everyone watching my humiliating retreat? I lost my temper, got up, climbed out and headed for the playground behind the school. There were few kids there. I went and sat under a tree, waiting for the bell. I could usually hear the bell, and when I couldn't, I'd know it was time to go in when the other kids started heading en masse for the classroom. I didn't feel like going back when the bell finally rang, and so I hid behind the tree. I knew exactly what was going to happen next. A teacher would come to look for me, and she'd come from the right. And she did. As she turned the corner, I went left, behind the tree. She called and called and this pleased me. Then she went back inside. I knew another one of them would come looking soon, and I knew they'd come out the back door, which they did. I saw to it that I was concealed by the tree, and had a fine time playing cat-and-mouse with them until I figured it was almost home time. I kept thinking how

stupid and predictable they all were. At home time, I simply went and sat right in front of the tree, clearly visible to all. The teacher who finally spotted me wasn't angry; she was almost in tears as she hugged me. I feigned innocence and simply said I hadn't heard the bell. To this day, I despise children and I have no desire to have any of my own. They're totally tactless, selfish and demanding. Although I guess this could be because they haven't been successfully socialised yet, but that doesn't mean I have to like them.

2. SONG

We sometimes sang songs in the afternoons at nursery school. I could never figure out what was being sung because I couldn't hear. Occasionally one of the teachers would bestow upon some fortunate child the honour of singing a solo in front of the class. I always prayed they'd never ask me. But one afternoon it happened: Aunty Renè (a teacher) decided to honour me and Linda by allowing us to sing a duet. From the teacher's demeanour, I sensed that I should be profoundly grateful to her. Linda was a beautiful, bubbly child with the best singing voice in the class. At some point I realised she'd already launched into song. To this day I've no idea what song she sang. She sang with verve and expression, moving her head and gesturing with her hands. I tried to copy her gestures, but of course, her head movements meant that I couldn't see her lips. So I uttered meaningless sounds just so the others wouldn't realise I wasn't singing too. But I saw pretty quickly that I wasn't fooling anyone. The kids were giggling openly and whispering behind their hands. Even the teachers were hard-pressed not to laugh openly too. When the song finally ended after what seemed an eternity, Aunty Renè leapt up, clapped with exaggerated pleasure and said: Oh! How beautiful! Linda! And Becky! You sing sooo beautifully!" – at which point she returned to her seat quite breathless. I pretended I bought her whole act, but I glared at her covertly and could scarcely believe the stupid woman was deluded enough to think I hadn't clicked. Fortunately I never got to go up front and sing again.

3. KICKED OUT

My mother only told me this when I was in high school. I can't remember it, but it upset me when she told me what happened. In White River we were friends with the Brittons. After we moved to Natal, they came to visit us one day. I sort of knew my mother didn't like Carrie Britton much, but I never knew why. When I said Auntie Carrie was really nice, my mother snorted derisively and said I didn't know her at all. Then she told me that Carrie Britton used to be the chairperson of the parent/teachers' committee. Apparently a parent announced at one of these meetings that I needed to be taken out of the school because her child's table manners had begun deteriorating. Another parent reckoned her child had begun walking queerly. All this was due to my bad influence. So they phoned my mother and told her to come and get me. The next year Carrie Britton wasn't the chairperson and that was the end of my early school career at least until I started primary school. I'm still angry at my mother for telling me this – it's humiliating.

4. BECKY THE STUPID IDIOT

I don't remember very much. Truth to tell, I don't think much happened. I can't remember how old I was – probably between five and eight years old. We were living on a farm, with outbuildings some distance from our house that were used as servants' quarters. I went to look for our maid there, but she wasn't in her room. When I came out and headed for home, the gardener took me by the arm and led me back inside the maid's room. He made me stand with my back to the bed, and I think he shut the door. I was curious, not afraid. He came back and pulled down my underwear and his own. Then he came and stood near me. I can't recall what he actually did, but I can remember that it was pleasurable. Then he suddenly stepped back, pulled up his trousers, opened the door and ran out. He just left me there. I remember that I felt terrible. I quickly pulled up my underwear and ran home. But Becky still hadn't learnt her lesson. Because of

the pleasurable nature of the experience, I returned the following day, and as luck would have it, the gardener was also at the maid's room. I took his hand and began to lead him to the room, but he pulled his hand free and walked away, laughing and shaking his head. This must be the most humiliating moment of my life. I will never forgive God for allowing me to make such a fool of myself. FUCKING NEVER. I never told anyone about this, until a day in matric. The sister of a friend had been raped and was having a difficult time of it. At the time I hadn't figured out that I'd been molested but not raped. I thought I could help her and wanted to go and speak to her, but I didn't know if that was the right thing to do. Perhaps I just wanted to unburden myself of the whole business too. So I told my mother (in one short sentence) and when my father arrived, I told him as well. They just stared at me for a moment. As I began talking about it, my mother abruptly silenced me and said she didn't want to hear about it. That was that. We never spoke about it or referred to it again. I think my father actually just forgot about it. And yes, I am bloody angry at them for that.

5. BOOK PRIZE

My brother, David, and I started grade one together. I was seven and turned eight in October of that year. At the prize giving towards the end of the year, I also got a prize. I remember the kids on either side of me prodding me and gesturing that I had to go to the stage to collect my prize. I hadn't even heard them calling my name. I felt light-headed and ascended the stage in a daze. When I returned to my seat, I inspected the book and looked inside. It was a rectangular book about camels. They'd pasted a certificate of sorts in the front, with my name on it ... and what the award was for. Progress. I got a bloody prize for PROGRESS? Did they think I was stupid or what? What kind of a prize is that? I was totally unimpressed with it and never opened the book again. My mother and everyone made a great fuss, but I was angry and bemused that they thought I ought to be delighted with a prize for progress. I felt humiliated because I knew

everyone knew that prizes like that aren't earned for real. They're awarded to the less fortunate. A consolation prize. And NATURALLY my teacher would have made sure my classmates knew I got the prize because I was deaf. I think they asked her why I got it.

6. A BAD-TEMPERED TEACHER GETS FIRED

Ms Barnard was our teacher in grade two. She was a tall, pretty woman. But she had a vicious temper and was totally unpredictable. She had a thickish little plank, wrapped in masking tape. It was called Sampie. Everyone had close encounters with Sampie – and often. She'd suddenly lose her temper and hit you with it – with all her might. One day she suddenly lost it with David and dealt him a helluva blow to his upper arm. For a long time his arm had a thick, purple weal. I was dreadfully upset about it and wanted to murder the bitch. She hit me often too. Because I was spastic, I couldn't write neatly like the others. So one day she walks past my desk and screams at me because of my handwriting or something. I had to put my hands out immediately. She hit me so hard that I had no feeling in them for a time. My hands shook so much I couldn't write at all. At break I stood outside and cried, verging on hysteria. My hands were still shaking and burning like fire; they were scarlet and swollen. David was outraged. Aunty Lilian was my speech therapist and gave me therapy for my spasticity. I don't know why she was at the school at that particular moment, but she found me in this state outside the classroom. My enraged brother told her what had happened, while I cried hysterically. She must have comforted me – I can't remember. After break we went back to class, but Ms Barnard wasn't there. After a long time, she came, but she was very subdued. That was the last time we saw her. I was less upset by the hiding I got than by my part in her being fired. I felt inordinately bad about that and I wondered if I hadn't overreacted – after all, pretty much everyone experienced her wrath via Sampie. I felt the poor woman had been fired because I was spastic and because she had unfortunately hit me on my hands.

That was what Aunty Lilian was particularly enraged about – that she had hit me on my hands.

7. ASTHMA ATTACKS AND GRANDPA'S TEMPER

I'm allergic to feathers, animal fur, pollen and dust mites. They give me hay fever and asthma. My allergy was quite bad when I was little. I often had asthma when I stayed over at my grandparents, because they had feather pillows. One night I had another attack and my grandparents came to my room to calm me down. But I couldn't breathe and began to cry with panic, which of course aggravated the asthma. The more they tried to calm me, the more I cried. In his distress, Grandfather shouted at me: "SHUT UP, MY GIRL!! STOP CRYING!!" Believe me, Grandfather in a mood is a frightening sight, especially when he's shouting at you. His face turns puce and his eyes look wild in his head, and then he also has this very big voice. I don't think it was that traumatic for me, except if you consider that even now I strike a total blank when someone shouts at me. I can't utter a word for the life of me.

8. STANDARD ONE – WITHOUT DAVID

The TDE had a policy against having siblings in the same class (heaven alone knows why), and from standard one the decision was taken that David and I would no longer be in the same class. Not that he and I lived in each other's pockets – he had his friends and I mine. We didn't even sit next to each other in class – he sat at the back and I in the front row. But I always took comfort from his nearness – we were and still are deeply fond of one another. Of course it also helped that he could hear – in the afternoon after school, I could just check with him what homework we had, and he could tell me about stuff I might have missed in class, although I don't think that happened much at that time. But things changed quickly! I felt lost without my brother's comforting presence in standard one, and I missed him. I also began to miss a lot in class. If I couldn't hear something, I would just let it go by. I was aware that I was missing a

lot and I constantly felt worried and anxious. It was as if I hadn't caught on that from then on whether I heard or not depended entirely on me. Or perhaps I did, and the new responsibility paralysed me – that sounds familiar! Luckily we moved to Natal in June that year, and we were together in a class all the way to matric. I still do that today: the minute someone gives me responsibility for something, I make a mess of it. I start out well, but then I become paralysed and for the life of me am unable to proceed past point A.

9. THE RACE

In standard one they had informal heats on the playground to determine who qualified for the athletics event to be held later in the year. I ran in the heats and David came especially to watch me. I won the race by far. David was ecstatic; I was just astounded that I'd even won. But the teacher immediately said I'd not been chosen and I wasn't allowed to participate. David almost exploded. I remember clearly how he stormed over to the teacher and said: "But, Ma'am, my sister beat everyone by FAR! She WON! Why can't she participate?" The teacher simply made no reply. David couldn't understand what their problem was. But I knew. At the time I was still walking queerly and it must have been embarrassing to see me run. So, another humiliating experience that I had to live with. I was dreadfully upset and I cried.

10. THE FILM

I was spastic because of brain damage I'd sustained at birth. At four, I couldn't really walk yet, and my mother still carried me around. When I eventually began walking, my coordination was poor and I kept falling down. I used to put my right arm and right leg forward, instead of my right arm and left leg. My spasticity improved dramatically when I began doing karate in standard one, after we'd moved to Natal. It was then that I began walking like a normal person. My parents often took photographs and made movies of the three of us. We had a projector and watched the films at home. One

day (it must have been in standard one because we were still in the Transvaal) they showed a movie my father had made of me walking, or rather stumbling and staggering, over the lawn. That was the first time I saw what I must have looked like to other people. I looked retarded, my mouth pulled skew with concentration, as I staggered along with the elegance of a drunk sailor. I can't tell you how this upset me. I actually felt nauseated. I jumped up and said something about how awful I looked, and asked them to switch it off. My mother just laughed and said impatiently that I was being ridiculous. She always did that when I became emotional. My emotional reactions were always ridiculous and out of proportion. My father was less impatient, but he also always thought I was being silly when I became emotional. I turned around and ran out of the room. Another bloody humiliation.

11. RECKLESSNESS IN STANDARD THREE

I came second in class (the A-class) in standard two, with an 89% average, but come standard three the quality of my work plummeted. Although I couldn't have done that badly because I was placed in the A-class again in standard four. I don't remember much about standard three, except this: I adopted a reckless attitude towards my schoolwork; did not do my best as I used to; and that it was a very long year. I never adopted this attitude to schoolwork again, not even in matric when I was drowning in a black depression. Oh yes, perhaps I should mention this: we had a history teacher, Ms Van der Merwe, whom I just could not hear no matter where I sat in class. Her voice had the kind of pitch that I could not hear well, added to which her voice was very soft. I always had an uneasy, anxious feeling during history. I never told her I couldn't hear, because I figured that's how she spoke and how can you change that? Sad to say it is in fact better not to say anything in these situations and to hope you can just get the notes from someone after class, because people speak the way they speak – if I were to ask someone to raise their voice a few octaves for the duration of an entire lecture, I'd be sorely

disappointed. They can NEVER sustain it, and after five minutes or so, resume their usual way of speaking. It's different if you ask a teacher or lecturer not to move around when you're in the class – people seem more able to control their movements, and somehow I'm more comfortable insisting on this. And anyway it wasn't a school for the deaf – I wanted to cope as unobtrusively as possible. And I did – from then until matric I was usually placed in the top five students, without any special assistance from anyone. That was how I wanted it.

12. INITIATION

This was the standard six initiation. Not much to be upset about. I could mention that the standard sixes would all sit on the steps while the prefects selected one or two of us to 'take under their wing', and I was always one of the last to be chosen. Naturally all the pretty girls were chosen quickly, and then the rest – and finally the ugly and the retarded (and I was both!). It's very obvious to everyone when you're the last to be chosen and I felt humiliated once again. It felt like the sandpit episode. I didn't know where to look and tried real hard not to make eye contact or to seem hard-up. But I was in fact dreadfully upset and close to tears. When the deputy head girl decided to saddle herself with me (she'd already chosen one other girl), I felt like punching her and telling her not to bloody bother. People who chose people like me are usually nice and kind-hearted, and she was both – she never did me any harm. But given what I am, she didn't put much effort into initiating me – not that the initiation was strenuous; it was just light-hearted fun really, but I was not included much. It wasn't a nice feeling. I think she didn't know what to do with me and she was probably scared to do something that might upset me. None of this makes me feel any better though.

13. THE DRAMA SOCIETY

This happened when I was in standard seven. As luck would have it, my mother and I had a serious conversation shortly before this event.

My mother said something to the effect that there are many opportunities in life, and that I shouldn't be afraid to try new things. I felt quite positive about myself after that. Our Afrikaans teacher, Ms Reyneveld, also gave a drama class after school, and when she asked one day whether any of us would be interested in the drama class, I remembered what my mother had said, and promptly put up my hand. Shit, I should never have done that! I even had a broad smile on my face! Ms Reyneveld, with an apologetic smile on her face, said she didn't think that would be a very good idea because of my speech problems, not so Becky? But you can participate behind the scenes by encouraging the other actors. BY ENCOURAGING THE OTHER ACTORS? As opposed to something constructive like doing the make up or helping to design the costumes. SHE CAN EAT SHIT AND DIE. I felt my face turn scarlet and I swallowed traitorous tears. I tried desperately to smile naturally and nod my head, I think, but I knew what I was feeling was abundantly clear to everyone. The entire class was silent for a few seconds. I was DREADFULLY upset – I don't recall how the rest of the school day passed, but when I got home to my mother I burst into tears and told her what happened. She was very angry at Ms Reyneveld because of the way in which she had humiliated me, and then she said softly, "Becky, what happened was terrible, I know, and I know I told you not to be afraid of trying new things, but you should also be realistic. For you to act would be like a one-legged woman wanting to be a model." I think I felt somewhat better after that, but I never forgot the humiliation and have still not forgiven Ms Reyneveld. I saw her again at our 1995 reunion and immediately had a bitter taste in my mouth as well as an urge to punch her. Oddly enough I still believe that with some love and encouragement, I would have been able to do it. But that's just it: When push comes to shove, I am alone and NO ONE is willing to take a chance on me. These stories in books and in the movies are BULLSHIT. People like that don't exist.

14. BECOMING A PREFECT AND ACADEMIC COLOURS

Although I'd achieved academic colours every year from standard six to standard eight, the highlight was towards the end of standard nine, when I was awarded academic honours at the prize giving. My reaction was the curious part. Naturally I was delighted, but I remember vividly the awful anxious panicky feeling as I stood on the stage with my award. I thought: "Shit, I'd better perform next year. All eyes are going to be on my grades." And that's how it was – and my grades went for a loop. I don't think I experienced the same anxiety the following year when I was made a prefect (although I did wonder what the other kids saw in me to choose me), but I was a particularly great prefect. I had no authority. NO ONE has ever listened to me. If I asked a kid to obey some or other rule, he or she'd simply ignore me or laugh and make a joke and then carry on doing whatever they were doing. That makes you feel fairly powerless and frustrated. Luckily David got academic colours that year, but unfortunately he wasn't chosen as a prefect. That was probably the only time David was jealous. He practically didn't speak to me that day, nor did he congratulate me. I felt DESPERATELY guilty, particularly because he had more of the right stuff to be a prefect than I did. What made it worse for him was that he was the only one in his group of friends who wasn't chosen as a prefect. My parents downplayed the whole thing because David was so upset, and so I didn't really have the chance to relish my achievement of the day.

15. DEPRESSION

I get a ga-ga sinking feeling when I think about my matric year. It was a complete nightmare. The work was too much for me, much too much. All I did that year was work. And I could never get ahead – I seldom completed my homework and never managed to catch up given that more homework came my way the next day. I worked myself to a standstill and I couldn't understand how come the other kids seemed to breeze through it – they had no problem keeping up! Worst of all, no one including me had the faintest idea what the hell

was up with me. Not my parents, not my teachers, nor my friends. I felt stupid and useless. I was practically permanently moody and I burst into tears if people just looked at me. I was exhausted – and panic stricken – and fat and ugly. And things didn't improve – they just became progressively worse as the year went on. One day during the latter part of the year, the maths teacher, Ms Viljoen, asked me to remain behind after class. I knew what was coming. After the others had left, she said, "Becky, why have you become so lazy? Why aren't you working?" I looked at her for a moment, dropped my head and ran out in tears. It enrages me just to think about it. SHE CAN EAT SHIT AND DIE, MAN! What kind of a question was that? Is that ALL she could figure out about me? If I were to be totally honest, I blame my parents in particular for not realising that I was terribly depressed – it never occurred to either of them to get me to a psychologist. I failed maths and science at the end of matric and didn't get university exemption. I should perhaps disclose my marks, because I'm sure you don't believe how poorly I did! I wrote maths and science on the higher grade ... and ended up with an F for maths lower grade and an E for science on standard grade. I did, however, get an A for English. It was my only subject that didn't go for a loop. How did my parents react? My best was always good enough for my mother – she knew how hard I'd worked, and so she was sorry on my behalf. Whenever I did poorly, she'd just say I should simply try again. When I got a distinction, she'd cry over the miracle. I was her little miracle. However, my father couldn't BELIEVE it. How was it possible to get an A but not exemption? That really hurt – to this day. My dear father is convinced even now that I'm the reincarnation of Albert Einstein, and if I proved to be less of a genius that he believes me to be, he jokingly calls me Bonehead. He really doesn't mean anything by it, but I don't find it funny.

16. ENGLISH PRIZE

Everyone, including me, knew I was the star in English. That was the case in Afrikaans as well, up to and including standard nine, but

sadly it was another of my matric subjects that went for a loop. I had to be satisfied with second place. Coert Human, the head boy, was quite brilliant and shone in everything except English. He literally took all the prizes at the prize giving. I was convinced I'd win the English prize. Was I ever in for a helluva surprise! I recall being quite ready to stand up when they came to the prize for English ... but it went to Coert. When they called his name, I turned towards my English teacher where she sat on the stage, with confusion written all over my face. Our eyes met for a moment and then she guiltily looked away. I could not believe it. The other kids turned to me questioningly and I wished for the earth to open and swallow me. Dammit, I really needed that prize! I never forgave her. And in the final exam, I got the A and Coert got the B. Great. Was I angry at Coert? Possibly. Who gives a shit?

17. MATRIC FAREWELL

Oh yeah, the bloody matric farewell. I was fat (or rather, plump) and ugly with pimples. I knew no one would invite me. David and Coert Human, the head boy, were best friends, and the latter had a girlfriend two years his junior, which meant he couldn't invite her. So he asked me instead. I felt quite flattered, but superficially so. I figured it was another kind-hearted action on his part and that the other kids knew this. On the night in question, I probably looked as good as I was able under the circumstances, and my dress WAS lovely and suited me. I think I felt as good about myself as I ever could and I'd hoped that it would turn out to be a fun evening. But early on in the evening Coert announced that he was going to visit his girlfriend, but that I should come along. (He could scarcely leave me behind at the farewell!) I couldn't believe what I was hearing, but what could I say? Once at the girlfriend's house, she was friendly in a lukewarm way, and very possessive over him, as if to warn me he belonged to her. Is she stupid or what? I thought to myself. What did she think I had in mind for him? I was hardly competition for her! OF COURSE I felt totally humiliated yet again, and even though Coert

died of cancer a year later, I'm still angry at him. I didn't expect that of him – he came from a fine home and he was an exceptional person. I realised he was under pressure from the girlfriend, but honestly he could have thought for himself just that once, and realised that you just don't do that.

18. INITIATION – FIRST YEAR

Fortunately I was able to go to varsity even though I didn't have exemption, on condition that I passed a school subject on first-year level before being admitted to any second-year courses. I obtained a distinction for Geographical Statistics. This was a surprise because I failed matric maths. Anyway, the first-year women often had to walk to campus with first-year men. We had to stand meekly outside the res like a bunch of idiots while the bloody men chosen a pretty girl (what else?) to walk to campus. I wasn't as plump as I had been at school, but I was evidently still not pretty or cute enough because I was always one of the last to be chosen, and boy did the guy drag his feet! God, it was so bloody humiliating!

19. MY MOTHER'S CRACKS

Practically all the first years put on weight as a result of the good food at res. I was no exception. Towards the second half of the year, my mother came to visit me one day. I remember how glad I was that she'd come. She was waiting for me in the car, and watched me as I approached. David was in the front seat next to her. When I reached the car (with a big grin on my face!) she said bluntly: "Becky, you're terribly fat." Or something like that. The smile disappeared off my face and I looked at her briefly and then turned and ran back to res. I felt SO hurt. I heard her calling me back, but I ignored her – she did not, however, come after me and drove away. Years later, she or David (I forget who) told me that she'd told him, as I was running away, that she should never have said that. Well, that doesn't help at all – there are some things that you just don't say to others.

Also during this time, my mother and I were driving somewhere when I said that unless a girl makes the first move, she would never land a boyfriend. This was a bit of advice some dumb first-year girlfriend gave me. I was practically the only first year who didn't have a boyfriend. I hadn't even finished talking, (this was literally the first time I'd had a conversation about guys with my mother), when she screeched the car to a halt in the middle of the road, and in the ominous silence of the car, she said: " I NEVER want to hear you talk to me about guys again. I NEVER want to hear this again." I dropped my gaze and stared into the footwell in front of me. She switched the car on and we drove all the way to our destination in icy silence. That was the very last time I raised the subject with her. That was in 1987 and she died in 1995. As I recall this episode, I feel HATRED for her.

20. THE LC DANCE

Take it from whom it comes, my mother always said, but I never managed to do that. It was just impossible for me. And so I guess I should recount this insignificant little event, one which other perfect people would doubtlessly have laughed off and dismissed TOTALLY from their minds within 24 hours. I'd mentioned to one of my first-year pals that I couldn't stand the dances and stuff, because I can't bear to offer myself on a plate and meekly wait for some or other asshole to deign to ask me to dance. It's humiliating and they never ask me anyway. So she said I am too aloof and I never make eye contact with them. My friends still tell me this, incidentally. Well, Becky the idiot promptly took this shitty bit of "advice" to heart – and went along to the dance in the LC hall. We'd scarcely been there for five seconds when someone asked my friend to dance. And there I stood, not knowing what the hell to do with myself. I noticed one of the assholes heading my way and I figured well, it's now or never. Our eyes met and we looked at each other until he was standing right in front of me. He put his hand out ... to the girl standing behind me without breaking eye contact with me. The humiliation was simply HORRIFIC. I turned tail and walk directly to another girl from my res

and asked her if she'd take me home. But His Holiness had still not finished with me, oh no! The girl said I should come back and asked her again in an hour if I couldn't find someone else to walk me back. No one wanted to go back with me and I thought I would go right off my head. I had to bloody hang around there until practically 10:30 before I eventually find someone to walk back with me. And before you ask, no, I was still fat and my skin was under control.

21. ATTORNEYS WILLIAM SMITH

I looked for work for three months in 1993, after graduating with my LLB in 1992. I eventually found a job in March 1993 as a clerk with Attorneys William Smith. I didn't land this job on my own. Aunty Jill, my mother's bosom buddy, organised it for me. This was something she would do a couple more times in the future, and each time my confidence took another knock. I was dreadfully unsure of myself and had no idea how to conduct myself in a working environment. For example, I found it impossible to socialise with my employer, even though others do it with ease. I still can't do it. I prefer to work at work and to keep the socialising to a minimum. Admittedly, I didn't have much respect for William Smith – I thought he was an arsehole and we had several contretemps that rather upset me, although I don't think they still bother me much. On the whole it wasn't so bad. The business was still in its infancy and in November that year, I was let go because business was bad and as the youngest staff member (and the one who meant least to the company) I had to go. Of course, I fell back into the old pattern of feeling useless and stupid.

22. ATTORNEYS JANET JONES

In December 1993 I was without the prospect of work again. At the time I was fairly depressed. However, in January 1994 Aunty Jill organised another job for me, this time as a full-on candidate attorney with Attorneys Janet Jones. I could start my articles. I was so excited. It was also during the following 18 months with the company that I obtained my most valuable experience, and for that I'll always be

grateful to Janet Jones. And I loved the work! I felt for the first time that I knew what I was doing and that's tremendously satisfying. There was, however, one fly in the ointment: Janet Jones herself. She was an arch bitch, utterly unpredictable, and with a temper that left her staff reeling. The atmosphere changed from relaxed to being fraught with tension the minute she came into the office. She'd suddenly explode over the smallest thing. Oddly enough, I wasn't really afraid of her – after all, what she could really do to me? – but I was apprehensive (who likes being shouted at?). My deafness was, however, a problem. I couldn't use the phone and that stuck in her craw. I had to fend for myself. I had to keep asking her secretary to make my calls for me and this was an ongoing battle – after all, my work didn't take priority over the boss's. One of my third-party claims expired because the secretary failed to see why she had to make my calls. I got no understanding and it was all my fault. It eventually reached the point where the secretary sighed with irritation whenever I stepped into her office. I wanted to slap the selfish little bitch. I didn't have the option, like other people, to pick up a phone and call a colleague to find how to do something – I had to stop off to find stuff out from colleagues in the city in between acting as messenger. Because Janet Jones explained NOTHING – you had to find everything out for yourself. Initially I went and asked her if I needed to know something, and the first time, she did explain, but the second time she exploded and shouted: “DON'T ASK ME! FIND OUT! FIND OUT!” I never asked her anything after that. Although she shouted at me a lot, it was NEVER about my work – she almost NEVER changed my work. I did it well. In June 1995 I decided I'd had enough of her and I decided to attend law school full time for six months and then write the bar exam. So I went to see her, and it's possible that my somewhat apologetic stance was the cause of what occurred. She sat back in her chair, arms folded, and said that I'd done my work so well that she felt inclined to make an exception in my case and appoint me as a permanent PA. PA posts were very scarce at the time. I felt like a dog. The next day I went to see her and told her

that I was pleased by her high opinion of my work and that I would like to stay on, if that suited her. She leaned back in her chair with a little smile on her face, and said I must have misunderstood her. She sat there and told me how completely useless my work was, how little money I brought in, and that she'd never dream of offering me a permanent appointment. I have no words to describe how this made me feel. Red-faced, I simply got up and walked out. I went to visit a friend that evening and just sat there staring into space. She kept asking what was wrong, but no words came out when I opened my mouth to speak. She told me afterwards that she'd never seen me like that and that she'd been frightened by what she'd seen. When I finally managed to speak, I was practically hysterical. She said I cried like nobody she'd ever seen. She said the bitch knew me so well and played me like a violin – and she was right. Janet Jones KNEW I'd come back to accept the offer she'd dangled like a carrot. My mother had been dead for three months already at this time (April 1995) and I don't think I ever discussed this with my father – it would have upset him too much. I don't know if it still upsets me much when I think about it.

23. MY MOTHER'S DEATH

I include this because I figured you'd want to know whether my mother's death was a bad experience or not. It's logical that it should be, but in my case, my mother's death was, shall I say, good and peaceful?, as one would wish death to be. It was a great relief to everyone – to her too, ESPECIALLY TO HER. I don't really have any bad memories about it. Let me explain: It was the week before the Easter weekend in 1995 and I would have flown home on the Thursday before Good Friday, but my father called on the Sunday night to say I should come IMMEDIATELY – things were looking bad for Mom. I flew home on the Monday night and I smuggled my guinea-pig onto the plane because my mother wanted to see him. From the airport we drove to Hospice in Port Shepstone – it was about 22h00 that night. My mother was very weak, but she chatted

and was charmed by the guinea-pig. We went again the next morning (Tuesday), but her condition had deteriorated so much that she was unable to speak. She struggled terribly to breathe (it sounded like a death rattle) and I thought of how her biggest, all-consuming fear during her life was of not being able to breathe, and I thought God was a SICK BASTARD. I don't understand cruelty like that. By 17h00 I just wanted to get away from there. Her deterioration over night was very distressing. Dad and I stayed there until 22h00 and then we went home. My father woke me around 1h30 that morning and said we had to go because Hospice had called and said they didn't think we'd be in time. We quickly dressed like automatons and drove to Hospice. On our arrival, the sister met us and I heard her say to my father: "I'm sorry, Derrick. She just died." I don't think it had hit me yet and we went into her room. I looked at her and thought how beautiful and peaceful she looked, as if she were sleeping. Her face was very peaceful, something she hadn't been for years. The sister said: "She died very peacefully" and I understood exactly what she meant. I kissed her and didn't look at her again as we collected her things. Then we drove home. You see, my mother never was a believer, but she always encouraged us children to nurture our belief because she thought the underlying philosophy good. All three of us children are believers today. During her last two to three months at Hospice, an American evangelist (a woman) worked on her until she eventually believed. But I know my mother and, of course, I know God. If she'd been healed, my mother would have lapsed back into her perfectionism of old (everything had to have a perfect answer). I'm pretty sure God came for her the moment she was ready and I believed it was absolutely the right time for her to have died. I never rebelled against her dying. We cremated her and she is in my father's cupboard, among his clothes in a little brown container and he greets her every morning! Sometimes I also open the cupboard door and say: "Hello there, Mom!" In fact, they're all there in the cupboard: my two grandfathers and my one grandmother. Why should you bury people in a godforsaken cemetery where weeds grow on them?

24. TRIX

I call terminal cancer God's Disease. It's his way of telling you: Listen, I'm coming to get you, so you'd better get your affairs in order. It's fruitless to pray to him to heal you – HIS DECISION IS FINAL. Unfortunately, humans have a very strong instinct to survive, which happens, also, to be a god-given characteristic. The following anecdote illustrates this, and it's one I have been unable to talk about in the past without bursting into tears. It's one of the saddest stories I've heard in my life. During my mother's stay in Addington Hospital for chemo, she made friends with a tiny little woman called Trix. Addington Hospital looks out over the sea. One day my mother and Trix were standing at the window, looking out to sea. My mother asked Trix: Trix, do you think you will get better?" Trix said: "Beulah, do you see the ocean?" My mother nodded. "Well, my hope is as vast as that ocean." Trix died the following week. I find that utterly unbearable. WE ARE SUCH FOOLS! People tell you there is always hope, and that prayer and belief are the answer, so you believe and pray and then you die anyway. BECAUSE HIS DECISION IS FINAL and bugger your pathetic little attempts to cling to hope as vast as the ocean. It is so HUMILIATING. I cannot understand why God persists in humiliating us like this! We deserve a little more respect than that!

25. LAW SCHOOL

Law school was a valuable experience but it wasn't a great year. Considerable emphasis is placed on group work – not something I buy into at all. Some wise guy or another (usually a bloody man) always dominates the project and my ideas are always dumb. No one ever sees things the way I do and it's terribly frustrating to follow procedures and do things that I am convinced I can do ten times better. It's such an excruciating waste of time and energy. I feel like a popped balloon when someone dominates things – I want to do stuff myself and I want to do it on my own. Furthermore, my grades were mediocre (dammit!) and everyone patronised me and was rarely inclined or willing to help if I'd missed something because I couldn't

hear. It was each one for her- or himself. At lunch I never knew where to sit and they paid me little attention. If I found an unoccupied table and sat down, no one else would join me. If they did, it was with reluctance and only because there was nowhere else to sit. THEY CAN ALL GO FUCK THEMSELVES! And before you ask, I was friendly most of time and I did try not to go about with a sour face all the time. But yes, I felt very humiliated and things just got progressively worse. I was so relieved when it was all over.

26. JAMES WEISS

I wrote my bar exam at the beginning of 1996 and ended up with a distinction average – YES PLEASE!! Because of my good grades, a colleague from Janet Jones days offered me a job at the firm where she was employed at the time. I was on cloud nine. But I came back to earth pretty smartly. James Weiss simply wanted someone to do the hundreds of outstanding cost accounts– it's grunt work and deadly boring too. But stupid, I Becky was so grateful and all fired up to deliver her best. They stuck me in the tiniest office and for the following four months ALL I did was compile cost accounts. I gained no other experience. After four months, James Weiss secretary (you'd think he would have done it himself) announced that there was no more work for me and that they would not be offering me a permanent appointment. I have not forgiven the bastard or my friend – she didn't even have the decency to say she was sorry. I'm still friendly with her, and I often help her company out in the deeds office when she goes on leave – without being paid. Isn't that just dandy for James Weiss?

27. PRIORITY PAYROLL SYSTEMS

Right, Becky is out of work again. And again Aunt Jill, the fairy godmother, saves the day – this time she offered me a job as labour law consultant at their company, Priority Payroll Systems. I knew at the start I didn't want the job – I have zero interest in labour law, added to which it is a highly specialised branch of the law. It is VERY

involved and really difficult. Also, it would have been pioneering work in the sense that they wanted to determine whether they could implement it as a sideline in the company. I was anxious from day one and it simply got worse over time, and as I've mentioned, I really didn't enjoy the work. They spent a good deal of money on me, which fanned my guilt – they paid me a fairly good salary and they flew me back and forth to Cape Town to consult with the senior consultant, a former labour court magistrate. Lorraine Visser was much younger than I was, and a rude, tactless little bitch. I couldn't relate to her at all and I never managed to like her regardless of how well I got to know her. Also, she was my boss, which made any informal interaction with her practically impossible for me. I couldn't go out with her of an evening and then resume the boss-boy relationship the next day. I mean, how do you deal with going out to dinner tonight, and then first thing next morning at the office, being told frankly and without any diplomacy that you work is useless? I wished she would keep it formal. This was also the first time since matric that I allowed my work to go for a loop. She and I disagreed about everything and I grew increasingly apathetic – it became virtually impossible for me to do my job well and with any kind of enthusiasm. Furthermore, Aunt Jill was and remains totally patronising towards me – she treats me like a child and then I act like a child, which reinforces her idea of me as a stupid, incompetent child. A vicious circle. She is a good person and she does a great deal for me (she promised my mother on her deathbed that she would watch over me), nonetheless there are times when I hate her, quite often passionately. It never occurs to her to wonder whether she really knows me as well as she smugly thinks she does. WELL, SHE DOESN'T KNOW SHIT ABOUT ME! In addition, her son (also younger than I am) is the project manager, and he's just like her. Not to mention the big boss – Aunt Jill's husband. Grant Weston has always been an arrogant, rude, domineering, selfish, thoroughly self-centred CUNT. The project ultimately came to nothing and I was obliged to do other little jobs. I had a pretty good idea as to where all this was heading, and I wasn't

surprised in the least when she called me into her office one day. “Becky, there’s no work for you to do here. I’m mentioning it now so that you have time to find a job elsewhere. But we’ll you can stay on here for another three or four months, which will give you a chance to find another job.” I felt like screaming: YOU CAN SHOVE YOUR BLOODY LITTLE FAVOURS! I was also terribly angry at myself for having allowed that kind of situation to develop again, and especially for not having taken the initiative to find another job earlier, and thereby turning the tables on her. More humiliation, and yet again of my own making. I RELLY HATE THAT BLOODY WOMAN. Oh brother.

28. UNCLE GRANT AND HIS EGO

This occurred while I was still working at Priority. My car broke down and I was obliged to stay with Aunt Jill while it was being repaired because I didn’t live near a bus route. As luck would have it, Aunt Jill had to go off to Cape Town for a few days on business. This meant Uncle Grant and I were alone in the house and I didn’t care for much for that prospect. I have nothing to say to him and he makes me feel uncomfortable. When I’m alone with him, my first instinct is always to get away from him, and bloody fast too! Well, my instinct proved to be accurate. One day he and I were on our way to my flat in Centurion (actually my father’s double-storied townhouse) to go and pick up more clothes. When we arrived I went upstairs and he sat on the sofa and watched TV. After I’d done packing, I came downstairs and hung around uncertainly, because I didn’t want to join him on the sofa. I actually just wanted to get out of there and go. But Uncle Grant had other ideas. Come and sit here, he gestures, and gritting my teeth, I complied. He moves close to me and puts an arm around my shoulders. I thought I would suffocate. He totally overcrowded me, and seemed sort of slimy. I hunched my shoulders, my face scarlet. My panic was growing by the second and I felt queasy. He said words to the effect that I was so shy, and then the bastard tried to kiss me. I think he tried more than once (I don’t remember clearly –

I think I went blank for a moment) but eventually the CUNT got the message and sat back with a little laugh. We drove back to his house and it was as if nothing had happened at all. Easy, huh? Later on after my fright had subsided, I became angry until I was so enraged that if he had entered my room at that point, I'd have shot him. What the hell was he thinking? That I should help him through his mid-life crisis, or what? I had absurd fantasies about telling Aunt Jill, thereby taking a little revenge for her smug attitude towards me, but I knew life didn't work like that. Uncle Grant would simply have protested wide-eyed innocence at the accusation, implying that my imagination must have run away with me to have drawn such a far-fetched conclusion. Yes, nothing actually happened, it was all way too subtle, but I DIDN'T imagine anything.

29. DEEDS EXAM

During my last month or so at Priority I wrote my deeds exam. The preparatory course I took for it was unsatisfactory and inadequate, and it was hard to study all that material and work at the same time. By that time, I felt exhausted again. I had a very bad exam – the papers differed significantly from the previous ones – and I knew I hadn't made it. I put a lot of effort in, particularly when it comes to studying, and then I expect results, which I usually get. I don't do it for charity. It's simple logic: make the effort and you will pass. A concerted effort means you'll do well. Except it didn't happen like that this time. I hit rock bottom. This was the cherry on top of a dreadful year. I took my Baby Browning and held it, contemplating the bliss of ending my shitty life. When it comes down to it, you're on your own and nobody really gives a shit about you. I don't remember much else about that night, but I know what stopped me was the thought of what blowing my brains out would do to my father. As it happened, I passed but only because everyone had done so badly that the examiner had to adjust the marks, so I hadn't imagined how poorly I'd done.

30. HOUGH AND ASSOCIATES

Life hadn't done with me yet, not by a long shot. I got a job as a legal researcher at Hough and Associates – the first job I got off my own bat. If I took that as a positive sign, I was in for a helluva surprise. Things started out OK (I don't enjoy research but if that was all I could get, I'd do my best), but eventually Hough and Associates showed its true colours. The longer you work there, the less mercy they have on you. Most of the employees used to be attorneys, advocates, magistrates, etc. – so they weren't a bunch of fools. But there they treat you like a child: you're told how much coffee you're allowed to drink; you're not allowed to take initiative at all and have to wait for the approval of one of the directors first; in meetings with clients you're dead if you even hint at knowing more about the design than the director; etc. The organisation had an annual staff turnover of 100%. I once did a project and they didn't like my suggestions, but no one ever said what was wrong with them. I submitted the document and about three weeks later, I saw it lying on someone else's desk, a new employee at that. It was her job to improve on my suggestions, but no one ever informed me. I discovered in time that this was the way their usual modus operandi. I found the work exhausting because of all the new information you had to stuff into your head constantly. You couldn't ever build on your prior knowledge – you started each new project from scratch, with zero knowledge. I hated that. I like to reach a point where I feel that I know what I'm doing and that I will become progressively better at it – this gives me confidence. Because they were competing for contracts, they'd make ludicrous promises about the timeframes necessary to complete particular projects – promises we would have to keep. We ALWAYS worked overtime (including weekends) and got NO remuneration for it, nor any gratitude. Just criticism and disrespect. I once managed to do good work on a project (in spite of everything) so they promptly gave me greater responsibility for the next on – as the manager – and I can't begin to tell you how badly I screwed it up. I reckon I was pretty far gone by then already. Never in my life have I

been that exhausted. The turning point came in November 1998 – after I'd been there for over a year, with my confidence shattered and my self-image in tatters. The rage inside just grew and grew, and in November it semi-exploded in the form of manic energy that I harnessed to write an entire law on my own, and in a very short time. I didn't have a SINGLE DAY off that whole month – I worked from Monday to Sunday from around 7h00 to 2h00 for 30 days straight. I was supposed to have worked on the law with another woman (Marion) but I didn't like her ideas and we decided that we'd each do our own version and submit both for approval. After Giorgio (one of the directors) had looked at both laws, he called both of us into his office, and launched into an animated discussion of my version with Marion, ignoring her version (and me) totally. I thought I would burst a blood vessel. I interrupted him and said frostily that he was in fact discussing MY law. He stared uncomprehendingly at me for a moment and then simply resumed his discussion with Marion. The bitch didn't put him right either, why should she? Then Giorgio decided MARION should do the fine-tuning on my law and that I should occupy myself with whatever. I was no longer needed. I took out my Baby Browning for the second time that night. I couldn't stop crying and I sat on the carpet behind my bedroom door in the dark for hours with the pistol in my hand. Thoughts of my father were what stopped me again. Or was it? Who gives a shit anyway? When I saw the final product eventually, it was clear that they'd hardly made any changes to my original work. I'd written a damn fine law. I was not, however, given any credit for it. On the last day of the year, before Christmas, the directors called us in one by one. I was told that my performance during the year had been pretty hopeless and that I should take a holiday to recover, or words to that effect. As I walked out, I just lost it, turned around and went to the senior director and said I'd like an appointment with her the following day. Next morning I marched in with all the evidence and proceeded to put her in the picture. Apparently she let Giorgio have it after our conversation. He came to me sheepishly and asked, the way grown ups talk to babies

(as if I was an emotional female who'd overreacted), whether I was feeling any better now. I glared at him and said "yes" as coldly as I could. Then he tried to lay the blame on me by asking (with some amusement) why I didn't tell him it was MY law. I let it go because I'd had it with the whole thing by then.

By March 1999 (after 18 months at Hough and Associates) I was looking for any excuse to leave. One morning one of the much younger employees asked (in fact ordered) me to file some papers of her, because at the time I again had nothing to do. At first I couldn't believe what I'd heard and just nodded meekly. After she'd returned to her desk, I recovered my senses and felt enraged. I walked over to her and put the papers down on her desk, saying: "I'm sorry, I am not your secretary. You can file them yourself. However, if you really don't have the time to file them, then I will gladly help you with it." I went back to my desk, trembling. After a bit she came to me and apologised and said she'd file them herself. The feeling of triumph was short-lived, however – I was sick to death of the place and everyone there and all I wanted was to get the hell out. I stood up and began packing my stuff and throwing it in the back of my car. I'd decided I'd bloody well just quit. On one of the trips back to my desk, Marion found me emptying my drawers. "What are you doing?" she asked. "I'm leaving! I'm out of here!" I replied somewhat hysterically. When she asked whether I had another job to go to (EVERYONE there was always looking for another job) I said: "No! And I don't give a shit either!" Marion stopped me as I was making my way to my car with another load of stuff and she said we ought to talk first. In her office, she let me vent for about an hour and then I calmed down and realised that it was foolish to leave before I had somewhere else to go. The very next day something else happened that incensed me (although I can't recall what) and I managed to get all the way to the car, where Marion found me starting the engine. I had already put my one-sentence letter of resignation ("Please herewith accept my resignation.") on Giorgio's desk (he was out), and had loaded all my

stuff in the car. But I stayed, again, after another hour of venting in her office. I've included this paragraph just to show my state of mind at the time. Fortunately I got another job that same month.

31. OWN PRACTICE

About a week after my two failed attempts to leave Hough and Associates, Aunt Jill (again!) let me know that she'd organised a post for me with a developer (ABC) – they do low-cost housing and I'd do their conveyancing. Words can't describe my relief. ABC were aware that I had no practical experience in conveyancing, but they appointed me anyway. I knew I was an affirmative action appointment, and that still rankles, as does the fact that Aunt Jill saved the day yet again. Low-cost housing transfers are not the same as general transfers and they differ quite a bit from the usual kind. And so I went to see about 10 different people (lawyers, deeds office inspectors, etc.) to try and get a handle on how to do them ... only to find that everyone's idea differed from everyone else's – no one had a clue. Perfect. And then I discovered I'm not actually allowed to work for ABC and that I had to start my own practice. It wasn't difficult, but honestly, to start your own practice when you're as clueless as the man on the street. I'd articulated too long ago and the law had changed considerably in the interim. Added to which projects drag on because of all the bureaucratic red tape, and ABC were paying me a helluva salary every month – sometimes there's a lot of work to do for them, but mainly I don't have anything to do. It's hard not to feel guilty. I actually think they regret offering me a salary regardless of whether there's work to do for them or not. I've been “working” for them for the past 18 months now. This state of affairs is honestly not conducive to a clear conscience. Luckily I haven't messed up too badly so far, and I've always been able to rectify the things I have done wrong. I really don't think they can complain about my work – I also still provide them with regular reports on the current state of things.

I am totally apathetic and make no effort to win new clients, because I feel and am clueless and I'm scared silly. The final hearing loss, fundraising and CI made matters worse. I still can't hear on the telephone (this is really a big problem) and I can't afford a secretary, even if there were enough to keep her busy, which there isn't. At times I have to ask friends to make my professional calls for me and that creates a bad impression, particularly when the client asks an unexpected question which they, in their ignorance, can't answer. Asking a colleague produces much the same results, because they usually think FOR you and put the phone down before you can stop them! Yes, I use e-mail and faxes, but this isn't always practical and the only thing for it is to make a phone call. Sometimes I ask people I encounter in the course of doing business to make a call on my behalf, but they don't understand why they should do MY work for me. And professional respect is lost as well in the process. Lately I've been trying to make my own calls, but it's a real trial. I usually end up requesting they fax me, but people are slow to comply. At times like these I become so angry with God for making me deaf – it's really not my idea of fun. I'm also angry with him because I have had to start my practice the hard way, like this, while others get to be PAs for a good few years, at big law firms, before they start their own practices, but I have to start mine like a clueless idiot. How much more difficult must my life be???? I am stone deaf, I can't use the telephone, I have practically NO experience, I don't have a proper office, and I'm

ng a branch of the law that few attorneys know anything about, but I have to start my practice nonetheless. What about professional accountability if I make a mess of a client's case because I'm not clear about what I'm supposed to be doing? Textbooks don't help much. And before you ask, asking colleagues is useful but they often neglect to disclose some or other pertinent information, so that you end up having to learn from your mistakes anyway. How much greater are my chances, do you think, of being disbarred in a cloud of scandal owing to professional negligence, when this happens so easily even to experienced attorneys? HOW

DIFFICULT DO THINGS HAVE TO BE FOR ME??? I constantly feel that God and other people expect me to be Albert Einstein, while I just feel more and more stupid.

32. THE CI

One night in June or July, while I was playing computer games, I went totally deaf in my right ear, in an instant. I was already totally deaf in my left ear. I thought the hearing aid was playing up, but in bed later that night I just knew there was nothing wrong with the hearing aid. The silence was deafening, and when I wore the hearing aid, the distortion of the little I could hear, made me feel I'd go crazy if I had to listen to it at all. The audiologist confirmed what I'd suspected, and I thought my "normal" life was over. I'd have to close my practice and probably have to learn bloody sign language, and to whom would I speak it anyway? The audiologist said I could have a CI and made an appointment with Dr Rayburn, but nothing impressed me. I was critical of everything. I just wanted back that last little 5% I could hear with my right ear. And then my medical aid (Discovery) refused to pay for the implant and I had to raise R145 000. Six dreadful months followed. I was difficult, moody and weepy. To top it all off Aunt Jill donated about R70 000. The operation in November 1999 was successful, and the switching on in December 1999 was hugely successful. But I still felt bitter and it took me about six months to thank God for the implant, and I only thanked him in the end out of fear that he'd give me a fearful clout if I didn't. I feel he owes me the CI.

33. LIEFLING AND EVIE

Ever since I finished studying, I've always kept a guinea-pig. They're adorable and they suit my personality exactly. They're affectionate and full of character; they like being held and cuddled. I can shower my love on them; there's no one else who wants it anyway. And they don't reject you. They're high-maintenance – it takes about 20 minutes to clean the cage and you have to do it twice a day. I used to

say they prevented me from becoming selfish. At the time of my CI I had two – called Liefing (she was the eldest; I'd had her for about four years already) and Evie (short for Evander Holyfield because she was missing part of her ear!), whom I got to keep Liefing company. The only disadvantage was that their fur gave me terrible hayfever and asthma. But they were worth it. I struggled with the CI for a while shortly after the operation, and at the beginning of 2000 Dr Rayburn said the hayfever was the problem and that I'd have to get rid of them. It cut me to the quick, and Aunt Jill in her opinionated way added her ten cents worth, saying she was sure the hayfever was the cause of the problem, and that I'd better do as the doctor said. My father comforted me by saying their little pea-brains would forget me soon enough once they were among their own kind. So I took them to the animal farm where I'd originally bought Evie. I wanted David to come with me a week later to visit them. But he didn't feel like it and so I postponed the visit to the following week. When I got there the next Saturday morning, the manager told me they'd both died on the Wednesday past. He said since their arrival they hadn't taken any food or water, would not interact with the other guinea-pigs and refused to come out of their little house. They couldn't forget me, and just sat waiting for me to come and get them. They died of starvation. The cunt manager wanted to blame me (isn't that bloody typical of men?) by saying I'd spoilt them – how that would have been possible and what relevance it could possibly have had, I still fail to comprehend. The bastard didn't even bother to take them to the vet to see whether he couldn't keep them alive for another week or two – it was obviously too much trouble and he wasn't prepared to pay the vet either. I WAS COMPLETELY BESIDE MYSELF. I had never ever been that heart sore in my entire life before. I couldn't BELIEVE that these helpless little creatures had died such a horrible death, especially not after the loving care they'd received from me. On the way home in my car, I sobbed and screamed at God: "I CANNOT BLOODY BELIEVE YOU!! ARE YOU OUT OF YOUR BLOODY MIND?!! WHAT THE FUCK IS WRONG

WITH YOU?!!” My throat was raw before I even reached home. It’s a miracle that I didn’t burst a blood vessel – I’ve not experienced that kind of rage before. He could easily have let them live ‘happily ever after’, but no, for some inexplicable reason he had to let them die like that. I got into bed and raged at God for practically the whole weekend. I think I was temporarily insane. No doubt you think I overreacted, and that people don’t get that attached to animals. Well, I don’t give a damn – I refuse to apologise for it. The rest of you have men in your lives, (and you take all the crap that goes with that) but I chose not to do that to myself – why do I have to be like everyone else? Oh, and just to complete the ghastly picture, the problems I had with the CI turned out to have nothing to do with hayfever after all – it had all been for NOTHING. I’m still waiting for Aunt Wilma to apologise, after all, they were just bloody guinea-pigs. And Dr Rayburn should be more careful with her bloody diagnoses. I wonder if I’ll ever forgive them (including the bloody animal farm guy). I consider animals helpless. They don’t understand the meanness of people. We have a duty to care for them. People and children, on the other hand, are everything but helpless. Yes, I also feel responsible for their death to an extent and just thinking about it makes me crazy. I try not to think about it. The dominant feeling at this point is: NOBODY UNDERSTANDS AND NOBODY GIVES A SHIT. You’re alone, unless you act like everyone else and do what they all do. No one will make the effort to understand how your mind works; according to them, you’re just plain wrong and mad as a hatter to boot.

34. A CI FRIEND

I made friends with a woman who also had a CI about two weeks after me. She is quite a bit older than I am (in her 60s, I think). Initially things were fine, but Ria is so busy trying to compensate for her inferiority complex that I can hardly stand it. She’s bossy and opinionated, is terribly competitive and is TOTALLY disinterested in anything I say. In fact, if I were to remain completely silent all

evening, she'd just talk non-stop about herself and not even notice my silence. She has humiliated me in front of some of her friends quite a few times already, and she hates it when I'm the center of attention. I often look at her and think: "But you are not even here with me. The only reason you do things for me is because it makes you feel better about yourself. That's fine, but, what about me? I have done things for you, etc. simply because I care about you as a friend, but you don't give a shit about me." I'd like her out of my life, but then it's not that simple. How do you do that without hurting the other person? What are you supposed to do when she doesn't even understand what she's doing? And before you ask, I have told her several times already that she'd upset me and that she was competing shamelessly with me. And what did she do? She turns it all around so that the whole thing is simply my imagination and overheated emotions, and then she'd add, as a aside, that sometimes her stupidity is such that she isn't even aware of what she's doing – and then she'd just go on as usual. I don't need people like that in my life, but whether I have the guts to get them out remains to be seen.

FREQUENT DREAMS

PLAY

I can't really remember what it was about. Something by Shakespeare. I play some or other part. It's just before curtain time, and I don't know my lines. I tell myself there's plenty of time to learn them, and I feel constantly anxious. Suddenly the performance starts and I

that I'm going to mess up totally. My fairy godmother can't and won't save me. And then it's my turn to go on stage and I go, my heart beating so fast in panic that I feel close to a heart attack. So, there I am on stage in front of an audience with nothing to say and I wish I were dead.

This theme (I don't have a clue what I'm supposed to do and no one will help) features frequently in my dreams. In all these dreams I go

to meet my fate knowing that things will turn out badly. I never run away. I also have no confidence in my judgment in these dreams. I always make the wrong decision.

HISTORY CLASS

I'm taking a course in something like the history of the Middle Ages. The lecture happens in a small room that has the feel of a library, and the students' chairs are arranged just anyhow. Class has already started and I'm late. I hurry in and sit down. The lecturer is reading from a book, but I don't have the book and I don't know which book it is. Anxiously I try to catch someone's eye, but everyone ignores me. I eventually put my hand up and ask the lecturer which book he's using. He makes some or other careless comment, which I don't hear, and continues with the lecture. I am close to tears and one of the other students hands me a book. I open the book and find the relevant page (I have no idea how I determine this), but the content on the page doesn't correspond with what the lecturer is saying. I realise the book is an old edition. I put up my hand and say I have an old edition, and ask where I can obtain the new edition. The lecturer glances my way with a total lack of interest and continues with the lecture. The other students display no interest either and none offers to share a book with me. The lecture continues and I don't have a clue. Everyone has the same attitude all the way through to the end of the lecture: They're disinterested and can't understand why I should be so upset.

A LITTLE FROG

There's a little frog in my room. I run out and ask my father to come and kill it. He says the frog is harmless and we should just leave it alone. But I insist that he should kill it, even though I actually agree that the little creature is harmless and innocent. My father gives a defeated sigh and goes into the room, and I hear the blows as he hits it with something. The feeling I experience is too dreadful. My father comes out, gives me look of resentment and sorrow and says in a tired voice that the frog is dead now. He sighs again, walks to his room and shuts the door. At this point, I'm practically dying of self-

recrimination and I have no idea how I will live with myself. I also don't understand at all what the hell is wrong with me. I just want to die.

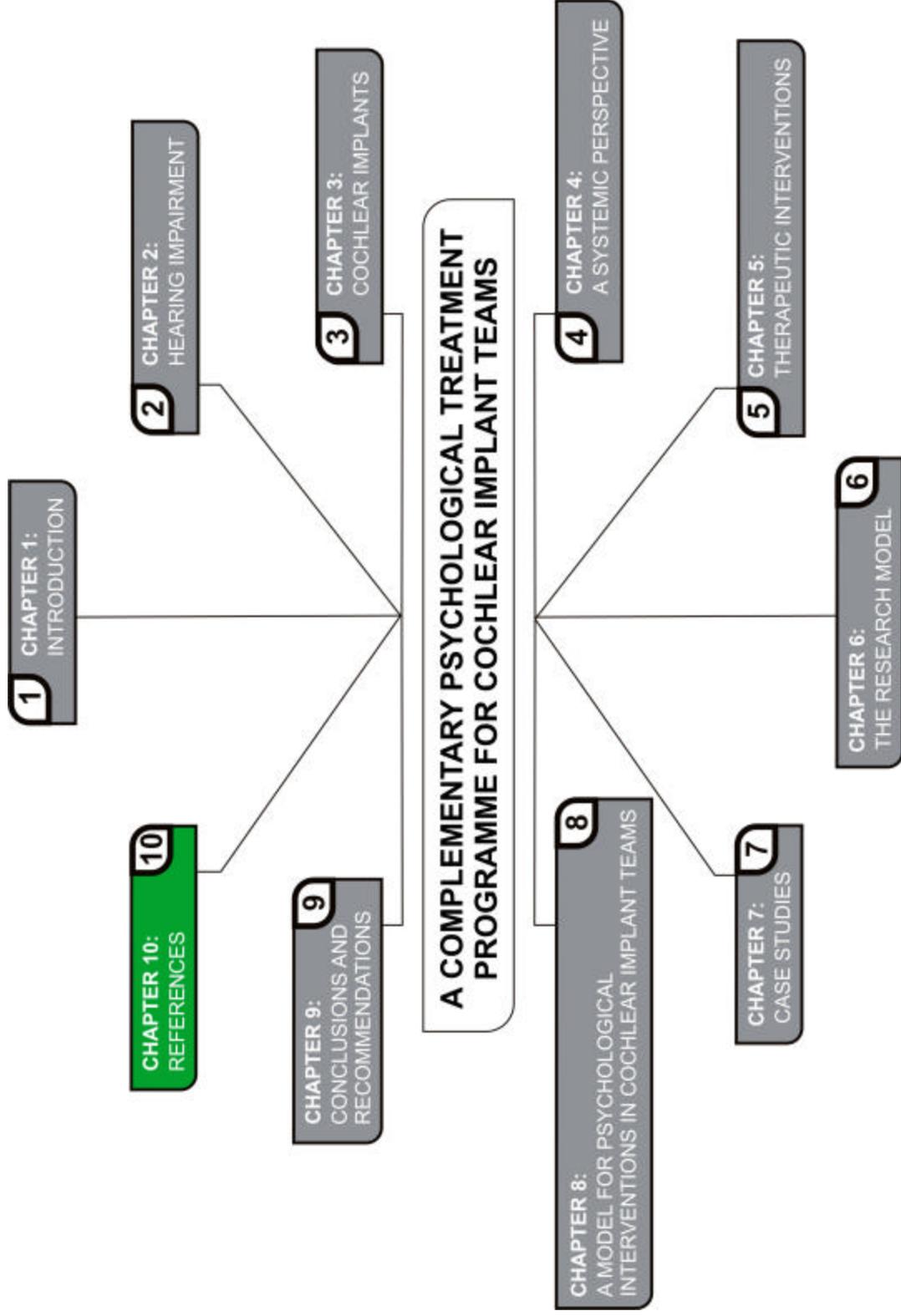
RAGE AND POWERLESSNESS

Can't recall anything specific (perhaps the anti-depressant?), but I do know that it happens OFTEN.

For example, I'll pray fervently that a particular problem won't arise or that I'll be able to solve a certain problem. My prayer remains unanswered. I feel like a fool, humiliated. And then I become incensed and, filled with rage, I address the problem and solve it quickly (but it's too late to save face), or I might do nothing about the problem and after a spell of fury, it recedes into the background. I think my motivation for the latter is related to my sense that the sword of judgment hangs over me because I had the temerity to be angry at God. No one but you has ever understood this. I've never been able to talk to anyone about it, particularly not with other Christians, because it shocks them silly – I always wonder, then, whether these bloody morons have any emotions at all or whether they might just be brain dead? Subconsciously, I can't understand how it can be wrong to feel this way – it's so logical.

Mostly I feel downhearted and fatalistic because I feel that I rarely get what I really want because no one, including God, believes I'm worthy of it. I think God thinks I ask for a load of crap. I'm afraid that God will grant me exactly what I don't want: Christians shouldn't be materialistic, shouldn't be worldly, and I so badly want job satisfaction, etc. And what do I get? I'm dirt poor, I battle with my weight, have skin problems, and bugger up work that I am perfectly capable of doing brilliantly. Yes, things do go better at times, like now my weight is OK and my skin looks better, but it remains a problem. I can't make peace with what I've been given and achieved – I NEED MORE, MUCH MORE!! I don't see what's wrong with that, nor why I should be limited – I DON'T WANT TO BE LIKE 90% OF PEOPLE!!

My IQ is, I'm told, very high, why can't I apply my bloody brain to get somewhere in life?!



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