

**The psycho-social impact on hearing children  
of deafness in their primary caregiver**

**Anna Ward**

**Primary Supervisor: Margot Solomon**

Dissertation submitted to Auckland University of Technology in partial fulfilment of the requirements  
for the degree of Master of Health Science in Psychotherapy

December 2009

## Table of Contents

Attestation of Authorship.....	3
Acknowledgements.....	4
Chapter 1 .....	6
Introduction .....	6
Process.....	7
Aim.....	8
Methodology .....	8
Method .....	10
Table 1.....	11
Method of key word search.....	11
Inclusion/Exclusion Criteria.....	14
Summary .....	14
Structure of Dissertation .....	14
Chapter 2.....	16
Child Psychological Development.....	16
Attachment Theory and the HC/DC Dyad .....	18
Separation/Individuation and the HC/DC Dyad.....	22
Maternal Mirroring.....	26
Communication .....	27
Chapter 3.....	31
Emerging Characteristics of the HC/DC Dyad.....	31
Shame .....	34
Parentification .....	36
Survivor guilt.....	40
Paranoia.....	42

Chapter 4.....	45
Clinical Implications.....	45
Characteristic Profile and Responsiveness and Sensitivity..	45
Potential HC/DC Client Traits .....	46
Communication Methods .....	47
Treatment and Intervention .....	47
Transference/Countertransference .....	48
Development .....	52
Chapter 5.....	55
Summary and Conclusion.....	55
Limitations and Further Research .....	56
My thoughts .....	57
References.....	59

**Attestation of Authorship**

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning except where due acknowledgement is made in the acknowledgements.”

Signature

Anna Jane Ward

Date:

### **Acknowledgements**

First and foremost to Lynn Charlton for her dedication to the profession of Psychotherapy, which has inspired me in my journey towards becoming a psychotherapist; my relationship with you has enriched my life and given it purpose. To my partner Adrian Tyler who has been my oasis throughout most of my training, I love you, you deserve an award. To my peers who have made the journey rich and wonderful. To Helen, Suz and T for helping me see the blind spots. Thank-you to Margot Solomon, for your guidance throughout the dissertation process. To John O'Connor, for your belief in me. Finally, thank-you to my mum, Rosemarie Ward, who has given so much of her time in making sure this document looks smart.

### **Abstract**

This study examines whether deafness in the caregiver impacts on the development and socialisation of their hearing child. Therefore this dissertation is guided by the question: “Can deafness in the primary caregiver be linked to a characteristic psychological profile in the hearing child and if so what are the characteristics of this profile?”

When thinking about the hearing child/deaf caregiver dyad many questions arise surrounding the possible impact of the deaf/hearing relationship on the child’s development: How does the deaf caregiver respond to the infant when the caregiver can not hear the child? How do they communicate with each other? How does the child adapt to a bilingual role? Does the child become an intermediary between the deaf and hearing worlds and can this lead to undesirable complications to their development? This study sets out to examine these questions and to provide a profile for psychotherapists who work with this unique population. Ideas and solutions for deaf caregivers of hearing children who have asked these questions are also addressed in this study.

## Chapter 1

### *Introduction*

#### **No Self**

Cross eyed cross faced little girl

Sad, bad little girl

Eared, heard little girl

Give me your ear

Give me your voice

Give me your tongue, your mouth

I gave you life

Your life is mine

I did not have ears

I made a pair

Be me, sad bad little girl

You are lost and I am lost

I love you for you are mine

Little girl, little girl

(Sidransky, 1990)

My interest in the impact of deafness in the caregiver of hearing children arose through the psychotherapeutic treatment of a client who grew up in an environment where both parents were deaf. During our work together many concerns arose surrounding what, if any, are the psycho-social implications for a hearing child raised by a deaf caregiver. What happens when the child cries and the caregiver cannot hear the call, how does the child learn to talk, is the attachment process disrupted due to the caregivers deafness, does the child identify with the hearing or the deaf community? In the positioning of the child as a go-between and interpreter for the hearing and

deaf cultures, do issues in the nature of bicultural tension arise? In order to protect my client's identity, no clinical material from my experience with this client will be submitted in this study.

Due to an absence in my knowledge base of the deaf community in general, I began to read autobiographies written by hearing adult children of deaf parents. These autobiographies produced illuminating insight into this area and provided parallels from my client's own experience and the lives of the writers (Greenberg, 1972; Oliver, 1989; Sidransky, 1990; Walker, 1986) which deepened my interest in this mysterious world.

Considering ninety percent of all children born to deaf parents are hearing (Schleif, 2006), research available on the hearing child/deaf caregiver (HC/DC)<sup>1</sup> dyad is scarce. This absence of material is mentioned by several authors whose work is cited throughout this study (Arlow, 1976; Bene, 1977; Wagenheim, 1985; Zarem, 2003). However, the absence of research discussing the developmental impact of the HC/DC dyad may be an indication that there is a large population of deaf caregivers providing the necessary developmental environment for their hearing children. Regardless of the reason for the lack of information available, my hope is there will be a group of people who may benefit from this work.

### *Process*

To begin the process of answering the questions raised concerning the developmental impact of HC/DC dyad a comparison of development in

---

<sup>1</sup> HC/DC refers to the hearing children of deaf caregivers. HC/DC dyad refers to the relationship between the hearing child and deaf caregiver.



the wider population of hearing children of hearing parents will be examined and compared with the development of hearing children raised by deaf caregivers. Then through a modified systematic literature review the experiences of hearing children of deaf caregivers will be presented. From this comparison any emerging characteristics will be examined.

### *Aim*

The aim of this study is to establish a characteristic psychological profile of the HC/DC to assist psychotherapists in their work with this client group. My hope is that this study assists deaf caregivers to identify aspects of the HC/DC dyad that can impact on a hearing child's development, so that with awareness solutions can be implemented to address these concerns. Such measures can then hopefully help prevent the need for psychotherapeutic intervention in their adult lives.

By assessing the experience of hearing infants of deaf caregivers through the lens of psychotherapeutic theories a characteristic psychological profile of the HC/DC may emerge. The characteristics of this profile will then be grouped and discussed.

This study aims to support therapists of hearing clients who present with issues directly or indirectly related to the deafness of their caregivers. It is not the intention of this study to suggest that deafness in a caregiver is invariably linked to some form of developmental arrest.

### *Methodology*

To conform with best practice the application of a modified systematic literature review will be adhered to. A description of what this methodology

consists of and how it shall be applied will follow. The concepts of evidenced based practice (EBP) and a systematic literature review will be discussed and defined in this section. The modification of the systematic literature review will be clarified. To conclude this section, the specific methods and techniques employed to find and gather information will be described.

The term 'evidence based' refers to scientific rationality and 'practice' refers to the behaviour of the practitioner (Locket, 1997). Evidence Based Practice (EBP) began as a medical paradigm and is the systematic process of finding, appraising and using contemporaneous research findings as the basis for clinical decisions (Rosenberg & Donald, 1995). Systematic reviews are said to bring together research and practice (Reynolds, 2000). All available research evidence is systematically gathered and compiled to answer the research question in a systematic literature review (Dickson, 1999). This methodology is considered the 'gold standard' in assessing treatment potency and was specifically designed for quantitative studies which used randomised control trials (Reynolds 2000). The possibility of bias is reduced using this method due to all the information written on the topic being obtained, compiled and synthesised.

According to Dixon (1999), the main components in a systematic literature review are: to define the research question, the methods of identifying research studies, inclusion and exclusion criteria, quality appraisal of the studies included, extraction of the data and the synthesis of that data.

This study mainly draws from qualitative data which is summarised and not statistically compiled which creates the necessity for the modified

component of the systematic literature review to be included (Cook & Mulrow, 1998). Qualitative research is usually applied to psychotherapeutic study as it is difficult to quantify the emotional, thoughtful, humanness of the psychotherapeutic experience (Geddes 2000). The complexity of clinical material in psychotherapy relies on qualitative methods to describe the material in the work (Lemmer, Grellier, Steven, 1999). This study uses the modified systematic literature review methodology, focusing predominately on qualitative data, to bring together research and practice.

### *Method*

This study assesses both personal accounts (case studies) and research literature to ascertain whether there is a correlation between therapeutic themes in hearing children and deafness in their caregivers. It then evaluates these themes against research which describes normal and abnormal development in children to determine if deafness in caregivers can be said to be a causative factor for deviation from normal childhood development. Due to there being many schools of developmental theory I have selected the theoretical approaches of John Bowlby, Margaret Mahler and Donald Winnicott to critique the study question as their theories address clear developmental areas of concern which arose for me in researching studies performed on the HC/DC (Bowlby, 1998; Mahler, 1973; Winnicott, 1965). The theorists mentioned also discuss the importance of feedback between the child and caregiver as this provides a vital function in the child's developmental process.

A compilation of evidence on and around the topic chosen is drawn from the modified systematic literature review. This evidence will then be

discussed. The emergence of certain psychological characteristics pertaining to the HC/DC dyad will be drawn from this data. These psychological characteristics will be compiled both for the purpose of assisting therapists who are treating adult HC/DC and to providing awareness and support for deaf caregivers.

My introduction into researching the world of the hearing child raised in a deaf environment began by reading autobiographies written by the hearing adults of deaf parents, which provided grounding in the HC/DC experience (Greenberg, 1972; Oliver, 1989; Sidransky, 1990). From that I performed a Google Scholar search of my topic which produced thousands of hits, of those only a few were credible and aligned to my topic. These articles then led me to the AUT Library databases. Searches were made on PEP, PsycINFO, PsycARTICLES and Pro Quest. These database searches produced approximately fifty articles and dissertations which were associated to my topic.

The table below shows the databases searched, key words used and total hits and relevant hits. Although choosing my key words carefully, based on the study question and topic, I found the majority of the findings were focused either on the deaf caregiver or deaf children. Then I collated the relevant titles from the references of the articles retrieved.

*Table 1*

*Method of key word search*

Databases	Key Words	Total Hits	Relevant Hits
PEP	Hearing & deaf	37	1

	Hearing Children & Deaf parents	27	7
	Hearing children <u>not</u> Deaf children	164	0
	Psycho-social & Hearing children, Deaf parents	0	0
	Parenting & Deaf Parents & Hearing Child	5	1
	Psychoanalysis & Hearing children Deaf parents	23	13
PsycARTICLES	Hearing children & Deaf Caregivers & Psycho-social	0	0
	Hearing children & Deaf Parents	37	0
PsycINFO	Psychoanalysis & hearing child & deaf parents	5	2
	Psychotherapy & developmental & hearing children deaf adult	0	0
	Find similar to: Signs of connection working with deaf parents & hearing children in a nursery setting	102	5
	Psychoanalysis & development & hearing child & deaf caregiver.	9	2
	Parenting & Deaf Parent & Hearing	8	3

	Child		
Pro Quest Dissertation & Thesis	Hearing children & Deaf parents	43	15
	Hearing children & Deaf Parent & Development	16	1
Google Scholar	Psychotherapy & hearing child & deaf parent	10	1
CODA	Website resources	6	2

CODA, an organisation developed by and for the hearing children of deaf adults was referred to when searching the hearing child/deaf adult dyad. A number of articles found on the website were from the perspective of the deaf parents' experience of raising their hearing children. However, several peer reviewed articles relevant to my study, mainly pertaining to the bicultural nature of the HC/ DC dyad, were discovered and have been a great contributor to this study (Grosjean, 1982; Myers, Myers, & Marcus, 1999; Preston, 1994; Singleton & Tittle, 2000; Weiner, 1997).

Overall, the articles retrieved from my searches, none spoke specifically or directly to the questions I was asking, however many studies contained relevant material which enabled a thorough investigation. This information was then grouped into recurrent themes. I decided to use developmental theory to highlight potential developmental arrests in the HC/DC dyad as this method was a useful tool to organise and interpret the data. Four themes emerged as central to answering the question and the data from the study was reviewed using those themes.

### *Inclusion/Exclusion Criteria*

Only studies pertaining to the hearing children raised by caregivers who were deaf from birth or early childhood will be examined. There are many variables with people that become deaf after a certain age including the development of speech and the ability to remember sounds which would lead this study into a broader context. The studies of deaf children are also excluded unless used in conjunction with hearing children. I have kept the searches to psychodynamic and psychoanalytic sites as this study is generated mainly for the therapists of hearing adult/children.

### *Summary*

In summary, this dissertation's topic is defined by the question "Can deafness in the primary caregiver be linked to a characteristic psychological profile in their hearing children and if so what is the profile?" The question will be approached through a modified systematic literature review and psychodynamic and psychoanalytic developmental research to provide a characteristic profile of a HC/DC to assist psychotherapists in the treatment of their HC/DC clients.

### *Structure of Dissertation*

Chapter one provides the foundation for this study by introducing the topic, the aim, why it is being written and who it is for. Following this is a discussion of the processes and methodology used to conduct this study and the methods used to obtain the information. The method and methodology are in place to provide structure and a process for the efficacy of this study. Inclusion and exclusion dynamics are also addressed.

Chapter two establishes the psychological and emotional environment which provides healthy development in children, specifically the areas of concern for the HC/DC dyad which relate to responsiveness and sensitivity in the caregiver. Chapter three provides a modified systematic literature review of all articles and qualitative material pertaining to the HC/DC. Chapter four discusses the clinical implications of working with the adult/child of a deaf caregiver and draws from clinical studies and hypothetical transference and countertransference interactions. Chapter five summarises and concludes this study, bringing together all the findings and thoughts pertaining to the subject of this study.



## Chapter 2

### Child Psychological Development

This chapter is designed to ascertain what environment provides the necessary qualities for healthy development in infants and children and discusses how arrests may occur in the HC/DC. The establishment of psychic structure and object relatedness is considered through a discussion on communication methods of the HC/DC dyad.

The question of what creates a normally functioning child has been a central concern for many psychoanalytic and psychodynamic theorists (Ainsworth, 1989; Bowlby, 1958, 1973, 1998; Mahler, 1967; Winnicott, 1965). Developmental theories such as Object Relations Theory have been developed to shed light on this process and as such may provide insight into where and how the impacts on a hearing child's development of being raised by a deaf caregiver may arise. Underpinning Object Relations Theory is the thinking that the relationship (relations) between caregiver (object) and infant is internalised by the infant and provides the environment for psychological and emotional development. This discussion will draw on work by Object Relations theorists Margaret Mahler, John Bowlby and Donald Winnicott who have each brought unique perspectives to the development phases and the relationship between parent and child.

Biochemical, hereditary, behavioural and environmental factors contribute to the developmental process of the infant, however the child/caregiver relationship is the focus for this dissertation. Bowlby (1982) notes that infants and caregivers are indeed influenced by each others reciprocal responses:

An easy newborn may assist an uncertain mother develop a favourable pattern of care. Conversely, a difficult unpredictable newborn may tip the balance the other way... The capacity of a sensitive mother to adapt to even a difficult unpredictable baby and thereby enable him to develop favourably is perhaps the most heartening of all recent findings in this field (p. 368).

The Object Relations Theorists all broadly agree that in early infancy there is a process in which emotional and psychological attachment to and separation from the caregiver occurs. It is also accepted that at certain stages there is a time where the infant is totally reliant on the primary caregiver to respond to their myriad needs. Coinciding with this period, the caregiver is required to balance their role as the safe, loving, constant and responsive object with the dynamism and flexibility to also allow for exploration, thereby allowing the child to develop autonomy (Bowlby, 1958, 1998; Holmes, 1996; Horner, 1984; Karen, 1998; Mahler, 1967, 1973; Stern, 1985; Winnicott, 1965).

The next section will describe the environmental factors that result in certain attachment styles. This sets out to outline the areas where healthy development in children occur and the possible dynamics that can create potential risks to their development. It is necessary to explain these areas in order to highlight the dynamics of concern in the HC/DC dyad. These dynamics mainly concern focus the qualities of responsiveness and sensitivity in the caregiver.

*Attachment Theory and the HC/DC Dyad*

An introduction of Attachment Theory will be discussed and potential areas of concern for the HC/DC will be outlined using this theoretical position, however a discussion of these concerns will be included in more detail in Chapter five.

Bowlby's Attachment Theory describes how differing parenting styles affect the attachment style of the infant (Bowlby, 1958, 1973, 1982; Erikson, 1968; Holmes, 2001; Karen, 1998). Van Ijendorn and Sagi (1999) summarised four categories in attachment theory: Universality, Normativity, Sensitivity and Competence which consist of the following hypotheses. Universality is the assertion that all human children attach to one or more caregivers. Normativity is the assertion that seventy percent of all children are securely attached, the rest are insecurely attached. Sensitivity refers to the provision of security by the caregiver and is dependant on maternal sensitivity. The provision of sensitivity links to Erikson's (1968) concept of 'basic trust', which proposes a requirement of maternal responsiveness, sensitivity and empathic attunement. Competence is the attainment of security within attachment which facilitates social competence; the child feels valued and respected and projects this internalised experience into the wider society.

When applying the theory of universality and sensitivity to the HC/DC dyad the opportunity for the child to acquire more than one attachment figure, perhaps a hearing father, aunt, sibling or family friend, could compensate for any unresponsiveness in the deaf caregiver (Arlow, 1976; Wagenheim, 1985), which in turn would provide the internalisation of a sense of security and later lead to social competence.

Ainsworth (1989) gathered data of attachment processes through a study named 'The strange situation'. In this study infants/children between 12-18 months were observed for attachment responses. This was demonstrated when the mother or caregivers were asked to leave the room for a period of time and then asked to re-enter. Through this practice they found the child had either secure or insecure responses to the caregivers' movements.

The ability of the infant to calm themselves and continue playing after the parent had left the room and how they connected with the parent when they returned determined the attachment style classification of the child. The securely attached child became distressed initially but regained calmness or equilibrium quickly and efficiently, compared with the children who were insecurely attached. In comparison the insecurely attached children were inconsolable or indifferent to the parent's exit and exhibited indifference or disturbed responses to the parent's return. For example, the child would lean away from the parent, not making eye contact or would stand rigidly. The behaviour of the children indicated psychological normality in the securely attached child and psychological disturbance in the insecure group (Ainsworth, 1989; Bowlby, 1998).

There are a further three hypotheses in Attachment Theory made by Holmes (1992) which describe how the attachment processes in childhood affect experiences in adulthood. These are listed as: Continuity, Mentalization, and Narrative Competence. Continuity refers to how attachment patterns in adulthood echo the childhood relationship experience. Mentalization refers to how secure attachment provides the environment where the evolution of reflection about the emotional state of self and other thought occurs (Fonagy,

1991; Meins, 1999). Narrative Competence refers to a component of mental health in adulthood that is recognised through the ability to form Narrative Competence and awareness of the ability to articulate one's history with all variants of affect experienced throughout his or her journey (Hesse, 1999). When these adult presentations are applied to the adult HC/DC certain areas of concern emerge. If the HC/DC has a different culture and ways of communication to the parent then the continuity, mentalization and narrative competence could be compromised.

There are six domains of attachment theory which are used in the clinical application of this theory. I will discuss only the domains that directly relate to this study. These are: 1. The secure base (SB) 2. Exploration and enjoyment. 3. Protest and anger. However, further research on attachment can be found in "The search for the Secure Base" (Holmes, 2001). After each domain there will be an indication of possible concerns for the HC/DC dyad which will be developed and discussed further in Chapter five.

The first of these domains is the Secure Base (SB). The Secure Base is the term used to describe the caregiver. This SB will provide a secure or insecure attachment experience. The SB is linked to survival as every infant needs a base, whether it is secure or insecure, to stay alive. The SB's response to the infant's distress at feeling threatened and the psychological state the infant results in, determines secure or insecure attachment. The internalised SB representation established in childhood determines the adult internal and environmental experience, which is an internal default position and is returned to in times of stress (Bowlby, 1973, 1998; Holmes, 2001).

In adulthood the SB not only consists of the caregiver or partner in relationship, it can be alcohol, eating disorders or a myriad of what is described as 'transitional objects' (Winnicott, 1965). Questions arise when applying this theoretical perspective to the provision of a secure attachment style in a hearing infant of a deaf caregiver, as the SB may or may not respond accurately to the infant's distress.

The second domain is labelled Exploration and Enjoyment. To explore and play requires some level of security. When people feel threatened their normal physiological state is inhibited and they will seek a secure base (SB) to help soothe them. Insecure children find it hard to play and enjoy themselves as they are pre-occupied with their caregivers' whereabouts. This domain raises a concern regarding the management of proximity within the HC/DC dyad due to the impaired ability of the deaf caregiver to respond to verbal cues from the child.

Domain three: protest and anger; suggests that anger is expressed when there is a threat of separation and is used as an agent to keep the attachment bond secure. A child that is constantly in fear of separation may have many responses to real or imagined separation. Usually underpinning the experience is chronic anxiety which manifests in protest or anger. If the responsiveness of the caregiver toward the infant in this state is inconsistent or insensitive the infant will internalise the distress. This theory highlights the question whether the deaf caregiver's is able to be responsive and therefore sensitive to the child.

Attachment styles are categorised by the adult's state of mind in relation to attachment and then linked to the response in behaviour of the infant to these states of mind. The categorizations are: Secure/autonomous (parent) - Secure (infant); Dismissing (parent) - Avoidant (infant); Pre-occupied (parent) - Ambivalent/ resistant (infant) and Disorganised/unresolved (parent); - Disorganised/disoriented (infant) (Bowlby, 1998; Holmes, 2001).

The secure parent provides consistency, empathy, responsiveness, and attunement which results in the infant feeling a deep sense of contentedness. A securely attached infant, once having developed a sense of basic trust, later achieves a state of self and object constancy. Whereas, insecure attachment produces unstable self esteem due to the presentation of a variation of the following factors in the parent: inconsistency, intrusiveness, unresponsiveness, anxiousness, unavailability, disorganisation, incoherence and passiveness (Holmes, 1996).

Schleif's (2005) study of the emotional development of HC/DC found if the attachment was secure; the child's overall development reflected this. To provide secure attachment within the HC/DC dyad, the need for electronic aids such as visual signalling devices and external supports from older siblings, extended family or friends and an interpreter may be required.

#### *Separation/Individuation and the HC/DC Dyad*

Like Attachment Theory, Margaret Mahler's Separation/Individuation Theory (Mahler, 1967), discusses potential areas for deficit in the developmental processes of the infant/child, in particular the HC/DC.

Stern (1985) notes that where attachment theory poses attachment and human connectedness as a developmental goal, Mahler's theory of separation/individuation is founded on the idea that attachment is an innate condition from which the infant must develop autonomy. Stern suggests that attachment and separation/individuation are consecutive phases (Stern, 1985). Separation/individuation theory has significant ramifications for the child of deaf caregivers for if attachment is innate, deafness is unlikely to impact on the infant's sense of security. However, whether attachment is developed or innate, it is clear that the success or failure of a caregiver's response to the infant in an affirming and sensitive way will have a large impact on the infant's emotional and psychological development.

Underpinning Mahler's Separation/Individuation theory are her concepts of Normal Autism and the Symbiotic Phase. Due to limitations of this study, I will briefly touch on the Symbiotic Phase as it directly relates to this study but a discussion on Normal Autism will be excluded. The Symbiotic Phase according to Mahler is where the new born baby and young infant seek homeostatic equilibrium. As part of this process the infant expels anything that causes it discomfort. Mahler describes how if crying, which is an indication of something needing to be expelled, goes unnoticed this can lead to Strain Traumata which inhibits equilibrium being fully achieved. This experience can cause severe disturbance of individuation and psychotic disorganisation (Mahler, 1967).

Studies indicate the occurrence of Strain Traumata in the hearing children of deaf caregivers as they describe being left for hours in their cots unable to gain the attention of the caregiver (Arlow, 1976; Wagenheim, 1985).



The occurrence of being left unattended created an uncontrollable rage response in the infant which was then internalised (Mahler, 1967; Wagenheim, 1985). Mahler (1967) recognises in the following sentence the importance of responsiveness:

Psychoanalytic theory allows us to speculate that when a very young baby experiences the failure of the environment to rescue him from unpleasure, "affectomotor storm-rage reactions" result, which culminate in exhaustion when he is not rescued by the external ego.

The Separation/Individuation phase asserted by Mahler (1967) is in continual development throughout life but mainly occurs during the first four to thirty six months. Mahler (1967) suggests that during this phase there needs to be a balance of boundary setting, encouragement of exploration and accessibility to the parent. In this phase the child attains some form of autonomy/separate functioning which can only take place if the caregiver is emotionally present and responsive. Considering the HC/DC dyad in light of this theory the possibility of deafness limiting the caregiver's ability to respond becomes apparent simply because the parent cannot hear the child's cues when out of sight (Mahler, 1967). Gerhardt (2004) describes how failure to attune to infant distress undermines the baby's confidence in the parent and the world, leaving the baby feeling dependent and anxious.

Seen through the lens of Attachment and Separation-Individuation theories the development in HC/DC could be seen as problematic from the out-set. Mahler (1967, 1973) proposes that for the infant to pass through the

separation-individuation phase successfully the environment (mother/primary caregiver) needs to be able to respond to the child's verbal cues from a distance. Constricting or restricting the child's ability to create proximity, in order to compensate for unresponsiveness to verbal cues, is likely to limit the child's exploration and thereby inhibit the separation/individuation process (Mahler, 1967, 1973). Support for this idea is found in Dent's (1982) study of two hearing children of a deaf caregiver. Dent found that through hide-and-seek played with dolls the children stressed the idea of being found by being seen. Dent interpreted this game as an expression of their sense that to be 'out of sight' was to be 'out of mind' which was a source of anxiety for the pair. Piaget's (1967) schema of the first stages of life, discuss a natural curiosity of the world that emerges in the infant, which creates a desire to explore. If this schema is applied to this example a failure in the process of separation/individuation would occur due to the parameters of proximity being restricted.

Mahler's (1973) sub phase of Rapprochement, which occurs from around the second year of life, is associated with affective and cognitive development and produces the formation of language skills. This phase requires a communicative and comprehending caring primary object. Language permits the achievement of more effective and accurate forms of communication with the primary object in regard to objects, events, and possibilities beyond the field of vision. Acquiring the use of language assists in affect being regulated by verbal expression. This phase is dependant on the listening caregiver's verbal responsiveness to the infant's testing out of newly learnt skills. Without language in some form, serious developmental and social

problems are believed to result. These findings suggest that if the HC/DC is encouraged to express herself through sign language and verbal expression, there is less likelihood of developmental arrest in ego and object relatedness (Arlow, 1976).

Of particular importance to this study are the phases in development where the infant requires a rapid affirming response from the mother/caregiver and that in which it begins to become autonomous. Mahler describes this latter phase as the practising sub phase which is part of separation/individuation. This occurs when optimal distance is balanced by the proximity of the mother - so the child can refuel or return to the secure base-and continue his/her exploration (Gergely, 2000; Holmes, 2001; Klein, 1981; Mahler, 1973). The modalities of hearing and seeing the mother and her responding from a distance, sometimes from another room, or out of sight of the child, allow for extended exploration but with a sense of safety underpinning the experience. The HC/DC dyad would encroach on this process due to the inability or inconsistency of the parent's response to the infant's cues, therefore the probability of an arrest in this phase may be increased.

#### *Maternal Mirroring*

Another central factor in child development is maternal mirroring, as portrayed by Winnicott (1967). This theory states that normal development in a child requires the mother to effectively mirror what the infant is experiencing through her facial expressions. If the mirroring is reflected to the infant with enough irony, which suggests that it is not the mother's expressions being projected but the infant's, the infant learns to have an

integrated sense of self. Winnicott (1965) states, "...the precursor of the mirror [on the wall] is the mothers face" (p.112). Conversely, if the reflection is not a representation of what the infant is experiencing or is terrifying or frozen, the child internalises this experience as part of oneself. The ramifications for HC/DC dyad here are obvious. If the deaf caregiver cannot hear the tone of what the infant is expressing then there is the potential to misinterpret the expression and incorrectly mirror the child.

Therefore, it is a necessity that the caregiver is required to be particularly attuned, responsive and sensitive to provide the right mirroring of the infant to avoid the establishment of a false self. The false self is established by the internalisation of un-attuned and mismatched mirroring by the primary caregiver (Winnicott, 1971). Broadly speaking, object constancy in an infant is obtained by caregivers who provide what Winnicott (1971) labelled as "good enough mothering", which permits attachment as well as separateness, autonomy, and independence. Therefore attachment without separateness would lead to developmental arrest.

### *Communication*

How does the bicultural nature of the HC/DC effect communication? Bowlby (1958), Spitz (1965), and others including Freud have discussed the importance of verbal communication shaping psychic structure. They conclude that the facility to form constant object relatedness depends significantly on all the sensory modalities' ability to exchange signals, and inevitably speech becomes the most important form of communication (Bowlby, 1958; Freud, 1911; Spitz & Coblinger, 1965). However, Arlow (1976) disagrees and states that normal development may not be arrested as

verbal cues can be compensated effectively by other forms of communication such as touch and facial expressions. He suggests that the personality of the primary caregiver is more important in the shaping of the infants' internal structure than deafness (Arlow, 1976).

Moreover, Bene's (1977) case study of a son of deaf parents concluded that it was the parents' lack of stimulation, physical signs of affection and their immaturity which caused his feelings of isolation. Rienzi's (1983) study of a group of hearing children with hearing caregivers/parents (HC/HC) and hearing children with deaf caregiver/parents (HC/DC) found that the HC/DC families were more inclined to accept their child's ideas and incorporated any information presented by the child into the family without questioning. Although this represents a high level of acceptance it may also contribute to the child's parentification and a distorted sense of self importance. In comparison, in the HC/HC families studied, the children's ideas were not accepted as readily and sometimes overlooked. Rienzi found that overall the deaf parents were more respectful and attentive compared with the hearing parent group. Several theorists have found that a child will have a stronger bond and a more positive experience of a parent if there are clear forms of communication between them (Arlow, 1976; Greenberg, 1972; Robinson & Weathers, 1974; Schlesinger & Meadow, 1972).

It becomes clear that within the HC/DC dyad it is essential to ensure the establishment of a mutual communication system, so as to avoid a restricted and asymmetrical relationship between the parent and child (Rienzi, 1990). The communication options available to the HC/DC dyad are: 1. Verbal – which is experienced by the hearing party when produced by the deaf

parent but which can be inhibited due to being a fragmented expression and reduced in clarity. 2. American Sign Language (ASL), or other forms of sign. ASL is a complete language and is not just a hand signed adaption of English on the hands or finger spelling. It has a complex use of grammar and a lexicon of words which produces a natural expression of emotions and thoughts (Grosjean, 1982). When ASL is acquired from birth from an ASL speaking parent the hearing infant will learn to communicate as naturally as a hearing child of a hearing caregiver (HC/HC) and also at the same developmental rate as HC/HC. If ASL is used in conjunction with spoken English the child is considered bilingual (Newport & Meier, 1985; Singleton & Tittle, 2000). If these methods are only loosely applied or if one person uses sign and the other verbal communication there is much room for misinterpretation, misunderstanding and frustration (Rienzi, 1990). Therefore, it has been strongly recommended that the deaf caregiver use the language they are most comfortable with as the hearing child can learn spoken English from other sources (Hoffmeister, 1985; Preston, 1994; Schiff - Myers, 1988; Singleton & Tittle, 2000).

Language provides the ability to problem solve but also brings about potential for more misunderstanding, as in the bicultural nature of HC/DC dyad. For example, if the child has been recruited as interpreter for the parent/s and they do not all have the same communication skills the prospect for misinterpretation and frustration are high.

In summary this research suggests that there are certain developmental phases which could be compromised by having a primary caregiver who is deaf. This could be compensated for by a sensitive, responsive caregiver,

electronic aids, assistance from extended family or friends, and wider society support systems. The developmental phases which are defined through attachment theory, rapprochement, separation/individuation and mirroring give a detailed outline of potential risk areas, which if responded to more rigorously could be used to avert developmental arrests in HC/DC. Broadly, these findings highlight compromises to development that may occur due to the responsiveness of the caregiver being un-attuned to the infant.

### **Chapter 3**

#### **Emerging Characteristics of the HC/DC Dyad**

The previous chapter outlines developmental theory through a discussion of Object Relations theorists; John Bowlby, Margaret Mahler, Donald Winnicott and their specific theories. These theories were chosen for their applicability to the issues inherent for the HC/DC dyad. This study of developmental theory has highlighted areas where possible developmental arrests could occur in the hearing child through in the environment of the HC/DC dyad. Moreover, the emergence of characteristic psychological presentations due to these arrests produce a trauma profile for the HC/DC. The characteristic profile will now be defined and discussed through a modified systematic literature review of clinical articles written on this topic.

Through researching psychosocial data written on this topic I have compiled a trend of characteristics and headed them under the following terms: paranoia toward the hearing community, shame, parentification, and a form of survivor guilt. These terms are not used to pathologise the hearing child or the deaf caregiver. They are provided to help define and describe the presentations emerging from the data in order to inform and enhance the treatment of hearing adult clients in the psychotherapeutic setting.

The manifestations of these characteristics are all interlinked and share a commonality with each other. Moreover, the manifestations of paranoia, shame, parentification and survivor guilt are apparent in many non HC/DC client presentations and can be due to a variety of environmental issues unrelated to the HC/DC dyad. For example similar presentations can arise in



the children of immigrants and alcoholics (Arlow, 1976; Frank, 1979; Preston, 1994).

I will briefly discuss how these characteristics form, overlap and intertwine. Literature written by and about the deaf community contains a consistent theme which is that a fairly high proportion of deaf people experience the hearing community with suspicion. Historically and still currently in some populations, the deaf have felt marginalised and manipulated by the hearing community (Arlow, 1976; Preston, 1994). A deaf parent who feels wariness and/or paranoia toward the hearing community, due to being a minority, has the potential to produce a dilemma for the hearing child “am I to be feared or am I bad?” The experience of the hearing child’s caregivers’ sense of being marginalised also produces a need in the hearing child to protect their family from the threats of the hearing community (Arlow, 1976; Frank, 1979).

Studies show the hearing first born child or the hearing first born female child will become the translator-mediator-interpreter between the hearing and deaf worlds for their deaf parent/s (Arlow, 1976; Frank, 1979; Preston, 1994). The occurrence of children interpreters is familiar to children of immigrants who cannot speak the native language, due to the child’s bilingual ability they become the parents medium of communication with wider society (Frank, 1979). In some studies the adult children felt encumbered by their responsibilities and envious of the younger children who were not given the role as interpreter (Preston, 1994). From a psychological developmental position, being given the role of interpreter provides an environment that produces a child who becomes parentified due to a loss of

childhood. However, other studies showed that the HC/DC experience fostered independence and autonomy, qualities that are highly valued in the deaf community (Bene, 1977; Preston, 1994).

As the HC/DC child becomes socialised into the hearing community through engaging with others at pre-school and school, an awareness of difference becomes apparent to the child. If the child has learned full sign language from their parents and is provided with a rich and dynamic experience at home, integration into the hearing community can create a well socialised child who has a bridge between the hearing and deaf worlds (Blaskey, 1984; Grosjean, 1982; Preston, 1994; Schiff & Ventry, 1976; Schlesinger & Meadow, 1972; Weiner, 1997).

However, this is not the outcome of four studies relating to biculturalism of the HC/DC. These studies found that if the bicultural dyad is not recognised or managed sensitively the differentness of the parents can lead to the hearing child feeling isolated and alienated, which can contribute to a deep sense of shame in the hearing child. In this situation the child may not know where to identify culturally or may result in the child feeling cultureless, like an outsider, due to an undefined sense of belonging (Myers et al., 1999; Preston, 1994; Weiner, 1997; Zarem, 2003). Moreover, if the communication between parents and child is cobbled together and inconsistent it can lead to learning and speech delays in the child, deepening the sense of feeling different and alone (Dent 1982).

The emerging trends gathered through studies touching on the HC/DC dyad can be characterised by the presence of shame, the effects of

the deaf caregivers' paranoia of the hearing community on the hearing child, parentification, and survivor guilt (Arlow, 1976; Bene, 1975; Dent, 1982; Frank, 1979; Freedman & Hansen, 1985; Johnson, 1980; Meilicke, 1996; Oliver, 1989; Schiff & Ventry, 1976; Searls, 1989; Vernon, 1974; Wagenheim, 1985; Walker, 1986; Waxman, 1996; Zarem, 2003). If these characteristics are drawn out, this study will serve to alert therapists to the possible presence of these issues in hearing clients who have been raised by deaf care givers and if not further research is necessary to define these characteristics.

### *Shame*

All studies and autobiographies that spoke of interactions between the wider hearing society and families with deaf caregivers disclosed the unwanted attention given to these families on outings and social occasions that were not held within the safety of the deaf community. These accounts described ignorance, lack of tact and sensitivity, scrutiny and hostility from the hearing community which produced underlying feelings of shame in their hearing children. There are echo's here of the discrimination experienced by many other minority cultures including indigenous peoples the world over (Livingstone, 1997; Oliver, 1989; Sidransky, 1990; Wagenheim, 1985; Walker, 1986). In Sidransky's (1990) autobiography she describes a scene when on a very special occasion as the family were dining in a restaurant the hearing patrons responded to their hand movements and her parents grunting by staring and whispering amongst each other. The attention made the author cringe and she found herself looking at her parents through the eyes of these

outsiders and feeling a mixture of deep shame of her parents and a fierce protectiveness toward them.

However Searls (1989) study produced findings that parental deafness, while an inconvenience to some, is not deterrent to their children's overall self-esteem if the parent is not disadvantaged by lack of education, socio-economic, psychological or emotional deprivation. This again suggests that there is strong evidence leaning toward parental sensitivity and responsiveness being the foundation for healthy development in children.

The eldest sister in Arlow's (1976) study was said to exhibit feelings of shame which presented as her shyness, insecurity and very low self esteem. This sister was ten years older than her siblings and presumably took on the role as interpreter and also some parenting responsibilities for the younger children. Furthermore, as her mother was also competitive for attention, I surmise there were additional reasons for her shyness and low self esteem unrelated to the HC/DC dyad. This presentation was not identified as a direct result of parental deafness and was only discussed briefly in a description of the family environment of the client studied although these traits are evident in other HC/DC studies. In Dent's (1982) study, a similar presentation occurred in the two daughters raised in the HC/DC dyad. These two daughters had severe learning disabilities which could have contributed to their feelings of shame. The occurrence of learning difficulties in the girls was contributed to their deaf mother who herself was disadvantaged by not having a specific method of communication and was also said to be disconnected and isolated from the deaf and hearing communities. Dent (1982) describes how the

presences of a deaf caregiver may lead to an environment where; “speech does not lend a response, language does not lead to understanding, cause may not result in effect” (Dent, 1982; Piaget & Inhelder, 1967).

Arlow (1976) and Wagenheim’s (1985) studies also discuss the deep feelings of shame induced in the male child because of simply having parents who were “different”. ‘Arlow’s’ (1976) client discusses the first time he was ever to hear a hearing family have a conversation, as he compared the garbled haphazard ways his family used to communicate with each other. He recalled what a fragmenting and dehumanising experience it was for him. The shock of this experience disintegrated his self esteem and to defend against his feelings of dehumanisation and disintegration he despised anyone who could hear and speak. This child’s overall experience was offset by extended family who were hearing and who were very involved in his parenting and education. This contributed to his socialisation and ability to adapt and become autonomous and independent. However many studies confirm that the healthy socialisation of children has more to do with the caregivers own socialisation, education, mental health and communicative abilities (Arlow, 1976; Bene, 1975, 1977; Dent, 1982; Frank, 1979; Preston, 1994; Wagenheim, 1985).

### *Parentification*

Parentification of a child can be defined as the adopting of a sense of adult responsibility by a child either autonomously or at the behest of the caregiver because of the absence or inability of the caregiver to adequately care for the child/family and fulfil adult responsibilities. Karen (1998) describes parentified children as being “caretakers of their own parent”

(p.221). Parentification is known to occur where the parent/caregiver is experienced as unresponsive, ineffectual and insensitive. There are many examples of children becoming parentified when raised in an environment of parents/caregivers who are drug, alcohol or gambling addicted, physically and mentally disabled, depressive, immigrant families, or families who are disadvantaged socio-economically (Frank, 1979; Preston, 1994; Wagenheim, 1985). In these situations the child learns to take on responsibilities that would otherwise be performed by the adult and as a result the child's natural developmental processes are arrested or interrupted.

Parentification or the loss of childhood through being given the role of interpreter in the HC/DC dyad has been mentioned in many HC/DC studies (Bene, 1977; Lane, Hoffmeister, & Bahan, 1996; Livingstone, 1997; Preston, 1994; Schleif, 2006; Searls, 1989; Wagenheim, 1985). The origins of parentification are said to develop through an environment where developmental processes are unable to proceed or are arrested due to the child developing adult skills prematurely (Herman, 1992). However, where psychoanalytic or psychodynamic theory would identify parentification, the deaf community view this as a building of independence and autonomy, therefore this quality in individuals is fostered and admired (Frank, 1979; Karen, 1998).

Arlow (1976) found that deafness in the primary caregivers spurred the development of initiative, independent action and self-reliance in the male children in the family studied. The prior findings may be due to the expectation of societal norms, which encourage men to be independent and encourage dependence in females, which speaks to a redefining of terms and

the observation that the females had far more complex presentation responses to their environment, including developmental delays (Arlow, 1976; Dent, 1982; Preston, 1994; Wagenheim, 1985). Preston (1994) indicated that the first born female child is more likely to become the interpreter for the family due to the inbuilt nurturing capacity of the female.

Charlson's (1989) study of social cognition and self concept in hearing adolescents of deaf parents describes how the mediators/interpreters of the family do not experience social or cognitive immaturity comparative to the non mediator group who were described as deficient in social and cognitive functioning. Although, the mediators and non mediators experienced different perceptions of themselves depending on their roles in the family, for example self concept was weakened if the parents were disadvantaged and unable to fulfil the child's dependent needs. Blaskey's (1984) findings were that the hearing children of deaf parents felt there was a greater degree of responsibility placed on them overall compared the hearing children/hearing parent dyad.

The role of interpreter is generally given to the first born female child of the HC/DC (Preston, 1994). The occurrence of the first born child maintaining this role throughout their childhood and as teenagers and not passing it on to their younger siblings is, I speculate, because once they have mastered these skills, which I assume would take some time to develop, it becomes unnecessary to re-educate the others and allows for the other children in the family to live unencumbered by this responsibility. Moreover, the interpreter child may maintain their role due to this then becoming their identity. Therefore, limitations for the younger siblings may occur as their

communication skills may be arrested due to the lack of appropriate bilingual practice (Arlow, 1976; Dent, 1982; Preston, 1994; Schiff - Myers, 1988; Weiner, 1997).

The first born children studied seem to have a different set of presenting issues compared with their other siblings, as some studies discussed how being the interpreter for the family produced conflicted feelings in the child of specialness and being the “chosen” one, but also resentment toward their parents and siblings for added responsibilities and expectations been made of them (Preston, 1994). These responsibilities include parenting younger siblings, making adult decisions for the family, communicating and negotiating for their parents for goods and services with the hearing community from as early as four years old (Arlow, 1976; Frank, 1979). It is not uncommon for any first born child to take on an authoritative role in the family.

Another facet of parentification may manifest through the expression of protectiveness of the parents, which could be described theoretically as a reaction-formation, due to a deep desire to feel protection from the parents. The experience in the hearing child of feeling an inflated sense of protectiveness for the parent due to the condition of deafness would also be considered a natural response in the child. In Weiner's (1997) study she quotes Higgins (1980) who describes the hearing child's relationship with the deaf community as being advocates for the deaf, which suggests more reason for the hearing child to feel used rather than respected and included.



Due to nature of the literature available for this study further study on the established forms of negotiation between the deaf and hearing societies may provide solutions for the issue of parentification in HC/DC. However, it is noted that many strategies are available to help reduce the parentification of the HC/DC which include the use of paid interpreters and extended family as well as communication and visual alert technologies (Weiner, 1997). Reliance on assistance from others appears to be resisted by the deaf community to some degree due to cultural and historical factors. It may be incumbent on the deaf community to critically examine these values.

#### *Survivor guilt*

The term survivor guilt is usually used in conjunction with survivors of traumatic events and emerged during the aftermath of the Holocaust. The definition of survivor guilt is when one person is felt to have experienced a lesser degree of trauma or has escaped the impact of a traumatic event unlike others close to themselves and feels a deep sense of guilt about this (Reber & Reber, 2001).

The observation of a type of survivor guilt in the hearing children of deaf parents evident in some studies occurs due to the child having an advantage that the parent does not have, that being the 'gift' of hearing, which provides many societal advantages, especially historically, in education. I placed inverted commas around 'gift' as most deaf do not think of themselves as being impaired or deficient in any way but see themselves as a separate community which is whole (Bender, 1960; Bene, 1975, 1977; Blaskey, 1984; Frank, 1979; Harris, 1983; Hoffmeister, 1985; Livingstone, 1997; Mathis,

1976; Myers et al., 1999; Preston, 1994; Schiff - Myers, 1988; Schlesinger & Meadow, 1972; Singleton & Tittle, 2000; Vernon, 1974; Weiner, 1997).

However, the guilt felt by the child, sometimes induced by the deaf parent, is uncovered by the adult child in Frank's (1979) study, who entered psychotherapy acutely depressed. The depression seemed to surface more acutely when she achieved academic success, especially when she felt her achievements had been gained by minimal effort. It was through her analysis that she learnt she was responding to unacknowledged feelings of guilt, for having the advantage of hearing, which was experienced at the same time as a deep resentment of her parents' impairment. She felt, at times, malevolent intent when describing her successes to her family as her unconscious resentment and fury toward them was expressed (Frank, 1979).

The issue raised of a client's inability to express resentment toward the deaf parent for being the parent's narcissistic extension e.g. ears and mouth as noted by Myers (1999), was said to present in the client as inhibition, guilt and remorse. Though resenting the parent, the client has been unable to express this resentment because of the perception that the deafness is not the parents fault.

This experience is echoed in Arlow (1976) and Wagenheim's (1985) case studies where the patient describes their achievements as a feeling of overtaking the parents' academic/life achievements, which resulted in an internal conflict of pride and guilt. The juxtaposition of pride and guilt produces obstacles, as part of oneself is operating in a covert manner, quietly extending and desiring the achievement to be noticed and praised.

### *Paranoia*

Paranoia in the deaf community toward the hearing community is alluded to in many studies and autobiographies. This experience is discussed under many guises such as, suspicion of feeling manipulated by, feared, treated as if they are freaks or disabled which compounds the experience of being marginalised by the hearing community (Frank, 1979; Livingstone, 1997; Schleif, 2006; Searls, 1989; Sidransky, 1990; Wagenheim, 1985; Walker, 1986). Paranoia, manifested through the HC/DC dyad, arises I believe specifically through a general disconnection between the hearing and deaf communities. The disconnection leaves room to create fantasies real and /or imagined about the unknown which occur in reports from the deaf community as feelings of suspicion, frustration, feeling manipulated, marginalised and misunderstood by the hearing community.

As discussed in the studies of Arlow (1976) and Zarem (2003), the paranoia the deaf parents feel toward that hearing community is passed on to and internalised by the hearing child, which leaves them conflicted. The dilemma the hearing child faces is; if the hearing community is so destructive and bad then are they themselves are bad? It could be said that there is a sort of paranoid/schizoid split that occurs, which the child is drawn into, of who is good and who is bad (Klein, 1975; Wagenheim, 1985). As stated in Wieners (1997) study, the deaf parents of hearing children may have a negative projection toward the hearing child due to their negative feelings toward the hearing community.

Marginalization of the deaf can be traced back to 530 AD where the Justinian legal code stated that if you were born deaf you had no legal rights

which extended to forbidding the rights to create a family. This effectively institutionalised a disparity between the deaf and hearing communities (Bender, 1960). It was not until the 1960's when afro Americans began to demand civil rights that the deaf community began its fight for equality (Harris, 1983).

To summarise, the correlation between the deaf community and other marginalised cultures is apparent. This marginalisation affects the deaf community in many ways and contributes to the continuing divergence between the hearing and deaf worlds. The exclusion, insensitivity and lack of interest in the deaf community by the hearing community could be seen as a mirror of the experience the hearing child's has, in some cases, of their deaf caregivers. That being the hearing community represents the insensitive and less responsive deaf parent to the deaf community, which in turn is inherently providing a dysfunctional environment for some hearing children.

To conclude this section a condensed version of the HC/DC characteristics are provided:

Shame: Reoccurring in the child due to the embarrassment of having different parents. Manifesting as feeling different or like an outsider. Difficulties in communication and understanding of how the hearing world works and/or feeling like they have no place in the world, transient between the deaf and hearing worlds (Arlow, 1976; Bene, 1975; Frank, 1979; Wagenheim, 1985).

Parentification: The child, especially if they are the first born child, having the role as interpreter for their parent/s (Preston, 1994; Schiff -

Myers, 1988; Schiff & Ventry, 1976; Vernon, 1974; Wagenheim, 1985).

Survivor guilt: Experienced by the child, originating from the child's perception of themselves, whether self generated or externally expressed, as 'able' in relation to the parent/s 'disability'. This can then develop into complex issues around envy in the parent/s and reactivity to this by the children (Arlow, 1976; Fant & Schuchman, 1974; Livingstone, 1997; Preston, 1994; Schiff & Ventry, 1976; Singleton & Tittle, 2000; Vernon, 1974; Wagenheim, 1985; Walker, 1986; Weiner, 1997; Zarem, 2003)

Paranoia: Felt by the deaf caregiver towards hearing community, which can be internalized by child as suspicion and can create a paranoid/schizoid split (Arlow, 1976; Wagenheim, 1985; Zarem, 2003).

A discussion of various clinical implications and solutions to these implications for the HC/DC will follow. These implications are drawn from the developmental findings and the characteristics mentioned this chapter.

## Chapter 4

### Clinical Implications

A discussion of possible clinical implications and applications tailored toward the HC/DC demographic, drawn from this research, is the topic for discussion in this chapter. This study has established that a characteristic psychological profile for HC/DC does emerge from the research assessed. The profile can be distinguished by the presence of the psychological characteristics of shame, parentification, survivor guilt and paranoia which are identified throughout the studies performed on the HC/DC dyad and also through autobiographies by hearing adult/children of deaf caregivers (Arlow, 1976; Beebe & Lachmann, 1994; Bender, 1960; Bene, 1975, 1977; Blaskey, 1984; Dent, 1982; Fant & Schuchman, 1974; Frank, 1979; Freedman & Hansen, 1985; Gergely, 2000; Hoffmeister, 1985; Lane et al., 1996; Livingstone, 1997; Myers et al., 1999; Preston, 1994; Schiff & Ventry, 1976; Schlesinger & Meadow, 1972; Weiner, 1997).

#### *Characteristic Profile and Responsiveness and Sensitivity*

Although the characteristic psychological profile of shame, parentification, survivor guilt and paranoia are present throughout the studies they do not necessarily occur in conjunction with each other and were not consistent throughout each study. Moreover, a more constant theme emerged throughout the data which suggested that the presence or not of responsiveness and sensitivity in the hearing child's environment by the primary caregiver/s underpinned a child's success developmentally (Arlow, 1976; Bene, 1977; Frank, 1979). These findings are consistent with the results of most developmental theories and have highlighted the importance

of providing an environment of responsiveness and sensitivity, which promotes a child's healthy development (Bowlby, 1998; Mahler, 1973; Winnicott, 1971). This suggests that, regardless of disability in a caregiver, a healthy human infant will flourish in an object relationship where the primary caregiver is sensitive and responsive. If there is potential for an absence of responsiveness and sensitivity in the child's environment it can be compensated for through the intervention of extended family, technological aids, friends and provision of support by wider society networks.

#### *Potential HC/DC Client Traits*

Throughout this study I have implicitly differentiated between the impact of deafness of the caregiver on their hearing child and of other trauma or object relations dynamics which cause developmental arrests in children/clients. For example the consequences of caregiver neglect may bear some similarity to the HC/DC profile but is not rooted in the same fundamental causes and thus would call for quite different approaches in treatment. A child may become parentified through the absence of being parented effectively or by taking on the role as interpreter. Also the issue of the child internalising shame due to lower economic status for example, compared with a child's shame of the parent's deafness which has the potential for shame inducing experiences (Arlow, 1976). Paranoia can be internalised in a child through an abusive relationship, however it should not be treated as indicative of such, as in the HC/DC dyad, paranoia has been shown to arise through the child experience of their parents' mistrust of the hearing society.

### *Communication Methods*

The findings of this study also discussed the importance of the development of communication methods in the HC/DC families as the issue of communication becomes complex in the HC/DA dyad. Preston's (1994) study suggests all family members require one modality of communication when together. The reason for this is that the parents need to understand the child to perform effective parenting. If there are two or more forms of communication styles developed or learned by each individual in the family, e.g. signing, speaking or home signing, which are not understood unanimously, there is much room for misinterpretation due to information being unintentionally or intentionally left out or relayed to the other in a style they do not understand.

In some cases, if the continuity of communication is not consistent, the interpretation of the information could be internalised by the child in disorganised thought processes and therefore assimilated, this could then lead to developmental delays in the area of cognition. However, if communication methods between family members are consistent and there are no obstacles for the hearing child in accessing hearing forms of communication, e.g.; preschool, play groups, or access to other hearing children and adults, the child can have a rich bilingual experience (Dent, 1982).

### *Treatment and Intervention*

The psychotherapeutic treatment of the HC/DC will be determined by assessing the dynamics of the early relationships to prepare for the potential transference and countertransference dynamics. From an attachment perspective, when a client enters therapy it is usually to search for the secure attachment that they did not receive in childhood (Holmes, 2001). However



when this is provided the client faces the dilemma of the desperate need for it and the terror of what intimacy has meant historically (Holmes, 2001).

With regard to the HC/DC dyad, attention drawn to the responsiveness and sensitivity the deaf parent/caregiver provided for the hearing child could lend insight for treatment. In providing an environment of active, attuned and responsive listening an acknowledgement of what is heard in the sessions is fundamental in addressing the underlying experience of the client. Belying the hearing adult's psychological presentation is the fact that their caregiver literally could not and did not hear them.

An approach to the presentations will now be demonstrated using transference/countertransference observations. Underpinning the following suggestions is the application of basic self regulation skills for the client, the therapist role-modelling active listening and providing a consistent, safe and containing environment (Havens, 1989).

This template of possible treatment presentation options for the adult HC/DC will be used in conjunction with the basic assessment of the client as it is not often that a client will present with one isolated issue. The client could for instance have borderline and depressive traits as well as being raised in a HC/DC environment which requires adherence to specific treatment methods.

#### *Transference/Countertransference*

Some potential transference/countertransference presentations will be discussed that relate to the HC/DC experience. The examples are drawn from published case studies and from personal clinical experience. The latter have been adapted and modified to protect the confidentiality of any case

material. Many transference/countertransference dynamics emerged from the discussed studies however the focus is that which directly relates to the interface between the hearing child and deaf caregiver.

Transferential phenomena which, in psychoanalytic and psychodynamic terms, is an explanation of the experience a client has of the therapist as a historical object relation, will be examined through the hearing adult client and psychotherapist relationship. Then a discussion of the hypothesised countertransferential responses of the therapist will follow. In psychodynamic theory countertransference is explained as the internalisation of the client's felt experience by the therapist, which is then reflected on and developed and given back to the client in a more digestible form, usually communicated through an interpretation of what was experienced by the therapist (Burke & Tansey, 1991; Hinshelwood, 1999). The effectiveness of the use of the countertransferential material is dependant on the self awareness in the therapist. To know oneself well reduces the potential for prolonged projective identification or acting out the countertransference. However the mistakes made by the therapist are usually where the work begins (Burke & Tansey, 1991).

Many case studies relating to the HC/DC dyad observe that the deaf caregiver literally cannot hear the infant cry and is not aware of any sound or attempts of the infant/child to communicate verbally when the caregivers' back is turned, or when in another room (Arlow, 1976; Wagenheim, 1985; Zarem, 2003). Given this observation and looking through the lens of the developmental theory mentioned in this study, and keeping in mind the desired environment that is required to fulfil normal development - accurate

responsiveness and sensitivity - I shall present a hypothesis as to how unresponsiveness could manifest in the transference with an adult client of a deaf caregiver.

The client's transference of unresponsiveness could manifest through an experience of the therapist as unavailable, absent, or avoiding contact. Although these transferential occurrences are not uncommon, in this case, the unavailability, absence and avoidance is experienced due to the infant's cues being unacknowledged by the caregiver (Arlow, 1976; Frank, 1979; Preston, 1994; Sidransky, 1990; Wagenheim, 1985; Walker, 1986). Another form of transference in the hearing adult child could be their inability to listen and/or to understand the therapist. This may be in response to not having this modelled or mirrored by the caregiver in the early stages of development. Furthermore, the experiencing of deep frustration in the therapeutic process - feeling like the therapist will never really know how they feel - may arise through the client transferring the role of the deaf parent, who could not know empathically what it is to hear, onto the therapist.

There could be confusion and suspicion underlying any communication between client and therapist if the client's early environment did not provide a distinct means of communication leaving room for misinterpretation and miscommunication. Furthermore, the early interaction styles the client used as a means of gaining attention from the caregiver when their attention was elsewhere may manifest within the psychotherapeutic relationship. Although this is not uncommon between people normally, the experience of the HC/DC could present as acutely frustrating and ultimately result in a sense of hopelessness felt in the countertransference.

Through the countertransference, the therapist may have a sense of a void in communication, metaphorically like the “Bermuda Triangle”, where the words spoken and any connection are lost. This experience may be due to the verbal cues and words spoken by the hearing child simply to their primary objects not being responded to. The therapist may feel disabled and undermined when experiencing complimentary countertransference due to the unconscious internalisation of the client’s parents’ disability. The therapist may act out the concordant countertransference by becoming a problem solver or fixer and feel like they are doing all the work for the client, as the parentified interpreter child experienced (McWilliams, 1994).

The previous hypothesised presentations may emerge from key developmental phases being arrested and manifest into underlying feelings of low self esteem/self worth and displacement in the client. The internalised negative self representations of being different or an outsider could manifest in the client as poor self image or in reaction/formation; trying to fit into society at any cost. The maladapted presentation in the interpreter adult/children group could be due to having to think and make adult decisions as a child, which were inappropriate and overwhelming, instead of fostering a healthy autonomy and agency. These presentations are not exclusive to the HC/DC dyad, as many environmental dynamics produce issues concerning self esteem and displacement. As stated by Preston (1999) who made links to the treatment of adult children of alcoholics and Zarem’s (2003) case study which describes the similarities between immigrant children and the HC/DC.

### *Development*

This section is designed to address issues raised throughout this study of the possible developmental arrests that could occur within the HC/DC child. These thoughts are drawn from issues that presented in peer reviewed articles (Arlow, 1976; Dent, 1982; Sidransky, 1990; Wagenheim, 1985; Zarem, 2003). The examination of developmental theory through Object Relations Theory of Attachment, Separation/Individuation and the concept of Mirroring and the HC/DC lens has lead to the distinct necessity for responsiveness and sensitivity in the caregiver or external supports to provide these qualities. These fundamental requirements provide an environment for the child which encourages the natural phases of development to proceed without major frustration and disruption to the process. To be noted is that developmental arrests that occur due to a lack of responsiveness or sensitivity can be offset by other environmental factors, for example extended hearing family who provide responsiveness to the infant's cues or a parent who is tactile and expressive in a non verbal sense.

The successful assimilation of the developmental processes of dependence and autonomy are suggested by Cybernetic Theory to be obtained by the family having the same cultural expectations (Myers et al., 1999). Preston (1999) makes a valid point, which is that although the hearing child has a different condition to the deaf parent, they inherit a unique cultural experience and legacy different to other hearing children.

The next developmental arena to be discussed is that of proximity as suggested through the second domain of attachment theory, which proposes that part of the maturational process consists of a natural curiosity and

expressed exploration, which in turn needs to be fostered in the child to create a sense of growing autonomy and agency. This process is potentially arrested or inhibited by the deaf parents' need to be in eyesight of the infant/child for protective factors and to facilitate communication between them (Dent, 1982).

Each case study or autobiography has its own individual and environmental circumstances which may or may not parallel others' experiences. Most studies show no conclusive findings to state that being a HC/DC directly results in developmental arrests. However, other studies mentioned that the information collected from the HC/DC could be biased due to the protective nature of the HC/DC for their parents. The fostering of independence and self reliance particularly in males by the deaf community is also fostered in the males in the hearing community, which could provide some sense of belonging in the HC/DC male population and less likelihood of psycho-social disruption (Arlow, 1976; Preston, 1994). Becoming apparent is the need to address and integrate the bicultural nature of the HC/DC, for when this aspect of the HC/DC dyad is nurtured in conjunction with the sensitivity and responsiveness either from the deaf parent or extended family and friends, the child has the potential to emerge free from experiencing the developmental impacts of when these factors are not in place, which create shame, paranoia, parentification and guilt in the child and future adult.

In summary this chapter described clinical implications for the adult/children of a deaf caregiver. Healthy psychological and emotional development is dependant on the responsiveness and sensitivity of the hearing child's environment. Transference and countertransference situations were identified to describe potential dynamics that could occur

with the hearing adult client. Awareness of these issues in childhood could provide a potent therapeutic relationship for the hearing adult.

## Chapter 5

### Summary and Conclusion

This dissertation was written to assist psychotherapists in their work with hearing adult/children of deaf caregivers and also with the hope of raising awareness in the deaf community as to where ameliorations can be provided for their hearing children. My intention is not to suggest deaf parents can not raise healthy, contented, psychologically and emotionally well developed hearing children. My purpose through this study is to make suggestions for further strengthening of the HC/DC dyad.

The thinking for this dissertation began by defining the research question, which emerged out of thoughts generated by treating a hearing client who was raised by deaf parents. What emerged from the research articles and autobiographies written by adult children of deaf caregivers were recurrent themes, which I have grouped under the headings of; shame, parentification, survivor guilt and paranoia. To assist in compiling this data an exploration of developmental theory was used as a filter to discuss and ground these findings. Bowlby's Attachment Theory, Mahler's Separation/ Individuation and Winnicott's concept of Mirroring were instrumental in defining areas of potential developmental arrest in the HC/DC.

These theories all concur that the provision of responsiveness and sensitivity in caregivers is necessary in the developmental phases for raising healthy children. The HC/DC dyad can achieve this responsiveness through incorporating technology and using a support network of older siblings, extended family and friends or hired interpreters to compensate for un-attunement in the primary caregiver. I suggest that the recommendation of an



older siblings to take on a role in providing support should only be made with the consent, and limited to when the older sibling is able to make an informed, educated choice to do so, to avoid the parentification of this sibling.

### *Limitations and Further Research*

This study was conducted through a modified systematic literature review and due to the nature and size of this dissertation the critique was restricted to psychoanalytic and psychodynamic theory. Research into non-verbal therapeutic cures may have also broadened the perspective of this study. A limitation in the examination of how other disabilities in caregivers affect their able children (including alcohol and drug addicted parents) could also shed more light on the bicultural nature of the HC/DC dyad. A discussion on social support systems for HC/DC such as CODA were also limited in this study.

Blaskey (1984) suggests that the deaf parent's positive attitude toward the hearing community and their involvement in the deaf community contribute greatly to the child's socialisation. The parent's comfort in moving between the two communities offers positive role modelling and perhaps lowers the level of mistrust and paranoia that emerges from disconnection (Blaskey, 1984).

My experience of the invisibility of the deaf community in wider society has alerted me to an area for further research. For, if I have been oblivious to the deaf community and the disparity between the hearing and deaf worlds, so I suspect are many others, which concerns me. The experience of marginalisation of the deaf community by the hearing community needs

more recognition. Active bridging programmes that address the bicultural nature of the deaf and hearing communities, which are easily accessible and offer education opportunities, would facilitate support for more connection. The access to other services could also provide support and comfort to those who are struggling with the issues raised in this study.

Throughout this study sociological concerns of how deaf culture operates within wider society have emerged. To bring this topical thinking into a cultural context and examination of Aotearoa/New Zealand and the effects this has had on Tangata Whenua today compared with experiences of the HC/DC dyad within broader society could begin the thinking for future study. I also acknowledge that I have not mentioned throughout this study that in New Zealand we have our own unique sign language (NZSL) which is considered an official language. NZSL consists of words and ideas particular to New Zealand including phrases, words and ideas of Tangata Whenua in Te Reo Maori.

#### *My thoughts*

William Harvey (1651) describes so perfectly how we are sometimes blinded to what we cannot recognise in ourselves as we have difficulty perceiving many aspects of nature unless we are deprived of them or they are deranged in some way (Freedman & Hansen, 1985). This speaks to an experience of an awakening in me at a deeper level concerning the experience of deafness and those who cross between the worlds of the hearing and the deaf. As I gained this awareness I was struck by how I had made assumptions of the deaf community which were completely unsubstantiated, and thankfully through this study have been challenged, as I begin to realise that the deaf

community has its own whole and separate identity and sub-culture outside of the hearing community.

Can the experience of being raised by a deaf caregiver be said to be significantly different from the range of challenges any child would be expected to face? And even if it is, does the experience lead to an enhancement of development and awareness in any way as other challenges in life may do? The answer, as confirmed by the research assessed for this study, is yes, for being raised by deaf parents may very likely lead to enhanced autonomy, independence and a deep sense of empathy for difference in others.

The outcome of a study such as this should be not only to raise awareness for therapists treating adult HC/DC and perhaps deaf caregivers as to possible deficits of their care giving but also to raise awareness in the broader community of the tensions caused for a child who straddles both hearing and deaf worlds. Framing this discourse is a much wider philosophical question as to the origins of tensions between the deaf and hearing communities and the impossibility of separating value, belief, history and tradition from the way society responds to deafness and the deaf respond to society. Although this discussion is beyond the scope of this study it is not possible to present this dissertation without acknowledging that the subject matter – the impact of deafness in the caregiver on a child's development – is the product not of deaf caregivers but of the way they and society position, understand and define deafness.

## References

- Ainsworth, M. (1989). Attachments beyond infancy. *American Psychologist*, *44*, 706-716.
- Arlow, J. A. (1976). Communication and character: A clinical study of a man raised by deaf-mute parents. *Psychoanalytic Study of the Child*, *31*, 139-163.
- Beebe, B., & Lachmann, F. (1994). Representation and internalization in infancy: Three principles of salience. *Psychoanalytic Psychology*, *3*, 127-165.
- Bender, E. (1960). *The conquest of deafness*. Cleveland: Press of Western Reserve University.
- Bene, A. (1975). Effects of deaf and dumb parents on their child's development. *Association for Child Psychoanalysis*.
- Bene, A. (1977). The influence of deaf and dumb parents on a child's development. *Psychoanalytic Psychology: Study of the child*, *32*, 175-194.
- Blaskey, P. F. (1984). *Socialisation and personality development in hearing children of deaf parents*. Temple University, California.
- Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis*, *39*, 350-373.
- Bowlby, J. (1973). *Separation, attachment and loss* (Vol. 2). New York: Basic Books.
- Bowlby, J. (1982). *Attachment and loss* (Vol. 1). New York: Basic Books.
- Bowlby, J. (1998). *A secure base: Clinical applications of attachment theory*. London: Routledge.

- Burke, W., & Tansey, M. (1991). Countertransference disclosure and models of therapeutic action. *Contemporary Psychoanalysis, 27*, 351-384.
- Charlson, E. (1989). *Social cognition and self-concept of hearing adolescents with deaf parents*. University of California, California.
- Dent, K. A. (1982). Two daughters of a deaf mute mother: Implications for ego and cognition. *American Academic Psychoanalytic Journal, 10*, 427-441.
- Erikson, E. (1968). *Identity, youth and crisis*. New York: Norton.
- Fant, L., & Schuchman, J. (1974). Experiences of two hearing children of deaf parents. In P. J. Fine (Ed.), *Deafness in infancy and early childhood*. New York: Medcom Press.
- Fonagy, P. (1991). Thinking about thinking: some clinical and theoretical consideration in the treatment of a borderline patient. *International Journal of Psycho-Analysis, 72*, 639-656.
- Frank, H. (1979). Psychodynamic conflicts in hearing children of deaf parents. *International Journal of Psychoanalytic Psychotherapy, 11*, 305-315.
- Freedman, D. A., & Hansen, D. B. (1985). The influence of early deficits on later development. *American Psychoanalytic Association, 33*, 631-644.
- Freud, S. (1911). Formulations on two principles of mental functioning. *S.E* 12, 213-226.
- Gergely, G. (2000). Reapproaching Mahler: New perspectives on normal autism and symbiosis. *American Psychoanalytic Association, 48*, 1197-1228.
- Greenberg, J. (1972). *In this sign*. New York: Avon books.

- Grosjean, F. (1982). *Life with two languages: An introduction to bilingualism*. Cambridge: Harvard University Press.
- Harris, R. (1983). Deaf parents' perceptions of family life with deaf and or hearing children. In G. Tyler (Ed.), *Rehabilitation and human services: Critical issues for the eighties, proceedings of the 1980 conference of the American deafness and rehabilitation association Cincinnati* (pp. 5-9). Cincinnati: The American Deafness and Rehabilitation Association
- Havens, L. (1989). *A Safe Place*. New York: Ballentine Books.
- Herman, J. (1992). *Trauma and Recovery: The aftermath of violence- from domestic abuse to political terror*. New York: Perseus Books.
- Hesse, E. (1999). The adult attachment interview: historical and current perspectives. In j. Cassidy and P. Shaver (eds) In *Handbook of attachment*. London: Guilford Press.
- Hinshelwood, R. D. (1999). Countertransference. *The International Journal of Psychoanalysis*, 80, 797-818.
- Hoffmeister, R. (1985). Families with deaf parents: A functional perspective. In S. K. Therman (Ed.), *Children of handicapped parents: Research and clinical perspectives* (pp. 111-130). Orlando: Academic Press.
- Holmes, J. (1996). *Attachment, intimacy, autonomy: Using attachment theory in adult psychotherapy*. London. Jason Aaronson Books.
- Holmes, J. (2001). *The search for the secure base*. New York: Brunner-Routledge.
- Horner, A. (1984). *Object Relations and the Developing Ego in Therapy*. New York: Rowman & Littlefield.

- Johnson, H. (1980). *A longitudinal, ethnographic investigation of the development of interactional strategies by a normally hearing infant of deaf parents*. University of Cincinnati, Ohio.
- Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. Oxford: Oxford Unity Press.
- Klein, M. (1975). *Love, guilt and reparation*. London: Vintage.
- Klein, M. (1981). On Mahler's autistic and symbiotic phases: An exposition and evaluation. *Psychoanalytic Contemporary Thought*, 4, 69-105.
- Lane, H., Hoffmeister, R., & Bahan, B. (1996). *A journey into the deaf deaf-world*. San Diego: Dawn Sign Press.
- Livingstone, R. (1997). *Growing up hearing with deaf parents: Influences on adult patterns of relating and on self/other awareness*. Columbia University, Columbia.
- Locket, T. (1997). Traces of evidence. *Health care today*, July/August.
- Mahler, M. (1967). On human symbiosis and the vicissitudes of individuation. *American Psychoanalytic Association*, 15, 740-763.
- Mahler, M. (1973). *On the first three subphases of the separation-individuation process*. New York: Brunner/Mazel.
- Mathis, S. (1976). *Hearing children of deaf parents*. Paper presented at the Gallaudet symposium on research in deafness, Washington.
- McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. New York: The Guilford Press.
- Meilicke, M. (1996). *Auditory processing in hearing children of deaf parents*. United States International University, California.

- Meins, E. (1999). Sensitivity, security and internal working models: Bridging the transmission gap. *Attachment and Human Development*, 3, 325-342.
- Myers, S., Myers, R., & Marcus, A. (1999). Hearing children of deaf parents: Issues and interventions within a bicultural context. In I. Leigh (Ed.), *Psychotherapy with deaf clients from diverse groups* (pp. 121-150). Washington: Gallaudet University Press.
- Newport, E., & Meier, R. (1985). The acquisition of American sign language. In Dislobin (Ed.), *The cross linguistic study of language acquisition: The data*. (Vol. 1, pp. 881-938). New Jersey: Lawrence Erlbaum.
- Oliver, S. (1989). *Seeing voices*. Los Angeles: Vintage.
- Piaget, J., & Inhelder, B. (1967). *The psychology of the child*. New York: Basic Books.
- Preston, P. (1994). *Mother father deaf: Living between sound and silence*. Cambridge: Harvard University Press.
- Reber, A., & Reber, A. (Eds.). (2001) (3 ed.). London: Penguin reference.
- Reynolds, S. (2000). The anatomy of evidence-based practice: Principles and methods In *Evidence-based practice: A critical problem solving*. Oxford: Blackwell science.
- Rienzi, B. (1990). Influences and adaptability in families with deaf parents and hearing children. *American Annals of the Deaf*, 132, 402-408.
- Robinson, L., & Weathers, O. (1974). Family therapy of deaf parents and hearing children: A new dimension in psychological therapeutic intervention. *American Annals of the Deaf*, 119, 325-330.



- Rosenberg, W., & Donald, A. (1995). Evidence based medicine: An approach to clinical problem solving. *British Medical Journal*, *310*, 1122-1126.
- Schiff - Myers, N. (1988). Hearing children of deaf parents. In D. Bishop & K. Mogford (Eds.), *Language development in exceptional circumstances* (pp. 47-61). New York: Churchill-Livingstone.
- Schiff, N. B., & Ventry, I. M. (1976). Communication problems in hearing children of deaf parents. *Journal of Speech and Hearing Disorders*, *41*, (348-35).
- Schleif, S. (2006). *Exploring emotion development of hearing children with deaf parents: A qualitative study*. Alliant International, San Diego.
- Schlesinger, H., & Meadow, K. (1972). *Sound and sign: Childhood deafness and mental health*. Berkeley: University of California Press.
- Searls, J. (1989). *A study of parental deafness as a factor in the development of self-concept in samples of deaf and hearing college students*. American University, New York.
- Sidransky, R. (1990). *In silence: Growing up hearing in a deaf world*. New York: St Martin Press.
- Singleton, J., & Tittle, M. (2000). Deaf parents and their hearing children. *Deaf Studies and Deaf Education*, *5*, 3.
- Spitz, R. A., & Coblinger, W. G. (1965). *The first year of life*. New York: International University Press.
- Stern, D. (1985). *The interpersonal world of the infant*. London: Basic Books.
- Vernon, M. (1974). Effects of parents' deafness on hearing children. In P. J. Fine (Ed.), *Deafness in infancy and early childhood* (Vol. 219-224). New York: Medcom Press.

- Wagenheim, H. S. (1985). Aspects of the analysis of an adult son of deaf mute parents. *American Psychoanalytic Association*, 33, 413-434.
- Walker, L. A. (1986). *A loss for words: A story of deafness in a family*. Glasgow: Fontana/Collins.
- Waxman, R. (1996). *A longitudinal study of deaf and hearing mothers' use of visual-tactile attention strategies with deaf and hearing children.*, The American University, Columbia.
- Weiner, M. (1997). *Raising bilingual and bicultural children: Deaf parents' perceptions*. Unpublished Dissertation, University of Maryland College Park, Maryland.
- Winnicott, D. W. (1965). The maturational processes and the facilitating environment: Studies and theory of emotional development. *The International Psycho-Analytical Library*, 64, 1-126.
- Winnicott, D. W. (1971). *Playing and reality*. London: Routledge.
- Zarem, S. (2003). Working with deaf parents and hearing children in a nursery setting. *Psychoanalytic Study of the Child*, 58, 228-245.