

Adapting Through the Looking Glass' Intervention Model for Deaf Parents and their Children

Paul Preston and Mimi Lou

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Project Personnel

Mimi Lou, Ph.D., Research Associate
Millie Stansfield, M.F.C.C., Clinical Coordinator
Julie Rems, M.A., Deaf Parent Peer Counselor
Paul Preston, Ph.D., RRTC Center Manager
Megan Kirshbaum, Ph.D., RRTC Director

Purpose

The purpose of this Rehabilitation Research and Training Center (RRTC) project was to adapt and apply Through the Looking Glass' model of early intervention to high-risk families of deaf parents and their children.

Significance and Rationale

There has been a growing national concern about high-risk families with deaf members, primarily low-functioning deaf parents with infants and young children. These concerns have been documented through several sources: professionals who have contacted Through the Looking Glass' national clearinghouse unable to find intervention services for deaf parents and their children; emerging local and regional networks of deaf parents who are trying to locate or develop appropriate services for themselves or other deaf parents in their communities; and the widespread interest and attendance at the first national conference on deaf parents and their children sponsored by Gallaudet University.

Many deaf parents have raised their families successfully, and are inappropriately stigmatized because of misguided presumptions about their parenting capabilities. However, some deaf parented families are vulnerable to dysfunction, child abuse and/or neglect because of risk factors comparable to those within hearing families. These risk factors include: low economic status and low social, lack of social supports, lack of parenting knowledge, single parent status, parental conflict, adoptive or step-child status, and the child's problematic behavior. Other risk factors include social isolation, parental substance abuse, parental history of abuse

with another child, parental history of abuse as a child, and multiple birth of children. For those deaf parents who need information or services, resources are virtually non-existent.

Without appropriate assessment or intervention, in the most extreme situations deaf parents are at risk of losing custody of their children due to presumed negligence or maltreatment. In less extreme cases, a number of barriers may seriously impede adequate parenting and increase the risk of family dysfunction or dissolution. These include:

(1) A general lack of parenting knowledge. Although parenting information is widely available including popular literature and through the media, much of this information is inaccessible to deaf people. Many deaf adults have low English language reading levels, and receive information almost exclusively through American Sign Language.

(2) A number of deaf adults have been poorly parented. As children, many deaf adults were disenfranchised from their families through severely inadequate communication within the home, and/or because of their hearing parents' unresolved issues over having a deaf child. Poor parenting as a child can translate to socioemotional difficulties as adults in forming intimate and caring relationships with others, including difficulty forming attachment relations with their own children (Bolton, 1983). Of additional concern is the higher degree of abuse of children with disabilities. At a national level, maltreatment of children with disabilities is 1.7 times higher than among children without disabilities (National Center on Child Abuse and Neglect, 1993).

(3) Cultural differences within the family. Almost 90% of all children born to deaf parents are hearing. Yet, many deaf adults report minimal contact or interaction with hearing people until the birth of their hearing child (Preston, 1994). This unique paradigm of significant cultural differences within a single family may present considerable challenges to routine parenting and parent-child interactions.

(4) Limited access to deaf peers. Deaf people have traditionally been the main source of information and support for other deaf people (Preston, 1997). Preliminary research indicates this peer model includes parenting information and support (Preston, 1998; Charlson, 1990). However, peer resources are not always available. In some situations, access is limited because of geographic distance. In other cases, a deaf individual may not have strong ties to the local Deaf community because of differences in ethnicity or socioeconomic status compared to the larger group. Still other deaf adults are minimally connected to the local Deaf

community because of poorly developed sign language skills and/or because they have not had long-term ties to the Deaf community; this is particularly true in the case of recent deaf immigrants.

(5) Inadequate support and services. Although deaf peers can provide a wide range of information and support for other deaf adults, some situations require more intensive professional guidance -- through trained professionals who are deaf and/or persons who are fluent in sign language and the cultural norms of the Deaf community. Such resources exist in certain realms (education, employment), are more scarce in other areas (psychosocial counseling for individuals), and almost not-existent with regards to deaf parents and their young children.

Early Intervention Programs

There are numerous parent-child early intervention programs for high-risk families. Some of these programs address the lack of parenting and child development knowledge in these families. Other programs direct their efforts to increasing social supports for the parents. Still other programs focus on providing treatment to enhance the development of the infants and children at risk. Very few programs work directly on improving the quality of the parent-child relationship, and even fewer programs include the full spectrum of intervention approaches to foster the healthy functioning of families and individuals in high-risk families. Only a tiny fraction of these programs are minimally accessible to deaf parents -- and this includes a number of programs in which staff are inadequately conversant with American Sign Language and Deaf culture. Nationally, there are a handful of programs specifically designated for deaf parents -- but there have been no intervention programs for high-risk deaf families which include clinical-developmental work, deaf peer support and educational approaches.

The underlying hypothesis for this research project was that a comprehensive clinical-educational-supportive approach which is peer-oriented is absolutely necessary in order to facilitate the development of strengths in high-risk families with low-functioning deaf parents. A peer approach to working with deaf parents is particularly salient since an interactive, interdependent peer orientation is a fundamental aspect of Deaf culture (Preston, 1997; Preston, 1998)

TLG's Intervention Model

TLG has developed a comprehensive parent-infant intervention program for families in which one or more members have a disability. This intervention is designed to foster the quality of attachments and relationships within the family, the emotional well-being of individual family members, as well as the general development of the infants and young children. To achieve these purposes, the TLG model includes: clinical intervention based on an infant mental health model as well as a family systems approach; developmental intervention for the infants and toddlers; a peer approach in which parents are actively involved in peer support and educational efforts; and the clinical and developmental professionals working with families are themselves peers --that is, these professionals have personal and/or family experience with disability. TLG's intervention model has been documented and evaluated within several previous research projects as well as through clinical assessments of families before and after intervention.

Although successfully utilized among parents with varied physical, sensory and developmental disabilities as well as medical conditions, the TLG intervention model had not been used with deaf parents until this RRTC project. One barrier to implementing TLG's model with deaf parents has been the lack of sign language proficiency among TLG's clinical and developmental staff. A second and more central barrier to implementation was the lack of deaf peers among the clinical staff -- that is, professionals who are deaf or from deaf families. Adaptation of TLG's intervention model for deaf parents required substantial and ongoing involvement of deaf peers.

Project Design

In order to adapt TLG's intervention model for high-risk deaf families, the project collaborated with an existing local program for deaf adults. The Hearing Impaired Program of Catholic Charities in San Francisco has worked with deaf adults including high-risk deaf families in the San Francisco Bay area since 1988. This program has provided clinical services to deaf adults as well as limited monthly parenting education classes. Services have been provided by a clinician who is fluent in ASL and is from a deaf family (adult child of deaf parents). However, the extent of services through this Hearing Impaired Program had been extremely restricted by minimal financial resources: there were no funds to provide regular weekly parenting classes, to conduct in-home visits, nor to hire a deaf parent peer counselor.

Additionally, the clinician had not been trained in infant mental health work nor in developmental issues.

As proposed under the RRTC, this project lasted 12 months. As part of adapting TLG's early intervention model for high-risk deaf parents and their young children, the project included expansion of services to parents, inclusion of a deaf parent peer counselor, weekly parenting classes, and training the clinical coordinator and the peer counselor in TLG's early intervention model. In adapting and documenting this project, the following resources were allocated:

(a) 25% FTE (ten hours a week) of the existing clinical coordinator's time to work with high risk deaf parents and their children.

(b) A deaf parent peer counselor at 50% FTE.

(c) TLG clinical supervision and training the project clinician and peer counselor in TLG's early intervention model.

(d) A research associate who oversaw all project documentation and data collection including the development of pre- and post-test measures.

(e) The project also covered the costs of running the weekly parent group including child care and refreshments. Limited funds were also available to cover public transportation costs to enable some families to participate in the project.

This project targeted seven families of high risk deaf parents for in-depth description and examination of the intervention program model. Additional families served by the Hearing Impaired Program also participated in the weekly parent support group and in developing parent training materials

At the time this RRTC project was near completion, TLG was awarded a statewide grant from the California Office of Child Abuse Prevention (OCAP). As part of this three-year demonstration project, TLG was able to continue comparable services to deaf parents for another 24 months. Deaf parents served under this latter project were part of a larger sample group of high-risk families served by TLG in which one or both parents or the child has a disability. Some of the measures developed in the RRTC deaf parent project were refined for use in the OCAP project. A separate report on this OCAP project is available from TLG:

Sullivan, C. (1997, October). Office of Child Abuse Prevention. Early in-home family support services project: Final report. Berkeley, CA: *Through the Looking Glass*.

(Please note, the OCAP report does not differentiate outcomes for parents by type of disability or deafness.)

Project Objectives

- (1) To adapt the TLG model to intervene with families with deaf parents in order to enhance the quality of parenting and of intra-family relationships, the social and emotional well-being of individual family members, and the general development of the young children.
- (2) To describe the adaptation and application of the TLG model for high-risk families with deaf parents.
- (3) To examine the effectiveness of this intervention with seven young families with deaf parents across the program year.
- (4) To collaborate with deaf parents in the program to develop training materials for parenting training.
- (5) To help develop deaf parents to work as peer professionals.
- (6) To further elaborate the TLG model with particular regard to increasing peer support through developing a community approach to networking families.

Research Questions

This project focused on adapting and elaborating TLG's early intervention model for high-risk families of deaf parents. Although data was gathered to examine the hypothesis that this kind of comprehensive and peer-oriented program would significantly enhance the family functioning, the intra-familial relationships, and the extra-familial support systems for each high-risk family, this research question cannot be experimentally addressed within the time frame of this project. The three-year OCAP project which continued comparable intervention

services to high risk families with deaf or disabled parents (see above) was able to more systematically evaluate the effectiveness of TLG's early intervention model.

The research questions which were addressed by this 12 month project are:

- (1) How can the TLG model be adapted for effective intervention with high-risk deaf parents and their children?
- (2) How can "target" deaf parents collaborate in developing training content and materials for other similar deaf parents? Will such active participation in developing training ideas enhance the learning of "better parenting" by "target" parents?
- (3) How can the support networks for high-risk deaf families be expanded to include the entire family (not only mothers and intervention-targeted children) into a larger community unit?

Sample Population

Criteria for seven families participating in this project were the following:

- 1) One or more primary caregivers were self-identified as deaf.
- 2) The family was identified by the clinical coordinator as at high-risk according to risk factors enumerated above.
- 3) One or more children were age 3 or younger and still living in the home.
- 4) Families voluntarily agreed to participate in the project and committed themselves to attending the weekly parenting group.

Although there were no geographic restrictions on project eligibility, the expectation of weekly attendance in the parent group effectively restricted participation to families living in or near San Francisco. The sample population of parents was also characterized by a high percentage of parents with extremely low-income, extremely minimal English language skills, and limited American Sign Language (ASL) skills. Additionally, because almost all these families were San Francisco-based, they generally had little or no access to the local Deaf community and

deaf peer resources. A significant portion of the San Francisco Bay Area Deaf community now resides in the general vicinity of the California School for the Deaf -- which re-located from Berkeley to Fremont nearly 15 years ago. This geographic shift represents an additional hour of travel time from San Francisco, and effectively precludes many deaf persons in San Francisco from active and ongoing participation in the Deaf community. This is especially true for persons with limited economic resources. Also, because a number of parents within this project were recent immigrants, they had no historical ties to the local Deaf community. Geographic, economic and historical factors combined with often poorly developed American Sign Language to increase the family's isolation from the Deaf community. Such isolation is an important factor in understanding the significant lack of resources available to these high risk deaf families as well as the difficulties this project faced in developing workable and long-term community resources for these families.

Data Collection

Two general types of data were collected in this project:

Observational data were used to describe the intervention (e.g., the clinical and educational work with mothers, the developmental work with infants, and the group support and educational work), and to evaluate the quality of mother-infant/child interaction for intervention purposes. The observational data included videotapes as well as written notes. The observational data was collected throughout the project and was analyzed to identify and describe the factors and components of intervention. Videotapes of mother-child interaction included free play, caretaking vignettes, as well as interaction in which the mother was asked to teach the child some new play activity or toy. These were analyzed in terms of rating scales developed by Schlesinger and Meadow (1972) to evaluate interaction between deaf children and their hearing mothers, as well as in terms of the Nursing Child Assessment Teaching Scale (NCATS; Barnard, 1978). The purpose of this analysis was not to evaluate changes in mother-child interaction that might derive from the program, but rather to identify difficulties in interaction as well as positive, reciprocal engagements that might suggest ways of intervening to parents, as well as to show to other parents as part of the intervention work itself.

The second type of data were two measures: a measure of parental stress and support, and a measure of maternal attitude. These measures were derived from the Family Support Scale developed by Dunst, Jenkins, and Trivette (1984); the Parenting Stress Index (Abidin, 1986); the Norbeck Social Support Questionnaire and the Brief Symptom Inventory (Derogatis and

Spencer, 1981). These questionnaires have been used in evaluation studies of early intervention programs (Shonkoff, Hauser-Cram, Krauss, & Upshur, 1992) or parent-support programs (Stein, 1990). For this project, the questionnaires were revised and administered in American Sign Language, Pidgin Sign Language or pantomime as appropriate to the parent. These measures were administered twice: once when the intervention program began, and ten months later. Differences in levels of parental stress, extensiveness of support, and maternal attitude about parenting across ten months of intervention were examined.

Results and Discussion

Three major types of activities were conducted during the course of this year-long project: (1) clinical services to individual families, (2) weekly parent support and educational group meetings, and (3) research activities to describe and evaluate the intervention work.

Services were provided to deaf parents with infants and young children applying and adapting TLG's intervention model. Seven families received direct clinical services through this project, ranging from only three to well over forty home visits or clinic sessions. Five of the seven families served were in crisis and often the intervention necessarily focused on crisis management, including issues of hospitalization, reports to Child Protective Services, basic nutrition and safety issues, financial emergencies, immediate food needs, and housing problems. When not helping to handle specific crises, the clinical work focused on enhancing the quality of parenting and of family relationships, the social and emotional well-being of the parent(s) and young children, and the general development of the infants and toddlers. Clinical work based on both the infant mental health model and family therapy has occurred around the crisis issues. Additional clinic visits have also provided the opportunity for more specifically clinical work with parents and their young children.

Parent group meetings were offered weekly through the year, with a month long summer break when the program moved to a new site. Over fifteen single parents or couples participated in the group meetings over the course of the year, with some attending regularly while others attended quite sporadically. Each meeting was scheduled for one and one-half hours, though parents always stayed for an additional hour to socialize with one another. The purpose of these meetings is threefold: 1) educational regarding parenting and child development issues; 2) supportive and empowering in the process of sharing with each other; 3) training in that these groups will develop training materials that can be shared with other deaf parents. The groups were facilitated by two peer clinicians from the project, one a deaf

mother, and the other the adult child of deaf parents. The meetings were open to any deaf parents. While several parents attend fairly regularly, no parents attended every meeting. Across the project, 21 different families participated in the parent group meetings. The topics covered across the year included discipline problems and techniques, communication between deaf and hearing, especially between deaf parents and hearing children; self-esteem of the children and the parents; the relationship between parental experience and that of their children -- particularly with regard to family life and school, children's sexuality, and grandparents. In addition unplanned discussions would frequently occur in response to immediate concerns of parents in the group: for example, a discussion regarding experiences and coping strategies with public transportation followed one parent's arriving at group after a distressing experience with a bus driver, another discussion about how to attend to your own children when depressed followed a mother's report of a friend's suicide.

The research component of this project has been composed of two parts: (1) description of the intervention activities, both of the clinical and wraparound services provided to individual families, as well as some of the parents in the parent group program; and (2) some evaluation of the effectiveness of the intervention for the families involved. In order to evaluate the effectiveness of the program, an instrument was developed to rate each family in terms of eight areas, with specific items as listed below:

1. Quality of parenting skills/knowledge
 - a. Uses effective & appropriate discipline
 - b. Appropriate behavioral expectations
 - c. Knowledge regarding care of children
 - d. Provides appropriate structure, routines

2. Degree of self-confidence as deaf persons/parents
 - a. Appropriate problem-solving persevering with child
 - b. Effectiveness in parental role
 - c. Flexibility in handling family situations
 - d. Uses family communication system appropriate to parent
 - e. Positive self-statements, assertive actions

3. Level of external stressor
 - a. Re. financial circumstances
 - b. Re. housing

- c. Re. child care respite
- d. Re. transportation

4. Extent of support system

- a. Personal/social:
 - 1. Friends
 - 2. Family
- b. Community
 - 1. Agencies Services
 - 2. Group support
 - 3. Counseling/therapy

5. Quality of interaction with children

- a. Enjoys child
- b. Responsive to child
- c. Communicates clearly to child (expressive)
- d. Understands child (receptive)

6. Emotional well-being of parent

- a. Internal stress (overwhelmed)
- b. Depression (apathy)
- c. Substance abuse
- d. Trust vs. suspiciousness
- e. Impulse control (anger)
- f. Self-reliance vs. dependence

g. Coping skills/practical judgment

7. Well-being of the child

- a. Emotional/ Behavioral
 - 1. Aggressive/ destructive
 - 2. Oppositional vs. cooperative
 - 3. Depression (withdrawn)
 - 4. Anxiety/fearful (bedwetting, sleep problems)

- b. Developmental status (age-appropriate development)
 - 1. Motor
 - 2. Social

3. Communication

c. School adjustment (when applicable)

1. Attendance
2. Learning
3. Behavior

Ratings were made at the beginning and end of intervention on five of the seven families in order to obtain an impression of changes in these eight areas over the period of treatment, while only single ratings were made on two families because they received very limited intervention. While the numbers are too small and the data collection was not rigorous enough for quantitative analysis of the data, nevertheless it is interesting to examine trends in the evaluation data. Of the five families evaluated at least twice through the intervention, one family is not included in the following analysis because the parent who provided the primary care and therefore was rated in the beginning of intervention differed from the parent rated at the end of intervention. The four remaining families scored either as no change or, more frequently, higher after intervention in the three areas of 1) quality of parenting, 2) degree of self-confidence as deaf persons/parents, and 7) well-being of child. In other words, it seems as if the program may have positively affected these areas for the parent and child. In the measure of quality of interaction with child(ren), again over the course of intervention, the four parents rated showed either no change or some progress with the exception of one parent who was rated as poorer in communication, both expressive and receptive, with her child over the course of the program. However, the intervention began for this family when this woman's daughter was 9 months old and preverbal and ended when the daughter was a 20-months-old toddler with expressive language. It is of interest to examine the areas which showed mixed results in terms of change over the intervention period. These are: 3.) Level of external stressors, 4.) extent of support system, and 6.) emotional well-being of the parent. The intervention program was designed to help respond to external stressors, but was not able to prevent external crises from occurring and from having an impact on the study families. In fact, one of the salient features of the families served in the intensive intervention program is that they faced serious external crises and stressors that were not easily addressed nor resolved in the course of the program.

Several of the families had severe financial difficulties: one parent had to deal with eviction from her apartment and a subsequent court case around that; another parent was found to be biologically unrelated to the boy he had been caring for as his son and, as a result, lost custody

of the child. Only one of the four families reported here had primary difficulties related to parenting and the parent-child relationship. Furthermore, it seems as if Area 6 (emotional well-being of parent), is an area that changes slowly for these adults. This is especially interesting because the trend was towards progress in the area of well-being of the child, but for parents we found primarily no change. This may speak to the difficulty of making changes in long-standing emotional distress and/or characterological issues for adults. Along these lines, one of the crises experienced by one of the intervention families involved hospitalization of the mother for severe depression. Additionally, it is probably not surprising, though we had not specifically anticipated this, that the non-primary parent in almost all of our families was not only not supportive, but created additional relationship difficulties and other stressors for the intervention families. Sometimes these partners were open to counseling services themselves but, most frequently, they were not. This may be related to the surprising finding that the intervention program did not uniformly improve the extent or level of community support for these families. Although the intervention program itself included agency services, group support via the parent group program, as well as individual and/or family counseling/therapy, the families did not always use these resources even when in need.

Overall, we found that while the clinical, support, and case management services provided by the program helped these families enjoy better relationships with their children, and seemed to lead to healthier functioning of the children, the families most in need of intervention services experienced such crises that simply making services available was not sufficient. For example, the families experiencing the most severe stressors were the families who were least able to attend the weekly parent group meetings for support and a sense of empowerment.

In order to adapt TLG's intervention model for deaf parents and their children, two major changes from the existing Catholic Charities Hearing Impaired Program were proposed: (1) training clinicians (already skilled in sign language and Deaf culture) in infant mental health; and (2) conducting in-home visits (rather than primarily center-based services). Because of the demands of high caseloads outside this project, the project clinicians' availability limited the duration and intensity of their infant mental health training. Additionally, although in-home visits were conducted, these were often sporadic in nature due to the clinicians' schedule and/or intermittent crises among participating families. These complications compromised the adaptation and implementation of TLG's intervention model.

Finally, the project's one-year time frame does not appear sufficient to adequately model and foster relationships within these highly stressed families. Two related TLG intervention

projects involving families with comparable levels of stress showed dramatic improvements when services were extended over time. In TLG's OCAP project, families were eligible for one to two weekly visits up to a maximum of three years; in TLG's ongoing intervention services for Regional Center clients, families are eligible for one or two weekly visits over a period of two, three or more years. Data from both of these programs document significant positive outcomes when intervention services to highly stressed families were provided long-term (Sullivan, 1997; Hansen, 1997).

The Development of Training Materials

One of the objectives of this project was the development of preliminary training materials in collaboration with deaf parents participating in the project. The project anticipated that the weekly deaf parent group would serve as the primary vehicle for the development and assessment of training methods and materials. Although beyond the scope of this project, these preliminary materials could eventually be refined and incorporated into more broadly disseminatable training materials for deaf parents. However, a number of factors mitigated the development of training materials. These factors are significant not only as they impacted anticipated project outcomes, but they also suggest conceptual and practical issues which must be addressed in future development of training materials for deaf parents. [Please note that those project training materials which were developed will be described and discussed in the next section.]

First, a much greater proportion of project time and resources were devoted to direct intervention services than initially anticipated. Because the majority of families participating in the project were frequently in immediate need of services and crisis management, project personnel made an ethical decision to prioritize direct services to families -- rather than extensive development of training materials. Within these constraints, the project focused on videotaped interactions between participating parents and their children in the development of training materials. Such videotape could enhance the services and skills development provided to participating families. Portions of these videotapes could also be used in subsequent training presentations to other deaf parents and professionals.

Second, by consensus, the parent group often favored problem solving the immediate needs of participating parents, rather than adhering to a more carefully planned and structured format. This more spontaneous group problem solving reflects the more peer-oriented and more pragmatic group dynamics familiar within Deaf culture. Although most parents within the

group participated in this brainstorming process, it was unclear to what extent problem solving specific situations engendered more broadly-based problem solving skills. However, this process strongly underscores the need for flexibility and practicality in the development of training materials.

Third, a more cohesive group process was impeded not only by irregular attendance of individual participants, but also by the great variation in language and communication abilities within the group. Discussions within the parent group often required considerable staff guidance, explanation and re-interpretation. Training materials for deaf parents need to accommodate these varying communication abilities -- particularly among deaf parents who are not fluent in English or ASL.

Finally, one of the underlying assumptions in the training process was that the deaf parent group would foster the types of interaction, cohesiveness and peer-bonding found within the Deaf community. As a result, previously isolated families would have increased peer resources available to them. In effect, parents could provide ongoing training for each other. This strategy met with limited success. A few parents did socialize outside the group, and one of the parents emerged to take on the role of a peer professional. In general, however, most parents did not actively seek out each other, and remained isolated unless encouraged to attend a local event organized by project staff. One mitigating factor was the often consuming nature of individual family crises which left little time to socialize with other families outside the group. Socialization opportunities (meals, entertainment, travel) were further limited by often severely limited financial resources. Additionally, many parents in the group diverged according to ethnicity, language or communication abilities. There was also the sense that, without a "critical mass" of deaf parents who were not in crisis and who could act as mentors, ongoing socialization and productive cross-training among the group would flounder.

These project outcomes have important implications for the development of training materials for deaf parents. For example, one of the only training materials currently available for deaf parents is a series of videotapes in which several deaf parents discuss their personal experiences and opinions regarding a wide variety of childrearing topics (*Parenting Skills: Bringing Together Two Worlds*, 1995). The overall format of this training package is to have a group of deaf parents watch the videotape. At predetermined intervals, a facilitator stops the tape and promotes discussion of a particular topic among the other parents. Although possibly excellent training for some deaf parents, these materials would have been inappropriate and/or inaccessible to most of the deaf parents within the RRTC project.

Almost all parents included in the training video are middle-class, white, well-educated and use ASL. The video does not have captioning or voice-over. Additionally, although many of the topics covered in the video have important parenting implications, the issues would often have been too esoteric or too removed from the immediate needs and experiences of the high risk parents participating in the current project. Nor does this videotape provide naturalistic examples of interactions or behaviors -- although, as will be discussed below, the current project had only limited success in this area.

Training Materials

The following training materials were compiled under this project:

Videotapes of Parent-Child Interactions. With the consent of those families participating in the project, parent-child interactions were videotaped within the family home. Approximately six hours of videotape documents interactions within six families -- approximately one hour of tape per family. These videotapes were immediately available for viewing by the subject family, and later shown to the parent group. These tapes appear to have been most useful to the family videotaped, and less useful for the other parents participating in the project.

Almost all of the parents who were videotaped reported increased awareness and understanding of their own parenting issues and behaviors after viewing the videotape of themselves and their children. For example, after watching herself on video, one deaf mother reported that she finally understood some of the concerns that the clinician had been discussing with her.

There were mixed results when a videotape segment was shown to the parent group. Occasionally, the topic illustrated on videotape prompted discussion among other parents in the group. More frequently, the group preferred to discuss a more immediately pressing issue of one of the parents. (In some cases, a presenting issue was prompted by what had been observed in the video.) A number of factors could explain this mixed result including the group preference to problem solve more immediately pressing issues, and/or the quality of the video (see below).

Because of constraints in the home (lighting, space) and limited program staff experience with videotaping, the quality of the videotape is generally fair to poor. Also, the parents and children who were videotaped were almost always aware of the camera, which limited the

naturalness of the interactions. This latter problem is worth exploring. A number of the parents did not sign fluently with their children while videotaped -- instead they primarily used their voices. Similarly, many of the children voiced rather than signed. In some cases, this may be because this was how these parents and children normally communicated with each other. It is also possible that the presence of the camera (outsiders) prompted wariness of using sign language -- that is, parents and children "performed" for the camera using a more socially acceptable form of communication (speech). This hypothesis is given more credence in that program staff observed more signing when parents and children were not being videotaped. In still other videotaped examples, parents signed in exaggerated or unnaturally slow ways -- again, demonstrating much more of a "performed" rather than natural interaction with their children. As a result of using their voices and/or exaggerated signing, it may have been difficult for deaf viewers to follow the interactions on videotape. It may be that more favorable responses by individual parents watching their own families on videotape was a result of better understanding the context and nature of the interactions. Another factor is that videotaping was generally kept to a minimum in order to reduce intrusion into already over-stressed families. This infrequency may also have contributed to the family's lack of naturalness in front of the camera. For example, in one segment a mother reads a book to the camera -- rather than to her children -- and frequently tells her children to behave because other people are watching them. Such staginess may have further contributed to the parent group's preference to deal with more realistic and pressing matters at hand.

Some portions of the existing tapes are of good quality and can be used in conjunction with TLG's ongoing training of parents and professionals. To be included in more broadly disseminatable training materials (such as a stand-alone training module), additional footage needs to be shot. Suggested issues to be illustrated on videotape are listed in the workshop outline described below. If these training materials indeed target high risk deaf families (and professionals working with them), the issues presented on videotape must reflect the experiences and needs of the targeted population. Videotapes also must illustrate diversity in ethnicities and socioeconomic status of families shown. In addition to improving the overall quality of the videotapes, sufficient time should be spent with participating parents and children in order to increase naturalness of interactions videotaped. As discussed earlier, the target audience needs to be carefully delineated in order to match the diversity of communication styles of viewers. This may mean multiple versions of the same video: one with captioning for hearing professionals, another which has an insert with an ASL interpreter, and still another with a Signed Pidgin English interpreter.

Workshop Outline. A Summary Outline of a Workshop on TLG's Clinical Model as Adapted for Deaf Parents is attached to this report. It includes an overview of a program for deaf parents and their children as well as suggested weekly Parent Group Topics

Videotape Presentation on this Project. At the conclusion of the project, a videotape was made of a presentation on the project to the professional staff at the University of California Center on Deafness and to invited Deaf professionals. This presentation was conducted by the project clinical coordinator, the deaf parent peer counselor, and a participating parent from the project. The videotape includes questions and comments from the audience. The one and a half hour videotape serves as an overview of the project and some of the issues described in this report. Portions of this tape can be used in conjunction with training professionals.

Videotaped Presentations at the International Conference on Parents with Disabilities. The first International Conference on Parents with Disabilities (October 1997) included a presentation on deaf parents and their children which can be incorporated into future training materials. In addition, selected segments from other videotaped conference presentations (e.g., children of parents with disabilities, violence and abuse among parents with disabilities, legal rights of parents with disabilities, cross-cultural issues) are also applicable to deaf parents and can be included in developed materials.

Family Interventions with Deaf & Hard-Of-Hearing Family Members Workshop Outline for a Peer-Based Clinical Model

Overview

Based on Through the Looking Glass' peer-based intervention model, the program for deaf parents consisted of three components: home visits; parent education/support groups; and case management and wraparound services. The program focused on developing a more positive self-esteem in order to increase the deaf parent's sense of empowerment, develop better parenting skills, and enhance communication skills with their hearing children. The theme of "families together" was emphasized because in the work with these deaf parents, we found that when they grew up isolated from their hearing families, they tended to repeat this separation with their hearing children. We focused on attitudes and activities that would enhance the quality of interaction between parents and children, and bring the deaf world of the parents and the hearing world of the children together. Another unique element was the peer model approach, using a combination of deaf and coda (child of deaf adult) facilitators. The sharing of the peers' own experience and pride as deaf parent and hearing child modeled what was possible for them as deaf parents.

Suggested Outline for a Deaf Parent Group and/or Training Module (Videotape Segments can introduce topics or illustrate specific issues)

- A. Your Child and School.
 - 1. Dealing with a "hearing" environment
 - 2. Advocacy

- B. Discipline.
 - 1. Developmental Issues/Age of the child
 - 2. Time Outs, Charts
 - 3. Using Good Communication to enhance discipline
 - 4. Home Visits

- C. Your Relationship with Your Child.
 - 1. Explore Own Relationship with Hearing Parents
 - 2. Attitudes to ASL/English
 - 3. Attitudes to Hearing Children (Music)
 - 4. Developing Communication Skills with Children
 - 5. Playing with Children as a way to Develop relationship and communication
 - 6. Story Telling

- D. Building Self-Esteem

E. New Rules for Deaf Culture Households

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