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ABSTRACT

Described is a milieu intervention scheme for treatment of disturbed deaf children (6-18 years old) in a residential school for the deaf. It is noted that the program sought to develop respect and awareness of the self and social group within the security of a specially adapted environment and to support reintegration into the social, academic, and vocational mainstream. Implementation is reported to involve the development of a therapeutic milieu providing: (1) individual and small group intervention daily with the therapist, in a resource center; and (2) selected integration in the mainstream supported by weekly consultations with the integrating staff. Strengths and weaknesses of the program are discussed, and sample evaluation forms are included. (Author/SBH)

DEVELOPMENT OF A MILIEU INTERVENTION PROGRAM FOR TREATMENT OF EMOTIONALLY DISTURBED DEAF CHILDREN

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Time and experience...alter all perspectives...
-Henry Adams

ABSTRACT

This article describes a milieu intervention scheme for treatment of disturbed deaf children in a residential school for the deaf. The program sought to develop respect and awareness of the self and social group within the security of a specially adapted environment and to support re-integration into the social, academic and vocational mainstream. Implementation involved the development of a therapeutic milieu providing: 1) individual and small group intervention daily with the therapist, in a resource center; and 2) selected integration in the mainstream supported by weekly consultations with the integrating staff.

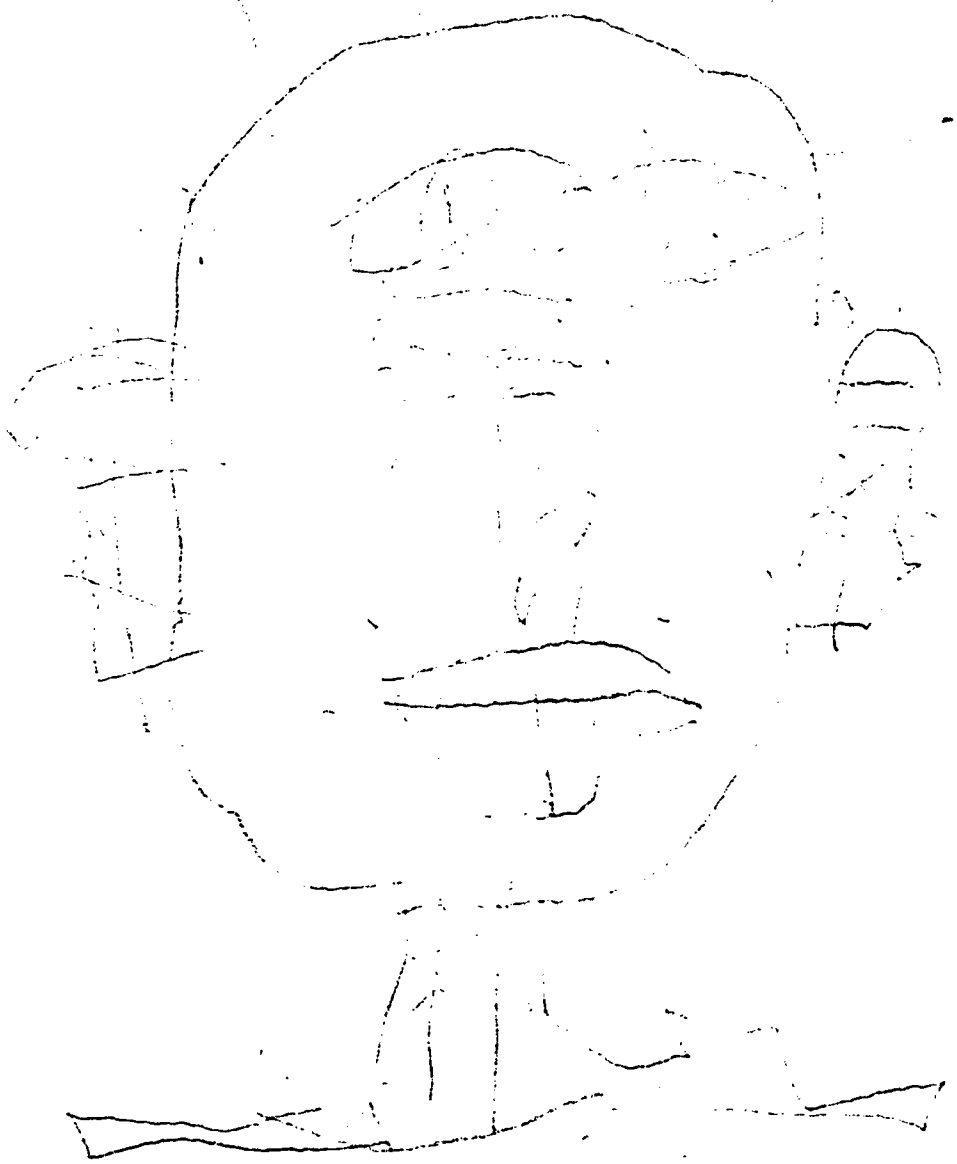
INTRODUCTION

Providing specialized programs for children with severe emotional and behavioral disorders is an accepted standard for intervention with hearing children. Unfortunately the same commitment to services does not exist for treatment of deaf children with emotional disorders. Even the potential for programming in this area is yet to be fully explored, although it is estimated that ten percent of deaf children are disturbed enough to warrant intervention beyond the special education required because of deafness.[1] The purpose of this project was to implement a special program to improve the functioning of emotionally disturbed deaf children and to evaluate the program operation and the progress of those receiving intervention.

The Program for Social and Emotional Development (SED) focused on 15 of the most disturbed students attending a residential school for the deaf with a total population of 500 students. (Diagram 1) The program was operated for three years, prior to which no regional or state facilities existed for treatment of childhood emotional disorders among the deaf.[2]

The goal of the program was to support the emotional and social growth of the disturbed child in a special therapy situation and to support integration in the social and

DIAGRAM 1 - SELF PROTRAIT



Male student - Age 13 - Profound Bilateral Congenital Deafness. I.Q. - 123
First year in program

academic mainstream. Consistent with the design of a therapeutic milieu, the programmer sought to expand the child's range of coping strategies in the therapy situation and to adapt the environment outside to foster opportunities for interaction that could reinforce individual therapeutic objectives.

Any clinical intervention is valuable only in so far as it relates and responds to the needs of those receiving therapy to cope more effectively with the challenges circumscribing their life space. With children this represents the dynamics manifest at the beginning ages of development, for children need to experience and achieve the fundamental tasks of early development before proceeding to a more mature level of integration.[3,4]

To effect these goals, it was felt that the individuals close to the child were instrumental in the development of his self esteem.[5] Therefore the concept of the therapeutic milieu[6] was employed to establish consistency and predictability in the environment and provide the opportunity to expand and reinforce behavior in the situation in which it occurs. It was also felt that children must be approached from a developmental perspective. Therefore the precepts of child growth and development were followed in the therapy situation that emphasized respect and trust in a relationship within which limitations and reality structures could be effected.

POPULATION DESCRIPTION

The 15 students enrolled in the SED Program were identified through annual departmental surveys coordinated by the Principal, Department Director, and teachers with subsequent evaluations by the school psychologist and SED specialist.[A] Students were 6-18 years old and enrolled in various departments throughout the school. All but 3 students tested within the normal range of intellectual ability. Academically, however, the majority of students performed below their potential.

There were as many different problem behaviors manifest as number of children seen. However, two dominant traits were a lack of security and self-esteem and an inability to function on an interpersonal level. Youngsters could not interpret personal, social, or work situations, and they responded inappropriately or not at all to their environment. Students were either overly dependent, angry, or detached from other people. For example, some students continually isolated themselves in corners and demonstrated self-stimulatory behavior. Other youngsters responded to situations by abusing themselves or exaggerating their head and body movements. A few youngsters were continually involved in talking to themselves or fantasized or inanimate objects. Some students could not establish eye contact or be in close proximity to other people. Others carried their personal possessions with them as they moved about a room, while others

had to be constantly touching or sitting close to a particular individual. Several children responded hostilely to social interaction with tantrum behavior that was either assaultive or destructive in its intent.

Still other students did not manifest any overt signs of disturbed behavior, but demonstrated more subtle signs of emotional problems. These were students with prolonged periods of depression, inappropriate affect, apathetic reactions, exaggerated but acceptable defiance of authority, lack of peer relationships, recurring self-doubt and/or negativism. Referral for services was more difficult in these cases. However, as the program expanded the school staff became sensative to identifying different types of students in need.

Students were on varied schedules each year. (Table 1) The itme spent in the SED Center was determined by a student's ability to maintain himself in the original environment. The vehicle for evaluation and placement was the school Child Study Committee of administrative, ancillary, educational, residential, and therapeutic personnel. Students were placed full time in the SED room if they required total support and intensive therapeutic intervention. Students were placed part time in the SED room if they required daily support or counseling but were capable of maintaining themselves for part of the day in the regular curriculum. The therapist-student ratio was 4:1

Table 1

STUDENT SCHEDULES OF PARTICIPATION IN THE ED ROOM

	Year 1	Year 2	Year 3
Student 1	full day	half day	one hour/day
Student 2	full day	half day	one hour/day
Student 3	half day	one hour/day	one hour/day
Student 4	three hours/week	----------	----------
Student 5	----------	all day	----------
Student 6	----------	one hour/day	one hour/day
Student 7	----------	one hour/day	one hour/day
Student 8	two hours/week	one hour/week	----------
Student 9	withdrawn	----------	one hour/day
Student 10	----------	----------	one hour/day
Student 11	----------	----------	three hours/week
Student 12	----------	----------	one half hours/day
Student 13	----------	----------	half hour/day
Student 14	----------	----------	one hour/day
Student 15	withdrawn	----------	----------

year one, more optimally 3:1 year two, and most ideally 3-2-1:1 year three. The dual placement procedure with part-time daily therapy worked well for many youngsters as it was found that daily support in the resource room relieved students of sufficient stress that they could continue partial participation in the original environment during therapy.

RESOURCE ROOM

The base of the program was the Resource Room (RR) where children were seen daily for therapy and intervention. The RR was a place of acceptance , a desensitized environment that respected individual needs and emphasized the development of responsive, trusting relationships. The intent was to change a child's perception of himself in the environment and to enhance his self-image.

The RR was organized into separate, self-contained activity areas (Diagram 2) designed for independent and small group participation. The activities in the areas or learning centers were geared to the levels of ability, interest and needs of individual students. Activities were developed to satisfy the needs of some youngsters for immediate success or to challenge the creative intelligence of the other youngsters. The concept of the design was to provide a situation a child could master and operate successfully. Students rotated among the centers by assignment and free choice dependent on the goals selected for and with him. Students functioned well in independent activity in an average of 4 centers. With encouragement most students could move through the majority of stations. The programmer supported each area project by making supplies available, demonstrating new skills, promoting social interchange, guiding experimentation and encouraging

original work. The learning center concept functioned most effectively for children scheduled for half or full-time in the RR, or for younger hourly scheduled students. Part-time students with upper school academic placements preferred counseling and small discussion related to their personal, social or school adjustment problems. Learning center activities with the older groups were oriented toward individual requests, special group projects, elective and assigned activities related to therapy goals, and trips.

THERAPY DESIGN

Individual long and short term goals were formulated for each child in the areas of personal and social adjustment with related suggestions for academic programming. Goals were set in relation to the child's psycho-social development and were the basis for intervention in the resource room and integrated placements. As such, structured routines, consistency of expectations, and channels for physical manipulation were arranged for some hyperactive, aggressive children; relaxed controls with freedom for creative expression were instituted for some depressed, dependent children; increased attention, emphasizing trust and support in an adult relationship were effected for some insecure children; and strong reality definition, contingency contracting and symptom extrangement were outlined for some hostile, destructive children.

Careful engineering had to be employed to support a child's participation or continuation in a group or activity. Therefore, it was most important to convey an atmosphere of warmth and security in the therapy encounter to protect the child where he was still vulnerable and build on his strength. A clear definition of expectations was emphasized in all interactions. Experiences were planned in graduated challenges to minimize frustrations and disturbances. Symptom behavior displays were tolerated until the individual was primed for its elimination. The general behavior rules in the RR mandated

respect for individual and social set. When difficulties occurred, either an alternative method was suggested, second person assistance lent, a channel established for feeling expression or ventilation, or a temporary change in activity effected. If a child became too desruptive, he was removed from the situation and could return when he regained composure. The child who was propelled by his own panic into an attack or tantrum was removed into isolation. The therapist remained with him, lending controls to help manage his fury during the episode. Some children were held, if it were possible, in hopes of maintaining a reality link and preventing further withdrawal. When some equilibrium was restored, it was accepted and acknowledged, and if possible a decision made as to what to pursue next. These elements of milieu[7] and reality therapy are not all inclusive, but were found to be valuable supports for a child in crisis and compatible with the desired attributes of ambiance and milieu effecting security and consistency in the therapeutic environment.

INTERVENTION ACTIVITIES

Activities in the RR emphasized development of 1) a positive self-concept; 2) an effective communication channel; and 3) satisfying social relationships. The objectives were to develop the child's image of himself as a capable individual; to develop social relationships through one-to-one and small group experience; and to expand the individual's ability to express himself through a reliable system of communication. While some students were receptive to developing more conventional behaviors, most were either too threatened or had no motivation to drop the response patterns that were familiar and comfortable to them. Before new roles could be adopted, the child had to have a) fundamental information about the behavior; b) positive experience and a sense of security associated with the behavior; and c) motivation to repeat the behavior in future situations.

Activities therefore, were used as catalysts for increased personal and social participation. The RR activities, whether quiet or active play, project work, group social interaction, or personal counseling, were presented with clear definitions of the situation and the expectations related to the situation. The intent was to reduce the number of unknown factors and insecurities about the external circumstances, and to protect the participation further by manipulating the internal pressure blocks impinging on the individual's life space. It was found then, that when comfortable opportunities for trail and error were presented with support for uncomfortable realities, youngsters did expand their realm of social strategies and did begin to respond appropriately.

INTERVENTION (CONTD)

Development of Social Relationships

The starting point in the development of social relationship was the establishment of trust between the child and therapist. Since most children entered or avoided new relationships with the same patterns that had incapacitated them in the past, the development of relationships in the RR had to be a process of reorientation and development of different, not just new relationships. Special RR activities were the tools devised to encourage interaction and open a child to intervention. Therefore, games, projects, and field trips were an integral part of the RR experience. The attractiveness of these situations provided the inducements needed to stimulate interaction and functioned effectively to counteract habitual avoidance patterns. Then once a youngster was involved in the activity, opportunities were available to demonstrate and record appropriate social play. Later one could capitalize on the experience and refer to it in other discussions or play.

Many students preferred individual instead of group activities and in fact did not possess a readiness to function as part of a group. Therefore, parallel play activities were introduced such as puzzles, movies, solitaire card games, exercises, shop work, etc. At this stage social boundaries were being learned and tested and the games offered a modality for more intense interaction and guidance than could be previously tolerated. It was possible to break some barriers

to the next stage of reciprocal play by offering something to the child that was potentially more valuable than his need to withdraw or be defensive. Trips into the community afforded unique opportunities for interaction among the group, with high interest contexts overcoming individual fears of new or group experiences. The trips created anticipation and encouraged a mutuality among the group, providing the first experiences of real social rapport among and between group members. The trips were scheduled weekly in small groups, with extended field trips monthly. Various preparations and activities preceded the day excursions, with particular direction toward the development of functional language, behavior and mobility skills related to the experience. Weekly community walks were used in some instances as incentives for maintaining appropriate posture in the integrated classroom situation.

Communication and Language Intervention

Language usage constituted a major function of the program, particularly for the younger and full-time students. Many students did not use language as their means for exchanging information. Some youngsters were limited by using methods of communication that were ill suited to their needs. Others relied on using behaviors that had been effective communicators for them in the past. Each student's situation differed; however, all but two had to experience and learn language and communication.

Communication was stimulated through experiences. Individual and group camera activities were particularly excellent tools. Use of the equipment was interesting and intriguing to students and the end product provided material for communication and information. Photographs that were captioned and catalogued or used in correspondence and demonstrations were also referred to for language models. Camera work was expanded further to include videotape presentations, original film strips and slide exhibits. The value of the medium was found to be limitless in the academic sense. In the therapeutic sense, it facilitated self-examination and confrontation, reflection, expression and expansion. (Diagram 3)

DIAGRAM 3 - EXPRESSIVE PHOTOGRAPHY

Male Student - Age 15 - Third Year in Program

Language usage was learned by providing information with experiences. The primary goal was to develop an ability to explain intent, have a vehicle for more elaborate expression, and to facilitate the least ambiguous, most reliable relay of information. Therefore 1) All modes of communication were used and taught to the SED student, and the system that was most effective, efficient and intelligible for a particular individual was the system that was emphasized for him. In most cases, that involved a combination of oral and manual communication. 2) Emphasis was placed on increasing vocabulary and developing a facility for using reference materials. Promoting independent language resources, of a standard or original design, reinforced a sense of self-reliance, as well as making material accessible to the student too threatened to receive direct instruction. 3) Written language was presented in patterns to identify vocabulary. The basic structures of the Fitzgerald Key [7] were most frequently used and were easily accepted and employed by the students to manipulate written language.

INTEGRATION AND CONSULTATION

Through extensive consultation services, the SED programmer coordinated a network of school facilities into a milieu responsive to the needs and goals of the SED students. Although most of the disturbed students enrolled for therapy had not been capable of functioning in the regular and/or dormitory environments, it was possible to re-integrate youngsters when regular support from the therapist was available to the child, the teacher, and in some cases the peer group involved. Therefore, integration of SED students involved an on going process of adapting the environment to promote opportunities for growth and positive interaction in the mainstream. Thus, while therapy expanded the individual's adaptive skills, selected mainstreaming with other deaf students provided models for growth and reinforcement of self-worth.

The pre-requisite for integration was the emotional readiness of the individual and therefore dictated a close attendance to the child and not the goal. Children requiring continued protection in the closed environment were mainstreamed on a select and narrow basis. Integration activities were increased in gradual steps when there existed reasonable assurances of a positive experience, and after careful consideration of the placement. There was no prediction table, and therapeutic and integration experiences had to be continually assessed and modified to enhance the emotional stability and growth of the child.

INTEGRATION AND CONSULTATION (CONTD)

All students' weekly schedules included physical education, art rhythm, library, shop, movies, and assembly periods. Students attended these activities individually or as part of the SED group. Partial academic and vocational placements were arranged for SED students beginning a transition back to the regular classroom or for new students requiring only part time services. Dual placements were facilitated for all students during the third year, as two regular teachers began to function as resource personnel for academic placement of small groups of SED children. In some cases these teachers had SED students placed in their class rooms the preceding semesters, and following a year of consultation, experience and support became skillful at incorporating some therapeutic techniques in their academic settings. There was great potential it was found for teachers to provide a modified clinical classroom to augment resource room intervention. However, one must exercise caution assigning responsibilities to teachers not trained, or receptive to intervention with emotionally disturbed children. It is not recommended in either case without the provision of extensive consultation and support services from a specialist.

In all cases of integration, students required clear definition of expectations. Class work schedules were in outline form, or behavior contracts were drawn up between the child and the therapist. It was especially

INTEGRATION AND CONSULTATION (CONTD)

important that the return of the SED child to the regular classroom be supported with a written contract. This provided security during the insecure transition period for both the student and the new integrating teacher. It also served to help the child transfer the positive behavior learned in one situation to another. Work charts also helped to develop a habit for the student and teacher of clearly identifying the knowns of the situation, communicating the information that is relevant, and indicating the expected returns. Goals were continually evaluated and adjusted in consultations with the staff to relate to the child's needs and accomplishments. Therefore, through weekly consulations and communication, the daily therapeutic classroom and dormitory activities served to amplify and reinforce the goals sought in each situation.

To evaluate behavior change, several rating scales were developed by the programmer. (B,C,D) The scales were marked at monthly, bi-monthly, and tri-monthly intervals by all persons involved with students enrolled in the program. Both the direction of change and the extent of change were tabulated for data collection and documentation for future placement. (Table 2) Annecdotal records, nine-week evaluation, short and long term objective records, and an annual battery of

TABLE 2

DISPOSITION OF STUDENTS AND AVERAGED RATING OF MONTHLY PROGRESS

	YEARS IN PROGRAM	PROGRESS RATING	DISPOSITION FOR NEXT YEAR
Student 1	2	Good	Academic Class-Full time Placement Contd
Student 2	3	Improving	Academic Class-Full time Integration Resource Room - Daily Intervention
Student 3	3	Good	Academic Class-Full time Placement Recommendation for other services
Student 4	.5	Good	Academic Class-Full time Placement Contd
Student 5	1	Improving	Academic Class-Full time Placement Contd Resource Room - Consultation to Teacher
Student 6	1.5	Good	Academic Class-Full time Placement Resource Room - Daily Intervention
Student 7	2	Good	Academic Class-Full time Integration Resource Room - Daily Intervention
Student 8	1.5	Good	Academic Class - Full time Placement Graduated
Student 9	1	Poor	Academic Class - Part time Integration Resource Room - Intensive Intervention
Student 10	1	Poor	Academic Class - Part time Integration Resource Room - Intensive Integration
Student 11	1	Improving	Academic Class-Full time Placement Resource Room - Weekly Intervention
Student 12	1	Improving	Academic Class-Full time Integration Resource Room - Daily Intervention Moved
Student 13	.5	Improving	Academic Class-Full time Placement Recommendation for Other Services
Student 14	.2	Good	Academic Class-Full time Placement Not in Need of Specialized Services
Student 15	.3	Poor	Withdrawn

INTEGRATION AND CONSULTATION (CONTD)

of psychological and achievement testing augmented the monthly graphings. To examine the long term effects of intervention, annual follow up data was gathered for students previously receiving services, and currently enrolled in regular programs.

CONCLUSION

Recognizing that years of repeated problems characterized these case histories, this report offers documentation that significant changes can be effected with emotionally disturbed children receiving specialized treatment within an educational facility for the deaf. Substantial changes in the behavior and personality development of the students were effected and sustained in the school and home. Some students remained in the program the full three years, some were maintained part-time, and some exited the program completing one year of therapy; but all students re-integrated successfully into the regular school mainstream. It was the experience of this project therefore, that disturbed children were responsive to treatment and could be helped, and that a milieu intervention scheme was an adaptable framework for implementing a treatment program in an established residential institution for the deaf.

The strengths found in the intervention program were: 1) The experience of the child as a capable individual in his environment, which contributed to the feeling of self-worth; 2) The respect and trust established between the child and therapist, which contributed to the influential role of the relationship in the child's life space; 3) The use of total communication, which was of prime importance in

CONCLUSION (CONTD)

securing a reliable communication channel for meaningful interaction; 4) The limited therapist-student ratio established in year three, in which support and control were best lent to groups not exceeding two or three; 5) The particular intervention activities employed, which were specailly adapted for the population; and 6) The flexibility of an intervention strategy which provided two basic services; daily therapy in a resource room,and milieu intervention supported by weekly consultation.

Throughout the project, it was found that as students began to perceive the environment as an enabler rather than an inhibitor, interaction within that environment provided satisfying personal and social experiences, and new role models could be established for productive channeling of energy. It was also found that a clear organization and definition of terms eliminated extraneous and unnecessary confusion, and that as information was processed in the context of a fair, consistent, supportive relationship, students began to understand and deal more effectively with personal and social situations.

> The total environment (then became) a "school for living" in which the patient can learn and test new attitudes and behavior, develop constructive social relationships and take greater responsibility in his own recovery.....

> and the therapist is brought into the relationship as a supporting and clarifying influence around the patient's need and desire to gain or regain a sense of his own worth.
>
> (Definitions for Milieu and Relationship Therapy)[9]

The limitations of the program were that certain needs for services could be approached, but not fully met. For example, although favorable changes in family interaction were evidenced in most cases, distance and staff limitations prevented substantive intervention with the family. Although the RR could be adapted as both a full and part-time facility, separate clinical classroom facilities could not be established for individuals requiring acute care as rendered in the program the first year. Although satisfactory accommodations were instituted in the dormitory residence, a resource specialist was not in residence to extend as effective a therapeutic intervention as was facilitated in the day environment. Although referral surveys were conducted throughout the school, intervention could not be instituted for children experiencing less severe or normal developmental crises.

This and other programs could not be diversified to extend the full range of services meeting the needs of emotionally disturbed deaf children without the availability of specialized staff for clinical assignments. In view of the needs to be met, and the documented value of programming for disturbed deaf children, an ever-present concern now should be for the development of internship and training programs to establish a body of professionals to expand treatment services for deaf children with severe emotional problems.

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A

PROCEDURE FOR REFERRALS AND PROGRAM EXPLANATION
SPECIAL STUDIES DEPARTMENT
CURRICULUM FOR THE SOCIAL AND EMOTIONAL DEVELOPMENT

REFERRALS

1. Recommendation to Principal by regular teacher through department head; then to psychologist for testing and psychological determination of problem. Concurrent notification of pending Child Study sent to Special Studies Director and S/ED Therapist.

2. Child Study to include present teacher, department head, academic principal, assistant superintendent, Special Studies Department head, S/ED therapist, home school visitor, psychologist, dorm parent, and dean of students. Final program determinations made at Child Study.

3. Observation of child in present classroom by S/ED therapist

PROGRAM PARTICIPATION

1. Cooperative determination of initial scheduling by referring classroom teacher, department head, and S/ED therapist.

2. Final Scheduling or alteration determined by S/ED therapist

3. Involving the part time student, academic responsibility remains with the regular classroom teacher. The domain of the S/ED therapist is that of psycho-educational intervention.

4. S/ED therapist to serve as consultant to classroom teacher or dorm personnel.

5. Weekly anecdotal reports exchanged between regular teacher and S/ED therapist.

6. Annual and/or bi-annual Child Study Follow-ups.

CURRICULUM INFORMATION

The primary objectives of this curriculum for the disturbed child is the development of ego support within daily tasks. It is the establishment of a psycho-educational milieu in which a child's perception of himself and his environment can be reconstructed. It is a carefully designed program to re-organize distorted perceptions and demonstrate how a child can become more in control of his own existence. The goal is ego development, an awareness of self and general cultural boundaries within which we operate. The tools used are skill mastery, social interaction, symptom ventilation, total communication, reality exploration and exploitation.

B

SPECIAL STUDIES PROGRAM MONTHLY RECORD

Therapist- Mrs. Edelstein Student_____

Please record how you feel your child is doing each month

S for September	F for February
O for October	M for March
N for November	A for April
D for December	Ma for May
J for January	Ju for June

Please return this to me the first week of each month.

	poor	improving	good
1. Communicates with others			
2. Understands direct communication			
3. Answers direct communication			
4. Can be reasoned with			
5. Expresses interest in things			
6. Interacts with children			
7. Interacts with adults			
8. Shows affection			
9. Controls aggression			
10. Responds well to situations			
11. Works independently			
12. Works in a group			
13. Follows directions			
14. Completes projects			
15. Acquires new abilities			

Relationship:_____ Name:_____

C

SPECIAL STUDIES PROGRAM
THERAPIST: Mrs Edelstein

MONTHLY RECORD-HOUSEPARENTS
Student_____

Please record how you feel your child is doing each month

S for September
O for October
N for November
D for December
J for January

F for February
M for March
A for April
Ma for May
Ju for June

	poor	fair	good
1. Communicates with houseparents			
2. Communicates with children			
3. Plays with houseparents			
4. Plays with children			
5. Shows affection			
6. Controls aggression			
7. Obeys houseparents			
8. Eating habits			
9. Sleeping habits			
10. Living habits			
11. Study habits			

D

SPECIAL STUDIES PROGRAM
THERAPIST: Mrs. Edelstein

BI-MONTHLY RECORD-INTEGRATING TEACHERS
Student_____

Please record how you feel your student has been functioning for the month underlined

S for September	F for February
O for October	M for March
N for November	A for April
D for December	Ma for May
J for January	Ju for June

	poor	fair	good
1. Communicates with teacher			
2. Communicates with students			
3. Understands direct communications			
4. Answers direct communication			
5. Usually can be reasoned with			
6. Controls aggression			
7. Responds appropriately to situations			
8, Works independently			
9. Works in a group			
10. Follows directions			
11. Completes projects			
12. Acquires new abilities			