

PARENTS, THE ESSENTIAL PARTNERS IN THE HABILITATION OF CHILDREN WITH HEARING IMPAIRMENT

Judith I. Simser, O.Ont., Cert AVT
International Consultant in Childhood Hearing Impairment

©First published in the *Australian Journal of Education of the Deaf*, Vol.5, 1999

Introduction

In the past thirty-five years revolutionary technological changes have occurred in the education of children who are hearing impaired. Although amplification devices have improved considerably and a more diverse range of educational options is currently available, the needs of parents of children who are deaf continue to be remarkably similar across the span of time.

This article will focus on what I have learned about guiding and supporting parents through the odyssey of parenting a child who has impaired hearing. The perspectives presented are derived from my being both a parent of a profoundly deaf son and a professional educator of the deaf. I will also relate some of my experiences over the past 25 years while developing programmes in Canada and Taiwan. Thus this article will have greater practical and clinical implications than theoretical research applications.

Although much of what will be discussed will benefit parents choosing any methodology, I will relate my experiences using the auditory-verbal approach. That was the approach presented to my husband and me at the time of detection of our son's hearing loss. We chose this approach based on very little knowledge but it seemed the most natural for our family. We understood that we would be our child's primary "teachers" and we knew that we wanted him to remain at home with us. Such a simple beginning to such a complex journey.

A. The diagnosis

The etiology of about fifty-percent of children with congenital hearing loss is unknown and around ninety percent of children who are deaf are born to hearing parents. As a result most parents have not had any previous experience in parenting a child who is deaf. At the time of diagnosis of their child's hearing loss, parents are given often too much technical information and too little counselling. This may be due to a professional's time constraints or due to a lack of counselling expertise. Parents may retain little of what is said at such an emotional time. I remember vividly as the otolaryngologist took a quick look into our son's ears, saying that his hearing loss was permanent and that nothing could be done. Along with very technical information from the audiologist, the impression was given that our child could not hear anything. "No response on ABR," or "Your child has a profound hearing loss," sounded so final! Such a feeling of frustration and helplessness prevailed. Everything seemed so foreign. Naturally, parents may feel ill equipped to help their child and that the solution is outside their spectrum of ability. Thus with a sense of anxiety parents turn to professionals to teach their child. It is like plunging parents into a totally new profession without any training! Coupled with that are many of the emotions of inadequacy, anger, guilt, vulnerability and confusion, so well defined in Luterman's, "The Young Deaf Child".¹ Parents are then asked to visit various programs and choose "a

¹ Luterman, D. (1999), *The young deaf child*. Baltimore, Maryland. York Press, Inc.

future" for their child. Never is a family so ill equipped for such a challenge. As professionals we may ask ourselves why parents "shop" to enter many programs, why they doubt their abilities to chose, and why they want a professional to assume the responsibility of teaching their child. For most parents, the consequence of learning that their child is deaf results in a series of challenges. Conflicting statements and emotions abound and anxiety drives decisions. At such a time it is difficult enough to be functional, rational and to accommodate the vital tasks of family and career management, let alone make serious decisions about a child's future in the face of such confusion and doubt.

B. Diagnostic therapy

With improved technology in hearing aids and with the availability of cochlear implants and frequency transposition hearing aids, the vast majority of children with hearing impairment now have hearing potential. This enables them to learn to listen and develop spoken language. It has been my experience, that most hearing parents choose a methodology which will most resemble the communication modality of the parent. With the available technology most children can learn to listen and speak, enabling them to converse with spoken language within their family constellation. If auditory skills are not developed early, it becomes much more difficult, if not impossible, to develop them later in life.

When parents participate in a diagnostic program which is suited to determining the best approach for a child, they will gradually learn about the theories, techniques, hierarchies and technical jargon. If the diagnosis is insufficient hearing potential to access the speech spectrum, parents can choose between cochlear implantation or a more visual approach for their child.

Technological and medical devices only give children physical access to hearing. Whether or not children learn to use this hearing depends on the program which follows and the vital partnership of parents and their therapists. Ideally children should learn to listen and to develop spoken language while in the security of their own homes. This occurs by interacting with significant others in a similar way to which hearing children develop spoken language.

C. The power of parents

In an early intervention program the main client is the parent! Parents are with their young child most waking hours. This enables them to create listening and language opportunities during their daily interactions. They know their child best and are needed to provide information that will make intervention more effective. Parents have a sense of caring that cannot be matched. They will be the one constant in their child's future. **The family is one of the most influential forces in human life. How we educate, nurture, guide and support parents of children with hearing impairment will significantly impact upon the development of that child.**

D. Teamwork

Through teamwork with the parents, social worker, audiologist, physicians, classroom teachers and therapists, the knowledge, understanding and confidence of parents increases. Parents need a united team to counsel, encourage and coach them. Initially the greatest assistance for parents may be in interpretive sessions where they meet each member of the team individually. This is a time to listen to parental concerns and deal with issues that parents perceive as important. Meeting other parents in the program is often useful but only if the new parents agree. It should be noted that at this time some parents are not yet prepared to expose or share their emotions.

E. Family characteristics

In order to understand the feelings, thinking and actions of parent's we need to consider the varying characteristics of families that affect family functioning. These include:

1. The composition of the family. In today's society there are a variety of family constellations affecting the care of the child. This in turn will impact planning. A constantly changing caregiver will affect the continuity of the interaction and may make it more difficult to set common goals. It must be established who is the primary caregiver and encourage their attendance at sessions.
2. Cultural and religious differences. It is important for the staff to become aware of cultural influences on parenting, and to be sensitive to individual styles. In Taiwan, where I presently live and work, the grandparents make most of the decisions and are often the key caregivers for their grandchildren. Many do not speak Mandarin Chinese, the language used in all the schools. Parenting roles, expectations and attitudes towards disabilities often differ from other societies. It should be noted however, that these parents, as I have discovered with parents everywhere, have become exceptionally eager to learn and adapt for the optimal development of their children.
3. Level of education and socio-economic status. When a team communicates with the family at their level so that information is accessible and desirable, then nearly all families can learn. Occasionally a family with great financial security may expect that someone else will teach their child and that services can be bought. This may require greater sensitivity by the therapist in encouraging the parents to take an active and rewarding role. At our clinic the same rules for attendance apply to all. Each family is expected to attend a one hour session per week for the parents and caregiver, (if applicable), as well as other regularly scheduled groups deemed desirable for that family.
4. Sources of support. The program staff can create groups as needs demand. This will be elaborated upon in another section.
5. The nature and severity of the disability. The degree of hearing loss, the challenge of additional handicaps, the personality of the child, can all alter the intervention plan. Parents frequently muse, "If only" ... "If only their child... had more hearing, was more sociable, could pay more attention, wanted to speak." They muse, rather than remaining focused on their child as he/she presents. The family of a child with a mild or moderate hearing loss and his/her parents are often neglected in emotional support and even financial support. These parents will go through the same initial challenges that all parents go through. The stigma associated with hearing aids is not easily accepted!
6. Individual personality factors of each parent and parents' attitude to child rearing and parenting role. Each parent brings to the parenting role a separate and distinctive history of customs, attitudes towards parenting, beliefs, hopes and expectations. Often the personalities of each parent differ, just as they do with each successive child. Behaviour problems often result from different attitudes to child rearing and the challenge of adapting to children's diversities in thinking and acting. The personality of the therapist will also add to the dynamics.
7. The family's experience and adjustment to earlier crises. The additional stress on a marriage can strengthen or weaken a marital bond when there is already discord prevalent. Some families have positive experiences in problem solving through a crisis and have grown stronger from the experience. Other parents will need help with an immediate crisis. The therapist or the social worker, (if available,) needs to differentiate between offering direct assistance or referring the parent to a community resource.

Each family and child is unique and they bring to the process of habilitation a wonderful challenge. The challenge is how to meet each family's variable needs and to work together in nurturing their child's special potential.

F. Parents as participating partners

We learn by observing and listening, but mostly by doing! For many years I observed many willing, eager and capable parents excluded from decision making and participating in their child's programs. It was due to this frustration and my strong belief in the power of parents that I became a professional in the field of deaf education. For any child's therapy program to be effective, parents must not just observe, but participate. As therapists, our goal is to guide parents to develop positive parenting techniques and encourage parents to become case managers for their children until these children can self-advocate.

G. Individualised auditory-verbal sessions

One of the principles of Auditory-Verbal therapy is that there be individualised diagnostic therapy with parent participation². By individualising therapy, therapists are able to adjust the program to account for differences in a child's and a parent's personality, their learning styles, their interests, the degree of handicap and current functioning level of the child. In therapy sessions, a favourable learning environment is created for the parent and child. Good acoustics, few distractions from others and a child in the presence of positive role models are needed. Toys in a therapy program should replicate the real activities in a home environment. When the parent and child return to their home and community, they have ample opportunity in a natural setting to practice the skills and activities that they learned in therapy sessions. It is beneficial for the therapist to make the occasional home visit so that each family's home environment and living style is considered in therapy planning. Activities that replicate a specific family's routine activities in the home and community will foster the use of incidental language throughout their day. Children learn by a parent/caregiver integrating the structured targets that are unrecognised by the child, into to the child's daily life. Therapy activities need to reflect activities of the family routines. Examples include:

- String up a clothesline between two chairs. Wash and hang out the doll's clothes,
- Buy fruit at a market. Return to the therapy session. Cut up the fruit and offer it to other children.

In our clinics in Taiwan there are situational therapy rooms: a bedroom, a living room and a kitchen to replicate those settings in the home. Parents are often nervous about children being in the kitchen. Parents learn that the kitchen has a wealth of listening, vocabulary and language learning opportunities when engaged in activities such as: making cookies, pudding, playdoh, toast with facial parts drawn with butter, cutting vegetables and sandwiches, making simple picture-drawn recipes. Many of these activities can be recreated in any therapy room!

H. Location of sessions

The auditory-verbal approach can be applied everywhere! Sessions can be held at the park, at the mass rapid transit station, at the local market or shopping centre or simply during a walk in the neighbourhood.

I. Why parents participate

It is through participation in therapy sessions that parents practice techniques and targets. They obtain the counselling, guidance and educational support to enable them to become actively involved, thus developing a greater sense of confidence and control. Parents collaborate with the therapist in adapting play activities to their child's interests and abilities. They interpret the meaning of their

² Auditory-Verbal International, (1991), *Guiding principles*. Auricle. Fall Vol.3. Alexandria, VI.

child's communicative attempts. Parents serve as a communicating partner in responding to a variety of linguistic features such as answering questions and using pronouns. Parents help to model communication techniques such as: turn taking routines, postures to promote thinking and listening, pausing and responding. By participating, parents gain insight into the forthcoming stages of development of their child. As parents develop their skills in active and critical listening, they learn to see the constant interplay of targets. Any one event can incorporate targets in listening, speech, language, cognition and communication. Targets and specific examples are given to parents/caregivers and classroom teachers to co-ordinate efforts and to build upon listening basics. When parents learn how to integrate auditory-verbal techniques into everyday meaningful activities and experiences, their children have the best opportunity to develop a good listening and language outcome. Parents can become the professionals' greatest allies. To ignore their contribution is to compromise a child's future.

Therapists may discourage a parent's participation because often it is easier for a therapist, (as an authority figure) to maintain control of a child without a parent in the room. However, it is not the number of teacher contact hours that develops a child's language! Nor is it the number of hours sitting at a table doing "therapy". It is not the quantity or quality of toys. It is not a set curriculum dictated by boards of education, as most early language learners do not have sufficient language to access that curriculum. How can a child follow established academic subjects when a child is unable to request needs, explain feelings and observations, or use language to communicate and to learn? A foundation of language is developed through natural interaction about subjects that are meaningful and interesting to a child. A parent's work is a child's play!

An individualised program, suited to the parent and child's needs, is created through ongoing assessment and teaching; as well as the teamwork of parents and therapist.

Parents are instructed in techniques to be the primary language facilitator for their child. Parent's active participation in therapy sessions can be reinforced by the therapist in the following ways:

- stating the goal to the parent before beginning an activity.
- modelling strategies clearly.
- beginning the activity then turning it over to the parent.
- providing encouraging feedback to parents.
- discussing how the parent would implement goals in other environments.

J. Parent progress

There are a variety of ways to assess and guide parents in their interactions with their child. Most methods involve interactional approaches such as in "Bromwich's Parent Behaviour Progression Form".³ Parent behaviours during different stages of their infant's development are recorded as observed or reported during conversations with the staff. In Cole's book, she provides a checklist for "Caregivers: Communication-Promoting Behaviours." This lists desired observations during interactions between parent and child.⁴ These forms can provide a framework for further discussion between therapist and parent.

³ Bromwich, R. *Working with parents and infants*, Baltimore, MA: University Park Press. p.341-359

⁴ Cole, E. (1992). *Listening and talking: A guide to promoting spoken language in young hearing impaired children*. Washington, DC: Alexander Graham Bell Association for the Deaf. p.48-50

K. Observe parent-child interaction

Frequently therapists will benefit from asking parents to bring some materials and activities from home. The parents then play with their child while the therapist observes. Some parents may prefer that the therapist watch through a one way mirror if possible. Sessions can be videotaped for discussion later. To build on the parent's strengths it is important for the therapist to emphasise the effective content and techniques which the parent uses. Then by modelling, the therapist can help the parent grow in skills and confidence. Many an anxious parent may succumb to the trap of continually testing their child. This often leads to parent-child conflict. It is suggested to leave the assessment to the therapist so parents can more readily follow their child's lead and develop a mutual trust in play.

Through parent's participation, the therapist assesses and coaches the parents/caregivers in a variety of techniques and skills during weekly sessions. Parents are assessed in the following:

1. Use of parentese. "Motherese" or "Parentese" is speech used by parents/caregivers in talking with young children to make speech more perceptible. This helps them in learning language. Research by Dr. Kuhl indicates that parentese is universal and plays a vital role in helping infants analyse speech.⁵ Regardless of age, a beginning child with a hearing loss and without language, is much like the hearing baby in that he/she is in the process of learning language. The use of parentese is a form of acoustic highlighting; an auditory technique that is extended in communicating with these beginning hearing aid or cochlear implant users to increase the audibility of spoken language. Speech is slightly slower, with lots of repetition, (but NOT single words as there is insufficient time to process them.) Language is meaningful, useful, and grammatically one stage ahead of the child's level. As a child learns to listen, the aim is to progress towards a more normal, less highlighted mode of communication.

Examples of acoustic highlighting are as follows:

MORE AUDIBLE	progressing to	LESS HIGHLIGHTING
(for a beginning child)		(for a child who is listening well)
No background noise		Increased background noise
6" from hearing aid or cochlear implant		Increased distance
Simpler language with shorter phrases		Complex sentences
Emphasis on key words		No emphasis on key words
Emphasis on unaccentuated words, (prepositions, articles)		No emphasis
Word position in sentence		
End of sentence	Middle	Beginning

⁵ <http://rainier.sphsc.washington.edu/sphsc/faculty/innews.htm>

Closed set	Open set
Slightly slower rate	Normal rate
Increased pitch variation and rhythm, (sing what you say)	Normal rhythm
Clearer enunciation (use of “clear” speech)	Less clear and/or unfamiliar voice
Increased repetition	No repetition
Greater acoustic contrast (vowel variation, rhythm contrast)	Less varied, (minimal pairs, same number of syllables)

However, having reached the goal of less highlighting, it must be remembered that there are many less salient acoustic environments where acoustic highlighting may continue to be necessary as it is with those who have normal hearing.

2. Use of age and stage appropriate targets. Each week, the therapist assesses the child's levels in five areas: audition, speech, language, cognition and communication. Targets developed are based on normal stages of development in these areas and on a hierarchical model, (from most audible to least audible and with increasing difficulty).⁶ Too often a child and his family experience failure because targets are too difficult for the child's stage and do not follow a natural sequential order. In order to build on success, parents need to know how to positively reinforce attainable targets into natural play and routines. Input is provided primarily through audition alone but may be followed by body language and natural gestures when appropriate at a beginner's level. Visual or kinaesthetic cues may be used to supplement hearing but the listening or speech target is then confirmed through hearing alone to facilitate learning through listening in the future. Only through individualised therapy with parents as active participants can a therapist analyse and modify the session to most appropriately determine weekly targets. Diagnostic teaching contributes to the development of weekly, quarterly and long-term goals. This in turn provides a framework in which parents can learn more of their child's level of functioning and future goals. It also supports high but realistic expectations.

3. Behaviour management techniques. Unfortunately, the diagnosis of hearing impairment often disrupts natural interactions between parent and child. Initially, communication may be perceived as difficult. The child may appear not to hear and may be unresponsive. Parents may conclude that their child cannot understand. Little do they realise that 80 percent of communication in the child under three is through body language.⁷ A parent's anxiety may cause them to be overprotective preventing

⁶ Simser, J. (1993). *Auditory-verbal intervention: Infants and toddlers*, The Volta Review, 95, (217-229).
Appendix B

⁷ Manolson, A. (1992). *It takes two to talk. A Hanen early language parent guide book.* (3rd revision.) Toronto: Hanen Early Language Resource Centre.

their child from learning by mistakes. A parent may demonstrate excessive affection and give in to all their child's requests in order to make life "nice" for their child. Or a parent may reinforce negative behaviour that the child has learned in order to gain attention from those he loves. This may lead to secondary challenges in the form of behaviour problems.

Many interventions are employed to assist parents with behaviour management. In therapy, teachers are constantly modelling and reinforcing desired behaviours and coaching parents to identify and reward them. The parent is encouraged to discuss behaviour concerns with the therapist and/or social worker. It may be suggested that behind the one way mirror, the parent and social worker observe behaviour techniques used by the therapist to develop a child's control and inner discipline. Parents may join parent groups dealing with behaviour challenges and learn through each other's suggestions. Parenting groups held at churches, community centres, or schools can be most reinforcing. Parents of deaf children may find it refreshing to note that most of the problems they are having are common to families of hearing children! As a team, the therapist, social worker and parents decide on a few positive changes to make each week in the quest for the child's development of self-control. Therapists observe the parent's use of encouragement techniques, the effectiveness of their body language, and their ability to positively reinforce their child's desired behaviours. There are times when the therapist and parent may find that role-playing certain difficult situations may prove helpful.

4. Expectations. When I arranged our first parent group in Taiwan, I inquired as to the expectations parents had for their children. The answer was, "Not too high as we don't want to be disappointed." Low parental/teacher expectations are a deaf child's greatest handicap. With today's technology, early detection and effective intervention programs; parents and professionals need to rethink their expectations for our deaf children. Most of these children should grow up as independent and confident communicators, with the same choices in future education, interests and employment as other youth.

5. Integration of targets into everyday routines and experiences. To develop listening as part of a child's personality,⁸ auditory-verbal techniques and goals need to be practised throughout the day. The goal is to develop listening to the extent that a child listens to learn.

L. Parental support and resources

Where can parents gain vital support? As outlined earlier, the family unit is the hub of support for the child, whether it happens to be positive or negative! This encompasses the spouse, other siblings and the extended family. The child's therapist and social worker provide not only direct support but can arrange many other sources as deemed appropriate. Meeting other parents who have similar characteristics and interests, observing other sessions, attending various parent support groups and effective parenting courses may provide guidance. Organised play programs such as play groups and nursery schools allow parents a regular weekly time for themselves. Local and international organisations, (such as the Alexander Graham Bell Association for the Deaf and Auditory-Verbal International) have parent sections in their journals and parent-centred topics at conferences. Private counselling may be beneficial at times. The therapist can help parents in recognising when counselling maybe useful, in retaining a resource file and encouraging them to seek help when needed. There is a

⁸ Pollack, D., Goldberg, D., & Caleffe-Schenck, N. (1997). *Educational audiology for the limited-hearing infant*. Springfield, IL: Charles C. Thomas (3rd Edition).p.141

wealth of articles, books, and videos. The parent listserves⁹ of the internet now assist parents via a support network. They represent parents from all over the world, from different situations and with many years of experience.

M. Parent supporting parents

As stated previously, one of a parent's best sources of support and guidance can be from other parents. There may be a wide variety of parent support programs.

1. Newly diagnosed families meeting with experienced parents.
2. Small parent groups with common interests. In Taipei, due to a co-operative program in infant screening with a local hospital, many infants have been fitted with hearing aids and attend the A-V program at the Children's Hearing Foundation. To better accommodate the needs of such young babies and their families, a "Baby Group" was formed. Parents meet together bimonthly to discuss common aspects of their special babies and to support one another. Therapists and/or the social worker facilitate the sessions. Babies have one to one auditory-verbal sessions once monthly in their homes or the clinic. From 8 to 9 months of age individualised therapy sessions begin once weekly.
3. Parents helping parents. Parents, who have successfully graduated from the program, volunteer to assist new parents. They attend in-service sessions sponsored by the social worker to guide them in how to help new families. Graduate parents are matched to new parents with similar family dynamics. The helping parent attends the family's therapy sessions to work on common objectives. Often the parents benefiting from additional support in their home may be immigrants, those who do not speak the chosen language for their child, single parent families, or those who are experiencing difficulties and asking for additional help. In Ontario, Canada, this parent program has been financially supported by the government under the auspices of social services.
4. Parents leading story telling or theatre group activities for small groups of deaf children.
5. Groups for parents who are having challenges and feeling the need for additional support.
6. "Mainstreaming" preparation groups to acquaint parents with school selection, classroom acoustics, FM systems, curriculum, teacher and principal liaison and child preparation. During the summer months, the children meet daily for one to two weeks with hearing children from a local school. They create and experience a future school setting before they enter the system in the fall.
7. Integration groups for parents of children already in the mainstream. This helps them problem solve and to guide each other.
8. Parent groups for the A-V program. A questionnaire provides insight into the perceived needs of parents. They rate suggested topics and offer suggestions. Topics such as parenting, communication approaches, behaviour management, mainstreaming, audiology, auditory learning, development of language, creating language opportunities, speech development, siblings and the teenager who is deaf, have been the focus of sessions. Parent groups are held every six weeks. It has been my experience that for parent groups to be successful on a continuing basis they need to

⁹ CI Circle, send message to majordomo@mysql.maxbaud.net. Type "subscribe cicircle".

be strongly supported and encouraged by professionals. Having a guest speaker for part of the meeting may motivate parents to attend and will allow for some new learning to take place. Small group interaction and long refreshment breaks will allow for the all-important parent to parent interaction and the opportunity for incidental guidance and support.

9. Social family activities. Parents gain much knowledge and practical help from gatherings that encourage a relaxed recreational activity together. Weekend camps, outings and special holiday events allow for parents to gain from one another's experiences in an informal environment.
10. Teen groups for youth who are deaf. No parents allowed! With a teacher as facilitator, these small groups allow for the all-important sharing of mutual challenges that these individuals experience daily. Social outings, which include larger groups of other children who are deaf and siblings with normal hearing, have proved to be popular and beneficial.

N. Parent counselling and coaching

1. Take time to develop a relationship between parent and therapist. Silence is sometimes difficult to endure but necessary if a therapist is to listen empathetically. Provide opportunities for parents to channel feelings and ask questions. Try to be objective and refrain from making judgements. Ask yourself why a parent is presenting this challenge and try to walk in their shoes. I have often said that only another parent of a deaf child can truly understand how a parent may feel. However, a team member can counsel and coach a parent successfully if they are sensitive to a parent's primary needs and priorities.
2. Parents need to be aware of all options and to make informed educated decisions. Being persuaded absolves parents from responsibility. Parenting is a challenging role: a parent makes choices for their child until the child can do so for him/herself. Although a professional may empathise with a parent's difficult position, parents will ultimately be the primary decision-maker on behalf of their child.
3. Parents need to participate in the intervention plan. Before a parent can begin to co-operate they require full, honest information to understand what is being recommended. Parents practise problem solving by discussing a variety of options with the therapist. When they have choices, parents are less likely to experience failure if one suggestion does not work for that family. When parents present obstacles to parenting or habilitation follow-through, begin to address these problems with the smallest and most basic intervention. Small increments of change can collectively lead to a great amount of change.
4. Parents need to enter into a contract setting out an agreement on common goals. The therapist should encourage parents to have high but realistic goals. We can predict but can never be certain as to what levels a child will attain when learning to listen with hearing aids and/or a cochlear implant. This is why diagnostic teaching is such a critical component of the auditory-verbal approach.

Attempt to attain some element of success for parents and child. It is important to know why therapists are doing specific activities. It is imperative that parents know what targets to reinforce

next. It is not useful to know what they or their child are not doing! They are probably only too aware of that. Parents require ongoing encouragement to help them through the cyclical changes in progress and resultant changes in self-esteem.

5. Parents respond to realistic hope! They become inspired when they meet and listen to students who are stages ahead of their child or have been through the process of developing spoken communication.
6. Try to encourage a positive attitude towards life in both parents and children. Acknowledge that deaf child will experience many daily challenges along each step of the way. Learning how to identify, analyse, initiate change in small increments and gradually solve problems, are the stepping stones to a life time of adaptation.

Conclusion

It seems appropriate to end with advice from parents. Firstly, a parent with suggestions to professionals. Then words of wisdom from one dedicated parent to another parent whose child was recently implanted.

From parent to professional

- When you give me large amounts of information, provide me with some means of later review, (summaries made by you, prepared handouts, a tape of the conversations), so I may ask questions later.
- Encourage me to take notes if we see one another regularly.
- Encourage my questions. Don't dismiss them as unimportant. Listen to me.
- Always have a positive word about my child and about my efforts. I need these to keep me going.
- When pointing out a fault in my child, avoid anecdotes about how you or someone else raised children so they never showed such flaws. (Don't tell me how poor a parent I am.)
- Tell me your concerns but be open to any opposing views I may have.
- Don't play, "I know everything of value and I will bestow this knowledge on you." Assume I'm intelligent unless I prove otherwise.
- Don't raise your eyebrows if I ask a seemingly dumb question.
- Be willing to explore new options with me. Perhaps a method you have not yet tried is best for our family.
- Never gossip about my life/child to others.
- Don't be judgmental. I won't trust you.
- Ask me how I feel about things.
- Don't make calls to other professionals I see, (e.g., counsellors,) without my permission.
- If I choose not to become involved in groups that you feel are "good for me," explore why. Perhaps I am overwhelmed. Perhaps I need some privacy.
- Don't dwell on the problems my child will experience 10 years from now unless there are medical concerns. I have enough to worry about today. I will ask you when I'm ready.
- Avoid "I told you so."

From parent to parent.¹⁰

"I am a Mom to two children with cochlear implants, (C.I.). Jessica is 5 and has had her CI for three years now. She is in mainstream kindergarten and loves taking ballet. She is a regular kid in every respect, except that she uses a microphone, computer and internal hardware to hear! Jared is 2 and has had his CI for nine months, (he was 18 months old when he received it). He was diagnosed early (at birth) and got an early start in hearing aids, (five weeks). He didn't enjoy any benefit from hearing aids but he is now nine months post implant and has just topped 100 words. He's putting two words together and several of his words are very clear. We are in the process of completing several different evaluations right now, but it appears so far that Jared is only about 6-8 months behind his chronological age, which is incredible given that his hearing age is only about nine months. We travel 200 miles round trip each week to see our therapist for the children's therapy. We have been making this trip for three and half years now and I can honestly say that I am tired of the drive. It is a necessity though as the therapists we see have wonderful experience and a good relationship with the kids.

I think some of the things that have contributed to our successes with the cochlear implant are: our choice of educational methodology, our children's early implantation ages, our commitment to therapy, and most importantly, our issues at home. If there is a way to milk an experience for language we'll find it. We have a separate "stash" of toys that are for therapy only. The kids are motivated to play because they don't get to play with these toys unless they're involved with Mum or Dad. We also make everyday errands into language trips and these are tailored to each child's level. For example, a trip to the grocery store for Jessica means that in the produce section, I tell her four items she needs to find, (working on auditory memory length in background noise). For Jared, it is an experience in learning the vocabulary-banana, grapes, lettuce, broccoli, etc. I think another thing that has really helped us is to take advantage of every possible opportunity, (near and far) to attend workshops and conferences. Not only do you benefit from the featured presenters, you come away re-energised and full of new ideas to take home. One of the most rewarding parts of attending conferences is the opportunity to network with families across the country just like your own, who are trying to make it all work out. There are also a lot of great books and videos available.

There is so, so, so much you can do to make language a part of every day and every household experience. It takes extra time, (lots of it), and loads of patience, be sure of that-but it is so worth it. I am reassured of that every time I hear Jessica sing, tell me a long story, tell me how much she loves me, teach Jared his language games, talk to her grandparents on the phone, interact with her friends. The list goes on and on of the joys we have seen in this journey."

REFERENCES

- Auditory-Verbal International. (1991). *Guiding principles*. Auricle. Fall Vol.3. Alexandria, VI.
- Bromwich, R. (1981). *Working with parents and infants*. Baltimore, MA: University Park Press.
- Cole, E. (1992). *Listening and talking: A guide to promoting spoken language in young hearing impaired children*. Washington, DC: Alexander Graham Bell Association for the Deaf.

¹⁰ Hill, Andrea. Madison, AL

- Ling, D. (1989). *Foundations of spoken language for hearing-impaired children*. Washington, DC: Alexander Graham Bell Association for the Deaf.
- Ling, D., & Ling, A.H. (1978). *Aural habilitation: The foundations of verbal learning*. Washington, DC: Alexander Graham Bell Association for the Deaf.
- Luterman, D. (1999). *The young deaf child*. Baltimore, Maryland. York Press, Inc.
- Manolson, A. (1992). *It takes two to talk. A Hanen early language parent guide book*. (3rd revision.) Toronto: Hanen Early Language Resource Centre.
- Pollack, D., Goldberg, D., & Caleffe-Schenck, N. (1997). *Educational audiology for the limited-hearing infant*. Springfield, IL: Charles C. Thomas (3rd Edition).
- Simmons-Martin, A.A., & Rossi, K.G. (1990). *Parents and teachers: Partners in language development*. Washington, DC: Alexander Graham Bell Association for the Deaf.
- Simser, J.I. (1993). *Auditory-verbal intervention: Infants and toddlers*. *The Volta Review*, 95, (217-229).
- Simser, J., & Steacie, P. (1993). A hospital clinic early intervention program. In A. Phillips & E. Cole (Eds.), *Beginning with babies: A sharing of professional experience*. Washington, DC: Alexander Graham Bell Association for the Deaf.
- Stokes, J. (1999) *Hearing impaired infants: Support in the first eighteen months*. Washington, D.C. Alexander Graham Bell Association for the Deaf.