

ONE GREEK MIGRANT FAMILY AND THEIR DEAF CHILD

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Introduction:

The sense of alienation, despair and hardship experienced by individual migrant families is often forgotten when discussions of migrant problems focus on general issues. This is an account of the experiences of one Greek family with two sons. The oldest, aged eight at the time, was healthy and progressing well at school unlike his younger brother who, although attending kindergarten was 'not talking'. Their parents, both factory workers, were migrants from rural Greece who had high expectations for their future in their new homeland. Unfortunately, life was to be fraught with misfortune. Not the least of this misfortune was a direct result of the insensitive welfare, medical and educational services of this state.

* * *

It has only been during the past few months that I have become involved with the disability of deafness. I received a referral from a local kindergarten in the Richmond area. They had a four and a half year old Greek boy attending the kindergarten. He was not talking. He was emitting loud screeching noises and was not relating to the other children in any way. The only activity that gained his attention for a few minutes were jig-saw puzzles.

The kindergarten teacher was very concerned. She could communicate a little with the parents and understood that they too were concerned. They had consulted Greek and Australian doctors and hospitals. They had sent the boy to Greece to his grandparents, hoping that a change of climate would help him, but he was still not talking. At the stage of referral the parents had refused to attend speech therapy classes, suggested by one hospital, as they felt these were of little value. The kindergarten teacher thought they were "babying" the child, and

she wondered whether he was severely retarded and what the future educational arrangements should be for him.

The initial meeting with this family took place in the kindergarten itself. A Greek speaking social worker introduced herself to the father and chatted in Greek, generally about the kindergarten. The conversation slowly focussed on his child, and he expressed his concern that the child was not talking. The social worker commented that the kindergarten teacher was also concerned and asked whether medical advice had been sought; then gave a simple explanation of the help that could be provided.

The social worker arranged to visit the family at their home, and there met the mother who was very willing to discuss her worries about their child. She said that everyone they had consulted had indicated that there was nothing wrong with him, and that "he would grow out of it". He would eventually talk and they were rebuked for being over-anxious. She eventually said "We think there is something wrong — after all, he is our child."

The next step was to offer assistance as an interpreter. The social worker attended interviews and consultations at the Royal Children's Hospital. The parents had in fact made arrangements, prior to the social worker's involvement, to take the child there. While attending these appointments a close relationship developed between the parents and the social worker, who learnt to sense their reactions and feelings, and to understand the family interaction. To reinforce the Royal Children's Hospital contacts the social worker began to co-ordinate these by eliminating others which seemed to be at cross purposes, or overlapped (e.g. psychological assessment at the baby health centre, and contact with a local G.P.). This was done with the parents understanding and cooperation.



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The crisis in the case came when the audiologist diagnosed deafness. The parents reaction was one of disbelief. At last they had been told what was wrong, but now did not believe it! Why should they, if so many doctors, hospitals, etc. had said there was nothing wrong? How could they understand “damage to the auditory nerve — an irreversible condition? How could they understand that the child would not benefit from corrective surgery? How could they understand that the child could hear middle range tones, thus giving the impression that there really was “nothing wrong” with him? Their knowledge of the physiological processes of the body was limited. To make matters worse the information was being provided by “strange Australian doctors”.

They wanted to understand the cause of the deafness. One doctor

dismissed their questioning as being “academic” — yet if they could have understood the cause they may have accepted the diagnosis more readily. The calm, patient, tolerant interest and accessibility of the audiologist at this stage was crucial. This, coupled with the social worker’s relationship and the kindergarten teacher’s warmth and encouragement, helped the parents to eventually accept the diagnosis.

There was evidence that there was a tension in the marital relationship. Mother reacted positively to the wearing of the hearing aid, father appeared not to. The kindergarten teacher noted that the child threw the aid down as soon as the father walked into the room. Was he sabotaging the attempts to help his child? Attempts were made to help him by talking about changes in the child’s behaviour. As yet, he had

not let the family and close friends here, or in Greece, know of the disability — the Greek derives pleasure from another’s misfortune, he claimed. This is a typical Greek reaction, for any disability carries a stigma. Blum & Blum¹, make the following point about the Greek villager’s attitude to a disability which is considered as a “shameful illness”.

“One consequence of all shameful ills is the expectation that one’s enemies will rejoice in them: one’s misfortune is the pleasure of his foes. Thus a shameful ill is a public weakness that gives a social victory to one’s enemies.”

Following the fitting of the hearing aid the child was enrolled at the kindergarten for the deaf. The social worker accompanied the parents when they paid their first visit to the kindergarten. It was a shock to find that no information had been forwarded to the kindergarten from the Special Service Division about this case. As a consequence, the head mistress was unaware of the difficulties inherent in the case, and the importance of creating an encouraging, receptive and understanding atmosphere on this first visit. The headmistress, having experienced difficulties with other Greek families, made statements which in effect stereotyped these parents and increased their anxiety. Were it not for the social worker’s relationship with the parents, they may have withdrawn the child from the kindergarten — at a stage where they were negotiating to purchase a house close to it, indicating their increasing acceptance of the disability. The headmistress stressed that they were to understand that:—

- (a) their child was deaf and dumb — and that he would probably NEVER talk proficiently;
- (b) they were not to waste their time seeking other advice;

- (c) they should not take the child to Greece for further assessment;
- (d) they were to speak to the child in English — it would be less confusing than attempting to develop a bilingual competence . . .
- (e) was the child toilet trained? It was difficult for the teachers if he was not;
- (f) sandwiches were to be provided for the child's lunch as there were no facilities to provide hot food;
- (g) he was to travel in a taxi to and from the centre, and be given permission to participate in excursions;
- (h) forms and information handed over were in English.

These were understandable reactions from a headmistress who had previously experienced a great deal of frustration in coping with migrant families who had deaf children. But these reactions did not take into account the following factors:—

PRIOR EXPERIENCES OF THE FAMILY

The experiences of these Greek parents, in Australia, with professionals and this includes Greek professionals, had been negative. There had been no-one sufficiently interested in the family to ensure follow-up. The child could have been at a kindergarten for the deaf at least one year earlier, if more persistent efforts were made to establish a diagnosis and to formulate management plans. One hopes that this does not reflect a general lack in services!

There was little understanding of the social and migration background of these parents who had changed their pattern of living from a familiar rural to an urban setting in an alien community. For instance, while these parents had some prior contact with an

Australian kindergarten, their prior Greek experiences would not enable them to understand the potential for the child's development offered by a 'special' one. Their knowledge and understanding of deaf and dumb children was negligible. Information given by a Greek publication in 1970² suggests that in fact very little provision is made in Greece for the training of deaf children.

The following information is provided by this publication:—

“THE DEAF & DUMB”

As in the case of the blind, there is an almost complete lack of information concerning the deaf and dumb, who are estimated by the Ministry of Social Services to be between 8 and 9 thousand people, of whom 10-12% are estimated to be children.

The State offers no direct services for the deaf and dumb, but subsidises a voluntary organisation, the National Society for the Protection of the Deaf and Dumb. This society runs five schools with a total of 985 places, for the primary education of deaf and dumb children. The schools are situated in the following areas:

1. In Greater Athens	150
places	
2. Macedonia	320 places
3. Thessaly	15 places
4. Peloponnese	500 places
—————	
	985 places
—————	

Apart from evening classes which are given in the Athens school, there are no provisions for the adult deaf and dumb. It is difficult to imagine how an individual can be more cut off from human society than by lacking the faculties of speech and hearing, and the

unhappiness which this must cause should be relieved by every possible means. The fact that the deaf and dumb, when trained to communicate with others, can lead an almost normal life and take a useful position in society, makes it imperative that they should be assisted to attain this position”.

It is comprehensible that these parents would wish for a reversible cure to their child's condition rather than having him participate in an educational setting which they did not understand.

ACCEPTING THE HANDICAP

It was intriguing to read Dr. Gorman's advice³ to a meeting at the Princess Elizabeth Kindergarten for the Deaf & Dumb in 1960, where he said “One of the biggest problems for the parents themselves is to accept that their child is deaf”, and he pleaded “Please do not waste your time running from doctor to doctor, hoping that some miracle man will eventually be able to restore the hearing of the child”. This is an even more understandable reaction from migrant parents in a foreign environment who have little trust in foreign doctors and who will undertake a trip to their homeland to seek further medical opinions. Greek parents have a strong desire to do all they can for their disabled child, thus they will undertake an expensive trip to their homeland to see other medical opinions in a familiar, less threatening environment. It is easy to judge these parents harshly because of this. During a telephone conversation concerning a similar case a hostile medical officer said that a Greek family, who were in financial difficulties as the result of such a trip, had no further right to expect further help from Australian personnel because of their stupidity!

LANGUAGE DIFFICULTIES

Certainly Australian professionals could point out the problems

of communicating with this family, and this is a difficulty. But what actions are these professionals taking to ensure the provision of trained and competently bilingual interpreters within their work settings? It is very easy to speak disparagingly of the migrant who cannot converse in English, but it is criminal to withhold efficient service until he does. It is also dangerous to presume that "they understand more than they let on". Of course the most salient feature, connected to language in this context, is the difficulties experienced in training a migrant deaf child in a foreign language, that is, English. This particular child had some hearing and responded to his parents who conversed in Greek. But it was difficult for this child to respond in an English speaking environment, and even more difficult for the parents to develop some competence in English.

This writer is not aware of any study on the question of bilingualism and deafness. It is understood that the general view is that it is difficult enough to train a deaf child in one language, let alone two. Suggestions are made to the effect that if the migrant parent wants to educate his deaf child in his native tongue then they should seek repatriation to their home-land.

BI-LINGUAL TEACHING

Consideration should be given to developing facilities which offer the migrant parents assistance through which they can encourage their child to speak in their own native tongue. One method could be to develop the training and use of bi-lingual ethnic teachers for the deaf. By this means one area of alienation between the home and training centre could be alleviated. Further methods could be through the provision of instructions regarding the home training of the deaf child to be made available in a variety of languages. Articles on deafness could be simplified and translated to communicate informa-

tion to the migrant parent. Nita Kent comments⁴ that the Shepherd Council "believes that adequately instructed and motivated parents are the major determinant of whether or not a child will ultimately speak and lipread." It may be that cultural and educational factors will preclude the migrant parent from responding to such material effectively and this would need to be researched, but despite this some recognition of their needs will have been made.

CULTURAL FACTORS

The headmistress's statements, during the intake interview, totally ignored the cultural milieu of these parents. The expectation is that migrants will change their cultural attitudes and assimilate into the foreign environment. Simple instances reflect this failure to understand cultural factors. Greek parents place a great deal of emphasis on the need for their children to eat a substantial lunchtime meal. Sandwiches are not known in Greek villages, and are not considered by the migrant to have any nutritional value.

There is a need for understanding what could possibly be regarded as the excessive over protectiveness of the Greek parent, which makes him fearful of allowing the child to travel alone in a taxi, or to participate in excursions which involve contact with strangers. Problems relating to toilet training may be related to this protectiveness, particularly if the child is ill or disabled.⁵ It is necessary to understand the stigma attached to having a disabled child in this cultural group, as has been discussed previously.

One positive aspect of this first meeting was the fact that the whole family was involved in the decision making processes; note Terrington's observation⁶ from her work with retarded children:—

Conspicuous by his absence: "Herein maybe lies a clue to the non-participation of men in the discussion of vital family issues. It would be easy, but over-simplified, to assume that financial reasons kept the men from attending. No doubt in many cases this was a factor, and working hours mean that men cannot readily be available. But it was striking that in migrant families usually in precarious financial circumstances, the fathers were more often present and active in the discussion. Cultural and language factors weighed here; but also, clearly, the sense that they needed to participate because planning and decision making was involved."

This is a pertinent observation and steps must be taken to ensure always that the Greek father is actively involved in any management plans designed for his (deaf) child.

WHAT CHANGES NEED TO BE MADE

Discussions with Australian parents of deaf children indicate that they too experience great difficulties in coping with their child. Not only do they have difficulties in accepting their child's disability, but feel that Australian doctors do not have a full understanding of the needs of the deaf and frequently were late in diagnosing deafness.

The editors' note to "Something Wrong"⁷, a book compiled from experiences of British parents of mentally handicapped children, is extremely critical of doctors, as this extract reveals:—

((The interviews began by asking questions relating to the onset of the child's difficulty and what sort of medical advice the mother had received, in an attempt to assess the process that led to acceptance for special education within the

Unit. It quickly became apparent that many of the mothers had either had a very bad time in the early years, in their attempts to sort out just exactly what was wrong, or were still very mystified as to the nature of their child's handicap and its probable outcome. Interview after interview told of rejection, avoidance and apparent disinterest on the part of the 'experts' when presented with an acutely anxious mother asking for help; time after time the mother's fears and demands were either ignored or dismissed. Many found themselves in completely bewildering situations not knowing how to handle behaviour they felt strongly was not 'normal', at the same time listening to vague reassurances from the experts, for example, "He's a late starter", "He'll grow out of it", "Don't worry". This tendency for those in professional roles to devalue the experience of the mother was the most obvious point to emerge from the first interviews, and with it grew the idea of collecting together the reports of the parents of their encounters over the years with the 'experts'.

If this situation exists between English speaking parents and "experts" the migrant parents feeling of total rejection and alienation would be more pronounced. Therefore there is a need to:—

- (a) generally improve the early diagnostic and screening processes available to ensure that children with handicaps needing special training receive it as early as possible.
- (b) recognise that all community services must take into account the presence of migrant groups in the Australian community

and that provision is made for these groups by an acceptance of the language, cultural and social needs.

- (c) train bilingual professionals, and develop educative programs for Australian professionals which reflect an acceptance of the non-English speaking migrant.
- (d) ensure the provision of trained competently bilingual interpreters who can work with the Australian professional.
- (e) develop innovative educative programmes geared towards engaging the participation of the non-English speaking parent in the management and training of his disabled child.

The onus is on each professional involved in the health welfare and educational fields to take action in these areas if other migrant parents are to be spared the suffering, rejection and anxiety experienced by these parents.

POSTSCRIPT:

This article was originally prepared in 1972. The child described is now severely retarded as a result of complications arising from a tonsillectomy. The parents' sense of alienation, anger, anguish and hardship was deepened by this tragedy as they vainly sought a cure for their child, and redress from the hospital they thought negligent in this matter.

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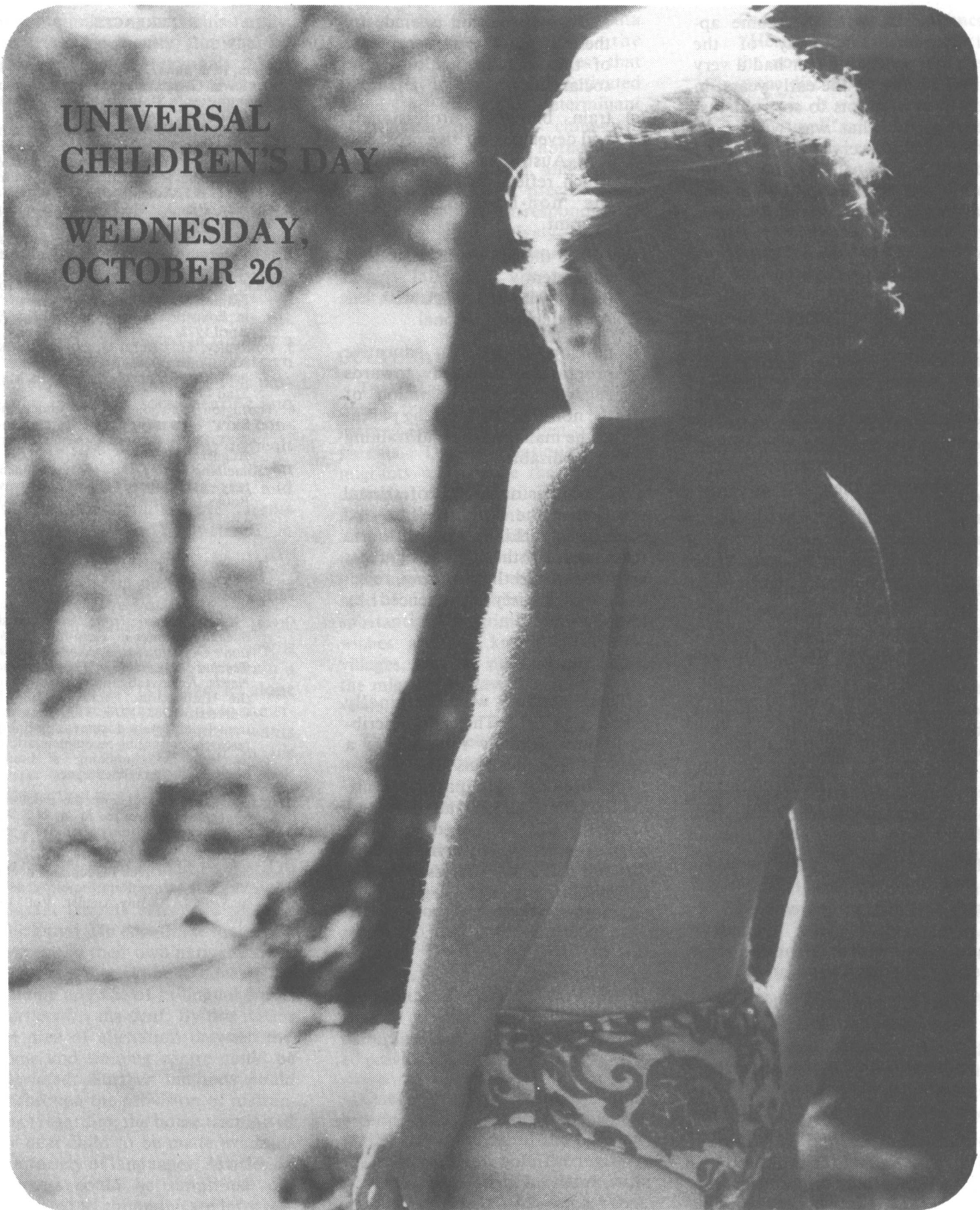
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Further Reading:

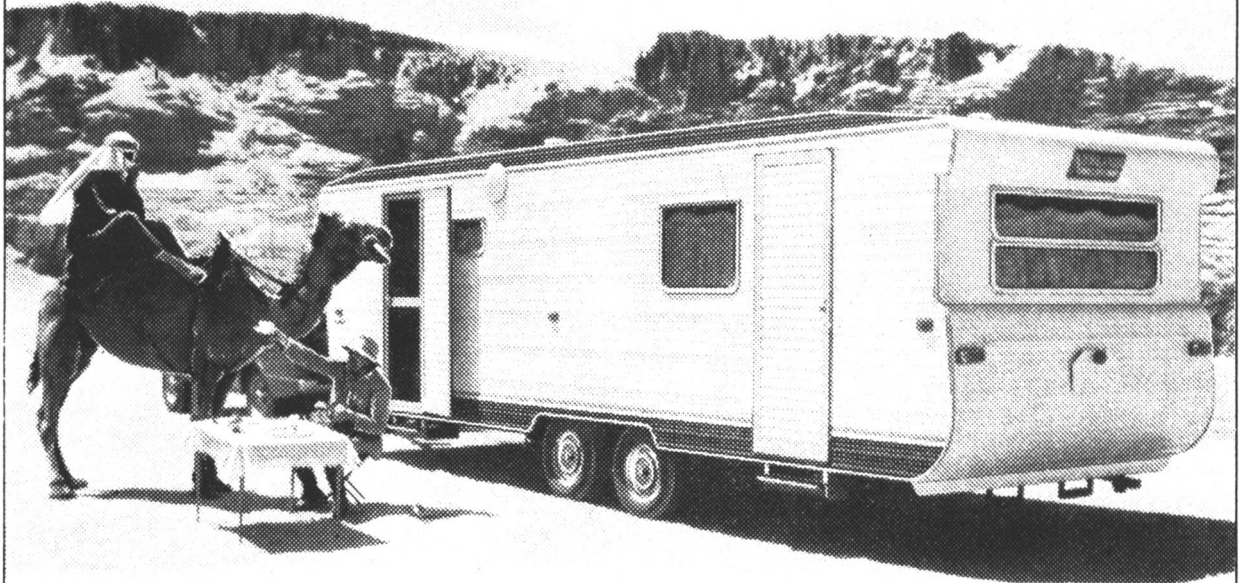
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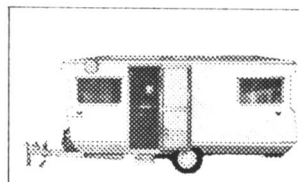
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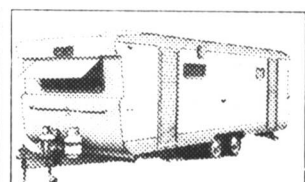
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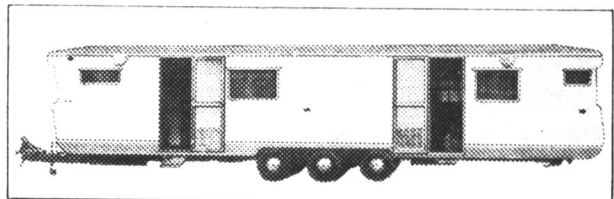
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