Author: **Jessica Meisel, ECSE**

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Activity: **Learned Helplessness Article**

The author of the article talks about learned helplessness in children who are deaf-blind, but this article is appropriate for any child with a visual impairment as well as children with multiple disabilities.
Our children rely on us to help them understand the world around them. They need us to be a bridge to our world, but oftentimes we make the mistake of doing too much for our children because we want them to succeed and we don't want to see them fail. But doing too much for our children can cause them to become passive, not willing to try new things because they know it will be done for them. Or we are giving too much guidance using our hands over their hands instead of hand under hand guidance, which gives the child the choice to remove their hands from whatever it is they are exploring. Too much hand over hand guidance could lead to tactile defensiveness which makes your child less likely to want to touch anything they are given.
I have highlighted the major points below. This is a long article, please don't feel overwhelmed by it. Pick out the strategies you need and leave the rest.
I hope this helps!
Best,
Jessica Meisel

AUTHOR: S.B. Marks

TITLE: Understanding and Preventing Learned Helplessness in Children Who Are Congenitally Deaf-Blind

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ABSTRACT
The absence of both distance senses creates the need for children who are congenitally deaf-blind to rely on others to motivate them to explore and to provide the connections between exploration and communication, which is the foundation of concept development. This article links the literature on learned helplessness with best practices in teaching children who are deaf-blind to address how caregivers and teachers can prevent or reduce learned helplessness in these children.

Children who are congenitally deaf-blind are at risk of developing a passivity that is both

pervasive and enduring. This learned passivity interferes with the intrinsic drive to achieve, often referred to as mastery motivation (MacTurk & Morgan, 1995). The loss of both distance senses creates the need for children to rely on others to motivate them to explore, for it is the distance senses that motivate the children to move beyond themselves. Young hearing-sighted children see or hear something of interest and want to attain it. Children who are congenitally deaf-blind require adults who understand how to provide supports that motivate them to explore while continuously providing connections between exploration and communication in their preferred form or forms of communication. It is through the connection between exploration and communication that children learn new concepts.

Congenitally deaf-blind children need support to learn how to control aspects of their environment through experiential learning; otherwise they will become increasingly more passive in their attempts to interact with the environment. This early passivity, coupled with the children's later learning experiences, sets the stage for the development of learned helplessness.

DEFINITIONS

LEARNED HELPLESSNESS

Seligman (1975) developed the concept of learned helplessness from observations of the behavior of dogs. Seligman administered shock to the dogs and denied them any possibility of escape. Once the dogs understood that they could not stop the shock, they no longer sought to escape because they realized that their actions had no impact on the outcome. This work has been extended to examine what happens to people who are confronted with situations over which they have no control. The effects of learned helplessness are experienced in one or more of the following domains: 1) motivational, 2) affective, and 3) cognitive (Abramson, Seligman, & Teasdale, 1978).

When an individual's efforts have little or no impact on the outcome, motivation and subsequent efforts are reduced. The person lacks the motivation to try because trying will make no difference in the outcome. In the most extreme form of this condition, the person does not try to initiate anything. This lack of initiation is the most characteristic behavior of persons who experience learned helplessness (Abramson et al., 1978; Seligman, 1975; Sweeney, 1991).

The inability to control or change the outcome may cause the individual to feel depressed and thus has an impact on the affective domain. As the person becomes depressed, he or she is likely to exhibit the behaviors of learned-helplessness. In fact, depressed people are apt to feel that negative events are their fault and to generalize their failure to other situations (Abramson et al., 1978). Under these circumstances, it is difficult to determine whether the depression or the learned helplessness is the precipitating factor.

People experience the cognitive effects of learned helplessness as they struggle to figure out "why" they are helpless. The nature and severity of the helplessness is connected to how they think about their helplessness. Seligman (1975) called this thinking a person's attributions. The impact of the uncontrollable outcome is subject to the person's interpretation of his or her personal competence. The individual may think, "Would everyone in this situation be helpless, or is the helplessness unique to me?" Thinking that no one could have an impact on the outcome, or universal helplessness, is not likely to have the same deleterious effects on one's self-esteem as personal helplessness, the belief that you are the only person who cannot affect

the outcome (Abramson et al., 1978).

Several other concepts are important to understanding how attributions affect the severity and chronicity of learned helplessness. An individual's attributions for his or her lack of control may be internal (ability or effort) or external (difficulty of the task or luck), stable (unlikely to change) or unstable (likely to change), and global (affecting many domains, including the daily living, mathematical, and vocational) or specific (affecting only a particular domain). It is possible to intervene and reduce learned helplessness. However, it is more challenging to do so with persons whose attributions are internal, stable, and global, rather than external, unstable, and specific, because people with the first set of attributions believe that their helplessness comes from within, is unlikely to change, and pervades many areas of their lives (Abramson et al., 1978).

TYPES OF HELPLESSNESS

Kay (1986) described two kinds of helplessness--inborn passivity and learned helplessness. The concept of inborn passivity may apply to some infants who are congenitally deaf-blind, who are poor feeders and rarely cry or otherwise make demands on the caregiver. Because of the lack of both distance senses, these infants may simply not know who or what to cry for.

The loss of both distance senses may also have an impact on a child's persistence. According to Harrel (1984, p. 11), "vision plays a strong role in encouraging continued efforts." Children who are deaf-blind have fewer opportunities to observe the self-initiation and persistence of others, which is the way sighted-hearing children learn to initiate and to persevere in their efforts. Children who are not provided with supports to gain access to such information respond to what they perceive as the expectations of others (Harrel, 1984); that is, they wait for others to tell them what to do before making another attempt. This passivity contributes to their lack of control over their own learning.

Children who are congenitally deaf-blind experience almost no incidental learning. Although more than 90 percent of them have some usable vision or hearing (Fredericks & Baldwin, 1987), the information they receive may be fragmented or distorted and hence difficult to interpret. Because neither distance sense is intact, these child have lost many opportunities to learn through observation, both visual and auditory.

Congenitally deaf-blind children are dependent on others to set up safe, predictable environments and to support them in making systematic connections to the world outside them. These connections must be continually made by communicating to them in their preferred forms, so they will gain knowledge about the world. In addition, these children must be supported in understanding the cause-and-effect relationships between what they do and what happens to them (Siegel-Causey & Downing, 1987). Persons with learned helplessness often feel a discontinuity between their actions and the resulting outcomes.

Caregivers and teachers may contribute to the learned helplessness of children who are congenitally deaf-blind by overgeneralizing their supportive role to situations where support is unnecessary and the children could perform independently. They may misinterpret the children's need for connections to be a need for direction. As a result, the children get a global impression of their dependence, which may reduce their control over their learning experiences. This loss of control is the critical element in the development of learned helplessness (Dudley-Marling, Snider, & Tarver, 1982).

Adults may have different expectations for children who are congenitally deaf-blind. The

many hours that must be invested in deliberately and systematically teaching these children things that children who are sighted and hearing seem to learn automatically may be overwhelming. Some adults may prefer to "do for" the children or continuously physically manipulate them through activities, thinking that they are being kind. However, in so doing, the children's efforts are reduced (Harrel & Strauss, 1986; McInnes & Treffry, 1984). Some adults may simply not hold high expectations for children who are congenitally deaf-blind. This is an unfortunate perception, since the expectations of others communicate the belief that children can learn and a respect for the children's integrity as learners.

Expectations may also influence the nature of the feedback that caregivers and teachers provide to children who are congenitally deaf-blind. Too much external reinforcement (rewards) for successes that require little or no effort may reduce the children's efforts (Sweeney, 1991). Too little reinforcement for efforts that may have been unsuccessful, coupled with too many experiences with failure, may also increase the risk of the children developing learned helplessness (Canino, 1981; Tollefson, 1982). Children who are congenitally deaf-blind may not observe the many forms of feedback, such as facial expressions, body language, and intonations of voice, that are available to sighted and hearing children. Therefore, they need to interact with caregivers and teachers who provide feedback in a way they can understand and at levels that are matched or contingent on the efforts they invest.

MASTERY MOTIVATION

Of the many definitions of mastery motivation, most include some association with the individual's approach to and persistence in performing tasks. MacTurk and Morgan (1995, p. 6) defined mastery motivation as "a psychological force that originates without the need for extrinsic reward and leads an infant or young child to attempt to master tasks for the intrinsic feeling of efficacy rather than because of current reward." The absence of vision and hearing and the ways that adults interact with children who are deaf-blind may interfere with the development of such intrinsic motivation to achieve.

IDENTIFICATION OF LEARNED HELPLESSNESS

It is difficult to assess the full impact of learned helplessness on children who are congenitally deaf-blind because many have little expressive communication that limits the ability to determine their beliefs and attributions. Although teachers may not be able to determine these children's attributions and the relationship of the children's passivity to their emotional states, they can observe numerous behaviors and environmental conditions that put these children at risk of learned helplessness. It is important to note that these behaviors may be domain specific; for example, a child may initiate and persist in dressing or other tasks of daily living, but may not initiate or persist in leisure tasks.

A child's limited initiation or performance of any particular skill or interaction does not necessarily connote learned helplessness. What may appear to be helplessness may simply be the lack of skills or opportunities to gain the skills needed to perform a task within a particular domain. For instance, since the development of language is particularly challenging to children who are deaf-blind, teachers would need to assess whether a child's passivity is due to the lack of interaction skills, instruction in those skills, or learned helplessness.

RISK FACTORS

The following risk factors were compiled from a review of the literature and the author's

experience teaching and consulting in the field of deaf-blindness. Some of the factors describe characteristic behaviors of children who are deaf-blind, and others speak to characteristics of current or past environments. The purpose of identifying these risk factors is to address them so a child's learning experiences are consistent with mastery, rather than helplessness.

Lack of initiation. The lack of initiation is the first consequence of learned helplessness (Abramson et al., 1978; Wedell-Monnig & Lumley, 1980). This behavior is of more concern when it pervades all domains of learning. Children must feel safe and understand an activity before they can reasonably be expected to initiate it.

Lack of participation or persistence. Persistence is a strong indicator of mastery motivation (MacTurk & Morgan, 1995; Mark, 1983). Children who have learned to be helpless demonstrate limited motivation during problem-solving tasks. They do not persist in activities even though they understand and enjoy doing them.

Dependence on prompts. In the most extreme form of this condition, children do not initiate without prompts (Sweeney, 1991).

Few known reinforcers. When caregivers and teachers are asked to name the children's reinforcers, only a few ideas may emerge (Sweeney, 1991).

What children do versus what others think they can do. Both caregivers and teachers consistently believe that the children are capable of doing more (Sweeney, 1991). They often cite examples of sporadic, extraordinary performance by the children.

Seeking others to "do for" them. Children with adequate vision may look toward the people they expect to rescue them (Sweeney, 1991). Those without usable vision may lean toward, gesture, or even pull adults into their physical space, so the adults can do for them. Some children may identify surrogates in each environment whom they expect will rescue them from difficult demands.

Avoiding interactions with adults. The lack of eye contact in children who have sufficient usable vision or the avoidance of physical proximity to adults who may place demands on them are attempts to avoid interactions with adults who may expect them to perform (Kay, 1986).

History of external reinforcement for little effort. Rewarding children for each performance of a task, regardless of the effort extended, does not encourage them to do their best (Sweeney, 1991).

High levels of tangible reinforcement. The continuous use of concrete reinforcers, such as food, creates a dependence in children who wait for the responses of others (Hoy, 1986). Children often pause as they anticipate a reward, rather than attempt the next step in the task.

Continuous physical manipulation. Children's initiations and persistence are reduced by adults who use the hand-over-hand or hand-under-hand techniques excessively. The message that these techniques convey to children is, "You need my help." Too many such messages across learning domains may contribute to children's sense of global helplessness.

History of failure. Children who have experienced failure more often than success are no longer motivated to try because their efforts have not paid off in the past (Abramson et al., 1978; Coley & Hoffman, 1990; Dweck, 1975; Falvey & Grenot-Scheyer, 1995).

Refusal to make choices. Children may refuse to make choices because they no longer understand that their behavior has an impact on the outcome (Kay, 1986).

Limited response to contingencies. Children with sensory disabilities have less experience with contingencies because the loss of sensory input results in less contingent feedback to

them (MacTurk & Morgan, 1995; Sweeney, 1991). For example, children who are deaf-blind may not hear objects hit the ground after they throw them. This lack of contingent feedback may cause delays in making connections between their actions and the results of their actions. Cause-and-effect relationships can take longer to form and lack predictability for children who are congenitally deaf-blind. If predictable contingencies are not made accessible to them, they do not develop trust in cause-and-effect relationships. In severe cases, others report that what they do has little effect on the children.

Depression. Although teachers' and caregivers' understanding of children's depression is dependent on children's communication skills, pervasive unhappiness and self-abuse are observable characteristics of depression that may be related to feelings of helplessness (Abramson et al., 1978; Greer & Wethered, 1987).

Refusal to try new experiences. Children show no desire or motivation to try new experiences even though their physical and emotional needs for safety have been attended to (Greer & Wethered, 1987).

REDUCING OR PREVENTING LEARNED HELPLESSNESS

The literature on the development of mastery motivation in children with disabilities is limited, and there have been no studies specifically of mastery motivation in children who are congenitally deaf-blind. Although some congenitally deaf-blind children may be passive from birth, caregivers and teachers can create learning environments at home and in school that prevent or reduce the development of learned helplessness. The following suggestions consider the characteristic behaviors of learned helplessness while applying best teaching practices in the field to address the unique needs of children who are congenitally deaf-blind.

Support children in building healthy attachments. Children who are congenitally deaf-blind, like children who are hearing-sighted, need to develop strong attachments to primary caregivers, while being supported to explore and separate from them (MacTurk & Morgan, 1995). Dual sensory disabilities may interfere with infants' ability to understand the predictability of the environment or the cause-and-effect relationship between their actions and the caregivers' responses. For example, infants with low vision and a severe hearing loss will not see or hear their caregivers approach in response to their cries.

Have appropriate expectations for children. Appropriate expectations communicate respect and trust in children's integrity. The expectations must be appropriate to the children's level of development, otherwise the children will become frustrated or bored and their efforts will be reduced. As children gain competence in communication, they can be taught to establish some of their own goals. The use of embedded choices, within the daily calendar system, is one instructional approach that supports children in establishing goal setting. Rowland and Schweigert's (1990) publication and videotape, Tangible Symbol Systems, present detailed information on how to develop and teach the use of schedule and calendar systems, among other helpful techniques.

Provide safe and predictable environments. Children's need for safety must be addressed if exploration is to occur. Children who are congenitally deaf-blind need support in orienting to any changes in their physical environments at home or in school and to any new environments.

Understand how deaf-blindness affects development. Young children's learning is based on exploration (Hauser-Cram, 1996). Children who are congenitally deaf-blind may have less or no motivation to explore because of the lack of sensory input or delayed body and spatial

concepts. Thus, the lack of motivation to explore delays the development of concepts and language. Hand in Hand (Huebner, Prickett, Welch, & Joffee, 1995) presents many suggestions on how children who are congenitally deaf-blind can be supported in the development of movement and exploration skills.

Reward independent behavior, rather than dependence. Children are less likely to develop mastery motivation when their parents and others are overly helpful and encourage their dependence by reinforcing dependent behavior (MacTurk & Morgan, 1995). Caregivers and teachers need to understand how much to help and how to recognize and reward independent behavior within the context of providing for the safety needs of children who are congenitally deaf-blind.

Identify and retrain surrogates. Surrogates are the persons whom children expect to rescue them when demands are placed (Sweeney, 1991). Often children will look or move toward the surrogates. Some children have received so much help that they have surrogates in each environment.

Surrogates are not always adults. Siblings, paraprofessionals, teachers, parents, and other relatives are all capable of crossing the line between sensitively supporting independence and creating dependence by doing too much for children. To ameliorate this problem with a child, the surrogate's ability to understand the child should be recognized, but the surrogate's sensitivity should be redirected to supporting independent behavior.

Provide multisensory stimulation. Children who may not seek stimulation beyond their own bodies must be exposed to stimulation if they are to learn to exercise control over the stimulation (Seligman, 1975). Chen and Haney (1995) suggested that the practice in special education of providing "noncontingent stimulation" or "passive stimulation" for children with visual impairments may reduce children's motivation to exercise control over the stimulation. Therefore, children must be given sensory stimulation over which they may have some control, rather than stimulation for stimulation's sake. This control may be developed as the children learn how to begin and end the stimulation through the use of switches or by having caregivers and teachers who respond to their individual ways of expressing pleasure and displeasure.

Communicate with children in their preferred modes. Many young children who are congenitally deaf-blind communicate through body language and gestures. They will benefit from adults who integrate the use of touch cues, tactile calendars, tactile referent pages, or journals to support their understanding of the world beyond them. Adults must be able to respond to the children's communications and to offer the children receptive opportunities in their preferred modes of communication.

Recognize and reinforce children's initiations. Many of the children's early initiations are through body language. They may include reaching to locate an object, leaning toward others to indicate a desire to interact, or vocalizing to gain attention. Adults can respond to such initiations by verbalizing their interpretation of the children's intent, responding to the interpreted intent, and socially reinforcing the children for their efforts.

Integrate orientation and mobility (O&M) and communication from birth. O&M and communication are often considered separate domains and have frequently been referred to as the two most critical areas of development for children who are deaf-blind. These two domains must be integrated into one if the world is to become sensible to children who are congenitally deaf-blind. Communication without exploration and subsequent experiential learning is

meaningless, while exploration that is disconnected from communication in the children's preferred modes is yet another random experience that the children cannot organize mentally.

The use of low-technology forms of communication, such as tangible and textural modes, can support the integration of O&M and communication for many children. The need for an integrated approach persists as children become adults and need professionals who can coordinate the aspects of guiding, route instruction, and communication (Sauerburger, 1993). Through this integrated approach, the children will come to understand various settings and be able to exercise some control over their environment. Hand in Hand (Huebner et al., 1995) can be used as a resource for the types of support that the children need.

Teach at the appropriate level for each child. Instruction should be responsive to the child and at what Brophy (1987, p. 42) called "an appropriate level of challenged difficulty." Vygotsky (1978) created the construct of "zone of proximal development" (ZPD)--the developmental level just above what a child can do independently--where instruction should begin for all children, including those who are congenitally deaf-blind. Teaching in the ZPD will reduce the need for prompts and allow for a reasonable rate of earned success.

Provide for success. Success is a cushion for failure. Caregivers and teachers can schedule children's days so that more difficult tasks follow several less difficult tasks in which the children can be independently successful.

Assign tasks that are active, interesting, and offer opportunities for children to solve problems and have control (MacTurk & Morgan, 1995; Sweeney, 1991). Active tasks that allow children to exercise control, such as switch-activated tasks and physical activities, support the prevention of learned helplessness. Children will be more motivated to participate in lessons or activities that are based on their interests. Interesting tasks prevent boredom and decreased effort.

Use lifestyle planning procedures to develop individually appropriate curricula. Lifestyle planning procedures, such as Personal Futures Planning, McGill Action Planning, P.A.T.H., and C.O.A.C.H., may help caregivers, professionals, and children establish individually designed, meaningful, functional curricula. Lifestyle planning incorporates a team approach with involvement from families, professionals, and children to establish future goals and dreams, while focusing on more immediate objectives. Rather than attempt to fit children into an established curriculum, these approaches to developing curricula focus on the specific needs and desires of individual children (Falvey, Forest, Pearpoint, & Rosenberg, 1994; Romer & Romer, 1995; Stremel & Shutz, 1995).

Avoid prompting what a child can do. The avoidance of prompting will reduce children's dependence on prompts and provide opportunities for independent success (Sweeney, 1991). When prompts are necessary, the least intrusive ones are appropriate. For example, teachers may be able to support learning by modeling tasks first with the children's hands placed over or under their own, as opposed to hand-over-hand or hand-under-hand manipulation as the children perform the tasks. In this way, they are providing models for the children to imitate.

Teachers may also find it useful to work side by side with children on identical tasks. For example, they could model how to wash a counter using hand-over-hand or hand-under-hand manipulation, followed by side-by-side washing of a counter or table space. The children can then seek them out for additional guidance.

Side-by-side instruction can also provide the children with models of persistence. Peers may also play this role.

Model persistence. Give the children opportunities to experience the work efforts and persistence of others in whatever modes (visual, auditory, or tactile) are functional for them.

Provide choices and teach choice making. Shevin and Klein (1984, p.159) defined choosing as "the act of an individual's selection of a preferred alternative from among several familiar options."

Consideration of children's preferences is a vital part of choice making. Although no one can choose everything, everyone should have the opportunity to make some choices. To make meaningful choices, children must understand the options and the process of choice making.

Adults need to provide children with opportunities to learn about options in particular contexts (Rawlings, Dowse, & Shaddock, 1995). These opportunities can be provided while mutually planning the schedule or spontaneously offered throughout the day. Gothelf, Crimmins, Mercer, and Finocchiaro (1994) suggested that mealtime is an appropriate context for choice making because it occurs naturally and regularly, is often naturally reinforcing, and occurs across environments. Adults should use strategies, such as a pause, to encourage active choice making. They also have to be able to recognize when a choice is made in a variety of forms of communication.

Provide appropriate feedback. Feedback must be specific and presented in a form that is understandable to a child. Feedback about the completion of a task may be provided by reviewing the task tactilely, hand under hand, and then expressing approval. If a child has made an error, it may also be shown tactilely, so he or she understands exactly what is wrong. Simply signing and voicing "right" or "wrong" in response to a child's efforts is not specific feedback. Caregivers and teachers can show children what they did that was right and what they need to do to change mistakes or failures into successes.

Respect children's feedback. All children communicate. They may provide feedback through their fidgeting, vocalizing, or engaging in aggressive behavior toward caregivers and teachers. Their actions may convey messages of boredom, frustration, or even illness. If an adult does not respond to a child's feedback, the child may disengage, reduce his or her efforts, and withdraw.

Provide reinforcements contingent on children's efforts. Reinforcement should be given only when children have made extended efforts. Attempts to perform difficult tasks and persistence in performing difficult and nonpreferred tasks may require higher levels of reinforcement. As children mature, they may learn to reinforce themselves for established routines and tasks. It should not be assumed that children need external, tangible reinforcements for every attempt or even for every task that is completed. Reinforcement should be based on each individual's needs. The school psychologist may be helpful in establishing reinforcement techniques.

Use interest inventories to expand children's repertoire of reinforcement. If a child has few preferred activities, adults may seek to expand his or her preferences. The first step is to inventory all the environments in which the child interacts. Parents, teachers, peers, siblings, neighbors, and others can contribute their observations about the child and the things that he or she enjoys. These observations in different settings will also provide helpful clues to the child's preferred activities. A master list of such preferences can then be used to support instructional activities.

Be sensitive to issues of dependence. The need of children who are deaf-blind for one-on-one support from professionals or paraprofessionals owing to the tactile mode of interaction may put the children at risk of learned helplessness. Although young children may

have to establish relationships with only one or two adults at first, older children may be expected to interact with a variety of individuals who have been appropriately prepared. A child in an inclusive setting needs opportunities to interact with the classroom teacher and other school personnel and peers, as well as his or her assigned paraprofessional. These interactions will communicate to all the children in the class that the child who is deaf-blind is worthy of everyone's efforts and attentions and reduce the risk of extreme dependence on one professional.

Help children establish friendships that are based on mutual interests. Although everyone needs help sometimes, friendships should not be based solely on the neediness of the child who is deaf-blind (Van Der Klift & Kunc, 1994). Mutual interests that are discovered or developed are a healthier foundation for friendship. Peers and overly helpful siblings may create dependence in the child who is deaf-blind. Therefore, when possible, children should be taught that help can be offered and refused and that help is reciprocal.

Introduce new experiences in respectful ways. New experiences must be approached with a respect for each child's need for predictability and tolerance. One effective way to introduce new things is simply to expand on what children are already doing. New experiences are more likely to be tolerated when familiar and trusted companions are present.

Observe the children for depressed affect and consult with appropriate professionals. In children who are deaf-blind, depression may be manifest by self-abuse or withdrawal. If caregivers and teachers observe such symptoms, they should consult psychologists or social workers with experience in the field of deaf-blindness.

CONCLUSION

Learned helplessness occurs when a person cannot control outcomes. Children who are deaf-blind are at risk of developing a form of learned helplessness that is global and chronic. The absence of both distance senses robs them of much incidental learning and creates the need for support from others. Caregivers and teachers foster dependence when they expect little of children. Mark (1983, p. 1) described learned helplessness as an "adaptive response to situational demands." For children who have rarely been successful, withdrawal may be an effective self-defense mechanism that protects them from greater failure. Many of the risk factors of learned helplessness can be eliminated by supporting the development of a motivation for mastery and giving children who are deaf-blind opportunities to achieve both independent and supported success.

Added material

Susan Bruce Marks, M.A., deafblind specialist, Department of Special Education, Michigan State University, 344 Erickson Hall, East Lansing, MI 48824-1034; E-mail: .

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