

## Persons Who Are Deaf And Mentally Ill

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(Editor's Note: This paper is an edited version of a chapter written by Dr. A. Barry Critchfield, Director of the South Carolina Department of Mental Health, Services for Deaf and Hard of Hearing People. It is used with his permission.)

People who are coping with mental illnesses have a right to receive treatment, and this treatment needs to be tailored to the individual needs of the person presenting for assistance. This principle seems self-evident, and it is clear that, given the profusion of "culturally competent" services and plans mandated and implemented across the spectrum of mental health services Often overlooked in this process, however, is the Culture of Deafness, and the fact that American Sign Language is the third most commonly used language in the United States, behind English and Spanish.

There is indeed, a Deaf Culture in the United States. Deaf people view themselves as a cultural and linguistic minority, rather than as afflicted with a handicap which must be minimized or overcome. This single statement supercedes all programmatic, social, psychological and mental health activities, and must guide the architects of human service as they develop programs to assist and support people who are deaf, and facilitate their participation in a productive technological economy of the 21<sup>st</sup> Century. In Padden and Humphries Introduction to their seminal work, *Deaf in America: Voices from a Culture*, they note,

*The traditional way of writing about Deaf people is to focus on the fact of their condition – that they do not hear – and to interpret all other aspects of their lives as a consequence of this fact ... In contrast to the long history of writings that treat them as medical cases, or as people with "disabilities," who "compensate" for their deafness by using sign language, we want to portray the lives they live, their art and performances, their everyday talk, their shared myths, and the lessons they teach one another. We have always felt that the attention given to the physical condition of not hearing has obscured far more interesting facets of Deaf people's lives. (p. 1)*

The deaf or hard-of-hearing population is estimated by the National Center for Health Statistics (NCHS) of the U.S. Department of Health and Human Services. According to their 1990 and 1991 Health Interview Surveys, approximately 20 million persons, or 8.6 percent of the total U.S. population 3 years and older, were reported to have hearing problems. In Alabama, 383,935 people meet these criteria.

People significant hearing loss depend heavily - even primarily- on visual and tactile channels for communication. Instead of calling out names to get attention, a tap on the shoulder or a flip of the lights, a stomp on the floor or pounding the table will be used. Many people, even some with profound hearing loss may enjoy music – they will just like it louder! Dim lights can make it hard to communicate and some deaf people with sensori-neural hearing loss have very poor balance. They depend a great deal on their eyes in order to maintain a sense of "balance" and to be able to stand or walk. Clothing can sometimes be a distraction for people who depend on their eyes and facial hear can make the guess game of lipreading next to impossible.

No other factor more distinguishes deaf people as a minority group, while at the same time is less understood by society-at-large than American Sign Language (ASL). It is the heart and soul of the Deaf community. ASL was not even recognized as a language until the 1960's (Stokoe, 1960; Woodward, 1978, 1980). Its formal acceptance as a language was met with fierce opposition in the linguistic and educational communities; even some deaf people refused to acknowledge its place as a separate, unique and fully functional linguistic form.

ASL is not English. It is a separate language with its own set of grammatical rules, structures, syntax, etc. Thus a deaf person who is fluent in ASL may not be as well-versed in English and, indeed, helping professionals have misdiagnosed mental illness based on the written English of deaf people.

*John was sent to the mental health center by his Vocational Rehabilitation counselor. Although the mental health center was informed of his Deafness, no interpreter was provided. His intake was handled by a competent social worker who wrote notes back and forth on a notepad. To her question, "What brings you here today," John responded, "God where terp. Damn" and he appeared quite agitated, making numerous unintelligible verbalizations. Later, John stood up and walked to the door, but was detained by the security officer on duty. He was then involuntarily committed to an inpatient unit with a diagnosis of Paranoid Schizophrenia. During his hospitalization, he wrote numerous notes such as, "Why interrupt none" and "Please to phone TTY my deaf." He signed a waiver, consenting to treatment with an atypical antipsychotic medication, but after several weeks of trial, his agitation and verbal outbursts continued. Finally, after seven weeks of hospitalization (and two court hearings), an interpreter was provided. He was released within a few hours of the interpreter's arrival.*

Typically, Deaf people experiencing the symptoms of mental illness will present for service with severe language deficits (in English). Thus, attempts to communicate with such people through written notes, lipreading or even the telephone (using a telecommunication device for the deaf or TTY) will be fraught with potential problems. In such instances, Deaf consumers are being required to function in a language in which they are not competent, so it is vital that communication be established in a modality which is most comfortable for the client. Under no circumstances should a family member (even one fluent in ASL) be used as the interpreter.

Despite numerous efforts to eradicate its use (See Lane, 1992), ASL continues to be the dominant communication modality in the United States among deaf adults, and mental health systems attempting to serve deaf people professionally, need to affirm ASL as the language of choice among deaf people, and to deliver services in the manner preferred by consumers. ASL is a difficult language to learn to use fluently. While a person may take basic classes and learn to express themselves comfortably in A.S.L., to be able to understand a native signer's language, and more importantly, to be able to understand the cultural milieu from which the deaf person has emerged, takes many years of dedicated, full-time effort. Most mental health professionals will never have the time or the aptitude to develop fluent, two-way communication abilities in ASL.

Unlike other language groups, however, who become somewhat assimilated into the mainstream of society, Deaf people cannot learn to hear, and their "assimilation" is blocked by the requirement imposed by many service delivery systems, namely that they hear and speak English. At least 8,000 Alabamians are profoundly deaf and grew up with American Sign Language (ASL.) Many more depend on ASL as their primary mode of communication.

Virtually all mental health intervention services delivered today rely on interpersonal communication between the service provider and the service recipient. The literature abounds with descriptions of service failures which occurred because Deaf consumers could not be understood by professionals, but where the professional "thought" they understood what the Deaf person was saying.

Interpreters can and do provide a communication bridge between deaf and hearing people. A well-trained interpreter can help mental health professionals better understand a deaf person's world-view and inner difficulties. And such a person can assist the deaf person to a better awareness of mental health treatment,

options and programs. Such advantages, however can be outweighed by disadvantages which may not be readily apparent to either deaf consumers or hearing professionals.

First of all, an interpreter provides the illusion of effective communication. If a hearing professional asks certain questions and hears anticipated responses through the interpreter, he or she will likely assume that communication is occurring. And if a deaf consumer understands everything the interpreting signs, and sees the interpreter voicing his/her response, that person also assumes that communication is occurring. What is often missed by both parties is the unavoidable involvement of the interpreter in the interaction. The interpreter serves both as a communication vehicle and a communication filter, unconsciously shielding both parties from information or affect that is uncomfortable to the interpreter. This occurs as a natural human process and is not necessarily a product of poor training or questionable ethics. The interpreter's own life experiences, educational level, values and attitudes all influence the communication process.

*Rosa is a Deaf woman, diagnosed with a severe and persistent mental illness. As a single mother, she had frequently been accused of abusing her young children, and indeed, she possessed few effective parenting skills. The psychiatrist treating her used a qualified interpreter, but after numerous objections and protestations from Rosa, the psychiatrist agreed to allowing Rosa to bring her own interpreter from her church, whom she claimed to understand much better.*

*Unknown to the psychiatrist, the church which Rosa attended believes strongly in faith healing, and has little confidence in treatment by mainstream medicine. The interpreter regularly "reported" to the church everything that was happening in Rosa's therapy, and soon she discontinued treatment against medical advice. Shortly thereafter, her children were placed in protective care by the state social service agency, and Rosa herself was "put out" of her church because of her mistreatment of her children. Since she was court-ordered to return to treatment, she did so and also agreed to use an interpreter selected by the clinic. After a period of re-stabilization on appropriate medication and taking some basic parenting skills classes, her children were returned to her care, and she continues to function in the community, with ongoing support from the Mental Health Center.*

A thoughtful professional, after some reflection on this issue, would be wise to carefully monitor the interpreting process as best they can. It has been found that a video camera can be used to monitor an interpreter's performance, and then "back-translated" to the professional (by another interpreter, of course). Outcomes of this process can be quite shocking to both a professional and a deaf consumer.

This is not to suggest that Deaf people are immune from the symptoms and impairments of mental illnesses. Deaf people experience Axis I mental health disorders at virtually the same rate as the general population (Altshuler, 1978; Grinker, 1969; Rainer, Altshuler and Deming, 1963; Robinson, 1978; Vernon, 1978, 1980). For Axis II disorders, and for behavior problems among children, the prevalence rates in the deaf population are significantly higher than society-at-large (Schlesinger and Meadow, 1972; Gentile and McCarthy, 1973; Williams, 1970; Graham and Rutter, 1968). By and large, however, mental health systems have done a poor job of responding to the needs of Deaf people, assuming that interventions, methods and services which work well for the general population are equally effective with consumers who are Deaf. It shouldn't be assumed that all the interventions and techniques used with hearing people will be effective with a group who have functioned for the majority of their lives with a major sensory deficit.

Deaf people have functioned as an "inferiorized" minority, similar to Blacks, Jews and gays (Higgins, 1980). Deaf people, however, tend to belong to a different minority group than their parents, and thus, the opportunity for social learning and values dissemination is severely impaired; deaf people tend to look to peers and other social counterparts for societal learning.

As a cohesive, politically powerful advocacy group, the Deaf Community is late in arriving. Deaf people are literally a silent minority; by and large, they don't complain to "Hearing" systems, although their needs are just as great, just as real as those of other consumers with mental illness. While organizations of and for deaf people have long existed in this country, most have been utilized as a refuge to protect deaf people from the ravages of a hostile larger society, or to attempt to assimilate them invisibly into the larger community. Political activism has not been a high priority with most of these organizations. Additionally, there is a long history of professionals in deafness collaborating to improve educational and/or rehabilitative services to deaf people, but not of deaf people themselves working together as an advocacy contingent. Only in the past 30 years have deaf people, as a group, taken on the task of challenging existing societal barriers, and of demanding accommodations for people who do not "fit" society's definition of "normal."

It should be recognized, that Deaf people are not evenly distributed throughout the population; there are "Deaf Centers" in each state. Typically, larger communities with Deaf churches, clubs or social agencies reflect larger numbers of deaf residents. Birmingham and Mobile are examples of cities in Alabama where there are organized social networks. The state residential school for the deaf is located in Talladega, the home of another large concentration of Deaf people.

The education of deaf children has been a disgraceful series of academic and pedagogic failure. The average reading level is of high school graduates is below 4<sup>th</sup> grade (Holt, et.al., 1997) and when, as is usually the case, Deaf people demonstrate normal performance IQ scores, these reading results become even more confusing. The implications of these failures are often not apparent to mental health practitioners, who may choose to rely on hand-written messages, TTY conversations or captioned television for communication purposes. When the client is functionally illiterate, such efforts are of little value. Mental health professionals need to be aware of the significant educational deficits experienced by the majority of potential mental health clients who are deaf.

Differences within the deaf community may also negatively impact on the delivery of mental health services. All deaf people are not alike, and the same racial, ethnic, religious, etc. differences which exist in society-at-large also impact on the deaf community. A consumer may not be comfortable with a counselor of a different race, gender or sexual preference. Simply hiring a single staff member as the deaf services "specialist" may not be sufficient to meet the needs of all consumers who could benefit from mental health services.

Estimates run as high as 80% to 90% of Deaf people with severe and persistent mental illness or severe emotional disturbance are currently unknown to the mental health systems of this country. Established "entry points" into mental health systems do not generally apply for the Deaf Community. Most deaf people are not comfortable walking into an agency which they fear will be unfriendly and not accepting of their differences. If the entire burden of communication access is left in the hands of the consumer, the likelihood that actual mental health service will occur is minimized. Deaf people tend to gravitate toward agencies which have traditionally served them, such as Vocational Rehabilitation, deaf community service agencies, and Educational institutions, such as residential schools for the deaf.

For a number of reasons, deaf children are particularly vulnerable to developing emotional difficulties. Approximately 92% of deaf children are born to parents who can hear (Vernon, 1968), and communication difficulties between parent and child are apparent throughout the developmental periods. It is estimated that only 15% of parents ever develop the sign language communication skills necessary to carry on meaningful conversations with their children, beyond simple commands and queries. Communication with siblings and extended family members is rare or nonexistent.

The education systems in this country are also problematic, and sources of emotional distress for children with hearing impairments. For those children who attend school in local school districts, education usually occurs in self-contained classrooms, with the same classmates, teachers and support staff for years at a time. Interaction with normally hearing “peers” may only happen during lunch breaks or at school-wide events. And meaningful communication between these groups rarely develops. For those children who attend state residential schools for deaf children, a different set of problems, no less debilitating, often develop. These children may live apart from their families five days a week, and never really understand or observe “normal” family interactions.

And deaf children seem to be particularly vulnerable to additional serious pressures which confront society today. Perhaps because of their “apparent” communication difficulties, potential sex offenders find deaf children to be “ideal” victims (because they may be perceived as unlikely to report the offense). It has been reported that abuse rates as high as 50% may exist in the Deaf Community. Deaf young people are also susceptible to the influences of drugs and alcohol, especially if they are trying to “fit in” to negative peer groups.

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