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Mental health services for the deaf and hard-of-hearing

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Abstract

In an effort to help increase the reader's understanding of the deaf and hard-of-hearing community, the author of this paper will attempt to describe and define this population. Specific mental health concerns of this population reviewed in the literature will be noted, and mental health needs of the population will be identified. Ethical and legal considerations found in the literature will be reviewed. Characteristics of specialized training programs for counselors working with the deaf and hard-of-hearing will be discussed, and recommendations for the establishment of more effective, comprehensive, and specialized training programs for counselors working with deaf and hard-of-hearing clients will be provided.

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Mental health services to the deaf and hard-of-hearing community have been lacking for years (Critchfield, 1992; Nickless, 1993-94; Wyatt & White, 1993). The specific reasons as to why this particular population continues to be underserved remain unanswered. Researchers have recognized the need for specialized services, as well as specialized training of mental health professionals who work with the deaf and hard-of-hearing community (Bricetti, 1987; Roe & Roe, 1991; Wyatt & White, 1993). Although the research indicates that services available to the deaf and hard-of-hearing community have increased over the years (Bricetti, 1987; Pollard, 1992-93; Roe & Roe, 1991; Wyatt & White, 1993), there is still reason to question just how available mental health services are to the deaf and hard-of-hearing community and whether or not services offered are meeting the needs of that population (Wyatt & White, 1993). Critchfield (1992) noted that the need for more research in this area is "undeniable" (p.15).

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community, the author of this paper will attempt to describe and define this population. Specific mental health concerns of this population reviewed in the literature will be noted, and mental health needs of the population will be identified. Ethical and legal considerations found in the literature will be reviewed. Characteristics of specialized training programs for counselors working with the deaf and hard-of-hearing will be discussed, and recommendations for the establishment of more effective, comprehensive, and specialized training programs for counselors working with deaf and hard-of-hearing clients will be provided.

The Deaf and Hard-of-Hearing Community

Who are the deaf and hard-of-hearing? Langholtz and Rendon (1991-92) reported the total number of deaf individuals in this country to be between 350,000 to 2 million. Nickless (1993-94) reported that there are approximately 212,000 hard-of-hearing mentally ill and 3,500 chronically mentally ill deaf persons in the country. Of this 215,500, approximately 15%, are in inpatient treatment. Nickless also reported that an estimated 180,200 hard-of-hearing mentally ill and

3,000 deaf mentally ill are within the communities with less than 2% of the total accessing mental health services. If these numbers are accurate, there is considerable cause for personnel at mental health agencies to consider agencies' level of accessibility and for mental health professionals to consider their role in becoming more available to the deaf and hard-of-hearing community.

Wyatt and White (1993) noted the difficulty in educating hearing professionals on the acceptance of the deaf as a "unique community versus pathology or disability" (p. 10). Likewise, Wax (1990) pointed out the importance of mental health professionals developing an understanding of the cultural differences within the deaf community. This notion of cultural sensitivity was supported by Myers (1993) who also reported effective treatment would take place in a "culturally affirmative environment" (p.21).

Traditionally, the deaf have been judged against hearing standards, considered to be inferior to the hearing, and thought of as psychologically disturbed (Pollard, 1992-93). There is agreement in the

literature that deaf and hard-of-hearing individuals have been considered to be less intelligent and less well adjusted than their hearing counterparts due to the lack of verbal communication skills of the deaf and hard-of-hearing (Pollard, 1992-93; Wax, 1990). Researchers have, therefore, questioned the cognitive thought processes of the deaf and hard-of-hearing (Pollard, 1992-93; Wyatt & White, 1993).

It is important to recognize the differences within this culture and not view all deaf and hard-of-hearing persons as a homogeneous group (David & Trehub, 1989; Wax, 1990). By obtaining relevant knowledge about who the deaf and hard-of-hearing are, professionals can become more culturally sensitive. It may be helpful for the mental health counselor who plans to work with such a diverse group of individuals to receive appropriate training about the different types of deafness, the differences between them, and the sociocultural and psychosocial aspects associated with each.

Wax (1990) noted deafness, as viewed by many deaf individuals, to be an "ethnic minority experience" as

opposed to a "physical disability experience" (p. 33). Wax also pointed out the importance of this distinction in determining just how effectively mental health services meet the needs of the deaf community.

There has been an increase in the understanding of the deaf and hard-of-hearing community over the years (Pollard, 1992-93). Many experts believe it is important for counselors who plan to work with the deaf and hard-of-hearing to expand this understanding (David & Trehub, 1989; Wax, 1990). It would be helpful to note the different types of deafness, the diverse nature in the experiences of deaf individuals, and the emotional aspects of the experiences which may have an impact on counseling situations.

Diversity Among the Deaf and Hard-of-Hearing

Pinter (cited in Pollard, 1992-93) noted the difficulty the deaf may have in adjusting to their environment. Pollard (1993-94) commented on the research conducted on sociocultural characteristics of the deaf community. Pollard pointed out that there are differences among deaf individuals in their communication preferences and proficiencies. Some deaf

and hard-of-hearing use American Sign Language (ASL) to communicate, while others may use Cued Speech or Signed Exact English. The various communication methods used among deaf and hard-of-hearing individuals is just one aspect of the deaf and hard-of-hearing culture which make it diverse. There are also several psychosocial and sociocultural factors in diversity among deaf and hard-of-hearing individuals, including the differences between the prelingually or congenitally deaf and the deafened.

David and Trehub (1989) noted the differences between the prelingually deaf or congenitally deaf (those born deaf or those deafened very early in life, prior to the acquisition of language) and the deafened. (The deafened may be adventitiously deaf, sudden severely deafened, postvocationally deaf, or late deafened). The prelingually deaf and the deafened differ in many ways that may have an impact on counseling situations. David and Trehub commented on the difficulty prelingually or congenitally deaf may have in learning language, as well as cultural norms and social rules, due to their profound sensory

deficits which are present at birth or very early in life. These authors further noted the implications of such communication deficits on familial interaction. Langholtz and Rendon, (1991-92) and Fletcher (1993) also commented on familial issues faced by deaf and hard-of-hearing individuals. David and Trehub (1989) noted the possible relationship between communication deficits and aggression and impulsivity.

The deafened, on the other hand, experience the loss of hearing as more emotionally traumatic than prelingual deafness (David & Trehub, 1989). David and Trehub noted deafened persons have described experiencing grief, anxiety, loneliness and anger. Those who experience a progressive loss of hearing (rather than sudden hearing loss) are more likely to experience longer periods of denial of their deafness and less likely to put effort towards acquiring communication skills (David & Trehub, 1989). Therefore, the deafened are not able to share their feelings as easily which may lead to "neurotic adjustment" (David & Trehub, 1989, p. 201). Sevigny-Skyer (1992) also commented on the feelings experienced

(e.g. feeling overwhelmed) by those who become deafened or experience progressive hearing loss and the communication challenges faced by those individuals.

David and Trehub (1989) further commented on how few services are available to the deafened and noted, "many are left to face their depression and isolation on their own" (p. 200). David and Trehub also pointed out that few professionals have the skills to help the deafened with the experience of losing their hearing. The implications of acquired deafness on counseling with such clients are tremendous, as they may be struggling to cope with their hearing loss and its impact on their lives as well as the lives of their families (Sevigny-Skyer, 1992).

Specific Mental Health Concerns

It is important to take a look at how mental health services are currently addressing the specific mental health concerns within this population. As previously pointed out, few research efforts have investigated the deaf. It comes as no surprise, then, that very little research has been conducted regarding the specific mental health concerns of the deaf and

hard-of-hearing. This may have something to do with the small numbers of deaf clients currently accessing mental health services. Although further research needs to be conducted concentrating on the mental health issues of the deaf and hard-of-hearing, the literature reviewed (Fletcher, 1993; Langholtz & Rendon, 1991-92; Rendon, Hills, & Rappold, 1992) represents a trend toward the development of a clearer understanding of who the deaf and hard-of-hearing are and how mental health issues might be considered differently for this population. Following is an overview of frequently discussed mental health issues addressed in the literature specific to deaf and hard-of-hearing. They are eating disorders, sexual orientation, alcohol and drug abuse, and problem solving skills. Although these are not the only mental health concerns of this population, to cover all needs or concerns would be outside the scope of this paper.

Eating Disorders

Fletcher (1993) pointed out the recognition of eating disorders among cultural minorities by professionals. Fletcher noted that the literature has

not recognized the hearing-impaired as one of these minorities with significant food issues. However, much like researchers continue to recognize the similarities among the deaf and hard-of-hearing and hearing individuals (Wyatt & White, 1993), the literature reviewed (Fletcher, 1993; Rendon et al., 1992), suggests eating disorders may be just as common among the deaf and hard-of-hearing as they are among the general population. Fletcher (1993) studied eating and dieting behaviors among college women and compared groups of hearing-impaired and hearing subjects and found out that attitudes towards food issues, weight, and dieting did not differ between the two groups. Rendon et al. (1992) also noted deaf individuals suffer from body image distortions and eating disorders. Rendon et al. (1992) commented on the few numbers of professionals trained in working with the deaf and fewer, yet, the numbers of those also trained in working with deaf clients with eating disorders. In contrast to hearing individuals, Fletcher (1993) found that the hearing-impaired group of subjects were not as

knowledgeable about why they engaged in certain behaviors.

Fletcher (1993) also pointed out the possible need for revision of eating disorders testing and the need for education about special needs of this population. These clients may not be able to read and write English and, therefore, eating disorders may be as easily detected through inventories and tests currently available (Fletcher, 1993; Pollard, 1993-94). If professionals in the mental health field are to take the documented research seriously and recognize the prevalence of eating disorders among the deaf and hard-of-hearing, it will be important to be equipped with proper tools necessary to detect eating disorders among deaf and hard-of-hearing clients.

Sexual Orientation

Langholtz and Rendon (1991-92) discussed gay/lesbian deaf individuals and the impact of communication problems on acceptance of themselves and acceptance within their family and community. Langholtz and Rendon referred to this culture as a "minority within a minority" (p. 34) and discussed the

difficulties they might experience in relationships as well as issues involving self-esteem and feelings of isolation. Langholtz and Rendon noted the difficulties experienced by gay/lesbian individuals in the coming out process. This difficulty may have something to do with the communication barriers experienced by the deaf and hard-of-hearing living in a majority hearing culture (Wax, 1990). It is also difficult for gay/lesbian clients to find counselors with specialized training in the issues faced by them (Langholtz & Rendon, 1991-92).

Alcohol and Drug Abuse

Moser and Rendon (1992) discussed changes that must occur within the system in order to provide recovery services to the deaf and hard-of-hearing. Recommendations are made for mental health professionals working with the deaf to receive training on drug and alcohol issues, assessment and interventions. Moser and Rendon described a program in place in the San Francisco Bay area in which such training is provided to deaf service providers, drug service providers, and mental health workers as well as

sheriff departments, police departments and probation departments. Such training focuses on deafness, the deaf culture, the use of interpreters, on-site and phone consultations, and the recognition of and interventions for drug and alcohol use. The authors encouraged taking a systematic approach including the following 5 components: needs assessment, advocacy, adequate funding, training, and evaluation.

Guthmann, Lybarger, and Sandberg (1993) discussed treatment approaches used with chemically dependent deaf or hard-of-hearing individuals at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals and noted that over 75% of the clients admitted had an additional diagnosis of chemical dependency. The researchers commented on treatment approaches used for dual diagnosis of chemical dependency and additional mental disorders such as depression, antisocial personality disorder, borderline personality disorder, developmental disorders, and post-traumatic stress disorder. Suggestions were made by these researchers to treat the

diagnoses simultaneously and reported they found that to do otherwise was ineffective.

Problem Solving Skills

Luckner (1992) conducted a study comparing the problem solving skills of hearing-impaired and hearing individuals and found that individuals in the hearing-impaired group were less skilled at problem solving. Luckner commented on the importance of helping these individuals improve problem solving skills through cognitive intervention as part of the curriculum in the schools and helping students to generalize those skills to their lives. In contrast, Pollard (1992-93) noted those in psycholinguistics discovered deaf individuals displayed problem solving strategies that were successful.

If deaf and hard-of-hearing individuals are indeed less skilled in the area of problem solving, then the counselor working with the deaf and hard-of-hearing may want to carefully consider the use of cognitive interventions which might be difficult for some clients.

Further research is needed addressing the specific mental health concerns of the deaf and hard-of hearing

culture; however, the research conducted in the areas covered in this paper provide an argument for the recognition of the unique concerns of the deaf and hard-of-hearing population in regard to specific mental health issues. The need for such services must also be recognized. The mental health needs of the deaf and hard-of-hearing population will be explored in the next section.

The Mental Health Needs of the Deaf and Hard-of-Hearing

Critchfield (1992) pointed out the discrepancy in the number of hard-of-hearing adults needing comprehensive rehabilitation and those who actually receive such services. Critchfield noted some identified needs among the population of low-functioning deaf adults as emotional problems, behavior maladaptation, cultural deprivation, communication and educational deficiencies, and other physically handicapping conditions. Myers (1993) proposed a Model Mental Health State Plan which would include recommendations for providing services to deaf and hard-of-hearing mentally ill, including guidelines for equal access and standard of care. Gore and

Critchfield (1992) also discussed developing a state-wide mental health system. Gore and Critchfield suggested improvements in the mental health system that might increase the accessibility of such services to the deaf and hard-of-hearing. In the next section, the availability of services to the deaf and hard-of-hearing in the schools and in community mental health systems will be examined. The value of feedback received from the deaf and hard-of-hearing community about such services will be discussed.

Services to Deaf Students

Research indicates that services to deaf students in the schools have increased (Bricetti, 1987; Wyatt & White, 1993). However, some disagreement in the literature was found regarding services to students. Bricetti (1987) noted that, although school psychologists recognize the need for counseling services, they actually spend more time administering tests than counseling students. Gjerdinggen (cited in Weaver & Bradley-Johnson, 1993) commented on the need for psychologists experienced in working with deaf children, the lack of experienced psychologists, and

the need to train more. Elliot, Glass, and Evans (cited in Weaver & Bradley-Johnson, 1993) noted the need for psychologists who work with the deaf to learn about deafness and the characteristics of deaf individuals. In a National Survey conducted by Levine (cited in Weaver & Bradley-Johnson, 1993), it was reported that professionals working with deaf students lacked knowledge about deafness and lacked the ability to effectively communicate with them. It was also found that professionals engaged in little preparation for working with individuals in this population.

Sevigny-Skyer (1992) noted that students involved in a course which discussed the psychosocial aspects of deafness also sought individual counseling to discuss feelings associated with the experience of deafness and concerns about family interactions. Counseling, combined with such a course, was reported to have resulted in positive feedback from participants (Sevigny-Skyer, 1992).

Community Mental Health Services

The literature suggests counselors who have specialized training in working with deaf and hard-of-

hearing are failing to reach a large percentage of this population who reside in the community and are not involved in traditional rehabilitation programming (Wyatt & White, 1993). Furthermore, although research indicates services in the schools for deaf and hard-of-hearing have improved (Bricetti, 1987; Wyatt & White, 1993), counseling services to the pre-adult population even in educational settings may still be lacking (Bricetti, 1987; Weaver & Bradley-Johnson, 1993; Wyatt & White, 1993). The research indicates deaf and hard-of-hearing individuals continue to lack access to community mental health services (Myers, 1993; Wyatt & White, 1993). Myers (1993) noted that deaf and hard-of-hearing individuals fail to access mental health systems due to the possibility of communication misunderstandings and because they believe them to be "inaccessible" (p.24). As Wyatt and White (1993) pointed out, the same problems (personal and interpersonal) experienced by the hearing are experienced by the deaf and hard-of-hearing. Similarly, Gore and Critchfield (1992) commented that, although the needs of the deaf are the same as those of

the general population, a distinguishing factor is that, due to communication barriers, deaf people are not adequately served by the mental health system. It may be helpful for professionals in the mental health field to listen to feedback from the deaf and hard-of hearing community and respond with efforts geared towards increasing accessibility of services to the deaf and hard-of-hearing community.

Input From Deaf and Hard-of-Hearing Individuals

Researchers have noted the importance of obtaining feedback from deaf and hard-of-hearing individuals (David & Trehub, 1989; Sevigny-Skyer, 1992). David and Trehub (1989) noted the importance of consulting with the deaf about their use of services and their problems and opinions about services offered. Critchfield (1992), in his discussion of low-functioning deaf adults, pointed out that the success of research efforts will be measured by the "quality of life" (p.15) improvements experienced by recipients. Pollard (1993-94) noted the value of feedback from deaf community leaders when conducting research and the connection they create between the deaf community and

researchers. Similarly, Wax (1990) proposed training deaf community leaders to serve as "bridges" or liaisons between the deaf community and mental health professionals which could aid in making services more accessible to the deaf and hard-of-hearing community. Legislation has also done a great deal to help facilitate this movement.

Legal and Ethical Considerations

The Use of Interpreters

According to Public Law 94-142 (Education of Handicapped Children Act, 1975) and Public Law 93-12 (Rehabilitation Act of 1973), interpreters are to be provided for deaf clients at agencies receiving government or federal assistance (Anderson & Stauffer, 1991-92; Roe & Roe, 1991). This opens to door for deaf clients seeking mental health treatment who may not have been able to afford it otherwise, as they would have had to pay for the use of an interpreter themselves.

American Sign Language is considered a distinct language (Pollard, 1992-93; Roe & Roe, 1991). Therefore, Roe and Roe (1991) pointed out the need for

a third party, a person fluent in both American Sign Language and in English, when a deaf person using sign communicates with a nonsigning person who speaks English. This leads to the ethical question of bringing in a third party which could have several implications in therapy. First of all, who should that third party be? Roe and Roe (1991) noted that a referral should first be made to a signing therapist; however, this may not always be possible and the use of an interpreter may be necessary. When considering an interpreter, Roe and Roe (1991) noted one with the highest skill level possible should be sought. Interpreters possessing the Comprehensive Skills Certificate from the national certifying board, the Registry of Interpreters for the Deaf, are recommended. Much like the shortage of mental health counselors with specialized training, there is also a shortage of interpreters. However, regional training programs for interpreters have now been funded and national research was conducted to identify standards of competency of interpreters (Anderson & Stauffer, 1991-92). There are also ethical issues of confidentiality when engaging a

third party that must be considered. The Registry of Interpreters for the Deaf Code of Ethics provides clear guidelines for registered interpreters when working in mental health situations (Roe & Roe, 1991).

Although Gardner (cited in Roe & Roe, 1991) pointed out there have not been any court cases involving the use of interpreters in counseling, the potential for such cases should be considered. Roe and Roe (1991) commented on the potentiality of such cases with regard to violations of the code of ethics, breaches in confidentiality, misdiagnosis, miscommunication, and privileged communication.

Confidentiality and Trust

Confidentiality and trust are issues when working with any client in a counseling situation. However, Stansfield (cited in Roe & Roe, 1991) noted the emphasis on the trust issue with deaf clients. Roe and Roe (1991) commented on the issue of trust for deaf clients and noted providing an explanation of the guidelines for confidentiality to the client.

Litigation

Katz, Vernon, Penn and Gillece (1992) discussed the increasing use of consent decrees in resolving

litigation between deaf individuals and mental health systems. When a lawsuit is filed by a deaf individual who feels he or she has been denied mental health services, a consent decree may be used as a method of resolution. This would essentially be an agreement between a plaintiff and defendant in which the suit would be dropped by the plaintiff if the defendant agrees to provide adequate services for the deaf community. The researchers discussed how effective consent decrees could be in leading to improved services for the deaf and to aid administrators of mental health agencies in the provision of programs for the deaf. The researchers further noted the use of consent decrees will become more common due to a new law, the American with Disabilities Act, which makes it easier for attorneys to acquire consent decrees.

Passed legislation, consent decrees, and the use of interpreters are all examples of ways in which mental health services to the deaf and hard-of-hearing have improved and, hopefully, because of such efforts, these services will continue to evolve. The next step towards improving mental health services to the deaf

and hard-of-hearing could be the specialized training of counselors who plan to work in community mental health settings (Wyatt & White, 1993).

Specialized Training Programs

Few qualified professionals in the mental health field have specialized training and expertise in working with the deaf and hard-of-hearing (Bricetti, 1987; Pollard, 1992-93; Roe & Roe, 1991; Wax, 1990; Wyatt & White, 1993). However, several specialized programs for training mental health counselors do exist across the United States (Wyatt & White, 1993).

Counselor Training Programs Currently Offered

Gallaudett University began a school psychology program with a specialization in working with deaf individuals in 1977. This was the first specialized training program for working with the deaf (Pollard, 1992-93). Ten programs across the country now offering specialized training in deafness counseling were recognized in the literature (Wyatt & White, 1993).

In a nationwide study conducted by Wyatt and White (1993), ten schools were identified as "National Training Programs in Deafness Rehabilitation" (p. 9).

All ten programs were CORE (Council on Rehabilitation Education) accredited, and one program had an additional accreditation through CACREP (Council on Accreditation of Counseling and Related Education Programs). The researchers found there to be a mean number of 8 to 10 graduates from these programs per year. Employment data obtained indicated that the majority of the graduates were working in traditional rehabilitation settings, as opposed to within community mental health agencies. The authors noted the lack of accessibility of community mental health settings to deaf individuals in the community.

Wyatt and White (1993) made an important point about the implications of their research as they noted that counselors with specialized training in working with the deaf and hard-of-hearing are either "not trained to work within community mental health settings" or "mental health agencies are not making an effort to recruit counselors with these cross-cultural counseling skills" (p. 11). These researchers reported that future studies are needed to examine administrative attitudes towards hiring counselors with

such specialized training, as well as the professional expectations of students graduating from specialized programs. The authors of this study further noted that graduates from counselor education programs may be more apt to be hired in community mental health settings than rehabilitation counselors. The authors commented on the possible implications for training if counselor education programs and CACREP were to recognize the needs of the deaf and hard-of-hearing culture.

Future research in this area is needed to determine what has lead this population to go underserved. The literature reviewed suggests specialized services and specialized training of counselors working with the deaf and hard-of-hearing are needed (Bricetti, 1987; Roe & Roe, 1991; Wyatt & White, 1993). The following section contains recommendations for what such programs might entail and how they might be offered to more counselors across the nation.

Recommendations for Specialized Programs

Specialized training programs could provide education about the different types of deafness and the

various emotional, sociocultural and psychosocial aspects associated with each. Ethical and legal aspects of working with deaf and hard-of-hearing clients should also be given great emphasis.

It would be helpful for training programs to incorporate classes in American Sign Language, eliminating the use of a third party interpreter in the counseling setting. Counselors graduating from such programs would be bound by the ethical guidelines which cannot always be expected of interpreters (Roe & Roe, 1991). Specialized training might be provided on assessment and diagnoses of mental disorders among the deaf and hard-of-hearing and how the disorders might be experienced differently by deaf and hard-of-hearing individuals as opposed to the general population. Lastly, specialized training programs must include rather intense clinical experience in which the counselor-in-training receives experience in working with the deaf and hard-of-hearing. This may be the most valuable of all recommendations provided for specialized training programs.

Furthermore, more training centers, possibly satellites if those already in place, could be established in other areas of the country. It might be feasible for students completing degrees in accredited counseling programs to have the opportunity to access additional training at a satellite center specializing in working with deaf and hard-of-hearing. It would then be likely that counselors with specialized training in working with the deaf might be more available within the community and, as a result of this increased availability, the number of deaf and hard-of-hearing clients served would also increase.

Lastly, graduates from counseling programs have a responsibility to ensure they receive proper training if they intend to provide services to deaf and hard-of-hearing clients. Therefore, while it is the responsibility of the prospective counselor to obtain proper training, community mental health agencies must take responsibility for hiring qualified professionals with specialized training in working with the deaf and hard-of-hearing (Wyatt & White, 1993).

Conclusion

The deaf and hard-of-hearing community and the specific mental health concerns of this population have been examined. The need for accessibility of services offered to this population have also been described. Similar to a person from another country who speaks a completely different language, the deaf and hard-of-hearing live as a minority in a society where they are able to communicate with few of the majority culture. Much like Langholtz and Rendon (1991-92) noted about gay/lesbian deaf clients, with the small numbers accessing mental health services, the deaf and hard-of-hearing diagnosed with mental disorders are really, in many ways, much like a "minority within a minority" (p. 34).

Specialized training programs for mental health counselors are clearly needed. It is hoped that, as research in this area continues to broaden, counseling education programs and graduate students enrolling in such programs will recognize the need for specialized training in working with the deaf and hard-of-hearing (Wyatt & White, 1993).

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