Techniques of Screening For Mental Illness Among Deaf Clients*

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The professional specialist in deafness who is able to identify those clients, patients, or students who may have incipient or manifest mental illness provides an extremely constructive service. Although this is not an easy responsibility to fulfill, it is often crucially important. As in conditions such as pneumonia, cancer and scarlet fever, the early recognition of emotional disturbances greatly enhances the potential effectiveness of treatment.

The purpose of this paper is to provide the vocational counselor or other professional working with deaf persons a description of specific behaviors and processes associated with mental illness. These are symptoms which suggest the need for referral to an appropriate specialist and which should be considered in the planning of a rehabilitation program. An effort is made to relate the basic work on symptomatology of Menninger (1962, 61-140), Grinker et al (1961, 31-94) and Redlich and Freedman (1966, 197-220) from the field of general psychiatry to existing knowledge about the psychological functioning of deaf persons (Rainer, Altshuler, Kallman, and Deming, 1964; and Vernon and Mindel, 1969). The reader is referred to these references for a fuller examination of the issues.
**General Problem**

Even for the highly skilled psychologist or psychiatrist unexperienced with deafness the problem of correctly identifying mental illness in deaf persons can be discouragingly confusing. For example, a survey of New York State Psychiatric Hospitals revealed that over one fourth of deaf patients had been diagnosed mentally deficient as contrasted to only 3.7 percent of the nondeaf (Rainer et al, 1964, 199-200). Yet, it has been established that I.Q. is essentially normally distributed in the deaf population (Vernon, 1968). Obviously gross errors had been made in the fundamental, but relatively easy to make diagnosis of mental retardation. The author’s experience surveying hospitals in Illinois indicates that similar misdiagnoses are at least as common here. Since these are two relatively affluent progressive states it is disturbing to project the number of intelligent deaf persons diagnosed and hospitalized as psychotic with mental deficiency, who may or may not be psychotic but who in an estimated 95 percent of the diagnoses are inappropriately labeled as retarded. Classification as “psychotic with mental deficiency” usually means placement in a back ward with chronic patients and with custodial rather than therapeutic care. Hence, such risdiagnosis can be ruinous.

In addition to errors of diagnosis in hospitals for the mentally ill there are many such cases in institutions for the retarded. The author has previously reported a number of these from his own research and clinical practice one of whom is now a college student (Vernon, 1967, 1968; and Vernon and Brown, 1964). The following documented case from Idaho nosis can be ruinous.

*Discover 30-Year Mental Patient is only Deaf*

A man with an intelligence quotient of 135 has been a patient at Idaho’s State School and Hospital for the mentally retarded for 30 years.

Dr. John Marks, school superintendent, said Saturday the man, who was not identified, was admitted as an infant
when his parents thought him mentally retarded. Marks said a recent stepped-up testing program revealed the man was not mentally retarded-only deaf.

"He spends his time studying and doing calculus problems in his mind, as he has for years, and nobody knew it," Marks said.

Despite the man's high I.Q., Marks said that 30 years in an institution has left the patient "socially inadequate" to cope with outside situations. He said the patient will continue to stay at the school for a while, but will receive special training to prepare him for work outside.

The confusion involved in accurately detecting symptoms of a relatively simple condition to diagnose such as mental retardation are compounded many fold when the complexities of determining other psychiatric nosologies are faced. Deaf people may be incorrectly classified as schizophrenic due primarily to their communication limitations growing out of deafness, limitations which may be totally unrelated to whether or not they are psychotic. In other cases labels such as paranoid are used because of folklore about deafness and paranoid states, not as a result of actual paranoid behavior by the patient (Rainer et al, 1964 198-292). In some instances psychological tests involving language comprehension far beyond that possessed by the deaf patient are administered and results used in diagnosis. Just as a multiple choice test given to us in a foreign language would elicit some rather bizarre answers and psychodiagnostic profiles so it is when deaf persons are required to answer questions they do not understand. Rosen's (1968) excellent paper documents this problem relative to the use of MMPI.

The point in presenting this evidence is to illustrate that the problem of diagnosis and treatment of deaf persons is not an easy one. Nor is identifying the deaf individual in need of help and referring him to a therapist or a rehabilitation program an assurance he will receive appropriate care. However, it is a necessary first step.
Symptoms of Mental Illness

There are a number of areas of psychological functioning that should be considered in a screening procedure. Each of these will be discussed separately. It is important to remember that much of the symptomatology described is present in everyone. Only when it is observable to a marked degree, in many aspects of a person’s behavior, or is incapacitating does it become indicative of mental illness.

Observable Physical Behavior and Action

Current research with the normally hearing (Ekman and Friesen, 1968; Shapiro, 1966; Mehrabian, 1968; and Rosenthal, 1967) demonstrates that “body language”, i.e., postures, facial expressions, mannerisms, etc., are major indicators of how people feel—of their affective state. This finding has astonished many clinicians and therapists who, as a group, have historically placed almost exclusive emphasis on the role of words in revealing such information. In fact the deprecatory term “veterinary psychology” was previously used to describe emphasis on nonverbal cues. Interestingly deaf persons and those who have extensive close association with them have long been aware of the vast amount of communication which occurs nonverbally.

In the absence of hearing the deaf individual is left to depend almost solely upon what he sees of others, not on what they say. Deaf persons’ remarkable social perceptiveness of affective states is in large part a function of the extent to which they “read body language” and are not distracted by verbiage. To illustrate with a personal example, the author has often attended social functions where his wife was the only deaf person present. While everyone else was busy exchanging platitudes and other conversation she was left dependent upon nonverbal observations. Inevitably her perceptions of the feelings of those present were uniquely valid as substantiated by later events and by later discussion with those present.
In brief the theoretical basis for this lies in the fact that feelings have a large unconscious component. Whereas, people can exercise reasonable conscious control over their selection of words, they rarely have the same capacity in terms of their body postures, gestures and facial expressions. By illustration, when exchanging a perfunctory greeting the affective message is not carried by the verbal symbols, "Good Morning," but by the overall motoric behavior (smile, aversive glance, hasty departure, etc.). When a dinner guest compliments the hostess' cooking the true message is not in the cliche' of verbal praise, but in the expressions and gestures which accompany it. A more romantic example of the intensity of nonverbal affective communication are the feelings one has when looking into the eyes of a lover.

The point of this rather extensive discussion of nonverbal communication is to demonstrate its tremendous diagnostic value, especially with deaf clients with whom verbal interaction may be limited. What follows are some ways this can be used to identify deaf persons who may have possible serious mental difficulties.

Anxiety—Excessive tension and nervousness are fundamental indicators of underlying conflicts. Whereas the psychologically healthy person experiences anxiety around crucial events in his life such as applying for a job, getting married, or facing danger many mentally ill individuals feel in a state of perpetual crisis due to unresolved inner turmoil. Generally the reason for this anxiety is unknown to the person. Examples of its manifestations are excessive smoking, nail biting, grinding of the jaws, fidgeting, inability to sit still or to concentrate, undue perspiration, wringing of the hands, foot tapping, etc.

All of this activity is highly visible and can be helpful in evaluating deaf persons in terms of their mental health. In caution is should be noted that some highly anxious individuals are able to mobilize their tensions and direct them toward constructive activities. In fact many successful and creative persons are motivated by inner turmoil and anxiety.
For practical purposes anxiety becomes unhealthy psychologically only when it threatens to overwhelm a person and reduce his capacity to utilize his energies effectively.

**Peculiar habits**—Tics and behaviors such as frequent blinking, repeated grimacing, and other similarly odd non-functional behaviors are symptomatic. Compulsions, which are useless irrational acts such as excessive hand washing, are also suggestive of psychopathology. Ritualistic routines, strange posturing, the mechanical repeating of a gesture, or unusual eating, sleeping, excretory, or sexual practices are other peculiar habits which may point to mental illness.

**Motoric activity**—Agitation, impulsiveness, and hyperactivity often reflect excessive tension. Stupor or rigidity of posture are symptoms at the other end of the activity continuum. At either extreme the behavior is often an effort to cope with excessive underlying tension. Hence, it may be symptomatic.

**Eye Contact**—An unwillingness to look another person in the eye was established in folklore and literature as having negative significance long before the advent of psychology. In extreme forms it is seen in some autistic children who make no eye contact at all under any conditions. A continuing inability or unwillingness to look into the eyes of another suggests pathological guilt or fear.

**Emotion (Affective Reactions)**

Warmth in human interactions and a capacity to relate to others are basic to normal adjustment. Thus, these areas should be evaluated. The points below offer some guidelines.

**Lack of affect**—Flatness, apathy, coldness, or blunting of feelings in extreme forms are most indicative. They reach an epitome in the catatonic schizophrenic who stands immobile for hours ostensibly unresponsive to all around him.

**Uncontrolled emotionality**—At the other end of the continuum and equally suggestive of psychological disturbance are
reCURRENT rage, jealousy, suspiciousness, remorse, fearfulness, lability, or elation.

In considering the area of affective reactions (feelings) the appropriateness of the behavior and the degree of agreement between the emotion and the action are crucial considerations. For example, a frank suspiciousness may be in order when purchasing a used car, whereas, it should not characterize interactions among friends. On the one hand it is associated with normality, on the other hand derangement.

Thought Process (Cognitive Reactions)

In the normal person there is basic curiosity, memory, fantasy, and range of ideas. Extreme deviation in these and other areas of thought process can be diagnostically valuable. In the deaf person of limited language skill great care and experience may be required to distinguish poor syntax and word usage due to deafness from cognitive disorders resulting from mental illness.

Distortions—Inordinate memory defects, delusions, hallucinations, excessive transparent lying (confabulations), and gross judgemental deficiencies are fairly obvious indicators that something is psychologically wrong. In some instances these symptoms are associated with organic brain damage, chronic alcoholism (Karsokov’s syndrome) for example.

Lesser deviations—Of more minor degree are symptoms such as vagueness, blocking, flight of ideas, irrelevance, and obsessionalism which are also suggestive of behavioral disorders. Once again caution must be exercised to avoid confusing the language handicap of some deaf persons with a number of these symptoms.

Relations to Self, Others, Things and Ideas

Ability to relate to others—This area is crucial. The interviewer can get an impression about it from the interactions which occur between himself and the client. Is there a warmth and friendliness conveyed? Does the basic mood seem one of
positiveness? Does frankness and openness characterize the interview?

Some effort should be made to determine the main persons in the client’s life, his best friends and worst enemies because this information yields an additional picture of interpersonal relations. Indicators of psychopathology to be considered are a lack of social relationships (withdrawal), perception of others as evil or undesirable, fear of people, excessively dependent relationships, or extreme hatreds. Since it is a common human trait to attribute to others those characteristics found most undesirable in the self, the kinds of projections which the client may make can be incisively revealing.

Relations to things and ideas—Psychological disturbance may manifest by unhealthy religiosity involving perceptions such as, “Everyone is sinful but me,” “God tells me things,” or “the Devil controls my body.” Excessive systematized racial prejudices are frequent symptoms of underlying abnormal rage and frustration. Hobbies can suggest whether or not the person is sociable or withdrawn and the kinds of areas in which he seeks satisfactions.

Time perceptions also reveal valuable clues. Is the client future oriented or preoccupied with the past? Does he procrastinate? Are there large amounts of time spent in fantasy?

Relations to Self—Most important here is whether or not the client sees himself as a worthwhile person. Ways to assess this are to ask about his ego ideals, i.e., whom would he desire to be like. What ethics does he feel are both good and realistic? How attainable are these in terms of the person’s actual accomplishments and potential? Excessive self reproach, perfectionism, and asceticism suggest unhealthy relations to self, and may be associated with poor adjustments.

Attitudes toward one’s body are psychologically important, but not easy to assess. Some clues to negative body image concepts are injury proneness, inhibition, hypochondria, compulsive cleanliness and a discrepancy between the actual and the self perceived appearance of one’s body.
Rather than simply summarize the material thus far presented an effort will be made to facilitate the practical matter of using it. First, aspects or referral will be discussed and then a symptom checklist will be provided.

When a deaf person is seen for whom it is felt further psychodiagnostics or treatment are needed two issues immediately arise. One, is where can a qualified person be found who can provide this service. Two, how best can the needed information about the client be conveyed to this person.

Initially it may seem impossible to find a psychologist, psychiatrist, or other professional mental health specialist able to provide service. Although there is a critical shortage of such persons the situation is not hopeless. First, the state residential or large day school should be contacted and asked about available skilled persons. The Directory Issue of the American Annals of the Deaf (Dr. Powrie Doctor, Editor, Gallaudet College, Washington, D. C.) lists psychologists and psychiatrists in deafness. If these efforts do not yield positive results two additional steps should be taken. First, through the Registry of Interpretors (write or phone Mr. Al Pimentel, Executive Director, 2025 Eye Street, N. W., Washington D. C. 20006) obtain the name and address of a person who can use the language of signs. Although, a few hearing impaired persons may not need an interpreter most will (Rainer, 1966; Vernon, 1965). Then from a local college, medical school, mental hospital, psychological or medical society obtain the names of the best available therapists. When financial considerations rule out privately paid for care of this kind, Division of Vocational Rehabilitation monies can often be used. For example, in Chicago there are a number of deaf persons now receiving care funded this way. Yet, the service is not used nearly as often as it should be because referring personnel do not realize the possibility or how to implement it. Deaf persons suffer as a consequence of this ignorance.

Granted the feasibility of these two means of serving deaf persons needing diagnosis one final issue remains. The issue is how to effectively communicate the information which
led to the referral, i.e., exactly what symptoms did the client present. There is tremendous value to all concerned if the referring counselor or other specialist can state in operational terms the facts that led to the decision that diagnosis and possibly treatment were needed.

To do this some case history material should be presented along with specific concrete data about the patient which was gleaned from the interview. In order to aid the referring person in doing this the following outline is provided. It takes the major areas considered in the screening interview and describes fairly specific symptoms within these areas. It is suggested that screening interviews be conducted and recorded using this outline as a conceptual frame of reference. Then in the referring report the relevant symptomatology should be reported and documented with specific examples of behavior. Without the examples the report is an unsupported armchair diagnosis. With the behavioral documentation it becomes an extremely valuable description of the patient which can greatly facilitate the service the psychologist or psychiatrist is able to provide. Corollary to this it will reduce the present unfortunate frequency of gross misdiagnosis of deaf children and adults.

**SYMPTOMS OF MENTAL ILLNESS**

I. *Observable Physical Behavior and Action*

A. *Anxiety*-The following are potentially symptomatic when excessive

1. Overactivity
2. Nail biting
3. Smoking
4. Grinding of teeth
5. Wringing of hands
6. Perspiring
7. Restlessness
8. Nervousness
B. **Peculiar Habits**

1. Facial tics
2. Grimacing
3. Compulsiveness (meaningless repetition of behaviors, such as hand washing)
4. Strange posturing
5. Bizarre eating, sleeping, excretory or sexual habits.

C. **Motoric Activity** (Overlaps some with “A” above)

1. Rigidity of posture
2. Muscular tightness
3. Stupor or inertia

D. **Eye Contact**

II. **Emotion (Affective Reaction)**

A. **Lack of Affect**

1. Flatness
2. Apathy
3. Coldness
4. Detachment
5. Blunting
6. Shallowness

B. **Uncontrolled Emotionality**

1. Rage
2. Jealousy
3. Lability
4. Euphoria
5. Suspiciousness
6. Depression
7. Fearfulness
8. Impulsiveness
III. Thought Process (Cognitive Reactions)

A. Distortions
1. Memory defects
2. Delusions
3. Hallucinations
4. Confabulations (lies)
5. Judgemental deficiencies

B. Lesser Deviations
1. Vagueness
2. Blocking
3. Obsessions
4. Flight of ideas

IV. Relations to Self, Others, Things and Ideas

A. Ability to Relate to Others
1. Hostility
2. Isolation
3. Suspiciousness
4. Nature of friends and enemies
5. Excessive dependence
6. Intense hatreds
7. Perceptions of others (as evil, homosexual, etc.)
8. Fear of social situations

B. Relations to Things and Ideas
1. Bizarre religiosity
2. Strong ethnic prejudices
3. Unwholesome hobbies
4. Fantasy
5. Procrastination
6. Preoccupation with past or future as contrasted to present.
C. Relations to Self

1. Self reproach
2. Perfectionism
3. Asceticism
4. Injury proneness
5. Hypochondria
6. Inhibition
7. Compulsive cleanliness

REFERENCES


Rainer, J. D. Interpretation, communication, and understanding. Deaf American, 1966, 19, 43-45.


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