Psychiatric Services for The Deaf: Some Unmet Needs

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PSYCHIATRIC SERVICES FOR THE DEAF: SOME UNMET NEEDS

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Last year many of you met with us in Houston to discuss the roles of our various disciplines in the mental health care of the deaf. The proceedings of that meeting which we tentatively entitled "Mental Health and the Deaf: Approaches and Prospects," edited by Dr. Altshuler and myself, are being printed and I hope that we will all have them before the end of the year. I do not want to use the time allotted to me this morning to repeat the description of our program in New York State (prevention, outpatient, inpatient, aftercare service and rehabilitation) a description which was recently published again in your journal, except to say that the program is going well and that it has continued to evoke a sense of accomplishment and devotion in all of us who are part of it. I would rather spend our time this morning outlining some of the problem areas, some of the gaps in service, some of the as yet unmet needs, some of the mental health areas in which more attention has to be given in the future.

Perhaps I may outline very schematically at first, at the risk of repeating things which I have said before, some of the particular mental health problems of the deaf as seen by a psychiatrist. All these problems essentially stem, in my opinion, from barriers in communication starting from the very earliest moment of life, going through the preschool period, the school period, and the period of adult socialization. Early feelings of rejection and abandonment, loss and anxiety, diffic-

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difficulty in expressing impulsive needs, lack of opportunity to develop a social sense and a feeling for others, problems regarding empathy, conscience, ability to handle power and strength and, as important as anything else, problems of identification and self-image, all these depend upon communication, upon a two-way path of understanding and emotional rapport with others. Now, when I have spoken this way previously, I have sometimes had the interesting experience of being approached later by a dedicated oralist and told “that was wonderful what you said about the need for oral communication;” then, walking, to the other side of the hill, I would be approached by an advocate of manual or combined communication and be told, “Why that was wonderful what you said about the need for manual communication.” Now, I certainly feel, as a research scientist, that all of the answers are not yet in regarding this thorny problem, but I can only say that when I do use the word communication I do not limit it to any one kind of communication. The picture may be different for different people, for different families, and future research may throw more light on the whole problem.

It is also not necessary for me today to discuss in great detail the problems of psychiatric diagnosis which have been covered in some of our previous writings. In addition to about the expected number of persons with severe psychotic disorder, one also finds certain particular types of adjustment difficulties including those associated with immaturity, with impulsivity, with dependence and with problems of empathy and relationship. What we have done so far has been to study the diagnostic problems, develop therapeutic techniques, set up first a clinic, then a hospital ward, then an aftercare and halfway house service and finally the beginnings of a preventive program in the schools and with the parents.

Let me turn then to some of the unmet problems as I see them. First, of course, there is the need to extend the basic services to the deaf which I have just described to other parts of the country and indeed to other parts of the world. Those of you who heard Rosenstein’s paper in Houston last year on the funds that are available to persons willing to make the effort will know that the lack of action in this area cannot
be blamed on the lack of potential support. It will be up to members of the various disciplines represented here to work within their discipline and to variously take the lead in coordinating the work of different disciplines to the end of establishing proper services. We have tried to spread the gospel to the psychiatric profession through our New York meeting of 1967 and to the various other mental health professions through the Houston conference of 1968. Perhaps the Hot Springs conference of 1969 can help to keep the momentum going. The biggest need, of course, is personnel: psychiatrists, psychologists, social workers, rehabilitation counselors, nurses, must be given access to the literature and be made interested in giving all or part of their time to so important and rewarding a field.

I might say now that part of the problem of recruiting personnel is that of making the public generally aware of the deaf, of their potential, of their needs as well as their contributions, so that this general feeling may trickle down into the professional areas and the whole problem not be so much an unknown territory for so many people. It is distressing sometimes to see how little is known about the deaf, even by such intimately concerned professionals as otologists or general educators, or psychiatrists. Here, the use of television media, of the theatre, of moving pictures in which the deaf are portrayed, or contribute, the increased employment of deaf persons where others may meet them as friends—these are among the avenues by which the public and professional groups may approach the deaf without a sense of strangeness or ignorance.

May I turn immediately to what I consider the most pressing new problem in the area of mental health care for the deaf, that is, the area of prevention and treatment for the young deaf child and the school age youngster. First, in the area of prevention we need early case finding, early detection of deaf children in the first year of life and immediate conferences with the parents so as to prevent the terrible sense of hopelessness and guilt, that can overcome such a parent, and to instill in the parent the need and the possibility for communication with the child on all levels. Individual counseling of parents and group sessions where parents may
pool their feelings, their experiences and their solutions, have to be organized in every community. At a recent session of this kind, it was interesting to note, for example, that whereas mothers usually like to extol their own child's achievement at the expense of others and feel twinges of jealousy when some other child does something which their child can not yet do, among groups of deaf parents there seem to be an opposite reaction. An accomplishment on the part of one child buoys up the spirits of the other parents because they feel that their child would soon also be able to do the same. Realistic discussions accenting both positive and negative factors are so important with these parents.

In spite of such mental hygiene programs, there will still be deaf youngsters who will represent mild, medium or severe behavior problems. Some of these will include children with multiple handicaps, neurological damage of various sorts related in some instances to the etiology of their deafness, or in other cases behavioral problems related to deprivation, over indulgence, or impatience at home. The parent cannot be considered out of the picture as soon as the child begins school at the age of three or four or five. We have seen so often even in residential schools, that the role of the parent on weekends, bringing the child to school, taking the child home, remains an important factor in the child's adjustment in school, in the child's ability to socialize, in the child's mood, and indeed in the child's learning capacities. Schools must have access to specialized psychiatric personnel, and physicians have yet to be trained to have sufficient experience in child psychiatry related to the needs of the deaf. More active steps must be made to contact centers for child psychiatry and one way or another to interest some of the child psychiatrists in problems of the deaf. This should not be as difficult now as it was formerly since the literature in the field is slowly growing and the fascination of its theoretical and practical problems is coming more and more to the attention of the profession.

There will still be some children whose disturbed behavior in spite of treatment at the site (change in approach, medication, work with parents) will continue to be so disturb-
ed that it would not be possible for them to remain in the ordinary classroom. For this, something which does not yet exist in most parts of the country must be established, namely, special classes or even special schools for such students where they may be transferred for as short a time as possible in order to attempt to treat them and make them ready for return to the normal classroom. I have seen such a school in England, at Stoke Poges, the Larchmoor School. We know, of course, of Dr. Basilier's work in Oslo. We need schools like that here. Nearness to a psychiatric teaching center would seem to be important. At the same time it would also seem that such a setting would be better physically at a school or in a school atmosphere rather than at a hospital or in a hospital atmosphere.

Another area in which there have been a few abortive attempts but more work must be done, one which is somewhat related to the last problem, is the problem of mental retardation in the deaf. Mental retardation may be due to a variety of causes some of which may include problems of deafness as well. Some persons may have multiple physical and neurological handicaps, others simply show an IQ deficit. Diagnosis, case finding, setting up training centers, both on inpatient and outpatient basis, are called for, and then rehabilitation, finding work, finding a place for the less severely retarded deaf and the proper institutional setting for the very severely retarded deaf. In these areas problems have barely been touched.

Another area in which I see much need for improvement is the relationship of criminal law and forensic psychiatry to the deaf. Just as it really is insulting to the deaf to consider them as retarded or defective or emotionally disturbed in the gross, it is also insulting to the deaf to consider that their delinquencies are only part of their deafness. The average deaf person is law abiding, though it might be helpful to have better avenues of communication so that the reasons for laws and the meaning for them are made more clear to those deaf people with lesser degrees of language sophistication. However, the tendency of courts to dismiss cases or place on suspended sentence deaf persons who have committee offenses
of a relatively serious nature is not helpful to the deaf or to society; yet here the need is very clearly pointed out for psychiatrists who can distinguish between mental illness, psychopathy, and wilful criminal behavior so that judges, courts and juries may be properly informed of the facts. I have examined a number of deaf persons for the courts, particularly on questions of competence, questions requiring psychiatric decisions that can only be made by physicians familiar with problems to a much more common emotional and potentially the diagnostic problems that arise.

We may turn from some of these more serious legal problems—the area of marriage and divorce. A number of deaf people have come to me and said that, because of their understanding and personal qualities, they have often been called upon by deaf couples who need marriage counseling. These people felt that they were not sufficiently qualified, and wanted to know how to become better equipped to be marriage counselors. Well, I think that in marital discord the first line of attack may very well be that of a sympathetic and understanding friend who can help the couple with some of their problems, but it is also true, if the problem is deeper, such a friend may become over involved and may not have the objectivity, or the psychological knowledge, or the experience to be of real help. Problems of choosing a mate of course even precede problems of marital discord. Most deaf people in our study and any other observations marry other deaf people. This limits, of course, the number of potential mates available to a given person, particularly if there are educational, religious, or other qualifications. The deaf person who has achieved high educational status will often particularly find it hard to choose a mate from the limited number of other deaf people in his group. Such deaf persons may sometimes marry hearing people and these marriages present particular problems though they often seem to work out quite well. On the other hand, there are many marriages that seem to be formed in haste without there really being the proper concord of minds, feelings and interests and the battle begins. Demands are made by either mate which the other cannot fulfill; problems of immaturity and dependency, problems of self-image and self-confidence, problems of concreteness and prob-
lems of impulsivity, all play a role in marital discords. Perhaps because of vocational problems there seems to be in many cases an accentuation of the different role of the sexes, so that I have seen many deaf married women feel that their potential has been far from realized and that they are being subordinated completely to their husband. Men on the other hand have often compounded this by insisting on many of their bachelor prerogatives even after marriage. This may be related to the residential settings with complete separation of the sexes that formerly (though not so much today) was the general rule in schools for the deaf, and is a reflection of the total problem of preparation for marriage and for life, including sex education. This is a problem which we took up ten years ago at a meeting of the executives of schools for the deaf and there have been a number of very worthwhile attempts since then to establish programs of family preparation in schools. It was only five or six years ago that I heard expressed by an old liner at a school for the deaf his feeling that money being spent on a sex education program should better be spent on building a brick wall between the girls and the boys side. Since then, I think some schools have gone quite a distance from this point of view, but I don’t think that it is time to stop—it is time for such programs to spread to other institutions. This development should lessen the amount of marital unhappiness and discord and there must then be further research into the courses of marital failure and divorce and further accessibility of marriage counselors in the persons of trained psychiatrists, psychologists or social workers.

Allied to the marriage counseling problem is the need for genetic counseling to provide deaf persons and parents of deaf persons with advice regarding the genetic aspects of deafness, the various syndromes associated with deafness, their prevention, treatment and management. There is needed still more research in this area as well as a sympathetic transmission of information to the interested parties. Often enough the genetic counseling results in researching people rather than scaring them, in making them understand that their fears were groundless, rather than providing them with new ones.
I have tried this morning then to explore some of the byways relating to mental health and the problems of the deaf and to look toward some future horizons. It is not too much to believe that some day the combined sciences of genetics, electronics, immunology, pharmacology, and virology may eliminate deafness or completely replace the missing pathways. As this happens, multiply handicapped deaf persons will probably increase relatively in proportion to the others, and psychiatric problems, if anything, will become more complex. In the meantime, however, we must really waste no more time in setting up the programs that are now needed so badly and that will be so rewarding humanly and socially.