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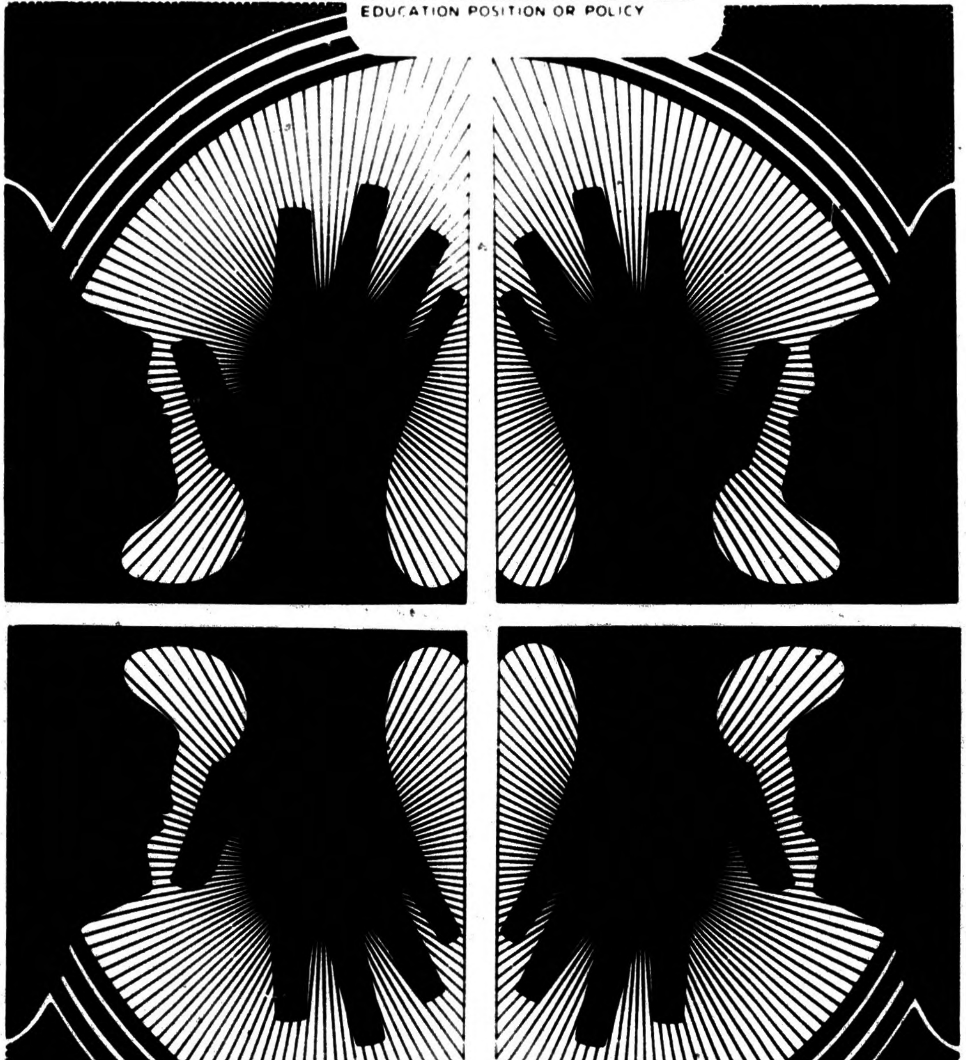
ABSTRACT

The publication contains four articles on the subject of mental health as it relates to deaf persons. "Deaf Americans and the President's Commission on Mental Health" discusses the Commission Report as a whole (by L. Robinson), the Report of the Task Subpanel on Special Populations (by B. Sachs), and the section on mental health needs of deaf Americans. "Mental Health and the Deaf -- A First Step Toward Epidemiology" (K. Altshuler et al) presents epidemiological data about major mental illness in persons with early profound deafness, focusing primarily on schizophrenia. A milieu intervention program for treatment of emotionally disturbed deaf children is also described (by T. Edelstein), along with efforts in Massachusetts toward a statewide coordinated approach to the development of mental health services for deaf persons (by B. Gerber). A section on relevant news briefs is also provided. (DLS)

National Institute of Mental Health

Mental Health In Deafness

Experimental Issue No. 2
Fall 1978



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Instructions to Authors

Individuals interested in submitting material to *Mental Health in Deafness* should communicate with:

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The editors will consider articles relating to mental health or mental illness in deafness, critical reviews of relevant literature which will be subject to defense, notices of recently published books on the subject (titles, prices, authors' names and publishing companies, but no critical reviews), abstracts of pertinent literature from other journals, and letters to the editor. Each original article submitted for publication must be accompanied by an abstract of no more than 135 words to be published along with the article. Manuscripts submitted will be initially reviewed by two or more members of the editorial advisory board or by other consultants as appropriate. After indicated changes are made by the editorial staff, the re-edited manuscript will be sent to the author for approval with a suspense date, usually 48 hours, for returning to the editor for publishing. The author is responsible for all statements made in his/her article, including changes made by the editor (unless the author challenges the latter at the time the re-edited manuscript is resubmitted for final review and publication).

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(Continued on inside back cover)

MENTAL HEALTH IN DEAFNESS

A Publication of Saint Elizabeths Hospital
National Institute of Mental Health

Mental Health in Deafness is an experimental publication of Saint Elizabeths Hospital; National Institute of Mental Health; Alcohol, Drug Abuse and Mental Health Administration. A limited number of copies of this experimental publication are available without cost to professionals in the field of mental health and deafness. To subscribe, write to Editor, Mental Health in Deafness, Saint Elizabeths Hospital, Washington, D.C. 20032. Material contained in this journal, including viewpoints expressed by Saint Elizabeths Hospital staff members, does not necessarily reflect the opinion, official policy, or position of Saint Elizabeths Hospital or the National Institute of Mental Health.

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Contents

Editorial

Experimental Issue #1 of *Mental Health in Deafness* was well received. Many favorable letters and requests for copies have been received. The current issue is proud to feature reports on the President's Commission on Mental Health. The Editor-in-Chief and the Associate Editor had the honor of serving on a Task Subpanel for that Commission.

The Editorial Board is more than pleased that the Commission gave such visibility and attention to the mental health needs of deaf people. The board also recognizes that the Commission assigned a major role to a deaf person to prepare the report on Mental Health of Deaf Americans.

Those of us in the field of mental health in deafness welcome this kind of interest and support.

Luther D. Robinson, M.D., Sc.D.
Editor-in-Chief

Special Feature

Deaf Americans and the President's Commission on Mental Health

A discussion of the Commission Report as a whole, the Report of the Task Subpanel on Special Populations, and the section on Mental Health Needs of Deaf Americans.

I. REPORT OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

Luther D. Robinson, M.D.

Overview

At an impressive ceremony held in the East Room of the White House on April 27, 1978, the First Lady and Honorary Chairperson of the President's Commission on Mental Health, Mrs. Rosalynn Carter, presented the final report of the Commission to President Carter. In attendance were the 20 Commissioners and some of the 450 additional persons who served on the Commission's 32 task panels. Among those present were the Editor-in-Chief and Associate Editor of this publication, both of whom served as members of the Special Populations Subpanel on Mental Health of Physically Handicapped Americans. The Associate Editor, Barbara J. Sachs, was called upon to prepare the oral presentation before the Commission on January 16th regarding the mental health needs of deaf Americans. This presentation was delivered in both spoken and sign languages simultaneously in order that deaf persons present at this hearing would comprehend the presentation more directly and that the efficiency of sign language would be demonstrated to the Commissioners as well. This presentation was subsequently expanded into a written report which is reprinted in its entirety elsewhere in this publication. The following consists of excerpts from the final report:

The Commission was established by Executive Order No. 11973, signed by President Carter February 17, 1977, to review the mental health needs of the Nation and to make recommendations to the President as to how the Nation might best meet these needs.

The Commission held public hearings across the country, and received the assistance of hundreds of individuals who comprised special factfinding task panels.

These task panels, made up of the Nation's foremost mental health authorities and other volunteers interested in mental health, produced and submitted to the Commission the reports which are contained in the Appendices to the Commission's Report.

The Report to the President from the President's Commission on Mental Health consists of four volumes:

Volume I contains the Commission's Report and Recommendations to the President.

Volumes II, III and IV are Appendices to the Report. These contain the reports of task

8

panels comprising approximately 450 individuals from throughout the country who volunteered their expertise, perceptions, and assessments of the Nation's mental health needs and resources in specific categories.

The Report to the President from the President's Commission on Mental Health will be available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. To order, cite Stock No. 040-000-000-00390. Allow approximately 3 weeks for delivery. Price of the report, Volume I, is $2.75

Reports to the Commission by its Special Task Panels and Study Groups are being published as appendices to the Commission report. These comprise Volumes II, III and IV, and may also be ordered from GPO as follows:

Volume II: Nature and Scope of the Problems—Community Support Systems—Mental Health Service Delivery: Planning and Review; Organization and Structure; Community Mental Health Centers Assessment; Access and Barriers to Care; Deinstitutionalization and Long-Term Care—Alternative Services—Mental Health Personnel—Cost and Finance. 556 pp. Stock No. 040-000-00391-6. $7.00.

Volume III: Mental Health in American Families; Learning Failure and Unused Learning Potential; Special Populations: Mental Health of Minorities, Women, Physically Handicapped; Mental Health of the Elderly; Rural Mental Health; Migrant and Seasonal Farm Workers; Mental Health Problems of Vietnam Era Veterans; 824 pp. Stock No. 040-000-00392-4. $8.75.

Volume IV: Legal and Ethical Issues—Research—Prevention—Public Attitude and Use of Media for Promotion of Mental Health—Art in Therapy and Environment—State Mental Health Issues—Liaison Task Panels: Mental Retardation; Alcohol-Related Problems/Psychoactive Drug Use/Misuse. 792 pp. Stock No. 040-000-00393-2. $8.50.

Individual Task Panel Reports contained in these appendices—as listed above—will be available from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Va. 22161.

Recommendations or Goals

1. Closer links of mental health services with each other, with general health, and other human services, and with those personal and social support systems that strengthen our neighborhoods and communities.

2. A responsive service system which provides high quality comprehensive mental health services throughout the country which are sufficiently flexible to respond to changing circumstances and to the diverse racial and cultural backgrounds of individuals. Such services should be adequately financed with public and private funds so that care is available at reasonable cost.

3. As insurance for the future, any plan for national health insurance should include appropriate coverage for mental health care, and Medicare and Medicaid should provide improved coverage for mental health care.

4. New directions for the Federal support of training to provide appropriately trained mental health personnel to meet the needs of special populations and to promote better distribution of personnel throughout the country.

5. Assure that mental health services and programs operate within basic principles protecting human rights and guaranteeing freedom of choice.

6. Broaden the base of knowledge about the nature and treatment of mental disabilities.

7. Undertake a concerted national effort to prevent mental disabilities.

8. Concerted efforts should be made to improve public understanding and remove the stigma of mental disabilities.

A pervasive theme in the report is the importance of meeting the needs of currently unserved and underserved populations, particularly children, adolescents, and older Americans; racial, ethnic, and other minorities; and chronically mentally ill persons.

The proposed programs of Federal Grants for Community Services would involve funding for the first year of transition to new community programs in the amount of $75 million and $100 million in each of the following 2 years. The goal is to create necessary community services in areas where these services were nonexistent or inadequate.

The Commission also recommended increased funds for research and for training.

The Editor feels particularly honored to have the opportunity to serve on this Commission. It should be especially noted that a deaf woman mental health professional served and reported on the concerns and needs of deaf people for appropriate mental health care.

II. REPORT OF TASK SUBPANEL ON SPECIAL POPULATIONS

Barbara Sachs, M.A.

> **"[Mental Health] services to be provided for the special populations should be delivered, . . . with a view toward the best possible of worlds, by persons who share the unique perspective, value system and beliefs of the group being served."**—*Delores Parron, Ph.D., Staff Liaison in her Executive Summary of the "Report of the Task Panel on Special Populations: Minorities, Women, Physically Handicapped,"* Task Panel Reports Submitted to the President's Commission on Mental Health, Volume III, Appendix (1978), p. 732.

Dr. Parron's statement wraps up in a nutshell the basic shared sentiment expressed by all seven Special Populations Subpanels making up this Task Panel, one of the 32 task panels reporting to the Commission. These subpanels included the following special populations of Americans, listed as follows according to their numbers in the U.S. population at large:

(1)	Women	51.3 percent
(2)	Physically Handicapped Americans	53 million
(3)	Americans of European-Ethnic Origin	50 million
(4)	Hispanic Americans	23 million
(5)	Black Americans	22 million
(6)	Asian/Pacific Americans	3 million
(7)	American Indians and Alaska Natives	1 million

The invitation to testify before the Commission on behalf of deaf Americans for the Subpanel on Mental Health of Physically Handicapped Americans reached this Associate Editor, appropriately enough, via a TTY phone call just before Christmas. Within an extremely tight time constraint, rough drafts of both oral and written testimonies were attempted for the presentation before the Commission in the New Executive Office Building on January 16, 1978. On the day before, however, this subpanel was brought together for a first meeting with the other Special Populations subpanels by Dr. Delores Parron, Staff Liaison to this Task Panel and one of the most beautiful human beings it has ever been my good fortune to meet. Under her very competent and acceptant guidance, we all shared with each other throughout the afternoon and over dinner what we planned to say before the Commission the next day. The viewpoints and sentiments expressed by the other subpanels struck a very familiar chord and brought about a *deja vu* experience, so to speak. We, deaf people the country over, have been there, too! Therefore, the written testimony was amended to avoid duplication of effort and repetition and to stick to pertinent essentials based on views currently expressed in the "deafness field."

Each subpanel was represented by two members of its minority group during the oral testimony before the Commission. Most of the subpanels had for many months several participating representatives as members from across the country to enable input for the final written report. The Physically Handicapped Americans subpanel, however, was added on as an additional subpanel at the "eleventh hour," primarily due to the increased awareness of the existence of this Special Population generated in time by the Final Report of the White House Conference on Handicapped Individuals (WHCHI).

Since a wealth of data on physically handicapped individuals had been prepared for the WHCHI in May, 1977, it devolved upon Ms. Margie Sloan (a paraplegic American), Georgia State Director for the WHCHI, to summarize the data and recommendations related to mental health. The written testimony by this Associate Editor (a deaf American) attempted to delineate the mental health needs of hearing-impaired and deaf Americans, with input from locally available mental health professionals: Luther D. Robinson, M.D., a non-deaf psychiatrist and founder of the Mental Health Program for the Deaf, Saint Elizabeths Hospital; and Allen E. Sussman, Ph.D., deaf psychologist and Director, Counseling and Placement Center, Gallaudet College. Since time had not permitted input that ideally should have come from participating representatives across the nation's deaf communities, the written testimony with its accompanying recommendations is submitted as a "blueprint," subject to subsequent modifications where deemed best and necessary for the mental health of all deaf Americans.

Mention should be inserted here that the Committee on Mental Health and Deafness of the National Association of the Deaf had its first meeting in St. Paul, Minnesota, in May 1978, under the leaderships of John M. Scanlon, M.D., non-deaf psychiatrist and Director, Mental Health Program for the Hearing Impaired, St. Paul-Ramsey Hospital and Mental Health Center; and Steven K. Chough, D.S.W. (another deaf American), Mental Health Administrator of this same program. This Committee has resolved that the NAD support and endorse the report on the "Mental Health Needs of Deaf Americans" to the President's Commission on Mental Health.

The issues relating to the mental health of each population were examined separately in view of the distinctiveness and diversity of the cultural influences of each. However, commonalities were found across all groups in certain characteristics, in their life and mental health experiences, and in their desires. Summed up as follows, these commonalities should be recognized as familiar by deaf Americans also.

I. Characterized by (1) uniqueness and diversity in terms of race, sex, ethnic origin, and physical status, and (2) de facto second-class status in American society.

Transitions and chances in their lives have been compromised overtly and covertly by racism, sexism, colonialism, and handicapism.[1] Their uniqueness and diversity have operated as a barrier to the realization of their full potential and deprived them of the opportunity to participate fully in American society which, "in principle, values pluralism."

II. Overrepresented in the existing statistics on mental health and clearly underserved or inappropriately served by current mental health service delivery systems in this country.

Current estimations point to some 20 million Americans with mental or emotional disturbances, but less than one-third receive professional assistance. Statistics, inadequate as they are, nonetheless show that there are approximately 14 million persons in need of mental health services but not receiving them: the overwhelming proportion of this group is found among the minorities, women, and physically handicapped.

III. Issues related to this underservice or inappropriate services have been found to be related to serious deficits in:

(1) Availability of service (too few choices as to where services can be obtained);

(2) accessibility of services (in terms of cost and location);

(3) acceptability of existing services (in terms of the attention those services give to the unique needs, value and belief systems of those who seek them); and

(4) accountability of services to the groups whom it seeks to serve.

Available data on voluntary utilization of existing mental health facilities by the Special Populations indicate a clear underutilization. Availability of services and utilization are found to be directly related to the supply of appropriate personnel to staff them. This underutilization appears to be rooted in the mode of service delivery which, in many instances, runs counter to the values of the consumer and is not flexible enough to employ alternative models for services which would meet consumer needs and facilitate entry and utilization of the system.

IV. Recommendations toward achieving the goals of availability, accessibility, acceptability, and accountability are stated in terms of specific modifications of public policy so that it becomes flexible enough to encompass the special needs of each Special Population group. Particular attention was focused on Public Law 94–63: Community Mental Health Centers Act.

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[1] "Handicapism," first coined by Dr. Parron in January 1978, denotes discrimination related to being physically handicapped and is a dynamic identically operative in other groups as racism, sexism, etc.

A review of the reports from all Special Population subpanels reveal that the bottom line for them in modifying service delivery is:

(1) to be an active part of the process of developing and planning services;

(2) to be in control of the services delivered in their communities;

(3) in the best possible world, to deliver the services themselves; and

(4) to have access to funding adequate enough to insure that services are provided for persons in need of them and not subject to erratic funding patterns which defeat the purpose of groups attempting to serve their own.

Existing data show that service providers drawn from the ranks of minorities, women, and physically handicapped will continue to be in short supply. All Special Population subpanels emphasized that, while it will be necessary to train personnel who clearly understand and are sensitive to the needs, values, beliefs, and attitudes of the Special Populations consumer, this training of other personnel is only a stopgap measure. While the Special Populations are poorly represented in the mental health disciplines, the supply of qualified professionals and paraprofessionals continues to lag behind the increasing demand for service. Pressing needs exist for professionals drawn from the ranks of the Special Populations in positions supportive to direct service delivery and for the recruitment and training of more Special Populations members to assume positions at all levels of the mental health system designed to serve these groups.

V. Substantive and reliable information is necessary in order to accomplish a rational approach to planning mental health service for the special populations. Basic and applied research is required on racial/ethnic minorities, women, and physically handicapped. Valid and reliable research has been hampered by poorly defined data collection procedures. The need is for data differentiated by race, ethnicity, sex, and physical handicapping conditions. All Special Populations subpanels insist that their members be allowed the opportunity to take a more active role in defining and implementing research strategies for solving the problems of the developing resources for their communities. Scientists drawn from the Special Populations must raise certain questions concerning conceptual, ethical, and methodologic bases of research relating to mental health issues and their application to members of the Special Populations.

VI. While the areas of concern noted here are cited by all Special Populations as priorities for improving the status of their involvement in the mental health system, what is crucial also is that attention be given to those sociocultural components that contribute to the diminished status of these persons and their overrepresentation among the mentally ill. Future research in the social and behavioral sciences areas should be directed toward changing conditions through improved understanding, changed attitudes, and the creation of a healthier environment. If prevention is to be a component of a unified and rational mental health system, then measures to improve the quality of life for the Special Populations is a necessary corollary. Recommended and supported are public policies and legislation directed toward eliminating racism, sexism, and handicapism.

III. THE MENTAL HEALTH NEEDS OF DEAF AMERICANS

Excerpted from the *Report of the Special Populations Subpanel on Mental Health of Physically Handicapped Americans,* submitted to the President's Commission on Mental Health, February 15, 1978. The remainder of the *Report* deals with the physically handicapped in general.

The members of the Subpanel were: Luther D. Robinson, M.D., Sc.D., Associate Superintendent for Psychiatry, Saint Elizabeths Hospital, Washington, D.C.; Barbara B. Sachs, Clinical Psychologist, Mental Health Program for the Deaf, Saint Elizabeths Hospital, Washington, D.C.; and Margie Sloan, Georgia State Director, White House Conference on Handicapped Individuals (1977), Atlanta, Ga.

Preface

Without a workshop meeting that ideally would have enabled input from participating representatives across deaf communities, this report may admittedly not be as comprehensive as it should be. Nonetheless, it is an attempt to delineate the mental health needs of deaf Americans and to present pertinent recommendations based on views currently expressed in the "deafness field."[1]

During the first meeting of this subpanel with the other special populations subpanels on January 15, 1978, striking similarities were noted in the discussions of the life and mental health service experiences between the various minority groups and Deaf Americans. Therefore, this report attempts to avoid duplication of effort and/or repetition in the discussion of similar needs and recommendations, not however discounting pertinent inclusion of Deaf Americans in them. This report focuses on those needs and recommendations considered unique and necessary to this population of physically disabled Americans.

Overview

The mental health status of Deaf Americans and the treatment of the mental illnesses that occur in this population, unlike those of most other special populations, have not been the subject of widespread discussion and debate. Further knowledge and awareness of this subject, together with dissemination of information to the furthest reaches of our society, cannot be overemphasized if the overall mental health of Deaf Americans is to be improved and the treatment of their mental disorders is to become more appropriate.

Population Characteristics

The population of Americans with hearing impairments runs upwards of 13 million. Out

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[1] This report was prepared for the Special Populations Task Panel by Barbara B. Sachs, Clinical Psychologist, Mental Health Program for the Deaf, Saint Elizabeths Hospital, Washington, D.C. Additional input has been received from personal consultations with two mental health professionals in Washington, D.C., who are involved in providing services to Deaf Americans: Luther D. Robinson, M.D., Sc.D., a nondeaf psychiatrist and founder of the Mental Health Program for the Deaf, Saint Elizabeths Hospital; and Allen E. Sussman, Ph.D., a deaf psychologist and Director of the Counseling and Placement Center, Gallaudet College. Input was also sought from other mental health professionals, both deaf and nondeaf, all from the "deafness field," as well as from deaf consumers and their families who at one time availed themselves of mental health services.

of this, about 500 thousand have been identified as either congenital or of early onset. Because of the commonalities experienced by those who "grow up deaf," this population is generally addressed as the deaf community. Notwithstanding commonalities, an accurate picture of the deaf community must reveal its heterogeneity. The psychologist responsible for the 1974 Census of *The Deaf Population of the United States* points out that, "Constant attention to averages without compensating glances at the deviations might create the false image of a population homogenized by their common feature, deafness. In many respects, deaf people differ as much from each other as they do from all other individuals."

Deaf Americans are not evenly distributed across the United States. Deafness occurs in and across all income levels and ethnic groups. If the country is quartered regionally, the largest prevalence rate for the deaf community is found in the North Central region and the lowest in the Northeast. The South has a higher rate than the West, both about 20 percent lower than that for the North Central region.

Educationally, the average attainment of deaf persons falls below that of the general population. Undereducation continues to be an issue of great concern and portends ominously for the future well-being of at least half of the deaf population.

Occupationally, deaf people are found in every industry. They are employed in all principal occupations from professional to domestic. They have demonstrated their capability to do almost any kind of work. Yet, employment is not as high among the deaf population as would be desirable. Of greater concern, however, is underemployment—employment in positions incompatible with deaf people's intelligence, skills, and education, resulting from discriminatory attitudes toward deaf job applicants.

The communication patterns adopted by deaf people reveal their biculturality and bilinguality. Among themselves, American Sign Language remains the primary language, even among those few who report little difficulty with spoken English.

Perhaps the most accurate portrayal of deaf Americans, penned by a deaf mental health professional some years ago, describes the population as constituting of a truly silent minority. "The silent minority has not yet reacted in the revolutionary manner used by some groups. They have set off no demonstrations, no violent acts, no cries for equality. Perhaps this patience [led to the description of deaf people as] 'The most misunderstood among the sons of men, but the gamest of all.' The patience of the silent minority is growing thin . . ."

Mental Health Status

There is little valid and reliable information, national in scope, to directly address questions of the mental health status of Deaf Americans. At the 1976 Orthopsychiatric Workshop on Deafness, it was determined, under the most conservative estimate of the need and the most liberal estimate of the available mental health service, that 85 percent of deaf people needing such services are not receiving them because they are not available. In other words, less than 2 percent of the deaf community receive needed services.

Of those deaf clienteles actually receiving the attention and scrutiny of mental health professionals, the diagnostic impressions have run the gamut of psychoses, neuroses, personality disorders, behavior disorders, and transient situational reactions. The available data consistently point to the behavior disorder category as having the largest numbers of the deaf persons seen. Generally, the number of deaf Americans needing mental health services is at least of the same order of magnitude as that among the nondeaf population, and the kinds of mental health problems are similar.

Mental Health Service Delivery Systems

Until 20 years ago, there were no mental health service programs and facilities for deaf persons. Now there are about 15 programs across the United States. Out of these 15, only 3 or 4 are fully functional and full-fledged programs while the others are of limited operation. Out of these 15, not one is a community mental health center. For a brief time in the recent past, there was one such center, headed by a qualified deaf psychologist, which, although understaffed, was highly overutilized and successful until funding cuts and the relocation of the psychologist pronounced its demise. Thus, the greater majority of deaf Americans presently in need of mental health services but not in need of hospitalization has virtually nowhere to go for therapeutic help. The emphasis remains on inpatient and custodial care. Finally, out of these 15 mental health service programs, not one is currently administered and directed by qualified deaf mental health professionals. Complaints centering around the lack of handicapist sensitivity and the lack of interest in the special needs of Deaf Americans remain to be problems.

Mental Health Personnel

The availability of professional mental health personnel qualified to work with deaf individuals gives an even more deplorable picture. Currently, there are in this country roughly only about 20 psychiatrists working with deaf people. None of them are deaf. Probably only four or five of them can communicate in the sign language of the deaf with any reasonable fluency. There are roughly about 16 psychologists who provide mental health services to deaf clientele. Only 5 of them are deaf. There are 19 social workers, only 1 of whom is deaf, and 27 psychiatric nurses with no deaf persons among their numbers. Obviously, the available manpower is insufficient. Of those currently available, many remain in need of specialized training to work with the deaf population.

Current knowledge and understanding of deaf Americans, however limited, have been based largely on studies of deaf children, stemming from the easy accessibility to them through the schools for the deaf. Comparatively little is known and understood about deaf adults. Moreover, clinicians and researchers, of which a disproportionate number are nondeaf, view the psychodynamics and behavior of deaf individuals within their own frames of reference, which is often dissimilar to that of the deaf individual. That deaf Americans are subject to the discrimination and disadvantages associated with other minority groups ("handicapism") is an additional factor serving as an impediment to quality mental health services for them. This, together with the communication and language barriers, serves to foster an atmosphere for the social stresses of helplessness and fatalism that operate in the etiology of much of the mental illness seen in Deaf Americans. Compounding the problem also is the fact that deaf Americans (with other physically disabled groups) do not possess the same kind of "roots" that other minority groups have: They are for the most part different from their parents and siblings who are not similarly disabled while other groups have families who are like them in skin color and other characteristics. This factor complicates the psychodevelopmental picture and makes for further difficulties in the provision of mental health services.

The physical disability of deafness is invisible. The sign language of deaf people is graphically visible. A population of persons possessing knowledge and fluency in sign language, which enables and facilitates communication between individuals, groups, and nations, constitutes the "roots" of Deaf Americans and their milieu for social support and survival as well.

Despite past efforts to promote civil rights and equal opportunities for ethnic minorities in this country, deaf Americans have—until recently—been largely neglected and ignored by governmental agencies, educational institutions, private corporations, telephone companies, the media, and other sectors of society. However, the future of mental health services for deaf individuals looks somewhat more promising today. With the advent of the President's Commission on Mental Health, the advances of the recently completed White House Conference on the Handicapped, and the ongoing enforcement of Public Law 94–142 and section 504 of the Rehabilitation Amendments of 1973, steps are being taken in the right direction. The recent adoption of the Total Communication concept in the education of deaf students in increasing numbers of schools and classes for the deaf is another case in point. Concurrently, greater reciprocal awareness of deafness and deaf Americans in the public at large and of the public at large in deaf citizens, has been enabled through the increasing efforts of the television medium. Finally, the publication of the first issue in the fall of 1977 of *Mental Health in Deafness*, journal of the National Institute of Mental Health, sets the appropriate tone for future exchange of information and research.

Lest progress and success from this time forward become jeopardized, however, care must be taken to insure that the dynamics operating in the equivalent deaf American experience of "bilingualism" and "racism" do not escape further scrutiny, amelioration, and remediation. It has been said that services given to a deaf clientele by a specialist and those given by a general mental health professional are as different as gold and Confederate money. That there are too many Confederates in the mental health service delivery systems continues to be the major input from the deaf community. The paucity of trained mental health professionals is compounded by the necessity of prolonged training and specific expertise. These professionals need to have, in addition, thorough knowledge of the developmental vicissitudes resultant from deafness, of the cultural and lifestyle ramifications of deafness, and to have competence in American Sign Language, Signed English, and other communication systems used among deaf children, adolescents, and adults. What has resulted from this paucity of trained mental health professionals possessing the requisite knowledge about deafness and the manual communication skills has been the emergence within the field of professionals insufficiently trained in deafness or in mental health. It has been stated that sign language competency does not replace mental health knowledge; nor does mental health knowledge replace sign language competency and knowledge about deafness. To go further, mental health practice with deaf individuals *is* a speciality. Above and beyond the training required in the mental health disciplines, work with a deaf clientele requires training in certain special competencies, two of which, to be mentioned presently, are perhaps the most important because they are the most difficult to learn or to accept.

Communication in American Sign Language

The notions of biculturality and bilingualism, operative in other ethnic groups, have more poignant significance in the mental health service delivery systems to Deaf Americans. The fairly recent struggle involving the transition from oral (method of education based on speech and lipreading) to bilingual education (all modes = total communication) has become a visible symbol of the larger struggle to gain and maintain deaf identity and pride. However, there remains a great deal of resistance to the learning of American Sign Language (ASL), the true and living language of Deaf Americans. This is particularly the case among the many nondeaf mental health professionels and may be interpreted to reflect the ethnocentrism inherent in the normally hearing population. Spoken language is considered to be primary and supreme, the only way to communicate interpersonally. American Sign Language is thought to be odd, different, weird, limited, and inefficient, and interpersonal communication without *spoken* language is thought of as inconceivable. The fact is that ASL is as efficient for interpersonal communication as any spoken language.

While it is recognized that the day is still distant when Deaf Americans will have fully trained and qualified, totally communicating mental health service providers, the sign language interpreter/translator is seen as a necessary adjunct to the interpersonal situation and relating to the mental health professional in much the same way as a nurse relates to the surgeon, both working in tandem to achieve a common goal. While their service is of enormous importance and benefit to deaf people in training and other settings, the use of interpreters/translators, particularly in the individual and group psychotherapies and in psychological assessments, however, is frowned upon: (a) it is an invasion of privacy and confidentiality by a "third" party, (b) it is resisted by most of the deaf clientele, (c) its use by mental health professionals is seen as a crutch to avoid the responsibility of learning what, in effect, is another language, and (d) the interpreter/translator is unable to tell the difference in the patients' expressions as linguistic patterns or as true personality responses.

To be effective, mental health professionals who deliver services to deaf Americans must have a thorough understanding of and sensitivity to the linguistic, communicative, and human-relational styles, and sociocultural characteristics of their deaf clientele. The psychotherapeutic communication is still conceived of along Sullivanian lines: a situation of primarily vocal communication where emphasis is on attending to the telltale aspects of intonation, rate of speech, difficulty in enunciation, etc., as signs or indicators of meaning. Only recently, in the area of kinesics, has attention been given to the question of whether social and other information in the vocal-auditory channel may be replaced effectively with visual analogs. Data to date, though not conclusive, are largely affirmative. Communicative and relational styles and characteristics of deaf Americans remain alien to the typical mental health professional and create situations that handicap the mental health service provider, alienate those most in need of professional assistance, and almost always result in ineffective and inefficient utilization of available resources. In the area of research, obviously, the need for culturally and linguistically sensitive researchers is equally as important. The contribution of present and future deaf researchers will free the development of an adequate data base of the biases and stereotypes that have characterized much of past findings and interpretations. Moreover, an understanding of the linguistic and cultural characteristics of the deaf population is required for the efficient planning and allocation of mental health resources. There is today a marked absence of Deaf American input concerning mental health policy and the administration and management of mental health resources for service delivery or research.

Discriminatory and Iatrogenic Attitudes

The notion of handicapism, operative in other ethnic groups as racism, remains the most pervasive mental health problem confronting Deaf Americans. The chief handicap of being deaf lies in the negative and devaluative attitudes of normally hearing professionals toward deaf clienteles rather than in the physical disability per se. Mental health practice by professionals and administrators working with deaf clienteles continues to be iatrogenic rather than therapeutic. Many of them harbor the impression or conviction that deaf individuals are incapable of being helped to develop insight into themselves; therefore, they are seldom selected for insight-oriented psychotherapy. This handicapist attitude stems from a basic ignorance of and lack of training in deafness, and also reflects the frustrations they experience in their failure to master American Sign Language. Rather than looking into themselves, they look at their deaf clientele and pronounce them incapable of abstract reasoning. Information garnered from the few qualified therapists attests to the insight capacities of deaf patients and the appropriateness and benefits of insight-oriented therapies.

Handicapism probably ranks first in the etiologies of the difficulties deaf Americans face and is not endemic to the deaf community. It is generated, operated, and perpetuated by the nondeaf community and its institutions. Deaf Americans continue to be placed in positions where they are forced to experience and attempt to endure daily insults, large and small, to their persons. If educational and mental health service delivery systems continue to perpetuate handicapism, they can never be considered systems of learning and care for Deaf Americans.

Indications point to the social milieu, not Deaf Americans, as the subject for change. It is, therefore, pertinent to the goals of mental health programs in deaf communities. Efforts in the mental health area can lead the way toward improving the quality of the social milieu. Training programs must be designed in such a way as to assist mental health professionals in developing the sensitivity to, and understanding of, handicapist issues. This sensitivity and understanding must, in turn support the development of service delivery and research models. As a psychologist stated during the Orthopsychiatric Workshop on Deafness held at St. Elizabeths Hospital in May 1976, "The professionals will fulfill their moral and professional responsibility to help, not hurt, only if they abandon their claims to be masters and work instead at earning the right to serve."

That Deaf Americans lack the same kind of "roots" enjoyed by other minority groups means that they are made to feel different from childhood on, even by members of their own families. This poses an enormous challenge to the concept of primary preventive mental health services, of which none exist today. It has been pointed out that mental health services for children in general are grossly inadequate to the point of being a national disgrace. Of mentally ill children in need of help, no single group is more destitute of services than emotionally disturbed children who are deaf.

Needed for a more adequate data base are (a) analyses of the psychopathology that exists in deaf children, (b) descriptions of the treatment needs of the children with mental health problems, and (c) examinations of existing gaps in mental health services to the deaf population. The major source of preventive mental health for deaf children, even more than for hearing children, is parental. While further research is needed, current impressions point to the "haunting themes [that] occur throughout all clinical and research work. It would appear that deaf individuals encounter throughout their lifespan significant figures who view them with distress, with ignorance, with conflict, with 'attitudinal apartheid,' or with distorted expectations." Information is needed on the hazardous circumstances impinging on deaf individuals in their lifetimes that diminish enhancing life experiences and of the effects of deafness on the physical, psychosocial, and socialcultural essentials for good mental health. With this necessary data, primary prevention would insure the deaf individual's realization of his own potentials and adaptation to the realities of his environment. It would, moreover, diminish the need for secondary and tertiary prevention, for which the demand today far exceeds the supply.

Handicapist attitudes that have assaulted Deaf Americans are now being viewed by several mental health professionals as a major factor in the development of a negative self-concept. This self-devaluation is manifested in the pathological denial of deafness found in some deaf persons and also in deaf men and women learning to hate themselves and each other because they are deaf. This self-devaluation is seen as stemming from their identification of themselves with negative and defective body parts, thoughts, and feelings. This negative identification materializes as a result of their finding themselves treated in ways similar to the treatment of their "defectiveness."

As with members of other special populations, Deaf Americans need to gain and maintain their sense of identity and pride. Deaf Americans want to be deaf without shame, to be deaf without guilt, to be deaf without anger, and to be deaf without being denied their own sense of power and competence. While recent social and educational developments are providing experiences that are serving to enhance the self-concept of Deaf Americans, mental health service delivery systems can further contribute enormously to the development in deaf people of higher concepts of themselves as fully functioning Americans.

Recommendations to the Commission

An attempt is made here to avoid duplication and repetition of, or overlap with, recommendations made to the Commission on behalf of other special populations. This is not to say, however, that most of them are not pertinent to the needs of Deaf Americans. What follows are those recommendations related to (1) underservice or inappropriate mental health services, (2) research, and (3) training of mental health personnel that would meet the unique needs of Deaf Americans.

Probably the first need is to provide existing mental health services facilities with the proper assistance for correcting inequities and deficits in and for services and personnel. The need is obviously for more services to be made available to more Deaf Americans and their families in many more locations. To prevent future underutilization of services or inappropriateness in service delivery, focus must be on today's availability which, when properly modified, will insure tomorrow's successful potentiality.

It is recommended, therefore, that:

1. The Civil Service Commission (or appropriate agency) be mandated to modify job requirements of positions in the mental health disciplines in mental health programs and facilities serving Deaf Americans to stringently include knowledge about deafness and sign language competency.
2. **The Civil Service Commission (or appropriate agency) be mandated to upgrade positions in the mental health disciplines in mental health programs and facilities serving Deaf Americans where knowledge about deafness and sign language competency are required additional skills.**
3. **Evaluation procedures be established, in accordance with accepted psychometric principles and procedures, to gauge levels of sign language competency; that such procedures be initiated in all mental health programs serving Deaf Americans; that all mental health service providers be evaluated at reasonable intervals; and that evaluation results be entered in each employee's appraisal and performance rating in the mental health disciplines. The establishment of such an evaluation procedure should ensure that mental health service providers be motivated to develop and maintain their language competency in order to be able to communicate with patients and clients in therapy, counseling, interview, and assessments.**
4. The Federal Government must give direction to training programs which will help them to realize the need to adjust their curriculums in ways that will produce professionals who recognize and understand the dynamics of individual and institutional handicapism. These professionals must also gain insight and skills that will assist them in their efforts to develop and administer programs designed to minimize the impact of handicapism on mental health treatment for Deaf Americans.
5. A pool of deaf administrative and managerial personnel be recruited and trained for work in programs designed to serve Deaf Americans.
6. Funding of master's level training be established as entry to opportunities for higher education for deaf people in the mental health disciplines.
7. Training funds be targeted to Gallaudet College (world's only liberal arts college for the deaf) for the development of doctoral-level programs in mental health disciplines.
8. The awarding of grants for research on Deaf Americans give priority to proposals submitted by deaf researchers and by hearing researchers who have demon-

strated their knowledge about deafness and sign language competency.

9. A board, separate from existing official boards and composed primarily of Deaf Americans, review and monitor hospitals and other mental health facilities to insure compliance with regulations as they affect deaf individuals and that this board accredit facilities and possess other powers given to other review bodies presently enforcing mental health service delivery regulations.
10. A national training program or center be established for the training of mental health professionals and paraprofessionals at all levels and that this national training program include in its administration and faculty deaf mental health professionals.
11. The establishment of a model mental health program for emotionally disturbed deaf children be mandated with the imperative that parents of these children are also provided mental health assistance in dealing with their disturbed offspring.
12. The establishment of a model mental health program for deaf individuals with behavior and personality disorders be mandated. Such individuals are so frequently referred to existing mental health programs ill-equipped to serve them.
13. The establishment of a coordinated system of data collection and dissemination be mandated for both the educational and mental health areas.
14. P.L. 94-63—Title III "Community Mental Health Centers" be amended to identify Deaf Americans as a target population, along with other minority populations, for this legislation.
15. P.L. 94-63—Title III "Community Mental Health Centers" be amended to insure the establishment of sufficient numbers of mental health delivery mechanisms so as to insure that all Deaf Americans have ready and easy access to quality mental health services regardless of their income levels.
16. Affirmative action should be taken to insure the communicative accessibility, via existing appropriate devices, to public private telephones for all Deaf Americans. The telephone, the invention of which was originally inspired by the hope of aiding deaf people, has placed them at personal, psychological, and economic disadvantages. Unless affirmative action is taken, Deaf Americans will continue to be penalized by the inaccessibility of telecommuncations.

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MENTAL HEALTH AND THE DEAF: A FIRST STEP TOWARD EPIDEMIOLOGY

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Abstract

This paper is an initial effort to develop epidemiological data about major mental illness in persons with early profound deafness. Focussing primarily on schizophrenia, it presents and tabulates the over 20 years of experience of the country's first special psychiatric inpatient unit for the deaf. The material is grouped to show the relationships between types of symptoms, lag time before hospitalization, the presence of other deaf family members, whether deafness was congenital or acquired, and whether or not affected individuals improved. It is hoped that in time others will use this framework so as to amplify the numbers and provide a still firmer characterization of how mental illness may or may not be altered in the presence of early profound deafness.

Introduction

With psychiatric interest in the deaf only 20 years old, few reports have dealt with epidemiologic aspects of mental illness in this special population. That the same major disorders existing in the hearing, are identifiable and treatable among the deaf has been established, but data on outcome and its relationship to such factors as lag before hospitalization, congenital vs acquired loss, presence of deaf parents, and the like, have not yet appeared.

This paper represents a first step toward the development of such data. It will report on the experience of the inpatient service of New York State's special mental health services for the deaf. Established in 1963, after 8 years of research and experience with outpatients, the inpatient service had treated, at the time of this compilation (October 1974) 171 patients. We will present the diagnostic distribution of these patients, the proportion of congenital and adventitiously caused deafness in schizophrenic and other types of psychosis, and the relationships between improvement and these and other parameters. Ensuing reports will present comparable findings on outpatients.

A few words of background and caution, however, must precede the data. The unit of 30 inpatient beds was designed to serve the entire State. At the time it was established, there were some 250 patients with early profound deafness scattered throughout the State's 21 hospitals, and most of these patients had been hospitalized long term (i.e., more than 5 or 10 years). The unit began selecting from this group patients for whom rehabilitation seemed at least a possibility. At the same time, it also admitted patients directly, but after preliminary screening, from the community at large. The dual admission policy has continued, so as to allow prompt admission (or transfer from other hospitals) of acute cases, and to enable rotation through the ward of chronic patients as well, until maximum benefit has been achieved.

Three limitations preclude generalization to the full deaf population of New York State. First, some of the patients deemed unfeasible have not been admitted to the special unit, and do not enter the frame. Second, the mix of patients served in the special unit has shifted over the decade (actually 11 years) from more of the chronic and older patients to more of the acute and younger type. A third limiting feature is that our work corresponded in time with the increasing availability of effective psychotropic medication. It is accordingly possible that a number of patients do not enter our population because they were treated quickly and successfully elsewhere, without referral to the special unit. In these senses, data from this special unit do not represent the full deaf population of New York State.

Persons with early (prelingual) profound deafness comprise only about 1 in 1000 of the total population, yet in a State like New York, with 16,000,000 inhabitants, this number is substantial. Nevertheless, the number of mentally ill deaf persons in the State of New York would at any one time be small. Thus, when the mentally ill are classified by type of illness, by age, by improved and not improved, with further subcategories like type of deafness and other deafness in the family, some of the final numbers are too small to permit meaningful generalizations. We nevertheless present all the data, along with interpretation, as an important first step, with the hope that other centers in the United States and elsewhere will add their data and experience. In this way, over time, a clearer picture of mental illness in the deaf will develop.

Enumeration of Patients

Table 1 indicates the total number of patients admitted to the ward by diagnosis and by sex as of October 1, 1974. The numbers do not support a difference of any consequence between males and females; hence classification by sex is not shown. Schizophrenia is the most common diagnosis, representing at least half the patient population. Rate of improvement by diagnosis, by number of admissions, and by whether on the ward or not at time of study are in Table 2. This table shows that about three quarters of the patients still living have improved, according to discharge and postdischarge examinations. Out of the 88 schizophrenics ever admitted (and not known to have died), only 18 (20 percent) remained on the ward. Eleven of the 18 had been discharged once, but readmitted at least once. Of these 11, 6 showed improvement since the last readmission; 5 did not. Of the 70 schizophrenics not on the ward, 49 (70 percent) had no readmission, once discharged.

Out of 72 patients with diagnosis other than schizophrenia (and not known to have died), only 11 (15 percent) remained on the ward. Three of the 11 had been discharged once, but readmitted at least once. Of the 61 not on the ward, 45 (75 percent) had no readmission, once discharged.

The success rates for schizophrenics and for others are thus about the same. Of course, the group of nonschizophrenics is a heterogeneous one and requires further study.

Table 3 separates improved and unimproved patients according to whether born deaf or not,

Table 1. Status as of 1 October 1974 of patients ever admitted to the ward—On the ward, and not on the ward, by diagnosis, by sex

Characteristic	Total	Male	Female
Total ever admitted	171	78	93
On the ward	29	15	14
Schizophrenic	18	8	10
Other	11	7	4
Not on the ward	142	63	79
Died	11	4	7
Schizophrenic *	70	31	39
Discharged to the community	66	30	36
Transferred to other hospital	4	1	3
Other *	61	28	33
Discharged to the community	56	25	31
Transferred to other hospital	5	3	2

* Not known to have died.

Table 2. Patients ever admitted to the ward up to 1 October 1974, on the ward, and not on the ward, schizophrenic and other, by number of admissions, improved and unimproved

Characteristic	Total	Improved	Unimproved
Total ever admitted	171	XXX	XXX
Known to have died	11	XXX	11
Not known to have died	160	118	42
Schizophrenic	88	62	26
1st admission only to the ward	56	40	16
2 or more admissions	32	22	10
Other	72	56	16
1st admission only to the ward	53	41	12
2 or more admissions	19	15	4
On the ward			
Total	29	18	11
Schizophrenic	18	10	8
1st admission only to the ward	7	4	3
2 or more admissions	11	6	5
Other	11	8	3
1st admission only to the ward	8	6	2
2 or more admissions	3	2	1
Not on the ward			
Total	131	100	31
Schizophrenic	70	52	18
1st admission only to the ward	49	36	13
2 or more admissions	21	16	5
Other	61	48	13
1st admission only to the ward	45	35	10
2 or more admissions	16	13	3

and according to age of onset of psychiatric illness. Among the total discharged patients, and among the schizophrenic patients discharged, there seems to be no difference in improvement rates between those born deaf and not born deaf, regardless of age of onset of psychiatric illness. (Age of onset is nevertheless presented for future reference.) We have often been asked whether total lack of auditory contact from birth is associated with more difficult clinical course. While the data do not appear to support this supposition, it must be remembered that those that became deaf later from infectious disease may have organic deficits that complicate their psychiatric illness. The net effect of these various features is hard to evaluate.

In particular, the age of onset of psychiatric disorder appears not to be a factor in the improvement of schizophrenic patients that have been discharged. The proportion of schizophrenic patients that were improved and discharged is very close to three out of four, regardless of age of onset, which ranged from under 10 to 40. Three out of four schizophrenic patients born deaf were improved and discharged. Ages 10–19 for onset of psychiatric illness appear to be most favorable for improvement, as 12 of the 13 patients born deaf and with onset at ages between 10 and 19 showed improvement and were discharged. Two out of three patients not born deaf were improved and discharged, with no variation worth noting by age of onset of psychiatric disorder.

As with the schizophrenic patients, age of onset of psychiatric disorder appears not to be a factor in the improvement of discharged nonschizophrenic patients. However, the proportion of nonschizophrenic patients that improved and were discharged is persistently higher at each age of onset of psychiatric disorder than the proportion of schizophrenics was, except for a possible slight dip for ages 10–19. The overall proportion improved and discharged is three out of four, the same as for the schizophrenics. Three out of four schizophrenic patients born deaf were improved and discharged. The proportions run close to this figure at all ages of onset of psychiatric disorder. There is some indication that non-schizophrenics that became deaf after birth have a better chance for improvement and discharge, the overall proportion being six out of seven, which proportion held about the same at all ages of onset of disorder.

Half the schizophrenic patients still on the ward showed improvement, with no variation

Table 3. Part A. Patients not on the ward on 1 October 1974, schizophrenic and other, classified by result, by born deaf and not born deaf, by age of onset of psychiatric illness

Age of onset of illness	Total	Improved			Unimproved		
		Total	Born deaf	Not born deaf	Total	Born deaf	Not born deaf
Total discharged *	131	101	57	44	30	18	12
			Schizophrenic				
All ages	70	52	32	20	18	10	8
Under 10	7	4	2	2	3	2	1
10–19	19	16	12	4	3	1	2
20–24	13	10	6	4	3	3	0
25–29	15	10	6	4	5	3	2
30–39	14	10	6	4	4	1	3
40–49	2	2	0	2	0	0	0
50 or over	0	0	0	0	0	0	0
			Other than schizophrenic				
All ages	61	48	24	24	13	9	4
Under 10	10	8	4	4	2	2	0
10–19	29	20	10	10	9	6	3
20–24	12	10	5	5	2	1	1
25–29	0	0	0	0	0	0	0
30–39	2	2	0	2	0	0	0
40–49	5	5	4	1	0	0	0
50 or over	3	3	1	2	0	0	0

* Not including 11 patients known to have died.

Table 3, Part B. Patients on the ward on 1 October 1974, schizophrenic and other, classified by result, by born deaf and not born deaf, by age of onset of psychiatric illness

Age of onset of illness	Total	Improved			Unimproved		
		Total	Born deaf	Not born deaf	Total	Born deaf	Not born deaf
On the ward	29	18	10	8	11	5	6
			Schizophrenic				
All ages	18	10	4	6	8	4	4
Under 10	2	1	1	0	1	1	0
10–19	10	4	2	2	6	2	4
20–24	5	4	1	3	1	1	0
25–29	0	0	0	0	0	0	0
30–39	1	1	0	1	0	0	0
40–49	0	0	0	0	0	0	0
50 or over	0	0	0	0	0	0	0
			Other than schizophrenic				
All ages	11	8	6	2	3	1	2
Under 10	2	0	0	0	2	0	2
10–19	5	5	4	1	0	0	0
20–24	2	1	1	0	1	1	0
25–29	2	2	1	1	0	0	0
30–39	0	0	0	0	0	0	0
40–49	0	0	0	0	0	0	0
50 or over	0	0	0	0	0	0	0

Table 4, Part A. Schizophrenics on the ward and not on the ward 1 October 1974, improved and unimproved, by age of onset, by lag between onset and first hospitalization*

Age of onset	Total	Improved Lag in years						Unimproved Lag in years					
		Total	Under 1	1,2	3,4	5-9	10 or more	Total	Under 1	1,2	3,4	5-9	10 or more
Schizophrenic, on the ward													
All ages	18	10	5	1	1	3	0	8	4	3	1	0	0
Under 10	2	1	0	0	1	0	0	1	0	0	1	0	0
10–19	10	4	2	1	0	1	0	6	3	3	0	0	0
20–24	5	4	2	0	0	2	0	1	1	0	0	0	0
25–29	0	0	0	0	0	0	0	0	0	0	0	0	0
30–39	1	1	1	0	0	0	0	0	0	0	0	0	0
40–49	0	0	0	0	0	0	0	0	0	0	0	0	0
50 or over	0	0	0	0	0	0	0	0	0	0	0	0	0
Schizophrenic, not on the ward													
All ages	70	52	15	13	7	5	12	18	5	4	4	3	2
Under 10	7	4	0	0	0	0	4	3	0	0	1	0	2
10–19	19	16	3	4	2	3	4	3	0	1	0	2	0
20–24	13	10	4	3	1	2	0	3	2	1	0	0	0
25–29	15	10	3	2	1	0	4	5	2	0	2	1	0
30–39	14	10	4	3	3	0	0	4	1	2	1	0	0
40–49	2	2	1	1	0	0	0	0	0	0	0	0	0
50 or over	0	0	0	0	0	0	0	0	0	0	0	0	0

* Patients known to have died are excluded.

Table 4, Part B. Other than schizophrenics, on the ward and not on the ward 1 October 1974, by age of onset, by lag between onset and first hospitalization, improved and unimproved

Age of onset	Total	Improved Lag in years						Unimproved Lag in years					
		Total	Under 1	1 2	3 4	5-9	10 or more	Total	Under 1	1 2	3 4	5-9	10 or more
Other, on the ward													
All ages	11	8	4	3	0	0	1	3	0	0	1	0	2
Under 10	2	0	0	0	0	0	0	2	0	0	1	0	1
10–19	5	5	3	2	0	0	0	0	0	0	0	0	0
20–24	2	1	0	0	0	0	1	1	0	0	0	0	1
25–29	2	2	1	1	0	0	0	0	0	0	0	0	0
30–39	0	0	0	0	0	0	0	0	0	0	0	0	0
40–49	0	0	0	0	0	0	0	0	0	0	0	0	0
50 or over	0	0	0	0	0	0	0	0	0	0	0	0	0
Other, not on the ward													
All ages	61	48	20	8	4	9	7	13	6	2	0	3	2
Under 10	10	8	0	1	1	3	3	2	1	0	0	1	0
10–19	29	20	9	5	2	3	1	9	5	2	0	1	1
20–24	11	9	5	2	1	0	1	2	0	0	0	1	1
25–29	1	1	1	0	0	0	0	0	0	0	0	0	0
30–39	1	1	0	0	0	1	0	0	0	0	0	0	0
40–49	5	5	3	0	0	0	2	0	0	0	0	0	0
50 or over	4	4	2	0	0	2	0	0	0	0	0	0	0

worth noting by age of onset of psychiatric disorder. Likewise, half the schizophrenics still on the ward and born deaf showed improvement, again with no variation by age of onset. Three out of five schizophrenics not born deaf and still on the ward showed improvement, but the numbers are too small to distinguish between the outcome of born deaf and not born deaf. Eight out of 11 nonschizophrenic patients still on the ward showed improvement, with a slight indication favorable to the age group 10–19. Six out of seven patients in this group born deaf and still on the ward showed improvement, again with a slight indication favorable to the age group 10–19. The number of patients not born deaf and still on the ward is too small (four patients, two improved, two not improved) to warrant any statement.

Table 4 was constructed to show whether age of onset and lag between onset and first hospitalization appear to be related to subsequent results. Of the 52 schizophrenics improved and discharged, 28 or a little more than half had a lag of 2 years or less from onset of psychiatric disorder to first admission to any hospital. However, 12 of the 52, or nearly one in four, had a lag of 10 years or more before first admission. Of the 18 schizophrenics unimproved but not on the ward, nine also had a lag of 2 years or less. Comparable data for the mixed group of non-schizophrenics are also in the table.

Of those schizophrenics still on the ward and improved, six out of 10 had a lag time of 2 year or less; of those unimproved seven out of eight had a lag time of 2 years or less.

In summary, it appears that lag time between onset of psychiatric illness—whether schizophrenic or other—and admission to a hospital makes no difference in the proportion improved. As well as can be ascertained from the small number, this finding holds for all ages of onset of illness.

Table 5 recapitulates results by type of deafness, with information about parents and siblings. In respect to relatives, about half the patients have no deaf relatives, one in five has a deaf spouse, more than one in ten have a deaf sibling, only six out of the 160 have one or both parents deaf. Of these latter six, all but one had a diagnosis of schizophrenia. Although this represents a significantly larger proportion than in the total ward, it may only mean that deaf parents—for whatever reasons—are more likely to request hospitalization for offspring who become schizophrenic. The numbers are too small to assess the effect of deaf relatives on rate of improvement, though as would be expected, those that were married (the spouse usually being deaf) fared better as a group than those that were not.

Table 5. Patients admitted to the ward to 1 October 1974, schizophrenic and other, improved and not improved, classified by type of deafness and by presence of deafness in parents and in siblings

Characteristic of patients	Total	Schizophrenic			Other		
		Total	Improved	Unimproved	Total	Improved	Unimproved
Type of deafness							
Total	160	88	62	26	72	56	16
Born deaf	90	50	36	14	40	30	10
Not born deaf	70	38	26	12	32	26	6
Parents and siblings							
Total	160	88	62	26	72	56	16
One or both parents deaf	6	5	3	2	1	1	0
Sibling, but not parents	18	10	7	3	8	5	3
Spouse deaf	33	21	17	4	12	12	0
Spouse and a parent deaf	0	0	0	0	0	0	0
Spouse and child both deaf	2	2	2	0	0	0	0
Child deaf, but not a parent nor sib	1	1	1	0	0	0	0
Other relative deaf	6	4	4	0	2	2	0
No deaf relatives	84	40	26	14	44	31	13
Unknown	12	6	3	3	6	6	0

Clinical Symptomatology

The next group of tables present the clinical symptoms of the patients and their relation to improvement or lack of improvement. Table 6 classifies all patients admitted according to the diagnosis and outcome. It will be noted that due to our procedure of selection, there is a paucity of organic brain syndrome and a relatively large number of patients with schizophrenic and personality and adjustment disorders, compared with admission of hearing patients to psychiatric hospitals.

Table 6, Part A. Patients admitted to 1 October 1974, classified by diagnosis

Diagnosis	Total	Improved	Unimproved
All admissions to date	171	XXX	XXX
Known to have died	11	XXX	XXX
Not known to have died	160	118	42
295 Schizophrenia	88	62	26
295.0 Simple	3	3	0
295.1 Hebephrenic	1	0	1
295.2 Catatonic	7	4	3
295.3 Paranoid	23	19	4
295.4 Acute episodic	4	2	2
295.74 Schizo-affective depressed	5	5	0
295.8 Autistic	3	1	2
295.9 Chronic undifferentiated	41	28	13
295.99 Pseudoneurotic	1	0	1
Other than schizophrenic	72	56	16
Psychotic	20	15	5
296 Major affective disorder	6	6	0
296.0 Involutional melancholia	3	3	0
296.3 Manic depressive	3	3	0
297 Paranoid	1	1	0
298 Depressive reaction (psychotic)	2	2	0
290–294 Organic brain syndrome (psychotic)	11	6	5
Non-psychotic	52	41	11
300 Neuroses	5	5	0
301 Personality disorders	17	13	4
307 Adjustment reaction	17	15	2
308 Behavioral disorder	3	1	2
309 Nonpsychotic OBS	3	2	1
310–312 Mental retardation	3	2	1
316 Maladjustment	4	3	1

In Table 7, certain symptoms are listed for the total group, schizophrenics and others. Sixty-four of the 88 schizophrenics showed at least two of the clinical descriptors impulsive, aggressive, or bizarre behavior, the most common being bizarre and impulsive. Of the total of 88 schizophrenics, 62 were improved and 26 not improved (ratio 7 to 3). About one-third of the 62 improved schizophrenics, and slightly more than one-third of the unimproved, showed aggressive behavior. Two-thirds of the improved patients were impulsive, and four-fifths of the unimproved. Of the 72 nonschizophrenic patients, impulsive behavior characterized 4 out of 5, aggressive behavior 4 out of 7, bizarre behavior 3 out of 7. In all patients, the improved and the unimproved showed about the same proportions of these three characteristics.

It has been of interest that certain signs of psychotic depression, namely psychomotor retardation and guilty self-incrimination, have appeared to be relatively rare among the deaf (Altshuler, 1971). In the eight patients classified as primary affective disorder (Table 8), six showed anxious agitation, one of them with psychomotor retardation, one showed only psychomotor retardation, and none showed guilt. Among the five schizophrenics with depression severe enough to warrant the classification of schizo-affective disorder, two patients showed psychomotor retardation, one being described also as having anxious agitation. Two showed guilt; one of them showed also anxious agitation. One showed only anxious agitation. Even among schizophrenics with some depressive symptoms, but not severe enough to be classified as psychotically depressed, none showed psychomotor retardation and none showed

Table 6, Part B. Patients known to have died before 1 October 1973, classified by diagnosis, improved and unimproved on the date discharged

Diagnosis	Total	Improved	Unimproved
Total	11	4	7
295 Schizophrenia	8	3	5
295.0 Simple	2	0	2
295.3 Paranoid	3	1	2
295.9 Chronic undifferentiated	3	2	1
Other than schizophrenic	3	1	2
293.0 Organic	1	0	1
298.0 Psychotic depressive reaction	1	0	1
301.82 Inadequate personality	1	1	0

anxious agitation. Thus, our earlier impression that psychomotor retardation and guilt are infrequent symptoms of psychotic levels of depression in the deaf appears to be borne out.

All patients diagnosed as having psychotic levels of depression improved. As Table 8 pools the schizophrenic and nonschizophrenic patients, it appears that affective disorders or a strong affective element as part of a schizophrenic process continue to have a good prognosis.

Neurotic symptoms in schizophrenic and nonschizophrenic patients are shown in Table 9. The presence or absence of anxiety, phobias,

Table 7. Patients admitted to the ward to 1 October 1974, schizophrenics and other than schizophrenic, classified by improved and not improved clinical picture

Characteristic	All schizophrenics			Other than schizophrenics		
	Total	Improved	Unimproved	Total	Improved	Unimproved
Total	88	62	26	72	56	16
Aggresive behavior	32	22	10	40	29	11
Bizarre behavior	75	51	24	31	23	8
Impulsive behavior	63	43	20	58	44	14
All three of the above	21	12	9	11	8	3
Two of the above	43	32	11	39	28	11
Aggressive and bizarre	4	4	0	2	2	0
Aggressive and impulsive	6	5	1	26	18	8
Bizarre and impulsive	33	23	10	11	8	3
Only one of the above	21	16	5	18	16	2
Aggressive	1	1	0	1	1	0
Bizarre	17	12	5	7	5	2
Impulsive	3	3	0	10	10	0
None of the above	3	2	1	4	4	0

Table 8. Patients with depression admitted to the ward to 1 October 1974, classified by improved and not improved

Characteristic	With primary affective disorder			Schizo-affective with psychotic depression			Schizophrenic with depression but not of psychotic proportion		
	Total	Improved	Unimproved	Total	Improved	Unimproved	Total	Improved	Unimproved
Total	8	8	0	5	5	0	10	7	3
Psychomotor retardation	2	2	0	2	2	0	0	0	0
Guilt or self-incrimination	0	0	0	2	2	0	0	0	0
Anxious agitation	6	6	0	3	3	0	10	7	3
All three of the above	0	0	0	0	0	0	0	0	0
Two of the above, not all three	1	1	0	2	2	0	0	0	0
Psychomotor retardation and guilt	0	0	0	0	0	0	0	0	0
Psychomotor retardation and anxious agitation	1	1	0	1	1	0	0	0	0
Guilt and anxious agitation	0	0	0	1	1	0	0	0	0
Only one of the above	6	6	0	3	3	0	10	7	3
Psychomotor retardation	1	1	0	1	1	0	0	0	0
Guilt or self-incrimination	0	0	0	1	1	0	0	0	0
Anxious agitation	5	5	0	1	1	0	10	7	3
None of the above	1	1	0	0	0	0	0	0	0

Table 9. Patients admitted to the ward to 1 October 1974, classified by anxiety, phobias, and agitation, by schizophrenic and other, by improved and not improved

Characteristic	Total	Schizophrenic			Other		
		Total	Improved	Unimproved	Total	Improved	Unimproved
All patients	160	88	62	26	72	56	16
With anxiety, or phobias, or agitation	122	67	48	19	55	40	15
No anxiety, no phobias, no agitation	38	21	14	7	17	16	1

or agitation does not seem to affect improvement in schizophrenic patients. Probably the apparent relation between improvement and the absence of anxiety in the other-than-schizophrenic group reflects reasonably consistent good results with a young group of primary behavior disorders or incipient personality disturbances.

Table 10 describes the prevalance of hallucinations, delusions, and regression in the schizophrenic group. Hallucinations and delusions are classified as organized (well-described, consistent) or fragmentary (suggested, fleeting). Of particular interest are the reported cases of auditory hallucinations. Some of these were well confirmed by repeated examination; others, termed doubtful, were reported at some time but could not be verified further.

The phenomenon of auditory hallucination in the deaf has been discussed by us in greater detail in a previous publication (Rainer, Abdullah, and Altshuler, 1970), where many of these and other cases were described more fully.

In the present table, it can be seen that 34 out of the 88 schizophrenic patients, or about 2 out of 5, had some kind of hallucination, mostly fragmentary in character. This comes close to the accepted figure of 50 percent for hearing schizophrenic patients. Seventy-eight, or close to nine out of ten, had delusions, again usually of a fragmentary nature.

The rate of improvement was higher in the group without hallucinations than in those with hallucinations of any kind. Specifically, of the 62 schizophrenic patients improved, 42 or two out of three had no hallucination. Only two of the 62 had organized hallucinations, 18 or one in three had fragmentary hallucinations, half or more being visual, but with five auditory confirmed and three auditory not confirmed. In contrast, of the 26 schizophrenic patients unimproved, 12 or almost half had no hallucinations, 13 or half had fragmentary hallucinations, mostly visual; five had auditory hallucinations confirmed, three auditory not confirmed.

Regarding delusions, the proportions with and without such symptoms were about the same for the improved and unimproved schizo-

Table 10. Patients admitted to the ward to 1 October 1974, schizophrenic, by improved and not improved—hallucination; delusion; regression, disintegration, and deterioration

Characteristic	Total	Improved	Unimproved
Hallucinations			
Total number of patients	88	62	26
No hallucination	54	42	12
Hallucination of any kind	34	20	14
Organized hallucination	3	2	1
Visual only	1	1	0
Visual with other	1	1	0
Auditory confirmed	2	1	1
Auditory doubtful	0	0	0
Auditory not present	0	0	0
Vibration	1	1	0
Touch or smell	0	0	0
Fragmentary	31	18	13
Visual only	14	9	5
Visual with other	17	9	8
Auditory confirmed	10	5	5
Auditory doubtful	6	3	3
Vibration	2	2	0
Touch or smell	1	1	0
Delusions			
Total number of patients	88	62	26
No delusions	10	7	3
Delusion of any kind	78	55	23
Organized	8	6	2
Fragmentary	63	44	19
Somatic	6	2	4
Hypochondriacal	4	3	1
Regression, disintegration, deterioration			
Total number of patients	88	62	26
No regression, no disintegration, no deterioration	31	24	7
With regression, or disintegration, or deterioration	57	38	19

phrenic patients, with some kind of delusion present in most patients of both groups.

Regression, disintegration, and deterioration were descriptors in two out of three patients, with no meaningful difference between the improved and unimproved groups. As a matter of fact, it was our experience that a number of patients that had been hospitalized at other hospitals for periods of up to 20 years were discharged improved after transfer to the special ward.

Status of Improved Patients on Discharge

One hundred patients were discharged as improved as of October 1974 (Table 11). These were about equally divided among schizophrenic and nonschizophrenic patients. For schizophrenics, 12 of 52 went out to jobs, seven to training programs, seven to return to homemaking, and three to sheltered work situations. Thus, nearly three out of five were placed in work situations of one kind or another. The results for nonschizophrenics are less meaningful as the group is a heterogeneous one, but are at least as good.

About half (51) of the 100 discharged improved went out to live with parents or other relatives, 16 with spouse, 18 with friends, or as lodger, 10 in county home or youth hostel, and 5 alone or in a supervised residence.

Discussion

The status of improved patients on discharge (Table 11) accents the care that has been taken to ensure adequate arrangements for home and for optimum placement in a job or in training-programs for those suited to it. These figures are in contrast to the oft-cited criticism of the discharge of patients from State hospital without attention to their assimilation in the community nor potential for rehabilitation. The cold proportions reflect a long-developing and dedicated effort on the part of the staff to search out and create conditions for living and rehabilitation, and to begin such plans for each patient early in his stay in the ward (Rainer, Altshuler 1970; Badanes 1973). Although this effort may have resulted in the earlier years of the project in a somewhat longer average stay for deaf than for hearing patients, the rate of recidivism has been satisfactorily low. The net result is that the number of deaf patients now in hospitals is only about one-seventh of what it was 20 years ago. To put it another way, the proportion of deaf persons in mental hospitals was over-represented 20 years ago by a factor of 2 compared with the hearing; now they are no more likely to be in a mental hospital than their hearing counterparts.

As with hearing patients, one necessary condition for maintenance outside of the hospital is an effective outpatient service. This we have had since the beginning; it now serves 250 patients, with 1500 visits per year. Coupled with our preventive (school) and rehabilitative programs, these form part of a structured, longitudinally organized system of mental health care for the deaf which has served as a model for other States and world areas. Data from the noninpatient services will be the basis of future reports.

Table 11. Patients discharged improved, not on the ward as of 1 October 1974

Job status or living-arrangement	Total		Schizophrenic	Other
	Number	Percent	Number	Number
A. Job status on discharge				
Total discharged improved	100	100	52	48
To take a job on discharge	27	27	12	15
Not to take a job	73	73	40	33
	73	100	40	33
To training program	16	22	7	9
To sheltered workshop (including IHB and FH)	5	7	3	2
To be homemaker (female)	12	16	7	5
To country-home or hostel	9	12	6	3
Unemployed, other (mostly at home, marginal function)	31	42	17	14
B. Living-arrangements on discharge				
Total discharged improved	100	100	52	48
With parents or other relatives	51	51	26	25
With friends or as lodger	18	18	6	12
With spouse	16	16	11	5
To country-home or youth hostel	10	10	6	4
To live alone or in supervised residence	5	5	3	2

Summary

1. Data are presented on the inpatient service of the New York State Mental Health Services for the Deaf between its opening in 1963 to October 1974.

2. During this time 171 patients were admitted, 78 male and 93 female. Of the 160 still alive in 1974, 88 had the diagnosis of schizophrenia, 72 had other diagnoses.

3. About 75 percent of patients overall improved. In the group of eight primary affective disorders, the rate was 100 percent; likewise with the five schizo-affective cases.

4. Being born deaf or becoming deaf in later infancy or early childhood seems to have no bearing on improvement. In the latter group, the benefits of early hearing ability may have been counter-balanced by organic concomitants of the cause of deafness. We are aware of the difficulties in recognizing the time of onset of deafness.

5. Lag time between onset of psychiatric illness and admission to a hospital seems also to have made no difference.

6. The numbers are too small to assess the effect of deaf relatives on improvement, though those that were married (usually to a deaf spouse) fared better as a group than the unmarried.

7. The paucity of depression with psychomotor retardation among the deaf is noted: practically all patients with depression showed anxious agitation, while very few showed psychomotor retardation or guilt. All of those with psychotic depression improved.

8. Improvement seemed unrelated to the presence of impulsive, aggressive, or bizarre behavior, all of which are common descriptors of psychiatric illness in the deaf.

9. Neurotic symptoms (anxiety, phobias) were found in schizophrenic and nonschizophrenic patients alike, and appeared to be poor prognostic signs in the nonschizophrenic patients.

10. Patients with hallucinations, even fragmentary, had a significantly lower improvement rate than those without. Auditory hallucinations were confirmed in 12 of the 88 schizophrenic patients and alleged by six more. Most schizophrenic patients had delusions, chiefly fragmentary in nature.

11. Of the improved patients, about a quarter were put into a job on discharge through the efforts of our rehabilitation counselor. Almost half of the others were placed in training programs, sheltered workshop or functioned as homemakers. All had adequate living arrangements on discharge.

12. The total picture over 10 years is that of a progressive decrease in the proportion of deaf residents in New York State that need psychiatric hospitalization, from double to no more than the corresponding proportion of hearing persons in hospitals. This result was accomplished mainly by active treatment coupled with an energentic rehabilitation program. Data on outpatient and aftercare treatment will be presented in a subsequent publication.

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DEVELOPMENT OF A MILIEU INTERVENTION PROGRAM FOR TREATMENT OF EMOTIONALLY DISTURBED DEAF CHILDREN

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Providing specialized programs for children with severe emotional and behavioral disorders is an accepted standard for intervention with hearing children. Unfortunately the same commitment to services does not exist for treatment of deaf children with emotional disorders. Even the potential for programming in this area is yet to be fully explored, although it is estimated that 10 percent of deaf children are disturbed enough to warrant intervention beyond the special education required because of deafness (Naiman et al 1973). The purpose of this project was to implement a special program to improve the functioning of emotionally disturbed deaf children and to evaluate the program operation and the progress of those receiving intervention.

The Program for Social and Emotional Development (SED) focused on 15 of the most disturbed students attending a residential school for the deaf with a total population of 500 students (Figure 1). The program was operated for 3 years, prior to which no regional or state facilities existed for treatment of childhood emotional disorders among the deaf (Directory 1974).

The goal of the program was to support the emotional and social growth of the disturbed child in a special therapy situation and to support integration in the social and academic

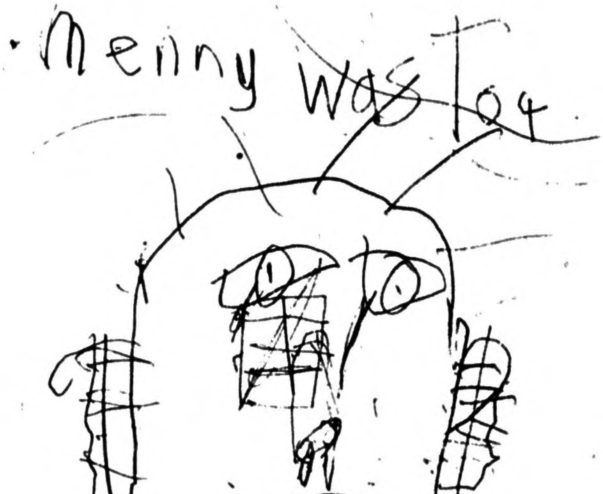

Figure 1. Self Portrait: male student, age 13, Profound bilateral congenital deafness. I.Q. 123. First year in program.

mainstream. Consistent with the design of a therapeutic milieu, the programmer sought to expand the child's range of coping strategies in the therapy situation and to adapt the environment outside to foster opportunities for interaction that could reinforce individual therapeutic objectives.

Any clinical intervention is valuable only in so far as it relates and responds to the needs of those receiving therapy to cope more effectively with the challenges circumscribing their life space. With children this represents the dynamics manifest at the beginning ages of development, for children need to experience and achieve the fundamental tasks of early development before proceeding to a more mature level of intergration(Geselle and Ilg 1949; Erickson 1959).

To effect these goals, it was felt that the individuals close to the child were instrumental in the development of his self esteem (Fenichel 1968). Therefore the concept of the therapeutic milieu was employed to establish consistency and predictability in the environment and provide the opportunity to expand and reinforce behavior in the situation in which it occurs (Redl and Wineman 1952). It was also felt that children must be approached from a developmental perspective. Therefore the precepts of child growth and development were followed in the therapy situation that emphasized respect and trust in a relationship within which limitations and reality structures could be effected.

Population Description

The 15 students enrolled in the SED Program were identified through annual departmental surveys coordinated by the principal, department director, and teachers with subsequent evaluations by the school psychologist and SED specialist (see Appendix A). All students were 6–18 years old and enrolled in various departments throughout the school. All but 3 students tested within the normal range of intellectual ability. Academically, however, the majority of students performed below their potential.

There were as many different problem behaviors manifest as number of children seen. However, two dominant traits were a lack of security and self-esteem and an inability to function on an interpersonal level. Youngsters could not interpret personal, social, or work situations, and they responded inappropriately or not at all to their environment. Students were either overly dependent, angry, or detached from other people. For example, some students continually isolated themselves in corners and demonstrated self-stimulatory behavior. Other youngsters responded to situations by abusing themselves or exaggerating their head and body movements. A few youngsters were continually involved in talking either to themselves or to fantisized or inanimate objects. Some students could not establish eye contact or be in close proximity to other people. Others carried their personal possessions with them as they moved about a room, while others had to be constantly touching or sitting close to a particular individual. Several children responded hostilely to social interaction with tantrum behavior that was either assaultive or destructive in its intent.

Still other students did not manifest any overt signs of disturbed behavior, but demonstrated more subtle signs of emotional problems. These were students with prolonged periods of depression, inappropriate affect, apathetic reactions, exaggerated but acceptable defiance of authority, lack of peer relationships, recurring self-doubt and/or negativism. Referral for services was more difficult in these cases. However, as the program expanded the school staff became sensitive to identifying different types of students in need.

Students were on varied schedules each year (Table1). The time spent in the SED Center was determined by a student's ability to maintain himself in the original environment. The vehicle for evaluation and placement was the school Child Study Committee of administrative, ancillary, educational, residential, and therapeutic personnel. Students were placed full time in the SED room if they required total support and intensive therapeutic intervention. Students were placed part time in the SED room if they required daily support or counseling but were capable of maintaining themselves for part of the day in the regular curriculum. The therapist-student ratio was 4:1 year one, more optimally 3:1 year two, and most ideally 3–2–1:1 year three. The dual placement procedure with part-time daily therapy worked well for many youngsters as it was found that daily support in the resource room relieved students of sufficient stress that they could continue partial participation in the original environment during therapy.

Table 1. Student schedules of participation in the SED Room

	Year 1	Year 2	Year 3
Student 1	full day	half day	one hour/day
Student 2	full day	half day	one hour/day
Student 3	half day	one hour/day	one hour/day
Student 4	three hours/week	---------------	---------------
Student 5	---------------	all day	---------------
Student 6	---------------	one hour/day	one hour/day
Student 7	---------------	one hour/day	one hour/day
Student 8	two hours/week	one hour/week	---------------
Student 9	withdrawn	---------------	one hour/day
Student 10	---------------	---------------	one hour/day
Student 11	---------------	---------------	three hours/week
Student 12	---------------	---------------	one half hours/day
Student 13	---------------	---------------	half hour/day
Student 14	---------------	---------------	one hour/day
Student 15	withdrawn	---------------	---------------

Resource Room

The base of the program was the Resource Room (RR) where children were seen daily for therapy and intervention. The RR was a place of acceptance, a desensitized environment that respected individual needs and emphasized the development of responsive, trusting relationships. The intent was to change a child's perception of himself in the environment and to enhance his self-image.

The RR was organized into separate, self-contained activity areas (Figure 2) designed for independent and small group participation. The activities in the areas or learning centers were geared to the levels of ability, interest and needs of individual students. Activities were developed to satisfy the needs of some youngsters for immediate success or to challenge the creative intelligence of the other youngsters. The concept of the design was to provide a situation a child could master and operate successfully. Students rotated among the centers by assignment and free choice dependent on the goals selected for and with him. Students functioned well in independent activity in an average of 4 centers. With encouragement most students could move through the majority of stations. The programmer supported each area project by making supplies available, demonstrating new skills, promoting social interchange, guiding experimentation and encouraging original work. The learning center concept functioned most effectively for children scheduled for half or full-time in the RR, or for younger hourly scheduled students. Part-time students, with upper school academic placements, preferred counseling and small discussion sessions related to their personal, social, or school adjustment problems. Learning center activities with the older groups were oriented toward individual requests, special group projects, and elective and assigned activities related to therapy goals and trips.

Therapy Design

Individual long and short term goals were formulated for each child in the areas of personal and social adjustment with related suggestions for academic programming. Goals were set in relation to the child's psychosocial development and were the basis for intervention in the resource room and integrated placements. As such, structured routines, consistency of expectations, and channels for physical manipulation were arranged for some hyperactive aggressive children; relaxed controls with freedom for creative expression were instituted for some depressed, dependent children; increased attention, emphasizing trust and support in an adult relationship were effected for some insecure children; and strong reality definition, contingency contracting and symptom estrangement were outlined for some hostile, destructive children.

Careful engineering had to be employed to support a child's participation or continuation in a group or activity. Therefore, it was most important to convey an atmosphere of warmth and security in the therapy encounter to protect the child where he was still vulnerable and build on his strength. A clear definition of expectations was emphasized in all interactions. Experiences were planned in graduated challenges to minimize frustrations and disturbances. Symptom behavior displays were tolerated until the individual was primed for its elimination. The general behavior rules in the RR mandated respect for individual and social

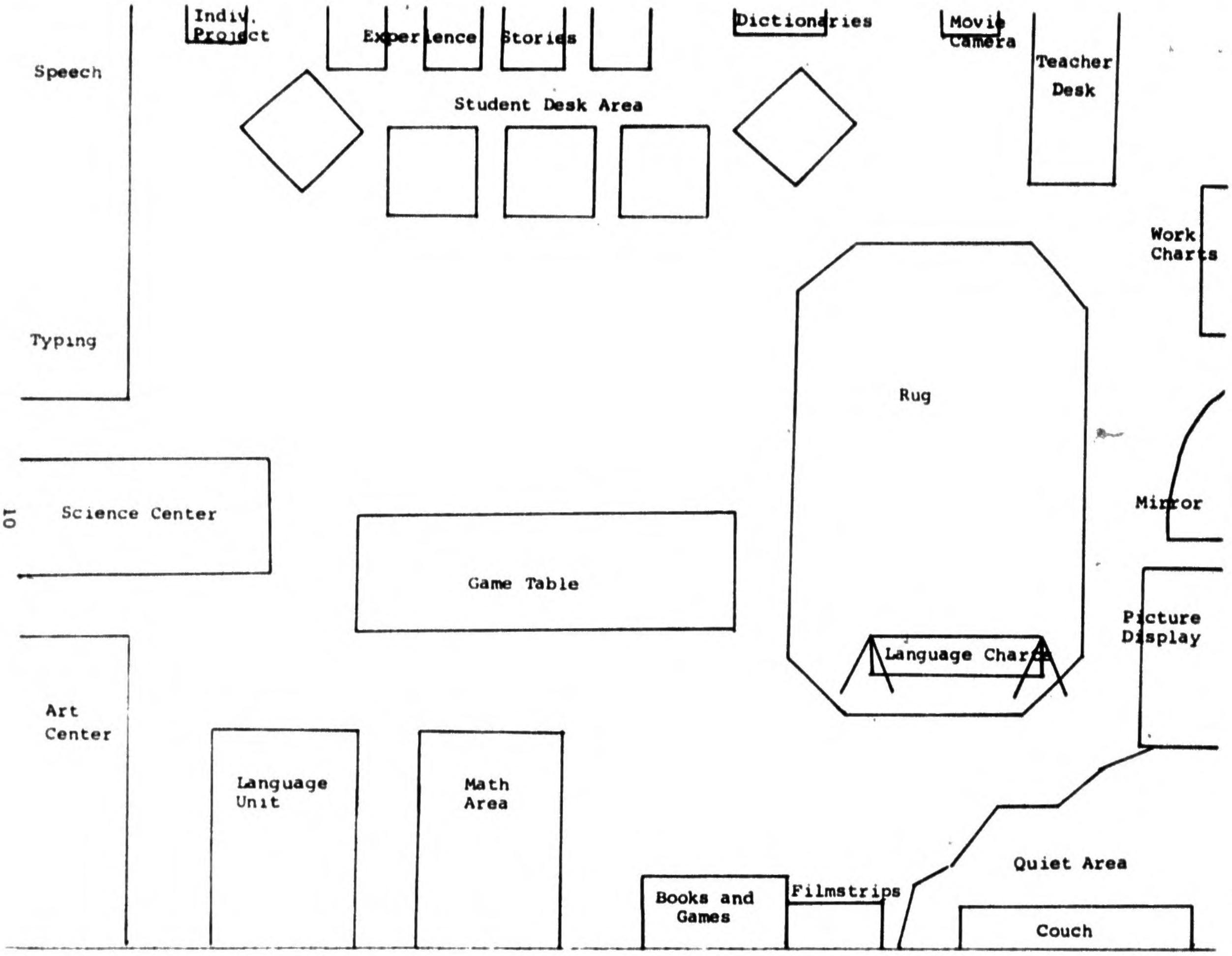

Figure 2. Learning centers

set. When difficulties occurred, either an alternative method was suggested, second person assistance lent, a channel established for feeling expression or ventilation, or a temporary change in activity effected. If a child became too disruptive, he was removed from the situation and could return when he regained composure. The child who was propelled by his own panic into an attack or tantrum was removed into isolation. The therapist remained with him, lending controls to help manage his fury during the episode. Some children were held, if it were possible, in hopes of maintaining a reality link and preventing further withdrawal. When some equilibrium was restored, it was accepted and acknowledged, and if possible a decision made as to what to pursue next. These elements of milieu (Redl and Wineman 1952) and reality therapy are not all inclusive, but were found to be valuable supports for a child in crisis and compatible with the desired attributes of ambiance and milieu effecting security and consistency in the therapeutic environment.

Intervention Activities

Activities in the RR emphasized development of (1) a positive self-concept; (2) an effective communication channel; and (3) satisfying social relationships. The objectives were to develop the child's image of himself as a capable individual; to develop social relationships through one-to-one and small group experience; and to expand the individual's ability to express himself through a reliable system of communication. While some students were receptive to developing more conventional behaviors, most were either too threatened or had no motivation to drop the response patterns that were familiar and comfortable to them. Before new roles could be adopted, the child had to have (a) fundamental information about the behavior; (b) positive experience and a sense of security associated with the behavior; and (c) motivation to repeat the behavior in future situations.

Activities, therefore, were used as catalysts for increased personal and social participation. The RR activities, whether quiet or active play, project work, group social interaction, or personal counseling, were presented with clear definitions of the situation and the expectations related to the situation. The intent was to reduce the number of unknown factors and insecurities about the external circumstances, and to protect the participation further by manipulating the internal pressure blocks impinging on the individual's life space. It was found that when comfortable opportunities for trial and error were presented with support for uncomfortable realities, youngsters did expand their realm of social strategies and did begin to respond appropriately.

Development of Social Relationships

The starting point in the development of social relationship was the establishment of trust between the child and therapist. Since most children entered or avoided new relationships with the same patterns that had incapacitated them in the past, the development of relationships in the RR had to be a process of reorientation and development of different, not just new relationships. Special RR activities were the tools devised to encourage interaction and open a child to intervention. Therefore, games, projects, and field trips were an integral part of the RR experience. The attractiveness of these situations provided the inducements needed to stimulate interaction and functioned effectively to counteract habitual avoidance patterns. Then, once a youngster was involved in the activity, opportunities were available to demonstrate and record appropriate social play. Later one could capitalize on the experience and refer to it in other discussions or play.

Many students preferred individual instead of group activities and in fact did not possess a readiness to function as part of a group. Therefore, parallel play activities were introduced such as puzzles, movies, solitaire card games, exercise, shop work, etc. At this stage social boundaries were being learned and tested and the games offered a modality for more intense interaction and guidance than could be previously tolerated. It was possible to break some barriers to the next stage of reciprocal play by offering something to the child that was potentially more valuable than his need to withdraw or be defensive. Trips into the community afforded unique opportunities for interaction among the group, with high interest contagion overcoming individual fears of new or group experiences. The trips created anticipation and encouraged a mutuality among the group, providing the first experiences of real social rapport among and between group members. The trips were scheduled weekly in small groups, with extended field trips monthly. Various preparations and activities preceded the day excursions, with particular direction toward the development of functional language, behavior and mobility skills related to the experience. Weekly community walks were used in some instances as incentives for maintaining appropriate posture in the integrated classroom situation.

Communication and Language Intervention

Language usage constituted a major foundation of the program, particularly for the younger and full-time students. Many students did not use language as their means for exchanging information. Some youngsters were limited by using methods of communication that were ill suited to their needs. Others relied on using behaviors that had been effective communicators for them in the past. Each student's situation differed; however, all but two had to experience and learn language and communication.

Communication was stimulated through experiences. Individual and group camera activities were particularly excellent tools. Use of the equipment was interesting and intriguing to students and the end product provided material for communication and information. Photographs that were captioned and catalogued or used in correspondence and demonstrations were also referred to for language models. Camera work was expanded further to include videotape presentations, original film strips, and slide exhibits. The value of the medium was found to be limitless in the academic sense. In the therapeutic sense, it facilitated self-examination and confrontation, reflection, expression and expansion (Figure 3).

Language usage was learned by providing information with experiences. The primary goal was to develop an ability to explain intent, have a vehicle for more elaborate expression, and to

Figure 3. Expressive photography: male student, age 15. Third year in program. (Original in color.)

facilitate the least ambiguous, most reliable relay of information. Therefore (1) All modes of communication were used and taught to the SED student, and the system that was most effective, efficient and intelligible for a particular individual was the system that was emphasized for him. In most cases, that involved a combination of oral and manual communication. (2) Emphasis was placed on increasing vocabulary and developing a facility for using reference materials. Promoting independent language resources, of a standard or original design, reinforced a sense of self-reliance, as well as making material accessible to the student too threatened to receive direct instruction. (3) Written language was presented in patterns to identify vocabulary. The basic structures of the Fitzgerald Key (1965) were most frequently used and were easily accepted and employed by the students to manipulate written language.

Integration and Consultation

Through extensive consultation services, the SED programmer coordinated a network of school facilities into a milieu responsive to the needs and goals of the SED students. Although most of the disturbed students enrolled for therapy had not been capable of functioning in the regular and/or dormitory environments, it was possible to re-integrate youngsters when regular support from the therapist was available to the child, the teacher, and in some cases the peer group involved. Therefore, integration of SED students involved an on going process of adapting the environment to promote opportunities for growth and positive interaction in the mainstream. Thus, while therapy expanded the individual's adaptive skills, selected mainstreaming with other deaf students provided models for growth and reinforcement of self-worth.

The pre-requisite for integration was the emotional readiness of the individual and therefore dictated a close attendance to the child and not the goal. Children requiring continued protection in the closed environment were mainstreamed on a select and narrow basis. Integration activities were increased in gradual steps when there existed reasonable assurances of a positive experience, and after careful consideration of the placement. There was no prediction table, and therapeutic and integration experiences had to be continually assessed and modified to enhance the emotional stability and growth of the child.

All students' weekly schedules included physical education, art rhythm, library, shop, movies, and assembly periods. Students attended these activities individually or as part of the SED group. Partial academic and vocational placements were arranged for SED students beginning a transition back to the regular classroom or for new students requiring only part time services. Dual placements were facilitated for all students during the third year, as two regular teachers began to function as resource personnel for academic placement of small groups of SED children. In some cases these teachers had SED students placed in their class rooms the preceding semesters, and following a year of consultation, experience and support became skillful at incorporating some therapeutic techniques in their academic settings. There was great potential, it was found, for teachers to provide a modified clinical classroom to augment resource room intervention. However, one must exercise caution assigning responsibilities to teachers not trained, or receptive to intervention with emotionally disturbed children. It is not recommended in either case without the provision of extensive consultation and support services from a specialist.

In all cases of integration, students required clear definition of expectations. Class work schedules were in outline form, or behavior contracts were drawn up between the child and the therapist. It was especially important that the return of the SED child to the regular classroom be supported with a written contract.

This provided security during the insecure transition period for both the student and the new integrating teacher. It also served to help the child transfer the positive behavior learned in one situation to another. Work charts also helped to develop a habit for the student and teacher of clearly identifying the knowns of the situation, communicating the information that is relevant, and indicating the expected returns. Goals were continually evaluated and adjusted in consultations with the staff to relate to the child's needs and accomplishments. Therefore, through weekly consulations and communication, the daily therapeutic classroom and dormitory activities served to amplify and reinforce the goals sought in each situation.

To evaluate behavior change, several rating scales were developed by the programmer (Appendices B, C, D). The scales were marked at monthly, bimonthly, and trimonthly intervals by all persons involved with students enrolled in the program. Both the direction of change and the extent of change were tabulated for data collection and documentation for future placement (Table 2). Anecdotal records, 9-week evaluation, short and long term objective records, and an annual battery of psychological and achievement testing augmented the monthly graphings. To examine the long term effects of intervention, annual followup data was gathered for students previously receiving services, and currently enrolled in regular programs.

Conclusion

Recognizing that years of repeated problems characterized these case histories, this report offers documentation that significant changes can be effected with emotionally disturbed children receiving specialized treatment within an educational facility for the deaf. Substantial changes in the behavior and personality development of the students were effected and sustained in the school and home. Some students remained in the program the full 3 years, some were maintained part-time, and some exited the program completing 1 year of therapy; but all students reintegrated successfully into the regular school mainstream. It was the experience of this project, therefore, that disturbed children were responsive to treatment and could be helped, and that a milieu intervention scheme was an adaptable framework for implementing a treatment program in an established residential institution for the deaf.

The strengths found in the intervention program were (1) The experience of the child as a capable individual in his environment, which contributed to the feeling of selfworth; (2) The respect and trust established between the child and therapist, which contributed to the influen-

Table 2. Disposition of students and averaged rating of monthly progress

	Years in program	Progress rating	Disposition for next year
Student 1	2	Good	Academic Class–Full time Placement Contd
Student 2	3	Improving	Academic Class–Full time Integration Resource Room–Daily Intervention
Student 3	3	Good	Academic Class–Full time Placement Recommendation for other services
Student 4	.5	Good	Academic Class–Full time Placement Contd
Student 5	1	Improving	Academic Class–Full time Placement Contd Resource Room–Consultation to Teacher
Student 6	1.5	Good	Academic Class–Full time Placement Resource Room–Daily Intervention
Student 7	2	Good	Academic Class–Full time Integration Resource Room–Daily Intervention
Student 8	1.5	Good	Academic Class–Full time Placement Graduated
Student 9	1	Poor	Academic Class–Part time Integration Resource Room–Intensive Intervention
Student 10	1	Poor	Academic Class–Part time Integration Resource Room–Intensive Intervention
Student 11	1	Improving	Academic Class–Full time Placement Resource Room–Weekly Intervention
Student 12	1	Improving	Academic Class–Full time Integration Resource Room–Daily Intervention Moved
Student 13	.5	Improving	Academic Class–Full time Placement Recommendation for Other Services
Student 14	.2	Good	Academic Class–Full time Placement Not in Need of Specialized Services
Student 15	.3	Poor	Withdrawn

tial role of the relationship in the child's life space; (3) The use of total communication, which was of prime importance in securing a reliable communication channel for meaningful interaction; (4) The limited therapist-student ratio established in year three, in which support and control were best lent to groups not exceeding two or three; (5) The particular intervention activities employed, which were specially adapted for the population; and (6) The flexibility of an intervention strategy which provided two basic services: daily therapy in a resource room, and milieu intervention supported by weekly consultation.

Throughout the project, it was found that as students began to perceive the environment as an enabler rather than an inhibitor, interaction within that environment provided satisfying personal and social experiences, and new role models could be established for productive channeling of energy. It was also found that a clear organization and definition of terms eliminated extraneous and unnecessary confusion, and that as information was processed in the context of a fair, consistent, supportive relationship, students began to understand and deal more effectively with personal and social situations.

> The total environment [then becomes] a "school for living" in which the patient can learn and test new attitudes and behavior, develop constructive social relationships and take greater responsibility in his own recovery . . .
>
> . . . and the therapist is brought into the relationship as a supporting and clarifying influence around the patient's need and desire to gain or regain a sense of his own worth (Goldenson, 1975—Definitions of "Mileau Therapy" and "Relationship Therapy").

The limitations of the program were that certain needs for services could be approached, but not fully met. For example, although favorable changes in family interaction were evidenced in most cases, distance and staff limitations prevented substantive intervention with the family. Although the RR could be adapted as both a full- and part-time facility, separate clinical classroom facilities could not be established for individuals requiring acute care as rendered in the program the first year. Although satisfactory accommodations were instituted in the dormitory residence, a resource specialist was not in residence to extend as effective a therapeutic intervention as was facilitated in the day environment. Although referral surveys were conducted throughout the school, intervention could not be instituted for children experiencing less severe or normal developmental crises.

This and other programs could not be diversified to extend the full range of services meeting the needs of emotionally disturbed deaf children without the availability of specialized staff for clinical assignments. In view of the needs to be met, and the documented value of programming for disturbed deaf children, an ever-present concern now should be for the development of internship and training programs to establish a body of professionals to expand treatment services for deaf children with severe emotional problems.

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Appendix A

PROCEDURE FOR REFERRALS AND PROGRAM EXPLANATION
SPECIAL STUDIES DEPARTMENT
CURRICULUM FOR THE SOCIAL AND EMOTIONAL DEVELOPMENT

REFERRALS

1. Recommendation to Principal by regular teacher through department head; then to psychologist for testing and psychological determination of problem. Concurrent notification of pending Child Study sent to Special Studies Director and S/ED Therapist.

2. Child Study to include present teacher, department head, academic principal, assistant superintendent, Special Studies Department head, S/ED therapist, home school visitor, psychologist, dorm parent, and dean of students. Final program determinations made at Child Study.

3. Observation of child in present classroom by S/ED therapist

PROGRAM PARTICIPATION

1. Cooperative determination of initial scheduling by referring classroom teacher, department head, and S/ED therapist.

2. Final Scheduling or alteration determined by S/ED therapist

3. Involving the part time student, academic responsibility remains with the regular classroom teacher. The domain of the S/ED therapist is that of psycho-educational intervention.

4. S/ED therapist to serve as consultant to classroom teacher or dorm personnel.

5. Weekly anecdotal reports exchanged between regular teacher and S/ED therapist.

6. Annual and/or bi-annual Child Study Follow-ups.

CURRICULUM INFORMATION

The primary objectives of this curriculum for the disturbed child is the development of ego support within daily tasks. It is the establishment of a psycho-educational milieu in which a child's perception of himself and his environment can be reconstructed. It is a carefully designed program to re-organize distorted perceptions and demonstrate how a child can become more in control of his own existence. The goal is ego development, an awareness of self and general cultural boundaries within which we operate. The tools used are skill mastery, social interaction, symptom ventilation, total communication, reality exploration and exploitation.

Appendix B

SPECIAL STUDIES PROGRAM MONTHLY RECORD

Therapist- Mrs. Edelstein

Student____________________

Please record how you feel your child is doing each month

S for September
O for October
N for November
D for December
J for January

F for February
M for March
A for April
Ma for May
Ju for June

Please return this to me the first week of each month.

	poor				improving				good		
1. Communicates with others											
2. Understands direct communication											
3. Answers direct communication											
4. Can be reasoned with											
5. Expresses interest in things											
6. Interacts with children											
7. Interacts with adults											
8. Shows affection											
9. Controls aggression											
10. Responds well to situations											
11. Works independently											
12. Works in a group											
13. Follows directions											
14. Completes projects											
15. Acquires new abilities											

Relationship:____________________

Name:____________________

Appendix C

SPECIAL STUDIES PROGRAM
THERAPIST: Mrs Edelstein

MONTHLY RECORD-HOUSEPARENTS
Student ____________________

Please record how you feel your child is doing each month

S for September
O for October
N for November
D for December
J for January

F for February
M for March
A for April
Ma for May
Ju for June

	poor	fair	good
1. Communicates with houseparents			
2. Communicates with children			
3. Plays with houseparents			
4. Plays with children			
5. Shows affection			
6. Controls aggression			
7. Obeys houseparents			
8. Eating habits			
9. Sleeping habits			
10. Living habits			
11. Study habits			

Appendix D

SPECIAL STUDIES PROGRAM
THERAPIST: Mrs. Edelstein

BI-MONTHLY RECORD-INTEGRATING TEACHERS
Student______________________________

Please record how you feel your student has been functioning for the month underlined

S for September
O for October
N for November
D for December
J for January

F for February
M for March
A for April
Ma for May
Ju for June

	poor	fair	good
1. Communicates with teacher			
2. Communicates with students			
3. Understands direct communications			
4. Answers direct communication			
5. Usually can be reasoned with			
6. Controls aggression			
7. Responds appropriately to situations			
8. Works independently			
9. Works in a group			
10. Follows directions			
11. Completes projects			
12. Acquires new abilities			

STATEWIDE PLANNING OF COORDINATED MENTAL HEALTH SERVICES FOR DEAF PERSONS

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Abstract

Efforts in Massachusetts toward a statewide coordinated approach to the development of mental health services for deaf persons are described. Emphasis is placed on the functions of the Director of Mental Health Services for Deaf Persons, in the Department of Mental Health, who is responsible for program planning and development, consultation, interagency coordination of services, and advocacy. Problems related to statewide planning in this area are discussed.

Some increasing interest in mental health services for hearing impaired persons is evident in the burgeoning literature on deafness and mental health and the expanding number of programs designed to provide clinical services to deaf children and adults (Rainer, Altshuler, and Kallmann 1969; Schlesinger and Meadow 1972b; NIMH, *Mental Health in Deafness*, No. 1, 1977). Although the actual number of deaf persons being served by existing programs may currently be small, relative to the estimated need for services, a coordinated, planned approach to service development is essential if redundancy and inefficiency are to be avoided and quality maximized.

Discussions of community psychiatric practice relevant to working with the deaf population (Schlesinger and Meadow 1972a) are useful guides to the various factors requiring attention in service development. Other descriptions of clinical program development include mention of community, consumer, professional, and governmental forces which affect program structure, and the need for education and training efforts in the field of mental health and deafness (Rainer and Altshuler 1971; Trybus 1977).

However, there remains the need for systematic coordination of services which can put these forces and influences to best use. In Massachusetts, such an effort has begun, with the author acting as statewide Director of Mental Health Services for Deaf Persons from July 1977 to June 1978 in the Massachusetts Department of Mental Health (DMH). This paper will describe the origins of this position, its functions, accomplishments, shortcomings, and future tasks, and will discuss the significance of statewide coordination of mental health services for deaf persons.

As with many similar happenings in organizational systems, the establishment of this position in DMH was the result of a combination of much effort and coincidence. The Massachusetts Council of Organizations Serving the Deaf (Mass COSD) and other interested groups had discussed with professionals in the field of deafness the need for the involvement of State agencies, including DMH, in expanding service availability to deaf persons. A task force was established by Mass COSD in 1974 to study the mental health needs of deaf persons in Massachusetts and to make recommendations to State agencies. At the same time, an interagency group representing DMH, the Massachusetts Rehabilitation Commission, and the Massachusetts Commission for the Blind was developing guidelines for cooperative projects to serve mutual clients, previously underserved by the human service system. Members of the task force and others in the Massachusetts Rehabilitation Commission developed a plan for a clinical pilot project to provide mental health services for deaf persons in eastern Massachusetts; the three agencies agreed to fund the project in 1976.

Having arrived in Massachusetts in 1974 for psychiatric residency training, and being interested in deafness, I participated in the Mass COSD efforts and in the plans for the clinical project. By 1976, I was spending half-time with DMH, involved in program planning, technical assistance, and consultation. DMH, having been convinced of the need for serving deaf citizens, then agreed to establish a new full-time post to coordinate these efforts, as of July 1977, and to increase its funding of the clinical project.

Four major functions of the statewide Director evolved during the first year. Any one project may involve any combination of these functions; many projects involve all of them. Since DMH had no experience in planning services for deaf persons before 1976, these activities are only the first attempts at developing a systematic program.

I. Program Planning and Development

A. Needs Assessment

Needs are being assessed through a variety of approaches. Since no census of deaf or hearing impaired persons has been done in Massachusetts, population estimates have been based on data from the National Census of the Deaf (Schein and Delk 1974). Need for mental health services is then drawn from research data based on general populations (Gruenberb and Turns 1975), including the recently published report from the President's Commission on Mental Health (1978). Additional data come from studies of school age populations of deaf children (Meadow and Schlesinger 1971; Freeman, Malkin, and Hastings 1975), and adult deaf populations (Rainer, Altshuler, and Kallmann 1969) which show a higher incidence of emotional and behavioral problems among deaf children than among hearing children, and a higher incidence of problems of living among deaf adults.

Questions on hearing and language functions have been included in a statewide patient assessment project, designed to study current functioning and needs of all inpatients in State Hospitals in Massachusetts. With assistance from the Director's office, the Boston Guild for the Hard of Hearing is completing a pilot project audiological screening of all patients in a State hospital near Boston, plus inservice training of ward staff on issues of hearing loss and related behavior problems.

Finally, the Massachusetts Office of Deafness, a State agency under the cabinet-level Secretary of Human Services, is planning the establishment of a statewide central register of hearing impaired persons, which will provide computer-assisted access to all identifiable hearing impaired persons, and allow for better studies of functioning and needs for services.

B. Clinical Mental Health Services for Deaf Persons

This program, located at the Massachusetts Mental Health Center in Boston, has been in operation for 1½ years, though it remains understaffed and its case load is relatively small. The program is designed to be a clinical mental health service, available to all deaf persons and their families in eastern Massachusetts, and providing a variety of evaluation and treatment approaches, including crisis intervention, psychotherapy, group and family treatment, and consultation.

Funding originally came from an interagency pool, through an agreement among DMH, Massachusetts Rehabilitation Commission and the Commission for the Blind. Since July 1978, however, all funding comes from DMH. The program is run by contract, and additional funding over the next years should allow for hiring of more professional staff, plus the use of part-time psychiatric and psychological consultation. Only outpatient services are available; no specialized inpatient program is planned at this time, though the program's staff is available for consultation to hospital staff elsewhere.

The statewide Director assists program staff in program development and in budgetary and contract matters, and services as a liaison between the program and other levels of the mental health system. This is especially important since normal service delivery in the DMH system is managed on a catchment area basis, while the program for deaf persons is available for deaf persons essentially statewide.

C. Early intervention

Planning related to early intervention programs has been a high priority issue during this past year. The problem, and often the tragedy, of families trying to cope with the diagnosis of deafness in their infants or young children has been well described (Mindel and Vernon 1971). Also stressed has been the need for professional sensitivity and availability to parents and families for information sharing, adjustment counseling, and psychotherapy. Such programs are rare. Planning toward providing these services is now taking place in Massachusetts between DMH, which runs numerous general early intervention programs, and the Division of Special Education.

One project model that has been considered is the establishment of a pilot project, added to an existing general early intervention service, designed to work with deaf infants and their families. This project could serve as a model as well as a training center for staff who wish to develop skills in this area.

D. Training

Training of mental health professionals to work with hearing impaired clients is also a high priority for this office. Model curricula have been developed, a partial training needs assessment has been done, and funds for a pilot training program are being sought.

Though the training was initially planned for psychiatrists, psychologists, social workers, and nurse clinicians, other professionals have expressed deep interest in training to work more effectively with their deaf students or clients. It seems clear that different training approaches and curricula must be developed for different professional groups. Of highest priority for the Director's office, however, is the expansion of clinical resources in Massachusetts by training already qualified clinical workers to evaluate and treat deaf patients. Except for the shortage of public money, the lack of trained clinicians is the biggest roadblock to increasing the availability of quality services in mental health for deaf persons.

E. Technical assistance

This help has been provided to various groups in planning and developing mental health programs. A multiagency, multiprofessional task force with consumer representation in western Massachusetts has been working for nearly a year toward building a network of services for deaf persons in that region.

The Western Massachusetts Task Force, with the assistance of the Director's office and the Massachusetts Office of Deafness, has obtained funding from the Regional DMH office for a clinician consultant, experienced in the area of deafness, who will provide both direct clinical services and consultation to other clinical workers in that region who are interested in serving deaf clients. Many of these clinicians are learning sign language and are involved in training programs to learn more about deafness. The group is also constructively meeting with the deaf community to receive needed consumer input and build a coalition of consumers and service providers which will greatly assist the group in its planning efforts.

Although the program of Mental Health Services for Deaf Persons, in Boston, will probably remain the major clinical service in Massachusetts, as well as a central training center, it is hoped that other networks of professionals can be developed in other parts of the State, to provide more local, front line services for deaf persons who may find it difficult to travel to Boston for them.

II. Consultation

Because the first Director was a clinician, both case and program consultation were provided. Psychiatric case consultation has been provided to school programs for deaf children, the Massachusetts Rehabilitation Commission, prevocational rehabilitation agencies, State hospitals, community hospitals, and others.

The scope of these clinical consultations may be more related to the Director's professional training than to his functions as a coordinator of services. In addition, as the program of Mental Health Services for Deaf Persons, Boston, and other service networks for deaf persons expand, such clinical consultation will be assumed by these personnel.

On the other hand, program consultation is a major function of this office, involving many different segments of the service system. Primary among them is the input provided to DMH regarding planning for compliance with Section 504 of the Federal Rehabilitation Act of 1973. Problems faced by public agencies in complying with these regulations are awesome, but in no way reduce the agencies' responsibility to comply. The Director has been in a unique position to provide DMH with background data, needs analysis, and recommendations for its use in planning appropriately for Section 504 related to deaf people.

Other work involves the Director's serving on the Advisory Council of the New England Regional Psychoeducational Center for emotionally disturbed hearing impaired children, at Beverly, Massachusetts. As part of this group, he provides input into administrative issues and long-range planning for this innovative program.

Activities which could be included under the category of consultation, but which are not purely so, are speaking at workshops and conferences, or other events which call for teaching or information sharing.

III. Interagency Coordination

The importance of interagency cooperation and coordination is increasingly recognized in all human services program planning, but joint effort is especially vital in serving the deaf population, because the problems and concerns are so numerous and agency responsibilities overlap. Confusion arises when an agency, as a top-level policy decision, commits itself to providing "comprehensive" and "community-based" services for all citizens in need, but does not have the money or the expertise to deliver them. As a rule, other agencies with partial responsibility for a particular client may defer their involvement with the client to the first agency, which has promised comprehensive care.

Another version of this confusing—and frustrating—situation occurs when clients "fall through the cracks" of the service delivery system because they have multiple handicaps or multiple problems, but individual agency staff see themselves as responsible for only one handicap or one segment of the problems.

Therefore, avenues of communication must be opened among agencies who may become involved with deaf persons. This must lead to careful assessment and planning of services on an interagency level.

The Director of Mental Health Services for Deaf Persons represents DMH on a number of committees, task forces, and advisory councils which are dealing with issues of interagency coordination, involving agencies such as the Department of Public Health, Department of Public Welfare, Division of Special Education, Office for Children, Massachusetts Rehabilitation Commission, Massachusetts Commission for the Blind, Regional Deaf-Blind Programs, Department of Elder Affairs, and the Massachusetts Office of Deafness. The latter agency has been instrumental in creating the format for regular meeting of an interagency group currently meeting.

Results of this interagency effort has been the beginning of the program of Mental Health Services for Deaf Persons in Boston, the Western Massachusetts Task Force on Mental Health Services for Hearing Impaired Persons, and increased awareness of the service delivery system about the needs of deaf people. Future rewards from this cooperation will be early intervention projects, training programs, and a central register of hearing impaired persons. Continued responsiveness to the needs of deaf persons will follow as long as communication and cooperation continue among agencies.

IV. Advocacy

This function of a Director within DMH on services to deaf persons speaks less of concrete programs than to the attempt to sensitize policy makers about the mental health needs of deaf persons. Partial success has been achieved, in view of the Department's beginning commitment to fund a clinical program, and the indications that this commitment will continue.

Clearly, much work remains to be done. A number of knotty problems continue to require a strong advocacy effort designed to convince administrators and legislators of the need to spend more public money for services to deaf people. Such persuasion must be backed by solid data on needs and programs, with the vocal support of the consumer and professional communities.

In fact, as this position has evolved, it is important that the Director not just function as a conduit for outside advocates to the government, but also serve to organize professionals and consumer groups for the purpose of making their views better known at the policy-making level. In a sense, productive advocacy requires careful planning and coordination similar to any other project, and the Director should play a major role in its development.

In addition to representing the mental health interests of deaf persons before the government, the Director must act as advocate in other situations. Enlisting the aid of private mental health lobbying groups, working with academic training programs to develop opportunities to learn clinical skills for use in helping deaf persons, helping to persuade directors of halfway houses to expand their programs to include special services for deaf persons—all of these activities should be part of the advocacy function of the Director.

In order to assist this office in formulating its function and in organizing and performing advocacy activities, an Advisory Council to DMH was initiated in September 1977 and has met monthly since then. This group provides crucial professional, consumer, and agency input to the Director in helping guide choice of priorities and planning strategy.

Advocating for expansion or development of service programs is only part of the job in this area; public education ought to be a high priority, and involves three components. One is education about mental health in general, and available services, directed to the deaf community. Speaking to social and civic groups of deaf people should be part of this effort, and could be coordinated with the director of the clinical mental health program. These discussions could focus on such question as "What is mental health?," "What is mental illness?," "How can problems of living, or adjustment problems affect our lives, our families?," "What can a counselor or a therapist do to help?," etc. Other ideas include the distribution of printed material or the availability of videotape or filmed discussions about mental health and present services.

The second component in public education is the awareness of the general public about deafness and the needs of deaf people. It seems universally accepted that much of the social isolation of deaf people stems from the hearing public's ignorance or negative attitudes about deafness, including an abundance of fantasy and myth about deaf people. The Director should share with others the job of developing literature and programs designed to provide information and to increase sensitivity. TV programs, newspaper and magazine articles, meetings with civic and community groups—these and other ideas need to be pursued to a greater extent, since this effort is a form of preventive mental health with potentially wide impact.

Education programs directed to other professionals is the third part of public education that requires advocacy from the Director. Misinformation and ignorance about deafness is not limited to the nonprofessional. A coordinated program of lectures, discussions, demonstration films, and other modes of information sharing should be developed to increase knowledge about deafness, especially its mental health aspects. These activities can be planned for use with teachers, physicians, family counselors, welfare workers, or any professional who may have contact with deaf people.

Need for Regional, Central Planning

The role of a statewide Director of Mental Health Services for Deaf People is an evolving one. It is likely that the job will change as more is learned about the needs of deaf people, as certain tasks are completed, and as services are developed and expanded. A few major problems are crucial for the future functioning of this position, and will be mentioned here.

Deaf people are a low incidence, geographically dispersed population. However, the community mental health system is constructed to serve discrete geographic units known as catchment areas, and responsibility for programming is at the area level. Since deaf people are only a small fraction of the population in any one area, provision of services to them does not become a priority issue at that level.

Clearly, planning and service development for deaf people must occur at a Regional or even Central Office level, in order to be most efficient in providing quality services. This presents a dilemma to planners, since developing centralized programs to serve a low incidence geographically dispersed population runs counter to the major policy direction of the mental health system, which aims for unitized, community-based services. Such a dilemma has faced this planner, and involves problems such as securing Central or Regional program money for clinical or training projects. In addition, problems arise in coordinating services between the clinical mental health service program, which serves a statewide population, and other programs in the system, which generally serve only clients within discrete catchment areas.

Since the system operates by placing program responsibility at the Regional and Area levels, a Central office coordinator has no line authority to direct program development, and must rely on achieving results and commitment for funding by persuasion—a necessary political skill crucial to the success of any such job at the governmental level. Persuasiveness is especially needed for this position, since the structure of the system is unlikely to change in the near future, and the population of concern is relatively small.

Another problem involves the permanence of the position of Statewide Director, or Coordinator, of Mental Health Services for Deaf Persons, within DMH. This position was created primarily at the request of the author, though strongly supported by the deaf and professionals concerned about deaf persons. Its continued existence depends upon the commitment of the administrative leadership of the Department.

Such commitment can certainly be reinforced by the increasingly public voice of the deaf community, the vocal support of other professionals and agencies concerned with deaf people, and requirements to conform to Federal regulations calling for quality services for handicapped people. I am confident that DMH has made this commitment.

Communication is the key for many human, as well as administrative problems, and this is no less true for someone trying to develop a statewide approach to services. Contact with those in other States grappling with similar issues is important, both for information sharing and for learning about new ideas and models of service development. Research collaboration among clinical programs for deaf persons (Trybus 1977) should also include sharing of planning and development data for those at agency levels or for those who wish to influence agency policy makers.

Conclusion

We have a start in Massachusetts in developing a systematic approach to mental health services for deaf persons, with coordination both within DMH and among a number of agencies concerned about deaf people. The increasing awareness within the deaf community of their right to quality services and the strong support of deaf leaders and professionals and agency staff working with deaf people are positive influences for the continuation of this work and the continued commitment of the Department of Mental Health to the realization of our goals. The function of the Statewide Director depends, to a large extent, on this support; with cooperation, gratifying results will be achieved.

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News Briefs

Programs and Projects

New Treatment Program

Forest Hospital, Des Plaines, Ill., has a new, comprehensive program for the treatment of the emotionally disturbed individual with hearing impairment. Treatment is offered on either an inpatient or outpatient basis and is of unspecified duration. The program encompasses individual, group, and family therapy; video therapy; workshop experience; and special education. The facility is especially well equipped to handle the special problems of this population. In addition to its regular staff, the hospital has engaged persons who have skill in dealing with deafness, as well as skill in their individual professional specialities. Video therapy provides an important adjunct to the treatment process and is used extensively.

The Forest Hospital Mental Health Program for the Deaf is accepting patients of any age from anywhere in the United States and is approved for third-party payment by Blue Cross-Blue Shield and other insurance carriers. For further information write to:

Patricia Scherer, Ph.D., Director
Mental Health Program for the Deaf
Forest Hospital
555 Wilson Lane
Des Plaines, Ill. 60016
Telephone: (312) 635-4100 ext. 236.

Psycho-Education Center, Beverly School for the Deaf

The Psycho-Educational Center accepts emotionally/behaviorally disturbed hearing impaired children for treatment in a therapeutic milieu. This is a treatment mode which recognizes the effect of the environment and incorporates the total environment into the intervention plan. The PEC, incorporating psychology, counseling, special education and expressive arts therapy into its treatment philosophy, has designed an environment which allows the child to learn and test new attitudes and behaviors, develop constructive social relationships, and take greater responsibility for his own development.

The PEC serves 6- to 10-year-old hearing impaired youngsters from New England who have been identified as having mild, moderate, or severe emotional/behavioral problems which impede learning in their educational settings. In the area of evaluation, the PEC provides psycho-educational, developmental/cognitive, psychological, and family assessment. Parents of youngsters referred to the Center for evaluation or treatment work closely with the team during evaluation and visit the center regularly for counseling; home visits are made when appropriate. The PEC staff shares with parents techniques of child management found to be successful and works with them in developing a contract with their child to be used in the home setting.

To insure conjoint psycho-educational planning, school personnel from referral sites participate in the development of a program to which the youngsters now in treatment will ultimately return.

For additional information contact:

T. Jordon Goulder, Ph.D.
Project Director, PEC
Beverly School for the Deaf
6 Echo Avenue
Beverly, MA. 01915
Telephone (617) 927-2996

1978 APA Gold Achievement Award

Saint Elizabeths Hospital's Mental Health Program for the Deaf received the American Psychiatric Association's Hospital and Community Psychiatry Gold Achievement Award for 1978. The Award is given each year to recognize outstanding programs for the mentally retarded and mentally ill. To be eligible, a program must have been in full operation at least 1 year. Other factors considered are as follows:

1. Has the program made a significant contribution to the field of psychiatry locally and or nationally?
2. Does it provide a possible pattern for the future?
3. Has it found a way to overcome handicaps or extend resources?
4. Does it represent a novel accomplishment?
5. Would this accomplishment be worthy of emulation by other hosptals or agencies?

The Gold Plaque was presented at the APA 30th Institute on Hospital and Community Psychiatry in Kansas City, Missouri, September 1978.

Conference on Mental Health Deafness

The University of California Center on Deafness, San Francisco, held a 5-day workshop July 31–August 4, 1978, for clinicians providing direct mental health services to a deaf population. It is expected that proceedings of the workshop will be published. These include a survey update on services currently available, prepared by Dr. Jan Zitz. Issues discussed included treatment strategies, program operations, data collection systems, training programs, and service surveys.

Study of the Prevalence of Deafness Among State and County Mental Hospital Resident Patients

In its report on the 1978 National Institute of Mental Health (NIMH) budget request, the Senate Appropriations Committee made the following statement: "The Committee recognizes that communicative disorders among inpatients in mental institutions often go undiagnosed and untreated. Therefore, the Committee directs the National Institute of Mental Health to utilize fiscal year 1978 appropriations to fund a prevalence study of communicative disorders in mental institutions" (Senate Approporiations Committee Report).

Further discussion with the Committee staff has indicated that the intent of the Senate was to deal with the problems of institutionalized persons who have a hearing impairment, particularly those in the State and county mental hospital system and that the study should obtain, in particular, the following information:

1. An estimate of the prevalence of hearing impairment among psychiatric inpatients in State and county mental hospitals in the United States.
2. A discussion of the major problems peculiar to this group, for example, misdiagnosis because of hearing impairment, neglect by hospital staff because of hearing impairment, etc.
3. A review of significant programs or techniques now in use in State and county mental hospitals for the benefit of hearing impaired patients.

This data will serve the needs of the Senate as expressed in its report. Furthermore, it will serve the needs of mental health administrators at all levels and of the deaf community, in that it will provide this necessary information which will help to motivate and channel much needed efforts on behalf of these persons.

The requested estimates are not available on a national level, and what very little partial information is available is for the most part not current enough to be useful.

The NIMH Project Officers for this study are Luther D. Robinson, M.D., Associate Superintendent for Psychiatry, Saint Elizabeths Hospital; and Mr. Carl A. Taube, Acting Deputy Director, Division of Biometry and Epidemiolgy, National Institute of Mental Health.

NIMH proposed to award a single sole source contract to the Office of Demographic Studies, Gallaudet College, Washington, D.C., to carry out the study. This study is expected to be completed by early 1979.

WISC-R Norms for the Hearing Impaired

The performance scale of the WISC-R has been standardized on a national sample of 1,228 deaf children. Data were collected from 18 residential and four day schools for the deaf located throughout the United States. The characteristics of the deaf sample were similar to those of Wechsler's WISC-R hearing sample. Information concerning the "hearing status of the parents" and the "communication method" used during testing is reported. Norms for deaf children between the ages of 6–0–0 and 16–11–30 are presented and the statistical procedures used to compute the norms described.

Deaf children performed similarly to hearing children on all performance subtests except Coding and Picture Arrangement; deaf children, particularly young, low-scoring deaf children, performed significantly below their hearing peers on these subtests. More raw score variance occurred within the deaf sample at all age groupings and on all subtests. Significant differences (beyond the .01 level) between the two groups were also found in the subtest scaled score patterns, the mean performance IQ scores, and the standard deviations.

This work was performed by Ms. Frankie Sisco and Dr. Richard Anderson. Copies of the report and normative tables may be obtained from the Office of Demographic Studies, Gallaudet College, Washington, D.C.

NAD Committee on Mental Health and Deafness

A Committee on Mental Health and Deafness has been set up by the National Association of the Deaf; Dr. John Scanlan, Director of the Mental Health Program for the Hearing Impaired at the Saint Paul-Ramsey Hospital and Mental Health Center has been selected as chairman.

The resolution establishing the committee lists objectives which include educational, information, and advocacy activity both within the NAD and with groups.

Committee members include: Edna Adler, Consultant, Deafness and the Hard of Hearing, Office of Deafness and Communicative Disorders, Rehabilitation Services Administration, HEW; Marvin Garreston, Assistant to the Dean, Pre-College Programs, Gallaudet College; Larry Goldberg, Clinical Lawyer Supervisor, Law Center for the Deaf; Tom Goulder, Director, Psycho-Educational Center, Beverly, Mass.; Gregory Kimberlin, Director, Mental Health Services for the Deaf, St. John's Hospital, Santa Monica, Calif.; Luther D. Robinson, Associate Superintendent for Psychiatry, Saint Elizabeths Hospital; Barbara Sachs, Clinical Psychologist, Saint Elizabeths Hospital; Hilda Schlessinger, Director, Mental Health Program for the Deaf, Longley Porter Neuro-Psychiatric Institute, San Francisco, Calif.; Fred Schreiber, Executive Secretary, NAD: Larry Steward, Director, Model Demonstration Program, Educational Rehabilitation Center, University of Arizona, Tucson; Frank Sullivan, Grand President, National Fraternal Society of the Deaf; Allen Sussman, Director, Counseling Center, Gallaudet College; Raymond Trybus, Dean, Research Institute, Gallaudet College.

Training Programs

Training in Mental Health in Deafness at Saint Elizabeths Hospital

Saint Elizabeths announces a stipended training program in Mental Health in Deafness. This program has been recognized by the U.S. Civil Service Commission and endorsed by the Executive Secretary of the National Association of the Deaf and the President of the American Deafness and Rehabilitation Association.

Saint Elizabeths Hospital has a longstanding reputation as a nationally recognized mental health training center. The Hospital's long range goal in specialized training to prepare workers for the field of mental health in deafness is a three-track training program as follows:

Track 1—Prebaccalaureate or no formal education beyond the secondary level.
Track 2—Graduate level students in the mental health core disciplines and other specialties which can provide services for the mentally ill deaf.
Track 3—Qualified mental health professionals in the core disciplines of psychiatry, clinical psychology, psychiatric nursing, and social work.

The Hospital will introduce Track 3 in October 1978; the development of programs for Tracks 1 and 2 will come later. Track 3 is a 12-month program which will begin on October 1, 1978, with the first group of trainees scheduled to complete training on September 30, 1979.

It will accommodate from three to five trainees with full-time appointments, beginning each October. At completion of the training program the graduate will be prepared to provide direct psychiatric services to deaf clients, applying the tools of their disciplines. In addition, graduates will be prepared to employ the psychotherapeutic interventions of counseling, individual psychotherapy, group psychotherapy, and family therapy. Each trainee will elect one area of subspecialization from choices that include education, consultation, administration, research, or program evaluation. Each trainee will, therefore, be prepared to provide direct psychiatric clinical services to deaf clients and to assume one of the following roles: educator, researcher, consultant, administrator, or program evaluator.

Eligibility

Core mental health professionals who have completed the following minimum requirements:

Psychiatrist—2nd year residency in psychiatry.
Psychologist—All requirements for a Ph.D. in Clinical Psychology with internship, but not necessarily the dissertation.
Social Worker—Master's in social work.
Nursing—Master's in psychiatric nursing.

Address all applications or inquiries to:

Luther D. Robinson, M.D.
Associate Superintendent for Psychiatry
Saint Elizabeths Hospital
Washington, D.C. 20032

Internship Program in Mental Health and Deafness

University of California Center on Deafness Research, Training, and Mental Health Services
San Francisco, California

Two internship training programs were initiated in the fall of 1978. The first, a 6-month, half-time program, is designed for professionals from vocational rehabilitation or counseling programs who have experience working with the deaf. Supervised experience and didactic seminars are scheduled, to develop a knowledge of mental health principles that will help trainees become more effective in their present work with the deaf. Sign language skills will also be emphasized.

The second internship, 1-year, full time, is designed for qualified clinicians in the areas of psychology, social work, and psychiatry who have not had previous training or experience working with the deaf. Didactic seminars in the area of deafness and an extensive clinical component are scheduled. Sign language skill will be emphasized. For additional information contact:

Paul M. Brinich, Ph.D.
Training Director
University of California Center on Deafness
1474 Fifth Avenue
San Francisco, Calif. 94143

Workshops for Psychologists: Psychological Assessment of Deaf Clients in Vocational Rehabilitation Programs

New York University—Deafness Research and Training Center

A series of 5-day workshops for psychologists working with deaf clients was held throughout 1977–78. Similar workshops are tentatively scheduled for 1978–79 in various cities. The program consists of seminars in: techniques of communication with deaf clients; assessment of client's communication competencies, academic achievement, and intelligence; vocational evaluation; emergency testing (dealing with difficulties in testing); and observation in testing of deaf persons. A practicum, review of case material, and seminars with service providers conclude the workshop. For more information contact:

Douglas Watson, Ph.D.
New York University
Deafness Research and Training Center
80 Washington Square E.
New York, N.Y. 10003

Research in Progress

Relationships of Deaf Persons and Interviewers

Ph.D. dissertation by Barbara B. Sachs: "Dimensions of Perceived Interview Relationship as Influenced by Deaf Persons' Self-Concepts and Interviewer Attributes as Deaf or Non-Deaf." The purpose of this research is to investigate, during an initial interview, (1) the influence of a deaf person's self-concept on his perceptions of therapist conditions in the relationship with the interviewer and (2) the influence of the attribute of the interviewer as deaf or non-deaf on the deaf person's perceptions of therapist conditions in the relationship with the interviewer. The differential interactive effects of the self-concept and deaf/non-deaf attribute variables on interviewee perceptions are also being studied. The population of subjects consist of deaf preparatory students at Gallaudet College. Instruments to be used include the Tennessee Self-Concept Scale and the Barrett-Lennard Relationship Inventory. The latter has been translated entirely into Ameslan. The experiment involves the viewing of interviews conducted entirely in Ameslan on videotape. A multivariate analysis of variance computer program from the National Institute of Mental Health is to be used in the statistical treatment of the data.

Survey of Mental Health Services for Deaf Children

A Survey of Mental Health Services for Deaf Children will be disseminated by Terry Edelstein, doctoral candidate at the University of Pittsburgh, in the fall of 1978 to psychiatric and education institutions, speech and hearing clinics, and counseling centers to identify treatment programs for children who are deaf and mentally ill. The first phase of the survey will be a general questionnaire to administrators of various institutions and centers regarding institutional policies toward emotionally disturbed deaf children. The second phase will collect data from the programs identified through the administrator's questionnaire. Mental health programs will be defined as special programs for disturbed children beyond the psychological services regularly provided in institutions to meet the needs of the general population (Bardon and Bennett 1974, Cantor and Spragins 1977, Levine 1974, NIMH 1974). Programs will be reviewed with respect to type of treatment services, staffing, population served, referral intake and termination policies, evaluation procedures, funding and research. A description and review of services is expected to be available in the summer of 1979.

Social-Emotional Assessment Inventory for Deaf Students

Kay Meadow, Director of Research at Kendall Demonstration Elementary School, has developed a Social-Economic Assessment Inventory for Deaf Students. It is designed to tap the areas of self-image, maturity, social adjustment and personal adjustment. A number of schools, with a total enrollment of more than 2000 students, are participating in a program for the development of norms based on a nation-wide population. The Inventory will be normed during 1978–79 and is expected to be available for general use shortly thereafter.

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Illustrations—Submit one copy of each chart, graph, or other illustration in reproducible form (either original drawings in black india ink or glossy prints). Refer to all illustrative materials as text figures. Type the figure number and legend for each in the text immediately after the paragraph in which it is described. Illustrations from other publications must be acknowledged.

References—Include a list of all articles and books cited in the text. Arrange alphabetically by major author. When referring to these sources in the text, place the author's names and the date of publication in parentheses immediately after the idea referenced. (If authors' names are used in the same sentence, place only the date of publication in parentheses.) Spell out all journal titles. Bibliographic style should follow that used in articles in this issue.

Footnotes—Use footnotes to clarify text material and indicate them by superior figures in the text. Insert footnotes as separate paragraphs immediately following the paragraphs in which they are mentioned.

Author Identification—Include a brief description of your own and each author's official title and academic degrees.

Manuscripts are received with the understanding that they are not being considered by another publication and that if they are published by Mental Health in Deafness, they are in the public domain. At any point in the total process of consideration, Mental Health in Deafness reserves the right to reject the manuscript and return it to the author without explanation for the rejection and will not be responsible for loss.

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