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ABSTRACT

The author supports the promotion of mental health for deaf individuals through improved and expanded mental health services. To illustrate the psychological, educational, vocational, and social implications of deafness, Chapter 1 presents a profile of the deaf individual with emphasis on the communication barriers which exist at each stage of life. Chapter 2 reviews categories of illness (functional psychoses, neuroses, personality disorders and certain othernonpsychotic mental disorders, psychophysiological disorders, transient situational disturbances, and behavior disorders of childhood and adolescence) and considers the relationship between mental illness and deafness in terms of causes and incidence, difficulties of detection, and occurrence of specific types of illness. A third chapter defines four types of therapies and describes ways in which the treatments are adapted to deaf patients with particular reference to the Mental Health Program for the Deaf (MHPD) at St. Elizabeth's Hospital (Washington, DC). Theory, purpose, and operating procedures are discussed for psychotherapy (individual, group, and family therapy); behavior therapy/modification; activity therapies (self expressive activity therapies, occupational and/or vocational therapies); and somatic therapies (pharmacological and physical therapies). A final chapter focuses on training and research in mental health and deafness with sections on training programs in the MHPD, new directions in academic training programs, and new directions in research. (SB)

Sound Minds in a Soundless World

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Contents

ILLUSTRATIONS

TABLES

Foreword

This book, *Sound Minds in a Soundless World*, as the name implies supports the promotion of sound mental health for all deaf people. Deaf people need mental health services just as hearing people do. However, society has turned a deaf ear to them in response to these needs. For centuries, this area of health care has been neglected. As was pointed out at the first National Orthopsychiatric Workshop on Deafness, which was attended at Saint Elizabeths Hospital in Washington, D.C., in May 1976, by local, State, and Federal representatives from mental health and educational programs for the deaf, less than 2 percent of the 43,000 deaf persons needing mental health services are receiving them. The necessity for improving and expanding mental health programs to meet the needs, with particular attention to deaf children, was emphasized The recent World Congresses of the World Federation of the Deaf have also recognized the need for expanding programs in mental health in deafness Saint Elizabeths Hosptial is to be commended for playing a pioneer role in establishing mental health services for deaf people The National Institute of Mental Health reaffirms its commitment to support efforts in the maintenance of sound minds in a soundless world.

BERTRAM S. BROWN, M.D
Director
National Institute of Mental Health
1970-1978

Preface

It is only within the last half of this century that interest in providing psychiatric mental health services for deaf people has slowly emerged. Prior to that time, such special services were virtually neglected, in spite of the obvious need for them. Perhaps the major reason for the delayed development of suitable programs is that deaf persons present a great challenge to therapists—the challenge to acquire special communication skills, as well as knowledge of the psychosocial implications of deafness In this context, communication entails more than linguistic ability, it implies a broader effort to understand the effect of hearing impairment on psychological and social development, and at the same time to realize the fundamental commonalities shared by all individuals, deaf and hearing.

My first contact with a deaf person was with one who was mentally ill, this meeting occurred in 1947, when I was on the staff of a State mental hospital It was not until 1963, however, that I decided to devote considerable time and attention to the understanding of deaf people and their problems relative to mental illness, this initiative was the beginning of what is now known as the Mental Health Program for the Deaf (MHPD) at Saint Elizabeths Hospital, Washington, D.C The program in its earliest stages consisted of group psychotherapy with deaf patients using manual communication (sign language and fingerspelling) primarily. The success of this pioneering effort soon led to an expansion of services and eventually to a full scale program for deaf people, which presently includes multidisciplinary treatment programs for patients, the training of deaf and hearing professional and paraprofessional trainees, and opportunities for research activities Development of the MHPD has also led, of course, to contact with fellow professionals at work in this field, it was in this way that I learned of the pioneering program developed at the New York State Psychiatric Institute and the Rockland State Hospital, and of later work at such places as the Michael Reese Hospital in Chicago and the Langley Porter Neuropsychiatric Institute in San Francisco With the gradual development of programs for the mentally ill deaf in a number of other States, and the concomitant exchange of ideas among professionals on both national and international levels, there have recently been welcome signs of progress in this long-neglected area

Because the MHPD at Saint Elizabeths has played a pioneer role in the development of mental health services to deaf people, the detailed account of the program presented in later chapters is intended to interest the staffs of other mental health facilities, and to promote the development of new programs There remains a great deal of work to be done, and it is my hope that this book will stimulate interest in several groups of readers, all of whom are important to future efforts The book is not designed exclusively, or even primarily, for mental health professionals, it is also meant for individuals who may know little about mental health, especially the mental health of deaf people, and who wish to be introduced to these subjects Thus laymen who are deaf may learn how to promote better mental health in the deaf community, as well as how to work together with hearing people to alleviate the suffering of the mentally ill deaf, hopefully some will be stimulated to pursue professional and paraprofessional careers in the mental health field, and will be encouraged to do so by parents and educators Laymen with normal hearing will find that deaf individuals are more similar to than different from hearing individuals, that fundamental causes of psychic disturbance are common to everyone, and that the elimination of the communication barrier between deaf and hearing is not only desirable but also of mutual benefit to all concerned In short, the book is designed to appeal to as broad a reading audience as possible in the belief that future progress in the treatment of the mentally ill deaf depends on coordinated efforts from all sectors of the community, and the existence of an enlightened and involved general public

From the time that I began to study manual communication under the tutelage of a deaf professor until the present—a period which includes 10 years as Director of the MHPD—I have enjoyed warm and meaningful relationships with a great many deaf people in a variety of capacities These have included student, teacher, cotherapist, coauthor, coworker, and friend There is no doubt that the good fortune of these many opportunities has contributed greatly to my efforts to establish comprehensive mental health services for deaf people, and it is hoped that this book will provide a means of sharing the benefits of my experiences with others, and of thanking indirectly my many deaf benefactors. I wish it were also possible to acknowledge my friends and colleagues on an individual basis, but the list is too long for me to do so I would, however, like at least to mention the following organizations and institutions with which I have had associations Gallaudet College, the Model Secondary School for the Deaf and its National Advisory Council, the Kendall Demonstration Elementary School (KDES) and its National Advisory Council, the Policy Advisory Council to KDES; the World Federation of the Deaf, the National Association of the Deaf, the Professional Rehabilitation Workers with the Adult Deaf, in particular, its Washington metropolitan chapter, the Alexander Graham Bell Association of the Deaf, the Registry of Interpreters for the Deaf, and two organizations whose functions are currently served by other organizations, the D C Association of the Deaf, and the Council of Organizations Serving the Deaf

I am equally grateful to the administration and staff at Saint Elizabeths Hospital, whose efforts made possible the establishment and continuance of the MHPD, and who gave assistance in many ways in the preparation of this book, and to the National Institute of Mental Health, which has continued to encourage and promote the work of MHPD since it assumed responsibility for Saint Elizabeths in 1967 To the many deaf patients who have participated in the program, and who have willingly cooperated in the efforts to establish effective modes of communication and treatment, I extend a special thanks

CHAPTER 1

Implications of Deafness

In our society it is said that silence is golden This may be true when it exists part of the time and at one's own choosing However, when silence is permanent and involuntary, as it is in deafness, it is anything but golden Our hearing society has little awareness of people who experience deafness, moreover, the awareness that does exist is frequently based on misconceptions Like many social attitudes, prejudice against deaf persons is partly a cultural inheritance, a legacy from past times when any kind of handicap was superstitiously equated with inferiority Though we like to think that we in the 20th century are too sophisticated to stigmatize people because of a physical impediment, it is not always possible to recognize the subtle forms which prejudice can take For example, the common phrase "deaf and dumb" is damaging on two counts first, the word "dumb" is inaccurate as a description of the physical handicap of deafness, since deaf people are not mute, second, the phrase connotes that "dumb" may refer to intellectual faculties as well as sensory ones The fact that relatively small numbers of hearing people have regular contact with deaf individuals tends to perpetuate these myths in the hearing community, and to make it difficult to open up a large-scale public awareness of the realities of deafness

Deaf people are not "dumb" in any sense. Most are able to make vocal sounds and, despite the difficulties of cultivating the voice into intelligible speech without the benefit of hearing, deaf persons may achieve varying levels of speech proficiency That deafness does not affect I Q has been amply demonstrated by both linguists and educators In *Thinking Without Language*, the renowned theoretical linguist Hans Furth concludes that deafness has no debilitating influence on the basic development and structure of the intelligence (1966), this conclusion has been verified by more than 50 I Q. studies of the deaf (Vernon 1968), and by the overwhelming consensus of professional opinion on the matter However, the understanding of deafness requires more than the laying aside of prevailing myths, which is fundamentally a negative approach, the hearing person should approach the deaf person through a framework of experiences which are common to both

Deaf people are human beings with the same basic needs as other human beings -- the need to love and be loved, the need for security, the need to feel wanted, the need to achieve and be recognized for their achievement, the need to be contributing members of society As tr noted psychologist Edna Levine puts it, "The inner well-being of deaf individuals is subject to the same psychological principles that govern the well-being of all humankind" (1960, p 28) Moreover, as we have seen, the potential of deaf individuals is no different from that of the hearing, thus the deaf should be able to satisfy their human needs as well as anyone else Presumably, the experiences of the deaf person as a child in the home, and later as an adolescent at school, and as an adult on the job and in the community should follow approximately the same developmental pattern as that of the person with normal hearing, and the social and educational achievements of the deaf should roughly parallel those of their hearing counterparts Unfortunately, however, great numbers of deaf individuals never realize their full potential, and for a reason that is only tangentially related to the condition of deafness, that is, because they are cut off from the kinds of communication that facilitate a steady and natural development

Communication is one of the most important human activities It is essential for personality development of the individual as well as for interpersonal relationships For communication in our society we depend primarily on verbal language, both vocal and written, most hearing persons take for granted the verbal-vocal language that makes day-to-day communication possible because they learn to speak their native language through the natural process of imitating what they hear as children The deaf person, however, lacks the normal means of acquiring language that is, hearing, and must depend on his environment to provide a substitute means by which he may learn communicative skills When these means are denied, the deaf child's problems in communication become progessively worse, without the system of language accepted by society as its mode of operation, the deaf individual is at a severe disadvantage in meeting society's expectations for educational, vocational and social achievement If a deaf person fails to achieve according to acceptable levels, he is then labeled "inferior," an indictment which tends to confirm the social prejudice which helped create some of his problems The deaf person's real handicap is not deafness, but communication problems that too often result from society's failure to provide him with the necessary resources and opportunities for a natural development The achievements of deaf people in the face of such obstacles have been truly impressive, and deserving of high praise, however such achievements also serve to demonstrate by contrast the large numbers of individuals whose talents are largely wasted To understand deafness is first to understand the problems in communication which deaf people confront every day, in all the ordinary areas of experience and to perceive the ways in which an individual can *become* seriously handicapped when his fundamental needs go unmet (Robinson 1977)

In order to illustrate the psychological, educational, vocational, and social implications of deafness, [illegible] chapter will present a profile of the development of a deaf individual, with emphasis on the communication barriers which exist at each stage, and a description of their possibly debilitating effects It should be stressed however, that such a profile attempts to identify commonalities among the deaf and therefore must disregard many of their very important individual differences Deaf persons cannot be stereotyped as a class any more than hearing people can, the complex process of human development is always an individual one Moreover, as sociologists who deal in statistics are quick to point out, there is even some danger that studies which attempt to isolate distinctive behavorial patterns might themselves contribute to the false stereotype of a homogeneous class It is important, then, to remember that profiles are useful as a way of providing essential information, they cannot hope to describe the many complexities of a heterogeneous group, nor do they intend to The intention of this chapter is to enlarge the picture of deafness for an uninitiated reader so as to provide a foundation for subsequent learning, and to encourage the reader to pursue his interest through the best learning process of all—direct contact with deaf people

DEFINITIONS OF DEAFNESS

It is well to begin by establishing what the term *deaf* will mean for our purposes We may define deafness as a hearing disability which makes it necessary for the person so affected to depend on means other than auditory ones for the reception of communication, putting it another way, deafness is a hearing disability so severe that it requires the victim to use primarily visual means for normal daily communication, and renders him or her incapable of carrying on a conversation in the dark without the use of the tactile sense This definition deliberately avoids the technical disputes over the minimal degree of decibel loss that may be said to characterize a deaf person and concentrates instead on the factor which most influences development—that is, difficulty in communication

As we have seen, deaf persons are not mute, however, speech proficiency is usually related to age of onset of deafness, as well as the individual's opportunities for s[illegible] training Since factors influencing the acquisition of language may [illegible] related to age of onset, it is useful to distinguish between the congenitally deaf and the adventitiously deaf The congenitally deaf are those who were born deaf, the adventitiously deaf are those who were born with normal hearing but in whom the sense of hearing became nonfunctional later through illness or accident Some of the adventitiously deaf became deaf before acquiring language skills through normal means, these are called the prelingually deaf Others of the adventitiously deaf became deaf after what is called the critical period in language development (i.e., 3 to 6 years of age), these are the post-lingually deaf. The profile presented in this chapter will concentrate on the congenitally and prelingually deaf (currently, the largest groups of deaf persons) together with the postlingually deaf who lost their hearing prior to 19 years of age, or before they were able to assume vocational responsibilities. According to the 1974 national census of *The Deaf Population of the United States* (Schein and Delk 1974), there are approximately 450,000 individuals who comprise these three categories, their collective experiences necessarily include the special problems in communication soon to be discussed. Although persons with other kinds of deafness—for example, those suffering from the progressive loss of hearing during the middle years, or in old age—may experience some similar psychological frustrations, such as a feeling of isolation, it is the congenitally, prelingually, and postlingually but prevocationally deaf who confront unique social handicaps in trying to establish a healthy developmental pattern.

The scope of this chapter does not allow for detailed consideration of the etiology, or causes of deafness, or for the medical descriptions of the types of deafness, though both features are commonly used in defining the handicap. However, it should be pointed out that deafness of certain etiologies may be accompanied by other disorders. [illegible] example, one of the causes of deafness, maternal rubella (commonly known as German measles) can sometimes result in multiple handicaps, including brain damage and related emotional disorders, this may also be true of certain types of genetic etiologies. It does not follow, of course, that a person with multiple handicaps has necessarily suffered organic brain damage, or that rubella induced deafness is always accompanied by an additional handicap. However, the reader should be advised that in describing the ordinary experiences of deaf persons, this book does not include those who suffer from another handicap which restricts the normal development of their intellectual capacities.

THE EARLY HOME LIFE OF THE DEAF CHILD

Communication between mother and child plays a vital role in the development of the personality of the child. Even before the hearing infant can perceive language, he or she gets certain cues from his mother which convey feelings of love, security, and comfort. These feelings are communicated through being held, caressed, fed, and looked after. The friendly, tender voice of the mother, or the sounds of her footsteps approaching can be greatly reassuring to an infant. Of course, certain sounds can be equally frightening, but learning to cope with these, and to distinguish them from friendly sounds, help facilitate the development of the child's personality.

As the child develops, he learns to relate to his mother even more directly through the communication of language. The acquisition of language is, of course, gradual, and largely unconscious. It is part of the carefully calibrated process by which an infant comes to terms with his own separate identity, and with the world as it exists around him. A child learns to speak "naturally," that is, he imitates what he hears and thus assimilates the basic structures of his native language without being taught them directly. As language proficiency develops, the child who does not have a communication barrier has increased opportunities for communication and warmth with his mother, and the relationship between the two grows stronger. By the time a child is ready to enter school, he has learned to communicate with the world outside his home as well.

A deaf infant is deprived of many of these advantages. Although he may experience the physical comfort of being fed, held, and carressed, he misses those other communications which are perceived by the hearing infant through the auditory mechanism. He cannot hear his mother's voice in the next room, reassuring him of her presence, he must depend on sight, tactile sensations, and vibrations for information about his environment, and he learns quickly that he is cut off from certain kinds of warning signals—for example, when a person approaches without his knowledge. As the child matures and tries to relate to the hearing world outside him, he encounters an even bigger stumbling block, he is denied auditory access to the means through which people in that world communicate—language. In order for the deaf child to develop normally, and to learn what he needs to know to communicate with the hearing world, the parents must be aware of his special needs, and take the necessary steps early to provide them.

Unfortunately, many parents are themselves quite understandably handicapped in learning to cope realistically with their child's deafness. Most deaf children have hearing parents, many of whom have had no prior experience with deafness, and no reason to expect deafness in their child, moreover, they have probably been affected, at least indirectly, by the stigma of shame which society places on deafness. Contrary to the reactions of deaf parents, who are usually psychologically prepared for a deaf child, hearing parents are apt to react with shock and disbelief, followed by what is sometimes called a period of mourning. As Solnit and Stark point out in an article describing this painful process, the mourning is not in itself unhealthy, since it allows the parents to adjust to the "death" of the normal child whom they expected, and to work through the feelings of guilt and responsibility which most have for having a handicapped child (1958). However, parents usually need help in clarifying the realities of their situation in order to avoid responding to the child in one of three fundamentally negative ways: first, by rejecting the child and later sending him away from home so as to avoid the reproach of what the parents feel as their failure, second, by denying the child's deafness in search of the so-called miracle cure, a lengthy process in which much valuable learning time is wasted, and third, by overprotecting the child so that he is unable to learn to cope for himself It is hard to gauge the extent to which negative social attitudes underlie these confused responses in parents, but there is no doubt that the general lack of knowledge about deafness contributes to the false and exaggerated notions which many of them hold

If the parents are able to work through their grief realistically, and to turn their attention to the healthy development of the child, they are often at a loss to discover the best means of educating their child in the early years They learn that there has long been a dispute between educators of the deaf over oral vs manual means of communication The oral method makes use of lip or speechreading by detecting words from the shapes made by a speaker's lips and from his facial musculature Strict oralists believe that a child should be taught to speak, and to speechread only, he should not be allowed any manual form of communication Those who argue for manual methods point out that the use of the hands is both natural and comfortable for a deaf child, and provides the best means of learning his native tongue the child may fingerspell, that is spell out words on the fingers by means of a manual alphabet, and/or sign, that is, form single configurations which convey a whole word or thought Most systems of communication in use today combine oral and manual techniques, such as the simultaneous method adopted by Gallaudet College, in which persons express themseleves through signs, fingerspelling, and speech and receive communications through interpretation of manual configurations, speechreading, and amplification, the Rochester method, which uses speech supplemented by fingerspelling as the mode of expression, and a variety of new sign language systems concerned with accommodating signs to English grammar (again as a complement to speech) and grouped together by the National Association of the Deaf under the term *Siglish* (Caccamise and Drury 1976) Although parents may be initially confused by the various arguments offered by proponents of these and other systems, most experts today agree that parents should never be forbidden by educators to use a specific means of communication, and that most will decide to combine methods in an effort to achieve as total a communication as possible with their child Thus parents may adopt a kind of sign language at the same time that they encourage and develop speechreading skills, they will provide various kinds of auditory stimulation and vibration in the early months, and they will encourage the child to communicate with them in a variety of ways, including, of course, speech What is important is that the child is made to feel that he is in touch with the people who love him, and with his environment, and that he is given a substitute means of learning what he must know to take his place in the world—language

The psychological ambivalence which some parents feel after giving birth to a deaf child, together with their confusion over how best to help the child, are not insurmountable problems, many parents both deaf and hearing, have great success in providing the environments which allow their children to develop normally There is little doubt, however, that others are in need of guidance and counsel, and that lack of such direction at crucial periods in the child's development may seriously retard the child's subsequent socialization Concerned professionals are thus calling for a wide range of reforms designed to help these new parents, including an informed medical profession that can provide parents with the facts about deafness, and refer them to appropriate agencies (Robinson 1974), psychological counseling where necessary (Schlesinger and Meadow 1972), an increase in social workers who may aid in family counseling over an extended period of time (Hurwitz 1969), learning resources through which parents may become educated in the various modes of communicating with their child (Mindel and Vernon 1971), and a strong national organization of parents of deaf children, with State and local chapters, in which deaf and hearing parents can exchange insight, knowledge, and experience (Williams and Adler 1974) Patterns for future adjustment are usually set early, when a child is most vulnerable to an environment which he cannot control Given the right kinds of opportunities, a deaf child may develop emotionally and intellectually in a healthy and satisfying way, denied these opportunities, the deaf child moves out into the world ill-equipped to cope with its demands

EDUCATIONAL IMPLICATIONS OF DEAFNESS

That far too many deaf children are not deriving maximum benefit from formal schooling is evident in the conclusions of many studies of deaf educational achievement There is no concensus about the extent of the lag in deaf achievement, but it is clear that the average graduate of a deaf secondary level school is not advanced as his hearing counterpart In addition, there is the problem of dropout, the studies of Altshuler and Baroff in New York (1969) showed that more than 35 percent of deaf students leave school before 16 years of age, and are thus even further behind in educational achievement It may be that the tests that have been used to measure the learning progress of deaf students are themselves in need of refinement, recent analyses made by the Office of Demographic Studies at Gallaudet College (March and August 1972, July and September 1973) show this to be so· Analysts there have demonstrated, for example, that the Stanford Achievement Tests commonly used to determine educational achievement and to compare deaf and hearing children contain several sections which are inappropriate for deaf students due to their emphasis on knowledge acquired through auditory means, the staff has modified the test accordingly and is in the process of presenting statistics measuring deaf educational achievement in its proper context The demographers do not use the new data to compare deaf and hearing students, but they do identify learning problems among deaf students which require immediate attention—for example, weaknesses in reading comprehension, vocabulary and related tests, and a rather slow rate of progress over periods of several years Language deficiencies were also found in a 1960 study by Roy and Schein of incoming students to Galluadet College, though there was a discrepancy of only 2 to 3 years in achievement between deaf and hearing college candidates, the deaf students scored much higher on nonverbal than on verbal questions However, the exact nature and extent of the deaf educational lag is not the issue here, what is important for our purposes is that the deaf student is usually not able to take full advantage of his educational opportunities, and that the reasons for this problem are once more related to communication handicaps

It is obvious that if a child goes to school without his native language, and some means of communicating it to others, he or she is going to have a great deal of catching up to do, thus many professionals stress the lack of early education in the home, and the lack of nursery school training, as causative factors in later learning problems However, the deaf child too often has had to contend with emotional trauma as well, since the pattern in the past has been for parents to place him at an early age in a residential school for the deaf where his contacts with his family and relatives were infrequent and unsatisfying The child, who often was not adequately prepared for such a displacement, might remain in such a setting until his late teens or early twenties with restricted access to the hearing world, although there were many obvious benefits to be derived from opportunities for friendships with other deaf students, and with concerned teachers and administrators, the residential setting nonetheless served to isolate the deaf child from a broad range of experience In addition, the child often found that in the residential school, manual communication of any kind was severely restricted, if not forbidden altogether, so that a natural and satisfying mode of self-expression was denied him Since the ability to learn is intimately tied to psychological security and well-being, and to the capacity to communicate with and absorb from the environment, it is not surprising that large numbers of deaf students failed to fulfill their learning potentials

Today, however, the situation is changing, and the educational prognosis for the deaf child is constantly improving The long struggle between purists of the oral and manual schools of thought has been greatly mitigated by the progress of the theory of total communication—that is, that a deaf child should be taught to speak, to speechread, and to communicate with his environment manually as well There is a decided increase in the number of children who receive preschool training, and a wider range of educational programs from which parents of deaf children may choose In addition to the public residential schools, there are private residential schools, public and private day classes, which allow a child to live at home, and an ever increasing number of special programs in hearing schools which are designed to keep deaf children close to their families, and integrated with hearing students On the campus of Gallaudet College are two modern, model institutions which are making great strides in educating the deaf The Kendall Demonstration Elementary School, opened in 1971, and the Model Secondary School for the Deaf, opened in 1969 Perhaps most importantly, the signing into law of the Education for All Handicapped Children Act (Public Law 94-142) in 1975 ensures Federal commitment to the education of handicapped children (ages 3-21), and to the development of preschool services in local districts and States

According to Stephen Quigley's 1974 review of the postsecondary scene, the opportunities for deaf students in institutions of higher learning have also shown marked improvement since the early sixties, he estimates that the number of deaf students in postsecondary education quadrupled between 1960 and 1970 Quigley points out that prior to the mid-sixties, the deaf student who was not among the fraction admitted to Gallaudet College did not usually have alternative options for higher education Now, however, he or she may choose from among an impressive array of possibilities the National Technical Institute for the Deaf (NTID) at Rochester Institute of Technology in New York offers a program for deaf high school graduates that is connected to the Rochester Institute's regular programs Deaf students may sign up for special classes for the deaf, or they may participate, with the aid of an interpreter, in classes at the Rochester Institute Most students combine types of classes and thus benefit from the advantages of integration Degrees are offered in such areas as electrical or mechanical engineering, photography, printing, business administration, and electronics Other special programs for deaf students are available at California State University in Northridge (on both undergraduate and graduate levels), Delgado College in New Orleans Louisiana, Seattle Community College in Seattle, Washington, and the St Paul Technical and Vocational Institute in St Paul, Minnesota The philosophy of all these programs is to provide the deaf student with opportunities for integrated education, and with the necessary knowledge and skills to keep him or her in the mainstream of American life A recent compilation of postsecondary opportunities for the deaf (Rawlings et al 1975) describes 43 postsecondary (college) programs distributed throughout the country, in addition, there are hundreds of community colleges which offer regionally oriented vocational programs in which the deaf may and do participate Gallaudet College, the original institution of higher education for the deaf (it has graduated over 4,000 people since 1864), has greatly expanded its undergraduate and graduate programs during the past decade, thus providing a wider range of choice for the potential student, it has joined the Washington Consortium of Colleges and Universities, which allows a Gallaudet student to take a course in any of the member institutions (with interpreting services provided free of charge), and in 1970 it established a model Center for Continuing Education which provides hundreds of varied course selections for adults Finally, there are many deaf students who are able to attend regular classes at hearing colleges which have no special programs and/or facilities for them Thus it can be seen that the severe restrictions in educational opportunities which the deaf individual faced in the past have been greatly diminished, and that professionals in deaf education on all levels are trying to ensure that the deaf student gets an even break When the learning potentials of deaf children go unrealized through no fault of their own, as has been the pattern in the past, it is necessary for the educational establishment to assume responsibility for reversing the trend The evidence of the seventies suggests that this is being done, and that educators and administrators at hearing schools, together with their supporters and friends in the general public, are making significant contributions to the effort

VOCATIONAL IMPLICATIONS OF DEAFNESS

Communication barriers erected in early life carry over into the area of vocation A deaf person does not, of course, expect to be hired for a job that specifically requires hearing, however, the language deficiency often begun at home and carried through the years of formal schooling becomes a serious restriction in the job market Studies of the deaf communities in the Washington, D C and New York areas (Schein 1968, Altshuler and Baroff 1969) show that the majority of deaf males were employed in some kind of manual labor, in New York, only 6 percent held clerical jobs (all college graduates) and less than 3 percent were employers or businessmen Thus deaf people are overrepresented in skilled trades and grossly underrepresented in clerical, professional, and managerial positions, many of which do not require hearing It is difficult to ascertain the extent to which social prejudice holds the deaf back (68 percent of the workers canvassed in Altshuler and Baroff's New York study felt they were discriminated against), the hearing supervisor may not even be aware that the impatience or frustration he feels at having to deal with a problem in communication may redound unfairly on the deaf employee However, it is undoubtedly true that language deficiencies contribute to the plight of the deaf adult looking for work, and that many of these adults, as Vernon (1969) points out, are forced to take up manual labor because they lack opportunity in higher levels of employment

The studies establish that the records of deaf workers are good They have stable tenure records, their earnings compare favorably with those of their hearing counterparts, they are not accident prone, their hearing loss does not interfere with their efficiency Moreover, employers generally view the deaf as satisfactory workers, so that whatever the barriers to promotion or change might be, it can be said that the deaf individual who acquires a position will maintain it under ordinary circumstances by performing well.

However, the evidence of the seventies indicates that there has been, and will continue to be a significant decrease in the numbers of manual jobs available through manufacturing firms—a major source of employment for deaf laborers (Mindel and Vernon 1971, Schein and Delk 1974) The deaf worker who is caught in this crunch will not find it easy to move into a clerical position with the same company, his or her only recourse is to retrain for another kind of occupation, with all the disruption of personal and family life that such a change entails This lack of flexibility also makes it difficult for the deaf worker to be as mobile as his hearing counterpart, when one's options are few, one is much less likely to go looking for new opportunities.

The employment prospects for deaf adults who dropped out of school, were discharged for disciplinary reasons, or who have very low levels of academic achievement are much bleaker. In addition to confronting the usual forms of social prejudice, these individuals are likely to have minimal language proficiency, and are often suffering from emotional disorders as well Such a group was recently part of a project at the Hot Springs Rehabilitation Center in Hot Springs, Arkansas Not surprisingly, the staff concluded that the limitations of these men and women did not result primarily from deafness, but from early deprivations; lack of healthy family interaction (all but one person in the group had hearing parents), of preschool preparation, of opportunities for total communication and self-expression in the years of formal schooling (Stewart 1974) Only 55 percent of the group completed the program It is easy to imagine how severely disadvantaged such individuals would be in maintaining a job in a normally competitive environment, much less in an environment tainted with prejudice against the deaf. There are, of course, also instances in which a deaf person who should be able to take his place on the labor force without undue difficulty feels discriminated against and has difficulty adjusting on the new job If the hearing supervisor does not take the trouble to try to understand his behavior, and fires him, the same problem is likely to present itself in a second job, and in subsequent jobs. Such a vicious circle might well result in the deaf individual's acquiring a reputation as a poor work risk, after which he is unable to get good references, finds himself barred from taking his place in society, and may begin to develop antisocial behavior. Oftentimes such a situation can be prevented if both employer and employee make mutual efforts to understand each other's point of view early, and to handle the difficulty together

It is clear that the problems of the average deaf worker in acquiring clerical, managerial, and professional positions, and the special problems of the severely disadvantaged deaf in acquiring and maintaining a job at all, have complex roots in their personal and social histories and are inextricably tied up with their problems in communication Vocational rehabilitation workers are aware of this, increasingly, agency services include opportunities for continued education and for psychological counseling, as well as for job training In addition, much research is being done into the causes of deaf unemployment and into ways to enable the deaf individual to cross the communication barrier before he reaches adulthood The Professional Rehabilitation Workers with the Adult Deaf, Inc (PRWAD), an interdisciplinary organization established in 1966, has spearheaded many of the most recent innovations in the field of rehabilitation, the establishment of the Bureau of Education of the Handicapped in January 1967 made possible vocational programs of all kinds through the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, and the Rehabilitation Acts of 1972 and 1973 authorized the establishment of centers for deaf individuals who cannot be served at existing facilities (for a complete listing of rehabilitation programs and services, see the April 1974 issue of *American Annals of the Deaf*) Perhaps most importantly, deaf individuals who are in need of some kind of habilitation or rehabilitation no longer have to face communication problems in the agencies designed to help them, as was true in the past interpreting services are provided either by the agency itself or through the Registry of Interpreters for the Deaf, established in 1965

However, there is still a severe shortage of social workers, counselors, and psychologists in rehabilitation work, and it would be gratifying to see more deaf professionals helping to reduce this shortage The deaf worker has several advantages he or she is usually able to communicate more easily with deaf clients, he knows from experience at least some of the communication handicaps which the client has faced in the past, his professional position in itself attests to the success which a deaf person can achieve, and thus acts as a positive influence on the client, he provides a bridge between the deaf client and the hearing world from which the client may feel excluded In the interests of encouraging deaf individuals to join with hearing associates in the field of rehabilitation, a special undergraduate program was established at Gallaudet College in 1969-70 to train deaf students in social work, in addition, there are programs at Gallaudet and elsewhere which are not specifically designed for rehabilitation work but which nonetheless provide students with the necessary educational background for on-the-job training The vocational problems of deaf individuals cannot be eliminated completely until major changes have taken place in the patterns of early development and education, however, the entrance of deaf professionals into the field of vocational rehabilitation is certainly a strong and positive step forward

PSYCHOSOCIAL IMPLICATIONS OF DEAFNESS

It is fitting that a consideration of the psychosocial implications of deafness should climax this chapter, since the social being that a person becomes is the sum total or aggregate of his or her psychological and social adjustment to all previous experiences, in addition, the problems that an individual has in relating to society are ususally extensions of earlier problem situations The hearing reader should have no difficulty at this point in imagining the frustrations which deaf people experience in ordinary social intercourse. How, for example, does a deaf person with language difficulties consult with experts regarding his insurance and financial security? If he is accused of breaking the law and taken to court, how can he consult properly with his defense counsel? If he is in need of medical help, how can he be sure that his doctor or nurse really understands him through the communication barrier? What about privacy when a third-party interpreter is present? Is he or she being short-changed? Deaf persons can tell many stories about situations in which they or their deaf friends failed to understand their doctors, and were too intimidated or ashamed to confess their confusion. It is therefore not surprising that many deaf people face everyday contacts with hearing people with a certain degree of uncertainty

This is one of the reasons for the establishment of the so-called deaf community, in which persons who share the same lifestyle and have had many of the same educational experiences come together through various organizations, professional associations, and clubs, and/or collect in the same area There has been much written about the deaf community as "clannish" and isolationist, and it has often been criticized as an unhealthy alternative to total integration with the hearing world, deaf persons sometimes share this view and prefer to be identified primarily, or even exclusively, with hearing society. There is, however, much that can be said in support of a deaf community, as a kind of culture in itself, it provides opportunities for work, for competition, for social interchange, without the discomforts of the communication barrier Moreover, members of the deaf community are not restricted to exclusive intercourse with the deaf on the contrary, the evidence is that most deaf persons move between worlds, benefiting from the advantages of both—and are more likely to do so when their roots in the deaf culture are secure. The deaf community should also not be sterotyped as a single body of people who all act alike, any more than the deaf individual should be stereotyped according to popular notions of deafness Though one may identify patterns of behavior in the deaf community, sometimes reaching back to shared experiences of segregated education in residential schools, the wide individual variations in educational level, intellectual ability, and socioeconomic status which exist in this culture are like those which exist in any culture.

With the foregoing reservations in mind, it is possible to generalize from the evidence of several studies about patterns in the lifestyle of the deaf community (Schein 1965, Schein 1968, Rainer, Altshuler, and Kallmann 1969, Vernon 1969) Over 90 percent of persons who became deaf before 6 years of age marry other deaf persons, family life is relatively stable and the divorce rate low (although the rate of divorce for deaf females in New York exceeds that of hearing females and deaf males) Most deaf adults claim to have a religious preference, although a large number attend exclusively deaf congregations There is ample evidence that deaf individuals are law abiding and commit fewer crimes proportionately than the general populace (those who do, confront another communication barrier, since there are virtually no treatment facilities for deaf criminals), in addition, there are studies which contend that, contrary to popular expectation, the driving records of deaf drivers are better than those of their hearing counterparts The majority of deaf persons vote, read newspapers daily, and enjoy an active social life comprised largely of the same activities that interest hearing people Sports is an extremely popular pastime—there is even a world-wide Deaf Olympics, or International Games of the Deaf, held every 4 years—and, with the great advances in technology for the deaf made recently, there is more interest than ever in movies and television The National Bureau of Standards provides captioning of telecast programs, the New York University Deafness Research and Training Center has organized a cooperative of cable T V systems (Williams and Adler 1974), and the Captioned Films and Telecommunications Branch of the Bureau of Education for the Handicapped provides a wide selection of popular and educational movies Advances in teletype-equipped answering services are also helping to relieve the deaf person of many social pressures Teletype-telephone systems (called TTY's) print out the caller's message on a teletype machine, the very portable manual communication module (MCM) is equipped with a typewriter keyboard, a cathode ray display panel for messages and, of course, telephone linkage Thus it is now possible for deaf individuals to call for emergency help, to make business contacts, and to enjoy social conversation with friends

Perhaps the most important aspect of the deaf community, however, is the way in which it promotes the establishment of deaf organizations, and ultimately the consolidation of deaf leadership Most deaf persons belong to at least one deaf organization or club (Schein 1968), some, like the American Athletic Association for the Deaf, have primarily social functions Others, like the National Fraternal Society, have dual purposes, NFS acts as a fraternal organization, but is foremost a life insurance, sickness and accident benefit organization Deaf men and women, like all self respecting individuals, do not like to be dependent on agencies and services provided exclusively by hearing people, moreover, they wish to take leading roles in the efforts to enlighten the public about deafness, although this is not always easy to do To take a case in point there is no doubt that hearing members of the medical profession can do a great deal to help the profession acquire greater awareness of the health problems of deaf people and greater skills in dealing with deaf patients, at the same time, as Vernon points out in The Deaf Community's Responsibility in Medical Habilitation' (1971), it is frequently up to the deaf patient to take the initiative in establishing a method of communication with his doctor When deaf people share experiences and work out ways of remedying problems together, it becomes easier for individuals to contribute directly to the resolution of communication difficulties, and to overcome the natural discomfort which attends many social situations with the hearing The importance of such organizations as the National Association of the Deaf (a confederation of State associations) is, then, very great it sponsors institutes, congresses, publications, and special projects in which deaf people contribute directly to the social, cultural, and educational progress of their communities, and it provides, through the monthly publication of *The Deaf American*, a means of exchanging valuable experience and expertise The modern move away from the paternalism of past times is largely due to the growth of deaf activism in a variety of such organizations and to the emergence of both professional and nonprofessional leaders from the deaf community Deaf activism is, of course, rarely divorced from that of concerned members of the hearing community, and there are many predominantly hearing organizations which link up with the deaf community through special projects, the new Center for Law and the Deaf, for example, is a joint venture of Gallaudet College and the National Law Center of George Washington University, and is designed to ensure that deaf persons may obtain professional legal counsel and services

Such journals as *The Deaf American, The Journal of Rehabilitation of the Deaf, American Annals of the Deaf* and the recently published journal by Saint Elizabeths Hospital, *Mental Health in Deafness*, have circulations which reach far beyond the deaf community, and contain reports of any and all projects designed to help the deaf Thus the identity which a deaf person may find within the deaf community eventually leads out into a much wider range of experience, there is no doubt that deaf people are becoming more sophisticated about society, and taking more responsible positions within it

It is also true that in recent years society in general has become more sophisticated about deaf people Much of this can certainly be attributed to such previously discussed factors as change within the educational system, allowing for greater integration between deaf and hearing However, the deaf community has also done a good job of advertising itself, as can be seen in such highly successful enterprises as the National Theatre of the Deaf, hearing persons who are exposed to the beauty, grace, and imagination of the company's signed performances come away with a unique aesthetic experience, as well as an insight into deafness There are other attempts to make the deaf culture available to a wide audience, for example, in the report of the Commission on Psychology of the VIIth World Congress of the World Federation of the Deaf (1975, p 13), the following two recommendations were included.

> IX The WFD ask its representatives from different countries to collect folk stories in sign language and film them The stories should be those of the deaf themselves, not those of the hearing These should be made available on tape and film
>
> X That there be added to the Department (*sic*) of Sign Language at Gallaudet College two chairs for the development of Sign Language as an artistic medium, that these chairs go to qualified deaf people regardless of their academic qualifications, and that one chair would be rotating, with a different artist from a different country invited each year for a one-year period

The Commission also recommended that the WFD set up a Peace Corps of young deaf to work in other countries, all of these suggestions reveal the pride which deaf persons take in their own culture, and their wish to share it with others

Perhaps the best way to illustrate the success that deaf individuals have had in overcoming the communication barriers and the social handicaps of deafness, and in benefiting from the resources of the deaf community, is to mention several contemporary achievers who are deaf, such as Jack Ashley, a member of Parliament in England; John Warcup Cornforth, the English winner of the 1975 Nobel Prize for chemistry, Boyce Williams, Director, Office of Deafness and Communicative Disorders in the Department of Health, Education, and Welfare (Dr Williams was also an initiator of the National Theatre of the Deaf), and the late Dr. Peter Fine, who lost his hearing late in life and was former director of medical services at Gallaudet College and editor of the book *Deafness in Infancy and Early Childhood.* When Jarvik, Salzberger, and Falek reported on a survey of deaf persons of outstanding achievement in 1969, many people were surprised to see what a variety of careers was encompassed by the 27 individuals so honored accounting, architecture, biochemistry, biology, chemistry, museum curating, dentistry, draftsmanship, editing, engineering, ministerial services, physical therapy, teaching, translating It is obvious that outstanding achievement by a deaf person requires considerable courage and determination, that a deaf professional who has made a significant contribution to his field has first had to overcome many problems in communication which his hearing competitor never faces There can be nothing more important to the prospects of future leaders from the deaf community than having the kinds of models these men and women represent.

Intelligence is sometimes defined as the sum of all an individual's learning experiences, neither the intelligence nor the psychological makeup of a person is fixed and immutable. For too long the deaf person has been confronted with what may be called a series of abnormal learning experiences—in the home, the school, at work, and in society in this sense, it is not the deaf individual who is abnormal, but the environment in which he has been expected to operate As a result, there has been a very great and unnecessary amount of waste. waste of intellectual potentials, of vocational resources, of social and professional talents Today, the picture is somewhat different, the old paternalistic attitudes of many well-meaning hearing people have faded with the recognition that deaf people don't need to be cared for, they need to be provided with the necessary resources for the development of language and communication skills. Only then may the deaf adult feel confident of a responsible place both within and without the deaf community Despite the most impressive advances in all areas of deaf development, and the proven successes of many deaf individuals, there is still much to be done before every deaf child may be ensured of the chance he or she deserves. By learning more about deafness, hearing people can contribute directly to the efforts to do away with stigmas, myths, and misconceptions and open the way for the kind of interaction that provides the ultimate solution to the problem of social discrimination. More importantly, deaf persons will have a better chance to grow up whole, and to avoid the types of illnesses which will be discussed in the next chapter. For the deaf and hearing alike, health is not only the absence of illness or disease, but a dynamic process of well-being

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CHAPTER 2

Mental Health Problems and Their Relationship to Deafness

The concept of mental health and illness is viewed in terms of behavior. All behavior is based on biological, psychological, social, and cultural determinants. Behavior may be broadly divided into three major components, viz. mental activity, physical activity, and feeling tone. Looking again at behavioral determinants, it is safe to say that a person is born with certain biological or constitutional endowments, but his future behavior is influenced by psychological, social, and cultural factors which interact with biological or constitutional factors. Turning now to a definition of mental health—mental health is a pattern of emotional well-being resulting from a wholesome interaction among those factors or determinants within an individual which enable him to live at peace with himself and with others, to experience disadvantages and advantages, failures and successes, disappointments, and fulfillments of expectation without losing his equilibrium and to carry out the responsibilities and requirements of daily living with equanimity. Accordingly, mental health is more than an absence of mental illness; it is a dynamic developmental process of emotional well-being.

In particular ways, any definition of mental health is relative to one's culture, since the society in which each person develops helps shape his or her expectations and subsequent satisfactions. However, living in any culture and, in fact, at any age, is always a process of accommodations, of adjusting to internal and external changes to allow maximum satisfaction and self-fulfillment. Such power of accommodation depends first on a healthy self-image and self-esteem, which, in turn, contributes to a realistic perception of the world outside and the development of satisfying relationships with others. The human developmental process is fraught with conflicts in the biological, psychological, social, and cultural areas resulting at times in crises, the mentally healthy person is flexible enough to weather these crises without fundamentally endangering his sense of identity and well-being, or his ties with the community of men and women

If mental health is a dynamic process of well-being, then mental illness represents a serious disruption of this process, resulting in marked impairment of functioning and severe disturbances in behavior Then, it may be said that a person who is mentally ill is one whose mental difficulties interfere seriously with his or her activities of daily living, who has serious difficulties accommodating to change in a normal way, and who is in conflict with his or her environment Common parlance refers to mental illness in a variety of ways, including mental disturbance or abnormality, emotional disturbance, nervous breakdown, craziness, although it is generally understood that persons may be emotionally distressed and still adhere to a daily routine, these terms usually imply a severe degree of functional impairment

Persons who suffer from mental illness are not a special class of human beings, separate from the race of men and women, they are individuals who have basic needs as mentioned in chapter 1, namely, the need to love and be loved, the need for security, the need to feel wanted, the need to achieve and be recognized for their achievement, the need to be contributing members of society. While attempting to satisfy these basic needs, the individual uses normal everyday methods to help him adjust to the vicissitudes of life These methods are called *defense mechanisms* They are generally automatic and do not require conscious thought These mechanisms are called by such terms as *identification, rationalization, sublimation, compensation, projection,* and others *Identification* is a method by which the individual tries to pattern his life after another person In other words, the individual identifies with another person. That other person may be a parent, teacher, fellow student, athletic star, public figure, or friend. The individual's self-esteem may be enhanced by the process of identification *Rationalization* is the method used when the individual abandons his attempts to reach a goal which is unattainable and decides that the goal is unimportant or even undesirable. A good example of this is the fellow who makes unsuccessful attempts to win a girl's affection and finally decides that the girl is really not his type anyway Thus, the individual avoids the feelings of frustration and disappointment When an individual uses *sublimation,* he diverts his unacceptable urges into channels which are personally and socially acceptable The popular example is the diverting of sexual urges into other activities such as intellectual pursuits, art, or athletics, and possibly excelling in these areas *Compensation* is the mechanism used to substitute one quality or behavior for a real or imagined deficiency. Thus, the basketball player who is short in stature may become an expert in distance shots on the court The defense mechanism which is perhaps most often used by the individual is *projection* He uses projection by blaming other persons or situations for his failures. "I could have passed the examination, but the teacher didn't like me" is the typical response to failure

Mental illness occurs when a person has serious difficulty attaining satisfaction of these needs and consequently creates maladaptive modes of behavior Thus, if behavior as we mentioned earlier encompasses three broad aspects of activity, viz mental, physical, and feeling, then maladaptive behavior, i e , mental illness, manifests itself in disturbed thinking, acting, or feeling These areas are not mutually exclusive, but are overlapping and interdependent, however, this delineation facilitates description Ofttimes symptoms are difficult to detect because they may appear to be exaggerations of normal behavior For example, most normal individuals forget some things some time, but symptomatic behavior in the area of thinking may take the form of chronic forgetfulness or confusion which is both pervasive and persistent Also, most normal people exercise a reasonable pace of appropriate physical activity with increases and decreases or show other modifications according to the situation present However, symptomatic physical activity may be characterized by persistent hyperactivity or hypoactivity Again, the ordinary feelings of happiness and sadness may come and go for brief periods in response to specific situations However, in the case of mental illness, one or the other type of feelings may assume a persistent and intense character or these feelings may alternate

The causes of mental illness are many and varied Some are quite clearly defined, such as those based on organic brain damage, while others are vaguely defined and poorly understood, such as those classified as functional or psychogenic in nature Research is continually developing to arrive at more definitive answers. Based on our current knowledge in the psychiatric field, however, and as mentioned earlier, the causes of mental illness may be attributed to two major classes of factors. (1) organic, and (2) functional or psychogenic Some of the obvious organic factors which impair brain tissue function are intracranial infections, as are sometimes seen in syphilis and certain other diseases, intoxication or poisoning due to alcohol, drugs, or heavy metals such as lead, circulatory disturbances including arteriosclerosis of those blood vessels supplying the brain, brain tumor, and direct injury to the brain Where brain tissue function is impaired, it is quite obvious that disturbed behavior may occur On the other hand, where the relationship between functional or psychogenic factors and disturbed behavior is not obvious, a good way to approach an understanding of this is to refer again to human behavior as a developmental process The end product of this process is known as the individual s personality and its development may be identified at various stages Several authorities have described this developmental process from their own individual frames of reference, but the description which seems to be the most popular and generally heard of is that given by the pioneering psychoanalyst, Sigmund Freud It might be well to discuss briefly the psychoanalytic formulation of early human development, so as to identify the major kinds of environmental influences which frequently give rise to unconscious conflicts in the individual (for a fuller introduction, see chapter 4 of Lawrence C Kolb's *Modern Clinical Psychiatry*, 1973, the outline of which this condensation follows) Freud divided personality into a three-part major structure the *id* is a collective name for biological impulses, or physiologically determined drives, such as for food, air, self-preservation, sex (the sexual instinct is referred to as the *libido*), the ego (a term which also includes a variety of functions) is the part of the self which tries to deal consciously with the requirements of reality, or to relate to the world, and which mediates between the *id* and the *superego*, the *superego* is a kind of conscience or ideal standard derived by the child from the behavioral patterns perceived in his environment (particularly in parents and authority figures) which acts to inhibit the drives of the *id* Serious imbalance between parts of the personality structure may result in mental disturbances

During the first year of life the infant becomes aware of the world around him, and of his own body parts At approximately 10 months, the infant becomes interested in various kinds of motor activity, some of which express aggressive impulses Motor activity must later be increasingly curtailed in the interests of social adjustment, thus, the infant moves closer to social interaction when he becomes mobile, and at the same time significantly strengthens his own sense of autonomy

We usually consider childhood as beginning with speech—sometime between 16 and 36 months The child's ability to communicate with his environment is a major impetus to social development and to the extension of his primary relationship with the parenting one(s) With improvements in speech and mobility, the child establishes closer relationships with other members of the family with whom he must learn to compromise and share The child also develops more sophisticated sexual awareness, such as the ability to discern between sexes, from about 3 to 7 years of age he becomes increasingly conscious of his own sexuality This is the period in which the initial struggle to establish sexual identification ensues the child sets himself up as the jealous rival of the parent of the same sex (this is commonly referred to as the Oedipus complex), and at the same time tries to absorb this parent's goals and standards into his own personality structure

In the major culture of the United States, the child's environment is broadened considerably at about age 7, when he goes to school and establishes new sets of relationships with peers and authority figures

From approximately 7 to 12, the intensity of sexual curiosity decreases, and the child is apt to identify more strongly with the parent of the same sex Group activities stimulate the development of social controls and also introduce the child to the pleasures of companionship with peers Adolescence begins with the phsysiological changes of puberty, with it comes a strong and renewed interest in sex (the genital stage) and in sexual activities, and a number of internal conflicts The adolescent is on the brink of maturity, struggling to establish the independence which will make adult life possible Often his attempts to break away from past dependencies are exaggerated and overly aggressive In order for the adolescent to emerge from these struggles as a healthy adult, he must find a way to satisfy his instinctive drives and needs, to maintain satisfying personal and social relationships, and to feel confident in his own identity.

The developing individual is vulnerable because he must depend on his environment for help in shaping himself, serious deprivations make it very difficult to move naturally from one level of growth to another For example if an infant is deprived of a parenting relationship, he or she begins life insecurely, such infants are usually apathetic and listless, and may seek physical reassurance through compensatory measures such as excessive thumb-sucking or masturbation Deprived of love in early infancy, an individual may well develop abnormal behavior later in life—primarily by seeking out emotional dependencies and infantile satisfactions Similar disturbances in other developmental stages may also retard personality formation. If a child is punished prematurely and with regularity for transgressions he does not understand, he may respond with fear, or with rage and defiant aggression In both instances, personality development is likely to be impaired, since extremes of both submissive and aggressive behavior do not allow for full satisfactions in later life Parents and authority figures also serve as models which the child unconsciously imitates, in addition, the strong and imperfectly understood emotional reactions which the child has to parents and significant others in early life are, at times, brought into use by the child in his future relationships with others, e g, therapists, spouse, employers. Thus, a daughter who develops feelings of hostility and inferiority because her father ignores her in favor of a sibling may later manifest an ambivalent attitude toward men—showing both anger and a desire to please, or gain approval Sexual deviations are similarly attributable in large part to parent-child relationships When a parent is seductive, either overtly, as in incest, or covertly, as in flirting, teasing, and tantalizing, or in less obvious ways, it usually precipitates a sexual crisis in the child or adolescent A daughter who is seduced by her father, or a son who is deliberately stimulated in both phallic and genital stages by a flirtatious mother often becomes guilt-ridden and fearful of relationships with the opposite sex, in spite of an adult desire for such intimacy; such individuals may even seek to avoid sexual activity altogether. Failure by parents and/or educators, or others specially trained to discuss and explain sex to children in a wholesome way at crucial stages of development may also contribute to sexual confusions and misapprehensions.

The above examples are oversimplified and it should be emphasized that human development is a delicate process, subject to many kinds of unhappy disruptions, and that negative influences and attitudes are usually assimilated unconsciously by the child

Based on the above account of the nature and causes of mental illness, one can readily see that detecting such is a very careful and delicate process for the clinician. This process consists of. (1) personal observation and evaluation, (2) data gathering in the form of the personal history, and (3) often the use of special diagnostic tests and procedures During the process of observation and evaluation, the clinician considers the patient's general appearance and attitude, affect and mood, physical activity, including manner of speaking, content of conversation and thought, clearness of thought, memory, orientation, attention span, intellect, judgment, and insight While gathering data, the areas of personal history considered are family background and environment, growth and development, ways of dealing with others and with situations, social, educational, and vocational history, medical history, and current medical information, including recent behavior. When special diagnostic tests and procedures are used, they may include, but not be limited to, the physical examination, X-ray, laboratory, and psychological studies The diagnostic process, of course, may be carried out by an individual or team effort and, when all findings are obtained, they are evaluated to determine diagnosis and treatment. The findings are evaluated in terms of the cause of the disorder, the severity, duration, and pattern of grouping of symptoms, and the effect the disorder has on the patient's ability to cope with his life and that of his family and community.

Attempts at classification of mental disorders extend from the time of pioneering work of Emil Kraepelin (1856-1926), who first described mental illness as a definite disease entity and gave us our first system of classification, to the present day work of the American Psychiatric Association which is developing the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III). These classifications may give the impression that mental illness manifests itself in perfectly predictable ways, and that symptoms always combine to form the pattern described in textbooks This is not, of course, the case, the system of classification is a convenience, always subject to further refinement in terms of the variables in individuals, moreover, it is often necessary for the diagnostician to provide multiple psychiatric diagnoses in order to describe major symptoms adequately Diagnostic classification will be discussed here, but treatment will be postponed to a later chapter Broadly speaking, mental illness may be thought of from two points of view one based on cause, the other based on description When we consider the causal bases of illnesses, we classify them as functional (or psychogenic) and organic When we consider description as a basis, we classify them as mental retardation, psychoses, neuroses, personality disorders, psychophysiologic disorders, transient situational disturbances, and behavior disorders of adolescence and childhood Although some of those disorders listed under the descriptive classification may, at times, be associated with organic causes or impairment of brain tissue functions, they are not primarily based on that condition according to our present knowledge and are therefore called functional or psychogenic The list, which will be described in greater detail, is from the 1968 edition (7th printing, July 1974) of the *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association, but it by no means includes all classifications and subclassifications of the manual

These disorders in relationship to deafness will be discussed in the latter portion of this chapter

CATEGORIES OF ILLNESS

Functional Psychoses

A psychosis may have an organic basis or a functional basis This discussion is limited to those psychotic disorders which are generally considered to be functional or of psychogenic origin By definition, a psychosis is a major mental disorder which sufficiently impairs the individual's ability to think, interpret reality, respond and behave appropriately so as to grossly interfere with his capacity to meet the ordinary demands of life The person so affected may have symptoms manifested by delusions (fixed illogical beliefs in the face of contradictory evidence) or hallucinations (sense perceptions not based on objective reality) He may withdraw from people For the psychotic, the only solution to his problem seems to be a flight into another world—a world of his own design, which he can control For him, the ordinary world is too restrictive, or dictatorial, or alien and insecure Accordingly, the psychotic rejects his environment and attempts to create a private refuge in some cases, he may even develop his own language and set of associates The degree of autism in psychotic patients varies, one patient may mix fantasy and reality, another may exclude the objective world almost entirely

Grouped together under functional psychoses are *schizophrenia, major affective disorders,* and *paranoia,* the symptoms of these types may overlap, but predominant symptomatology identifies the type *Schizophrenia* is a broad term used to describe a variety of psychotic disorganizations of personality, the disease is essentially characterized by fundamental disturbances in reality relationships and concept formations, which usually include delusions and hallucinations Persons who are schizophrenic have strong tendencies to regress, or adopt infantile manners and attitudes, are emotionally immature, with reduced capacities for attachments and relationships with others, and are frequently withdrawn, assuming the role of spectator rather than participant in life The usual age of onset is from late childhood to middle age, with the highest incidence in adolescence and early adulthood There are several types of schizophrenia In *simple* schizophrenia, the individual gradually withdraws from social interaction and interpersonal relationships, there may be progressive deterioration in functioning, shallow emotional response, and indifference to the future (hallucinations and delusions are rare). Examples of more complicated forms of schizophrenia are *hebrephrenic*, characterized by severe regression and withdrawal, delusions, hallucinations, incoherent speech, posturing, and silly, inappropriate giggling and laughter, *catatonic*, which may take the form of paralyzing stupor, in which the patient makes little or no movement, refuses food, and is unresponsive to external stimuli, or excessive excitement, in which the patient becomes violently active and may be unpredictably destructive; *paranoid*, in which the patient suffers from a number of delusions, often combined with hallucinations, and is convinced that he is the object of persecution, or that he is some other, more grandiose personality, and *chronic undifferentiated type*, which formerly included cases now diagnosed as *latent type*, or *other*. Patients with illness in this category show mixed symptoms of schizophrenia with definite schizophrenic thought, affect, and behavior

Affective psychoses are severe disturbances in mood and feeling not directly relatable to a recent life experience and, at times, accompanied by delusions and hallucinations. The *manic-depressive* psychosis is characterized by radical alterations in affect, in which the patient experiences extremes of elation and depression At any one time an individual may experience an episode of psychosis which is of the manic type which alternates with the depressive type More often, individuals suffer from either a *manic*, or a *depressive* psychosis, such affective reactions are ordinarily encountered in early adulthood or late adolescence, and are almost twice as frequent in women as in men Underlying psychopathology usually includes an overdeveloped superego, repression of instinctive drives, and severe dependency needs True *paranoia* (as distinguished from the appearance of paranoid elements in other psychotic illnesses) is rare, and characterized by persistent, logically constructed delusions based on an actual event and chronically projected onto objects and situations outside the patient Paranoia develops gradually, and is not usually diagnosed as psychosis before the age of 30, it is more prevalent in men than women Patients frequently come from harshly authoritarian homes in which they have developed patterns of hatred, aggression, and fear. In this condition, other aspects of the patient's thinking and personality are not affected

Neuroses

The second major class of mental illnesses is the *neuroses*, also called psychoneuroses, they may be defined as disturbances in which anxiety is the chief characteristic, either directly felt and expressed or automatically controlled by a variety of unconscious behaviors called defense mechanisms. This anxiety is produced by a threat within the personality, with or without specific stimulus such as loss of love or prestige, it results primarily from the repression of unwanted feelings, desires, impulses, and thoughts. In most cases, patients are so preoccupied with controlling the anxiety through one or more of the defense mechanisms that they do not or cannot recognize its source Anxiety itself is a feeling of painful stress or tension, often accompanied by fear or the expectation of harm. Some minor symptoms of anxiety found from time to time in normal persons are excessive perspiration, headaches, palpitation of the heart, choking sensations, or "butterflies" in the stomach. When such symptoms or groups of symptoms persist without obvious explanation, they represent symptoms of a neurosis Many neurotic illnesses may be treated on an outpatient basis since the patient, however acutely he or she may suffer from symptoms, is ordinarily not in full retreat from the reality of the objective world, he is aware that his distress is an indication of mental disturbance The age of onset for neuroses is usually between late adolescence and 35 years, when the pressures of life's responsibilities during these years reactivate earlier conflicts.

Neurotic disorders are classified in terms of the mechanism one uses to control the anxiety, examples are *hysterical, phobic, obsessive-compulsive* and *depressive* neuroses. As with the psychotic illnesses, the distinctions between types are not absolute, symptoms overlap in varying degrees.

In *anxiety* neurosis, the anxiety, which is not focused on particular situations or objects, places the patient in a more or less continual state of apprehension He is likely to be timid, uncertain about decision making, hypersensitive to the judgments of others. overscrupulous, and inflexible in his attempts to live up to self-imposed standards Acute disturbances may be manifested by terrifying dreams or anxiety attacks, in which the patient experiences sustained sensations of panic An *hysterical* neurosis of the *conversion* type converts anxiety into functional symptoms involving parts of the body or organs, usually those that are ordinarily under voluntary control, the patient might develop psychogenic blindness, deafness, or paralysis

Ofttimes associated with this is a characteristic lack of concern called the beautiful indifference In the *dissociative* type of hysterical neurosis, anxiety produces a dissociation of some aspects or functions of the individual's identity, so that he develops a form of psychic escape, such as amnesia (loss of memory), or fugue—a state of suspended consciousness in which he acts out fantasies The individual may assume a different identity and live a kind of life apart from his usual character A *phobic* neurosis is one in which an individual detaches his anxiety from its real source, such as unconscious fears or forbidden desires, and displaces it to an object or situation which is symbolic of the fear or wish Thus a terror of confined spaces (claustrophobia) or of open spaces (agoraphobia) may operate as a concentrated focus for anxiety In the *obsessive-compulsive* neurosis, the patient fends off intolerable impulses or desires by associating his anxiety with repetitive thoughts and acts, which the individual cannot control even though he is aware that they do not make sense. Typical examples are recurring thoughts of the words to a song, repetitive hand washing, and performing tasks in a specific order as if by ritual regardless of the appropriateness of the situation An individual suffering from a *depressive* neurosis turns anxiety inward upon himself, emotions of hostility and anger are repressed out of guilt, which in turn leads to the state of depression

Personality Disorders and Certain Other Nonpsychotic Mental Disorders (Sexual Deviation, Alcoholism, and Drug Dependence)

Personality disorders are those mental illnesses characterized by pathological trends in the personality structure, in most instances, the disturbances are manifested by a life-long pattern of maladaptive behavior, and are deeply ingrained In these disorders, the severe regression seen in psychotic states is lacking, as are the fixed defense mechanisms of the neuroses In some personality disorders, individuals suffer minimal subjective anxiety and little or no sense of distress

The disorders now classified as other nonpsychotic mental disorders (sexual deviation, alcoholism and drug dependence) were previously classified as personality disorders

Examples of personality disorders are *explosive, schizoid, inadequate, paranoid, hysterical, obessive-compulsive, passive-aggressive,* and *antisocial* personalities In the *explosive* personality, the individual is given to periodic and uncontrollable outbursts of rage and aggression, these explosions contrast with the patient's usual pattern of behavior, which is likely to be outgoing and amiable The person who has a *schizoid* personality is withdrawn, seclusive, and lacking in confidence, hostile emotions are repressed and intimacies avoided, such self directed activities as daydreaming are common Persons with the diagnosis of *inadequate* personality are unable to adjust to social, emotional, and occupational pressures, despite adequate education, opportunities, and intelligence, they are easy going and pleasant, yet unconcerned about their ineffectiveness, lacking in mature judgment, and unable to think beyond the pleasure of the moment Perhaps the best known type of personality disorder is the *antisocial,* sometimes called the psychopathic, individuals with this disorder are chronically in trouble, unable to profit either from experience or from punishment, and excessively demanding They are incapable of love, loyalty, or a sense of responsibility, are satisfied with their inadequate emotional and social lives, and lacking in guilt or remorse. This disturbance shows severe retardation in the development of the superego, and is therefore difficult to treat psychiatrically Studies indicate that patterns of rebellion often begin in childhood, usually in response to parental brutality or gross neglect, and quickly progress to openly criminal acts, often violent or sadistic in nature It should be understood that not all criminal acts are the result of antisocial personality disturbances, however, those which are seem to represent greater problems in both their legal and psychiatric implications

The behavior pattern of the *paranoid personality* is manifested by unwarranted suspiciousness, envy, jealousy, feelings of excessive self importance, and a tendency to blame others Patients with this disorder frequently have difficulty in interpersonal relations In the *hysterical personality* the behavior pattern is one of immaturity, emotional instability, self dramatization, excitability, and overre activity The patient may or may not be aware of the attention-seeking and ofttimes seductive aspects of the behavior The person with an *obsessive-compulsive personality* may be overinhibited, overconscientious, and rigid because of excessive concern with conformity and adherence to standards of conduct Some individuals have a pattern of expressing hostility by being aggressive in a passive manner For example, such behavior as pouting, procrastination, intentional inefficiency, stubbornness, or obstructionism are both passive and aggressive and are typical of the *passive-aggressive personality*

Sexual deviations, and *drug* and *alcohol dependencies* are other nonpsychotic disorders which also have serious social ramifications and are frequently subjects of controversy Illegal acts committed as a result of one of these disturbances raise the same question in the courts "Is he sick, or is he criminally responsible?" It is not within the province of this book to consider how such transgressions should be treated legally, looked at from a psychiatric perspective, however, it is indisputably true that many socially unacceptable or criminal acts are the result of mental disorders whose symptoms are manifested primarily in the social sphere

Sexual deviation is not always easy to define, due to the difficult distinction that sometimes must be made between what is considered normal and abnormal behavior For example, *homosexuality*, or love of the same sex, is not considered a sexual deviation *per se* by the American Psychiatric Association, however, if homosexuals suffer distress as a consequence of their sex preference, and wish to change it, they are diagnosed as having a *sexual orientation* disturbance In general, however, a sexual deviation represents a rechanneling of heterosexual drives, usually as a result of abnormal developmental influences, to inappropriate objects, or to bizarre and vicariously gratifying situations Examples are (1) *necrophilia*, or sexual intercourse with a corpse, (2) *fetishism*, or sexual interest centered on a part of the body or an inanimate object serving as a substitute for the original object, (3) *voyeurism*, or the attempt to satisfy sexual needs by looking (usually surreptitiously) at the unclothed or partially unclothed sex object, (4) *transvestism*, or the assumption of the clothing of the opposite sex for sexual purposes, (5) *scoptophilia*, or excessive interest in looking at genitalia, sex acts, etc , as sexual stimulus, (6) *pedophilia*, or the erotic craving for children, (7) *exhibitionism*, or the exposure by an individual of the genital organs or other parts of the body for sexual stimulation

A person suffers from *alcoholism* when his or her intake is damaging to physical welfare and/or normal functioning, or when the consumption of alcohol must precede ordinary functioning Degrees of dependency vary, an individual may become intoxicated irregularly, he may drink more or less habitually, and become intoxicated at least 12 times year, or he may have an addiction, which makes it highly difficult or impossible to go a single day without drinking Chronic alcoholism, as mentioned earlier, can lead to impairment of brain tissue, and the subsequent onset of organic psychosis The short-term benefit of alcohol are a relief from anxiety and a feeling of exhilaration, although alcohol is usually referred to as a stimulant, it actually works to depress inhibitory centers on the brain and to allow the individual unhampered expression of underlying drives Almost always, addiction is a symptom of an underlying personality disorder frequently, alcoholics have suffered early parental loss, and/or have been overprotected by mothers who have continued to indulge infantile, oral demands—though these are by no means the only contributing factors to the disease Alcoholism is a major health problem in the United States, and is most prevalent in men between 30 and 55, psychotic reactions which culminate long histories of drinking occur commonly in the 40's

Drug dependency, like alcoholism, is a major social problem, particularly among adolescents and young adults It, too, may be physical and/or psychological, chronic or periodic Individuals who repeat the use of a drug continually for emotional needs are habituated, addiction connotes a physical dependence, requiring larger and larger doses to achieve the same effect, and the experience of painful withdrawal symptoms, such as vomiting, diarrhea, and cramps, when use is discontinued Although technically speaking, a drug is any substance which has a chemical effect on mind or body, such drugs as alcohol, tobacco, and caffeine are ordinarily excluded from discussions of drug dependency Included are marihuana and hashish, the hallucinogens (including so-called mind-affecting drugs such as LSD, and mind-manifesting drugs such as peyote and mescaline), the narcotics (including opium and opium derivatives such as morphine and heroin); the amphetamines, or stimulant drugs, and the barbiturates, or sedative and tranquilizing drugs Not all drugs are addictive, but all are potentially dangerous in terms of unpredictable individual variables, dependency on any drug is always debilitating Addiction frequently leads to crime, since the maintenance of a habit is expensive, addicts must concentrate most of their energies on efforts to obtain drugs

Persons develop drug addictions in search of many of the same benefits provided by alcohol release, excitement, escape into a fantasy world, and for some young users, a means of expressing dissent or defiance Long-term risks are very high there were 900 deaths from narcotic overdose in New York City alone in 1969, statistics indicate that the lifespans of addicts may be shortened by 15-20 years, underlying mental disorders are sometimes suddenly and dramatically intensified when the brain is overstimulated, and chronic abuse can lead to organic psychosis Studies of the psychogenesis of drug addiction show arrests in ego and superego development, and the recurrence of certain patterns a large number of heroin addicts, for example, have antisocial personalities, many hospitalized hallucinogen users are diagnosed as schizoid, or schizophrenic

Psychophysiological Disorders

Psychophysiologic, or psychosomatic disorders, are those in which physical symptoms develop from emotional causes, anxiety gives rise to physiologically expressed symptoms involving a single organ system Since the patient directs his attention to the bodily malfunction, he often does not recognize its emotional cause Such factors as personality traits, attitudes toward sickness, and social environment contribute to the developments of these disorders, highly intense emotions, whether experienced suddenly or over a prolonged period, are able to disrupt physiological processes The physical symptom is not necessarily symbolic of its emotional cause, as in neurotic illnesses, it is instead an organ response to a strong affect, and may or may not contain symbolic meanings

Types of psychophysiologic disorders include a wide variety of common ailments (all instances of these ailments are not, of course, of psychogenic origin) Disorders of the skin, of the musculoskeletal system, such as backache, muscle cramps, and tension headaches, of the respiratory system, such as asthma and hiccoughs, of the cardiovascular system, such as hypertension and migraine, of the gastrointestinal system, such as peptic ulcer, chronic gastritis, or colitis, and constipation, and of the genitourinary system, such as disturbances in menstruation, dyspareunia (painful coitus), and impotence frequently have roots in emotional factors Psychophysiologic symptoms can become life threatening hyperobesity, for example, endangers several vital systems, on the opposite end of the spectrum, *anorexia nervosa*, which is a relentless drive to stay thin resulting in gross weight loss, occurs rarely but also has a high mortality rate Oftentimes, physiologically based illnesses are intensified by emotional determinants heart disease, for example, is directly complicated by stress, postoperative recovery may be conditioned by anxiety factors Underlying causes for the development of psychophysiologic symptoms are multiple, corresponding to the wide spectrum of disorders, severity of symptoms also varies greatly

Transient Situational Disturbances

This category refers to more or less transient disorders however severe, that occur in response to overwhelming environmental pressure Prolonged reactions—or those which continue beyond the stress of a current situation—require a change in diagnosis The following examples of particular crises are illustrative of those which might occur at different stages of life

Adjustment Reaction of Infancy describes, in most instances, the response of an infant to the deprivation of his mother, or mother surrogate, through separation or sickness Symptoms are withdrawal, loss of appetite, excessive crying, and insomnia, symptoms usually disappear with the return of the mother

Adjustment Reaction of Childhood can occur when a first child is called upon to accept the birth of a sibling, or in a similarly threatening situation Jealousy frequently gives rise to such symptoms as regressive thumb-sucking and nocturnal enuresis (bed-wetting), nail biting, and other attention-getting acts

Adjustment Reaction of Adolescence may be related to any of the emotional physiological, and social changes required of a young person during this difficult period Responses range from angry outbursts, petulance, and acts of defiance, to depression and brooding

Adjustment Reaction of Adult Life might result from a sudden shift in living conditions, involving a change of scene and loss of family and friends, with accompanying depression, or from guilt and anxiety feelings associated with an unwanted pregnancy.

Adjustment Reaction of Late Life usually involves feelings of rejection and depression associated with retirement, or similar changes in social and economic status

Behavior Disorders of Childhood and Adolescence

This is a special category designated for disorders that are more stable and difficult to treat than *transient situational disturbances*, but less so than *psychoses, neuroses*, and *personality disorders*, according to DSM II, "This intermediate stability is attributed to the greater fluidity of all behavior at this age" (p 50) Primary causes are disruptions in the developmental process, particularly in parent-child relationships Many symptoms are also apparent in children and adolescents with organic brain damage, in these cases, disorders are classified as *organic brain syndromes*.

Examples of behavior disorders in childhood and adolescence are *hyperkinetic reaction*, characterized by excessive activity, garrulousness, restlessness, and a short attention span, *withdrawing reaction*, characterized by seclusiveness, worrying, undue submissiveness, shyness, difficulty in forming interpersonal relationships and a tendency to daydreaming and fantasy (all qualities of the schizoid personality, which may be a later development), *overanxious reaction* characterized by chronic anxiety, exaggerated fears, and sleeplessness. and appearing in persons who are lacking in confidence and self-conscious (overanxious reactions have affinities with the more serious anxiety and psychophysiologic neuroses), and *group delinquent reaction*, characterized by an individual's identification and association with a delinquent peer group or gang, from which he derives security and support, and with whom he engages in truancy, stealing, and other delinquent behavior Again, etiology in early behavioral disorders is complex, but the mother-child relationship is a crucial factor, in particular, the parental extremes of oversolicitude and overly punitive behavior may contribute directly to the onset of disturbance

As explained earlier this review of the categories of *psychoses, neuroses*, and *personality disorders* is not comprehensive, though most of the illnesses occurring most commonly are represented Many distinctions are made on the basis of degree, thus, a withdrawn child can eventually develop the symptoms of a schizoid personality, and may, under particular stress, have a schizophrenic episode Though each disorder is diagnosed separately, many of the symptoms change only in duration and intensity Early conflicts which go unresolved, even though the individual may not be conscious of them, may be the basis of future development of a mental disturbance The history of symptoms reveals a pattern leading back to disruptions in the initial stages of personality development

MENTAL ILLNESS AND DEAFNESS

Causes and Incidence

The foregoing classification of mental illnesses describes disorders that appear in deaf and hearing individuals alike, the same kinds of behavioral manifestations, or symptoms, are used to diagnose underlying psychopathologies The determination of causation, as has been shown, is always a complicated procedure one must not only decide the relative weights of constitutional and environmental factors, but must also identify specific developmental influences for each individual case As was made clear in chapter 1, deaf people experience one or more of a variety of situations which are stressful, for example, communication problems in greater and lesser degrees which affect all areas of living, and usually begin in infancy, separation from family at an early age, job discrimination, prejudice, ridicule, and social isolation from the mainstream of society There is no doubt that these factors may contribute to the development of mental illness, but it should be remembered that they represent those forms of emotional and social stress which a deaf person is most likely to encounter, a hearing individual may have to contend with equally damaging kinds of experiences that are shaped by different circumstances What is common to all mental illness is the deprivation of fundamental needs The particular combination of influences which frustrates these needs will vary, but the effect will be the same Attempts to create a substitute reality through psychoses, to use a defense mechanism in order to escape conflict, or to compensate for personality malformations through abnormal adaptation are made by all human beings whose lives and minds are disordered and who are in need of protecting themselves from real and imagined threats

Nonetheless, one might expect that the incidence of mental illness would be higher among deaf people than among hearing, since the fact that large numbers of deaf persons have been and are subject to unusual kinds of developmental stress is well documented It is therefore surprising to note that the 1974 report *The Deaf Population in the United States* by Schein and Delk shows the frequency of occurrence of mental illness to be only 3 percent, as compared with 10 percent in the general population These findings tend to corroborate an earlier study of the deaf population of New York State (Rainer, Altshuler, and Kallmann 1969), in which it was reported that the incidence of mental illness among the deaf was perhaps no greater than in the hearing population On the other hand, there have been several studies of deaf children, the conclusions of which seem to point in the opposite direction Schein reported in 1974 that about 40 percent of deaf children have another educationally handicapping condition, and that the most common additional handicaps are emotional and behavioral disorders (approximately 125 per 1,000 students) A survey by the Demographic Studies Department of Gallaudet College (1973) of 42,513 students enrolled in special education programs for the deaf, during the year 1971-72, arrived at similar conclusions. 32 percent of the students were reported by teachers to have one or more additionally handicapping conditions, the types of handicaps which occurred most frequently were emotional or behavioral problems (18.9 percent). These figures seem to complement those reported earlier by Schlesinger and Meadow (1972) and based on a series of questionnaires sent to teachers and counselors at a State residential school in California in 1966, this survey showed that there were approximately five times as many severely disturbed deaf children, and three times as many moderately disturbed deaf children as there were severely and moderately disturbed hearing children in the Los Angeles County school system

Since for our purposes the discussion of mental illness has concentrated on disturbances arising primarily from psychogenic rather than organic causes, it is not possible to determine the incidence of such illness among the deaf according to the statistics presently available. For example, in the followup studies which Schlesinger and Meadow did of their subjects, it was found that the etiology of deafness in 55 percent of the severely disturbed students was unknown; and in a later (1975) study of emotional and behavioral problems in hearing impaired students, the demographers Jensema and Trybus at Gallaudet concluded that the highest percentages of disturbances were among males born in 1958-59 and 1964-75, the years of the rubella epidemics. Since rubella can cause brain damage that may manifest itself in behavioral disorders, it is quite possible that the abnormal behavior reported by teachers had primarily organic causes. All forms of mental disorder must of course be treated by whatever means are most effective, and it is important to gather information from teachers and counselors on behavior that is recognizably abnormal in order to determine the scope and extent of the help that must be provided. according to the recent surveys of deaf school children, there is clearly a mental health problem among students that demands immediate attention However, it is difficult, and perhaps not even worthwhile, to try and resolve the incompatibilities between these findings and those earlier surveys of adult deaf communities, and it is even more problematic to make accurate statistical comparisons between deaf and hearing communities Suffice it to say that there is enough manifest mental illness among deaf persons to warrant a great deal of attention and concern, and no indisputable evidence that the incidence of psychogenic illness is any higher in the deaf than in the hearing community

Difficulties of Detection

Though deaf persons suffer the same kinds of illnesses as hearing persons, they have only recently been able to obtain the same types of treatment, which will be described in detail in chapter 3 One of the major reasons for this long-standing neglect is that mental illness in a deaf individual is difficult to detect and evaluate by a hearing diagnostician who has not had special training. Past problems in evaluation usually arose from the diagnostician's lack of understanding of the lifestyle and communication of the deaf person, and the deaf person's lack of orientation to mental health implications as pointed out by Galloway (1969) and his difficulty in understanding the verbal productions of the diagnostician.

There have been many instances of mistaken diagnoses or inappropriate interpretation of symptoms. For example, deaf patients with severe language deficiencies sometimes appeared to an uninitiated diagnostician to be manifesting the disjointed language patterns of schizophrenics (the language pattern quoted on page 79 is unrelated to mental illness), or if they scored low on I.Q. and psychological tests because they did not understand the language of the directions, they were likely to be diagnosed erroneously as autistic or mentally retarded. Some of the tests themselves depended heavily on language skills which deaf patients often did not have; it was difficult if not impossible for them to communicate the cause of their confusion, particularly to a person who had no knowledge of their educational backgrounds. The diagnosis of deafness itself was frequently missed and instead the patient's reaction as a result of deafness was often considered to be a symptom of psychosis or of mental retardation On occasion, lack of proper diagnostic facilities resulted in tragic and unnecessary waste. Denmark and Eldridge (1970) report the case of a deaf boy who was admitted to a hospital in England for the subnormal (or mentally retarded) at an early age; his parents knew he was deaf, but rejected both the boy and the fact of his deafness. The hospital did not discover the auditory impairment until the boy was 11 years old; when fitted with a special amplification aid, he was able to hear! By this time, of course, he had developed severe psychiatric problems in connection with his long isolation and his inability to communicate with his environment. The author reports the occasional difficulties in distinguishing a deaf mentally ill patient from a withdrawn hearing patient (Robinson 1965).

Mistaken diagnoses have not been the only hazards for deaf persons with emotional and behavioral disorders. As Vernon points out in an article welcoming the salutary changes of recent years (1975), prior to about 15 years ago, hospitalization of the deaf was actually antitherapeutic custodial isolation A deaf person removed from his home for hospitalized treatment was taken from an environment in which he could communicate to one in which he could not—a terrifying displacement; he was not able to derive maximum benefit from the therapies offered because most of them were designed for hearing patients; and he rarely had opportunities to meet other deaf patients. In fact; in some cases, the hospitals themselves could not identify their deaf patients; such was the alarming discovery made by Dr. Roy Grinker (1969) of the Michael Reese Hospital in Chicago during a visit in 1968 to a mental hospital in Illinois The hospital staff informed Dr Grinker that they did not know who was deaf, but that such information could be obtained in a computer print-out The computer provided eight names of deaf persons Grinker's staff found that only one of these was deaf, however, there were five deaf patients on one ward alone whose names did not appear on the print-out It is clear that none of the deaf individuals could have benefited much from the hospital's treatment facilities, except indirectly or accidentally The findings of Rainer and Altshuler in their pilot study of New York (1966) were not very different they identified 230 deaf patients scattered throughout 20 hospitals, without access to special facilities and informed staff, as a result, many of these patients stayed in the hospital for decades As will become apparent in the next chapter, prior to the establishment of the MHPD, the deaf patients at Saint Elizabeths Hospital also had to settle for treatment facilities that were not adjusted specifically to their handicap, in fact, as Vernon points out, the changes that have taken place in hospitals in Illinois, New York, and Washington, D C , as a result of the discovery of inadequate facilities are still not typical of many mental health facilities across the country

Perhaps the inequities which have long characterized the treatment of the mentally ill deaf have contributed to the attitude of fear and distrust toward the subject of mental illness held by many deaf people In an article entitled, "Mental Health What It Means to the Typical Deaf Person," (1969) Galloway explains that among the deaf the idea of mental illness is commonly equated with that of complete breakdown,that deaf individuals show great resistance to the idea of psychiatric treatment, and usually adopt a punitive attitude toward persons who make use of it, and that individuals who have suffered breakdowns are sometimes overtly rejected Several of my deaf friends tell me that the stigma of mental illness is stronger in the deaf than in the hearing community, and my own experiences tend to corroborate this view and those of Galloway To give an illustration Several years ago, when I wanted to have group discussions with some deaf vocational rehabilitation clients, the counselor, who was hard of hearing and who was very well acquainted with the deaf community, advised me of the risk involved in that the members of the group may be stigmatized as being "crazy" and ostracized by the deaf community. Fortunately, we are making progess in removing prejudice against mental illness and fear of mental institutions Community mental health care helps remove the stigma, however, as Galloway points out, the deaf community needs more education, both in the facts about mental illness, and in the facts about mental health facilities, especially those that have recently been made available on both inpatient and outpatient bases through special programs The detection—and ultimate reduction—of mental illness among deaf persons depends upon adequate training of mental health personnel to work with deaf people and to carry out a program of prevention.

There is another reason for deaf distrust of mental health facilities, which again derives from knowledge of the kinds of treatments that have been available in the past—that is, the realization that confidentiality may be jeopardized if the counselor is not able to communicate through sign language. Since it is highly unusual for the average practicing physician to have registered interpreters for the deaf, from the Registry of Interpreters for the Deaf, in his office, the deaf person must bring a hearing friend or acquaintance or family member to serve as interpreter This also triggers obvious kinds of inhibitions and embarrassment The very understandable wariness with which a deaf person approaches a situation in which he must talk intimately with one hearing person in the presence of another forestalls many efforts to seek help when it is needed. A satisfactory answer to this is to indoctrinate current and future psychiatrists in the understanding of deafness and its implications for deaf people, and for those psychiatrists and mental health care facilities to provide a system of communication to facilitate understanding Optimally, psychiatrists should learn how to communicate with deaf people

In summary, then, most of the problems in the detection and treatment of mental illness among deaf persons can be resolved through programs of education, professionals and paraprofessionals in the field of mental health must understand the psychosocial development of deaf individuals and must facilitate communication if they are to properly diagnose and treat them for their emotional problems, deaf people must understand that new mental health programs designed especially for them provide positive kinds of quality health care, and at the same time ensure privacy and confidentiality. In the last 20 years, we have come a very long way in the identification of past mistakes in diagnosis and treatment, it is now possible to administer psychological tests adapted specifically for language deprived people, to conduct sophisticated audiological tests which can distinguish between organic deafness and psychotic states of withdrawal, and even help determine levels of hearing loss in schizophrenic patients, and to provide all the usual forms of therapy without the barriers of communication Specific types of available therapy will be illustrated in the next chapter primarily through a description of the MHPD at Saint Elizabeths, Washington, D C Programs at such facilities as the Rockland State Hospital in New York, the Michael Reese Hospital in Chicago, and the Langley Porter Neuropsychiatric Institute in San Francisco, as well as others both in the United States and abroad, also provide a spectrum of mental health services The dark ages of neglect of the mental health needs of deaf people are over, as professionals throughout the world pool knowledge in the development of their programs, the prognosis for better and more sophisticated methods of detection and treatment will continually improve

Occurrence of Specific Types of Illness

The accumulation of evidence in recent years has also aided in the identification of the types of mental illness most likely to occur in deaf people, and some of the reasons for them, although all of the findings are not compatible, and more research needs to be done There does seem to be general agreement among professionals today that psychopathology itself is not inherent in deafness and that, contrary to the early findings of Myklebust (1964), the psychological organization and structure of the deaf personality are not qualitatively different in infancy from that of the hearing personality Moreover, in the study cited earlier by the Office of Demographic Studies at Gallaudet College of emotional problems in students (1975), the age of onset of hearing loss did not seem to be related to the frequency of occurrence of emotional/behavioral problems, thus one cannot say that a child who is profoundly deaf from an early age will have a greater chance of developing a mental problem than one whose age of onset is later This is not surprising when one remembers that deaf infants born to deaf parents are frequently more emotionally stable and more educationally advanced than their counterparts in hearing families because of the deaf parents' awareness of deafness and their readiness to accept it with its implications for communication Thus, it may be said deafness can play an indirect role in disturbed patient behaviors, insofar as it may give rise to problems in communication which can affect development, particularly in early parental and family relationships, however, if environmental deficiencies are rectified, development of the deaf individual can proceed normally

According to studies, deprivation experienced by deaf people can result in development of the so-called "primitive personality" (Rainer, Altshuler, and Kallmann 1969), that is, one in which normal intellectual potential is combined with an almost total lack of language, resulting in unruly, impulsive, sometimes bizarre behavior which may take the form of an antisocial reaction (Rainer also points out that the primitive personality may easily be misdiagnosed as schizophrenia) Other symptoms of personality disorders resulting frequently from the insufficient development of the infant ego in relation to the mother, and compounded by additional environmental influences, are immaturity, lack of emotional empathy for others, lack of mature judgment, and dependency Rainer and Altshuler found that in New York, drug addiction and alcoholism are less frequent among the deaf population than among the hearing, that the incidence of schizophrenia and paranoia are about the same, that there is an excess in the number of deaf patients with special forms of organic psychoses and of psychoses with mental deficiency (effects of genetic conditions), and that there is a singular absence of severe depression in deaf persons (1967, 1969) Rainer attempted to explain the low incidence of depression by relating it to retardation in the development of the superego, or "conscience," in many deaf children, later in life, these individuals are less able to internalize anger, and convert it into guilt (1969).

The findings of Grinker (1969) at Michael Reese differ in several respects Among a total of 159 patients, Grinker reports a high incidence of paranoid schizophrenia (25 of 43 schizophrenics, with 8 others showing paranoid components in behavior), moreover, of 13 nonschizophrenic psychotic patients, 6 had some form of paranoid diagnosis He concludes that paranoid schizophrenia may be more prevalent among the adventitiously (though not prelingually) deaf than among the general population Grinker and his staff also found many cases of severe depression, such was the primary diagnosis for slightly over 6 percent of the patients (others had depression as a secondary symptom) Grinker believes, in contradistinction to Rainer, that the frustration and isolation of the deaf condition are quite conducive to depression, since they force an internalization of occupations and interests (p 29) Other of Grinker's findings complement those of the New York group Of the patients, 4.4 percent had some form of sexual deviation as a primary symptom, including homosexuality, promiscuity, exhibitionism, and pedophilia The personality disorders and severe ego defects reported by Rainer and Altshuler also appeared, symptoms in Grinker's patients included passivity, dependence, and imperfect control over impulses

The studies of Schlesinger and Meadow (1972) at the Langley Porter Neuropsychiatric Institute in San Francisco (an outpatient facility) confirm the prevalence of abnormal impulsivity and lack of internalized controls in deaf patients Schlesinger and Meadow also provide diagnostic categories for 135 patients treated over a 4-year period Of these, 26 (19 percent) were psychotic with 22 cases of schizophrenia (6 of the paranoid type) and 3 cases of paranoia, 4 percent depressive neurotics, 15 percent suffered from personality disorders, 2 percent had special symptoms (such as a specific learning disorder), 15 percent were transient situational disturbances, 27 percent had behavioral disorders, 4 percent were socially maladjusted, 7 percent were mentally retarded, and in 6 percent of the cases, the diagnosis was deferred Diagnostic categories for patients in the MHPD at Saint Elizabeths will be presented in detail in the next chapter, however, it is worth noting here that 40 of 44 patients in the MHPD diagnosed as psychotic on first admission were schizophrenic (10 of the paranoid type), and that transient situational disturbances accounted for almost 35 percent of total first admission diagnoses (screening procedures for admissions at Saint Elizabeths have a bearing on which illnesses are most commonly represented, so that these figures are not necessarily representative of the deaf population)

On balance, then, it would seem that although there is agreement among professionals on the high visibility of various kinds of behavioral and personality disorders, and on the connection between problems in communication and the development of these disorders, evidence concerning the likelihood of deaf persons to develop schizophrenia (especially paranoid schizophrenia), paranoia, and depressive reactions is inconclusive Perhaps part of the problem results from the nomenclature we use Grinker has argued that we should not rely heavily on psychiatric categories in discussing mental illnesses, particularly in connection with deaf patients, about whom there is still much to learn, he believes that a more profitable approach is to stress behavioral factors This suggestion is a good one, at least until such time as we have a broader base of information from which to draw conclusions Just as our statistics on the relative incidences of psychogenic illness among the deaf and hearing populations should be more accurate in the future, when we have the benefit of more refined surveys, so the current evidence on the prevalent types of illness among the deaf will be continually modified in the light of new research

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CHAPTER 3

The Treatment of the Deaf Mentally Ill in Saint Elizabeths' Mental Health Program for the Deaf

As was made clear in chapter 2, treatment and care of the mentally ill deaf, though restricted to a few patients, is now provided both in the United States and abroad by a variety of facilities, including inpatient and outpatient hospital programs and outpatient clinics The therapies provided by these treatment centers vary according to the facility's size and resources, however, the person who is mentally ill and deaf may be fortunate enough to have access, depending on the program, to the complete range of major therapies available to hearing patients This chapter will first define each of these therapies according to its theory, purpose, and operating procedure, it will later describe ways in which the treatments are adapted to deaf patients, with particular reference to therapeutic experiences in the MHPD at St Elizabeths Hospital

GENERAL DESCRIPTION OF TREATMENT MODALITIES

Treatment modalities will be discussed under four major classifications, viz, psychotherapy, behavior modification/therapy, activity therapies, and somatic therapies

Psychotherapy

Broadly defined, psychotherapy is "the treatment of emotional and personality problems and disorders by psychological means" (Kolb

1973, p 588) Today there is a wide variety of treatments which qualify as psychotherapy according to this definition, ranging from formal psychoanalysis, a lengthy procedure undertaken only by those who have had systematic training in its methods, to the widely popular sensitivity or encounter groups often organized by industries to help employees work out specific problems in interrelations In this book, the term *psychotherapy* is limited to therapies which examine problems through communication between therapists(s) and patient(s), thus we shall discuss *individual psychotherapy*, *group psychotherapy*, and *family therapy*.

Psychotherapy involving an exchange between therapists(s) and patient(s) is ordinarily conducted by psychiatrists and clinical psychologists (especially in the case of psychoanalysis), or by specially trained professionals such as psychiatric social workers and nurses under technical supervision of a psychiatrist or clinical psychologist However, other mental health personnel not professionally trained may carry out sociotherapeutic activities with patients, some mental health facilities refer to such activities as *individual therapy*, or group *therapy*, as opposed to *psychotherapy* In most mental health programs, fully qualified psychotherapists coordinate efforts with other mental health personnel and supervise therapeutic work where necessary, in order to provide the broadest possible range of services for patients

Individual Psychotherapy

Formal Psychoanalysis

Psychoanalysis is a type of psychotherapy originally developed by Sigmund Freud, it investigates the relationship between conscious and unconscious psychological processes, and attempts to provide the patient with insight into how past attitudes and behavior unconsciously persist into his present life and interfere with optimum functioning Psychoanalysis explores the unconscious primarily through the technique of free association, in which the patient says whatever comes spontaneously to his mind, and the analysis of dreams, which are comprised largely of unconscious or repressed material presented to the dreamer in disguised or symbolic form The therapist helps the patient to interpret the unconscious material, and to see the connections between past repressions and current behavioral problems

Freudian psychoanalysis also makes use of the concept of *transference*, in which the patient unconsciously assigns early feelings and attitudes, especially toward parents and siblings, to the therapist, thus the patient-therapist relationship itself provides evidence of unconscious conflicts Psychoanalysis usually takes from 1 to 3 years, with therapist and patient meeting 5 or 6 days a week in 40- to 50-minute periods

Other Kinds of Individual Psychotherapy

It is not always therapeutically sound for patient and therapist to undertake formal psychoanalysis Patients often have neither the internal commitment, the time, nor the resources to do so, some have illnesses which seem to respond more positively to a modified form of psychoanalysis, or to another kind of psychotherapy

Psychobiological therapy (associated with the Swiss-American psychiatrist, Adolf Meyer), for example, approaches the patient's problems primarily through the level of conscious awareness Patient and therapist examine biological, psychological, and social life experiences, and attempt to modify behavior accordingly, unconscious attitudes and impulses are not stressed, nor is the transference phenomenon utilized in treatment

In still other kinds of individual psychotherapy, a therapist might encourage a patient's self-expression in an open-ended and sympathetic conversation, which is free to take a psychoanalytical turn, depending on the patient's capacities and disposition, or he might provide a person in a severe state of distress with overt support in the form of verbal reassurances and direction for the future, called *supportive psychotherapy* A skillful therapist combines or changes methods as the situation warrants, thus a patient who needs direct support in a crisis may be ready for a more analytical therapy later Many patients are discouraged—at least at particular periods in their illnesses—from attempting any kind of individual psychotherapy, in making such determinations, diagnosticians take into account patient aptitude, as well as type and severity of illness

Group Psychotherapy

Group psychotherapy bears strong affinities to individual psychotherapy in certain respects the relationship of each member of the group to the therapist and to the other members of the group provides important evidence of the patient's personality structure and problems A group unconsciously shapes itself into a family unit, with patients naturally assuming roles which are extensions of their past experiences and patterns of interacting The therapist is initially perceived as an authority figure, or parent, which aids in the organization of the group, however, in conducting the sessions, the therapist avoids assuming an authoritarian role in order to discourage patients from depending too greatly on him, and to encourage the free interchange of feeling Once group structure is established, patients are able to act out ambivalent feelings Thus a woman who is jealous of her daughter might express these feelings to a member of the group whom she identifies with the daughter, or, to take another example, a girl who seeks the approval of her father might attempt to seek a father identity in the male therapist The free expression of ambivalent feeling which the group encourages is also checked, or corrected, by group reaction, thus the jealous woman who interacts with the person she sees as the daughter surrogate is helped by the group to examine and evaluate her feelings, and to perceive distortions in her behavior On one hand, then, group psychotherapy establishes a social context, or family unit, in which, through group dynamics, members may reactivate a number of disturbing relationships and experiences in their past or present lives, at the same time, group reaction to an individual's expression of disturbed feeling is a continual source of insight and a stimulus to the modification of behavior The therapist helps structure the interactions, and provides assistance in the interpretation of behavior and the resolution of conflicts

Group psychotherapy has another important benefit. It helps a patient realize that he or she is not alone in an illness, that others have similar problems and experiences equally distressing or symptoms equally embarrassing Such mutual exchange increases self-esteem and significantly reduces anxiety, thus the group experience is itself therapeutic as a means of support Group psychotherapy has been found particularly effective with persons who fear individual psychotherapy as too threatening, or who are hostile and antagonistic toward all authority figures, and for those whose family and/or social lives are maladjusted or deprived It is sometimes used as a preparation for individual psychotherapy, and can also be helpful diagnostically—that is, a patient who reacts negatively to a group, and does not participate, frequently reveals important aspects of his illness which can be treated more effectively in another kind of therapy. Group sessions usually last from 50 minutes to an hour and a half, compared with forms of individual treatment, a program of group psychotherapy affects more patients in a shorter period of time, and is thus a widely used and efficient form of treatment

Family Therapy

It is often difficult for an individual to resolve his fundamental conflicts, or to maintain his gains in therapy when he must continue to exist in a milieu which contributes directly to his problems Family therapy attempts to provide help for the family unit whose interaction is pathological or unhealthy, and thus to modify or correct many of the contributing causes to individual illnesses A family unit may be comprised of a couple seeking help for marital problems, or of larger groups, such as parents and children, or parents, children, and significant relatives The type and frequency of meetings vary, therapists may wish to meet with individual members of the family on some occasions, and on others with a selected group, or with the entire unit The objective of the therapist is to help each person in the family to become consciously aware of how he or she contributes to the disturbed atmosphere which affects all family members, particularly the patient whose problems were the initial focus of attention and concern

The dynamics of family therapy are different from those of group psychotherapy in that participating family members already have roles in a preestablished social institution, the reactions and resistances of group members must be interpreted by the therapist in terms of the patterns of behavior in an actual family situation. The therapist also takes note, as in individual and group psychotherapy, of attitudes and images that are transferred onto him during the course of treatment, and helps the patients to interpret the significance of these transferences Successful therapy results in the lowering of individual defenses, and the establishment of more effective and insightful communication between family members, which in turn reduce the pathological influences in the home environment Family therapy has been found very useful in efforts to arrest behavior disorders of children and adolescents, and in some types of marital difficulties, it must be precluded in instances where members of the patient's family are themselves so disturbed that they are unamenable to any sort of psychodynamic treatment.

Behavior Therapy/Modification

Unlike psychoanalytic forms of treatment, behavior therapy, or behavior modification, is concerned with consequences rather than causes, it works on the premise that behavioral patterns are learned, and are thereby able to be altered by procedures which eradicate the original learning experience and/or provide new learning experiences previously denied the patient Behavior therapy "focuses on modifying [illegible] behavior by means of systematic manipulation of the environmental and behavioral variables thought to be functionally related to the behavior" (Frazier et al 1975, p 19)

Behavior therapists use a wide variety of techniques to help condition behavior, several examples will serve to illustrate their methods In *positive reinforcement*, an attractive stimulus is added to the environment of the patient in order to strengthen a desired response, thus a retarded child who is learning to wash himself may be rewarded with a piece of candy each time he performs well As the child's social adaptation improves, the positive reinforcements are faded out *Negative reinforcement* subtracts an attractive stimulus from the environment, thus an unruly hospital patient may be denied a special privilege until he corrects his behavior In the system of *token economies*, tokens, or credits, are provided for patients who have engaged in a desired behavior, the tokens may then be exchanged for a predetermined reward, or privilege One of the more controversial techniques used by behaviorists is *aversion therapy.* "stimuli associated with undesirable behavior are paired with a painful or unpleasant stimulus, resulting in the suppression of the undesirable behavior" (Frazier et al., p 20). Aversive techniques have been used with alcoholics (always on a voluntary basis); the patient learns to associate the consumption of alcohol with such unpleasant effects as vomiting and nausea Aversive techniques are properly accompanied by some kind of positive reinforcement

Activity Therapies

A number of therapies are directed at involving the patient in a specific activity, designed to stimulate social interaction, to provide a positive release for emotion, and/or to help in rehabilitation. Activity therapies may be broadly divided into (A) those concerned primarily with the therapeutic expression of repressed feelings; and (B) those concerned with occupational and/or vocational adjustment, directly or tangentially.

Self-Expressive Activity Therapies

Psychodrama

Psychodrama is an action therapy which allows a patient to involve his whole self in an interactive process. Dr J. L Moreno, the founder of psychodrama, describes the elements in a psychodrama session as follows:

> The chief participants in a therapeutic psychodrama are the protagonist, or subject; the director, or chief therapist, the auxiliary egos; and the group The protagonist presents either a private or group problem; the auxiliary egos help him to bring his personal and collective drama to life and to correct it Meaningful psychological experiences of the protagonist are given shape more thoroughly and more completely than life would permit under normal circumstances (1964, p. VII-VIII)

In a psychodrama, the patient, or protagonist, explores his problems and his feelings toward them by spontaneously acting out his conflicts, he helps create the drama of his own life. The auxiliary egos are other "actors," usually patients, who represent figures from the patient's world, both protagonist and auxiliary ego are guided by the chief therapist, who helps them to interact and to express emotion freely There may be an audience, composed of patients, therapists, and sometimes relatives, which also interacts with the people on stage.

The purpose of psychodrama is insight, gained from an active and dramatic interaction rather than a private and verbal one.

> Basically, psychodrama is nothing more than a grand extension of the clinical interview The main difference between them is that instead of the patient being in a one-to-one relationship with the psychotherapist, he finds himself removed from the privacy of the counsulting room and placed in a position where he is given opportunity to act out and thus experience various aspects of his problems in a larger-than-life dimension (Greenberg 1974, p 13)

Spontaneity in this context is of essential importance, "acting" is not consciously formulated and preplanned, as in theatre The *situation* which is developed on-stage is one which is of significance to the protagonist, it may require enactment of the resurrection of dead relatives, or the projection into some future condition which is viewed with apprehension "time, space, and states of existence are obliterated so that everything on the psychodramatic stage occurs in the present, or *in situ*, in the "here and the now" (Greenberg, pp 16-17) *Tele* is the term used for the involvement between "actors", it is a sympathetic interaction, a capacity for emphatic exchange of identities *Catharsis*, or an emotional purging, and *insight* are the goals of psychodrama—the means through which a patient is able to change his behavior

The psychodrama method utilizes a number of techniques in order to achieve therapeutic acting out and changes in behavior (for full listing and descriptions, see Moreno, Zerka 1969) *Warm-up* is the preparation for acting, under the guidance of the director, the patients are emotionally and physically prepared for the psychodrama Warm-up sometimes includes *soliloquy*, which is a patient's monologue about the situation which will be acted (soliloquy is also used within the psychodrama) *Role reversal* requires that the protagonist take the role of someone else in the dramatized situation Thus a young girl who is acting out a conflict with her mother assumes the role of the mother, she is able not only to identify with some of her parent's feelings, but also to see herself as the mother does The *mirror* technique is another way of expanding the perspective of the protagonist, he allows his identity of the protagonist and stands with him in order to assist and actors reproduce their view of his behavior On occasion, it is necessary to use a *double*, or an auxiliary ego who assumes the identity of the protagonist and stands with him in order to assist and support his interaction with the other auxiliary egos There are also techniques for experiencing fantasies, for example, in *the magic shop*, the proprietor is able to offer the patient anything he wants, but the patient must be willing to give up something he values in return, the patient is thus forced to choose between values, or at least to choose not to bargain

Although the psychodrama centers around the experience of the protagonist, the therapeutic effects extend equally to all participants

In order to assume the role of auxiliary ego, a patient must be capable of sympathetic projection, and of relating to the other "actors", he must also be responsive to the guidance of the director Thus any kind of participation is a learning experience, with two important benefits the patient gains insight into his own behavior and/or his attitude toward the behavior of others, the patient extends his own capacity for personal and social interaction by consenting to express his feelings spontaneously in a dramatic context Psychodrama is currently a much practiced therapy in hospital programs, and is oftentimes continued for outplaced patients on an outpatient basis Some groups which do not originate in hospitals, such as community-based gatherings of alcoholics, also use psychodrama as a treatment method

Creative Drama

Creative drama, like psychodrama, acts as a medium of self-expression and utilizes theatre techniques (with particular emphasis on pantomime), however, it focuses on social situations rather than on the personal problems of individuals Patients participate in skits in which they adopt social roles and interact accordingly, spontaneous dramatizations might include a hat shop exchange between salesgirl and customer, an interview for a job, or a busy street scene during rush hour with various patients acting as motorists, pedestrians, and traffic cops In some instances, the skits become funny and the patients enjoy the drama almost as a kind of recreation, in others, the acting out of social stereotypes triggers emotions of hostility and anxiety, in which participants express anger and fear The therapist works flexibly with the group, and applies psychodrama techniques for interaction where appropriate, individual responses are expressed within the context of the adopted role

Creative drama is especially beneficial to persons who have little social awareness, such as patients who have been hospitalized for long periods of time, or who come from severely restricted home environments Simple exercises in practical, real-life situations inspire confidence as well as reveal underlying attitudes Creative drama also serves as a diagnostic tool, therapists use it to measure the degree of a patient's contact with social realities, which is particularly helpful with chronic hospital patients

Dance Therapy

Dance therapy makes use of body movement and rhythm as a means of communication, patients are encouraged to express themselves both individually and in groups The dance therapist does not teach dance technique, neither is patient participation viewed as a form of recreation Dance action provides an outlet for the release of tensions, emotional stress, and repressed energy, it strengthens the body and stimulates awareness of body image, and it brings patients together in a positive interaction Dance therapy can be extremely effective with patients whose communicative skills are poorly developed, or who remain unresponsive to verbal communications, as a natural, fundamental form of self-expression, rhythmic body movement helps to combat isolation and inhibition The medium requires no particular skill on the part of the patient, dance action can be as simple as clapping the hands, swinging the arms, or swaying the hips or torso When the patient acquires confidence in his ability to communicate through the medium of dance, he can usually use it as a bridge to more complex forms of communication

Music Therapy

Music, like dance, makes a nonverbal appeal that is strong and fundamental, it is very effective in quieting states of distress, and in eliciting emotional responses Music itself is structured, or ordered to the extent to which a patient participates in a musical experience, he shares in the order of a reality outside himself, at the same time, he is able to release tension and anxiety (Sears 1968) Listening to music is one kind of experience, making music individually or in groups is another. Musical self-expression is, of course, a way of developing self-esteem, group activities enlarge social awareness as well It is often true that the emotional appeal of music can break through blocks in communication, or depressive states, more quickly than any other medium, in responsive patients music may also control mood fluctuations, and strengthen feelings of security Although music therapy is limited in its application to deaf people, some deaf people can perceive the pitch and tempo of music

Art Therapy

Art therapy also allows for nonverbal self-expression and communication,drawing, painting, and sculpturing are pleasurable activities which help release pent-up emotions and tensions The therapist makes it clear to the patient that he need not be talented in order to be expressive, and that his work will not in any way be judged or criticized, the object of art therapy is to permit the free flow of feeling through a creative medium Frequently, a group of patients cooperate on a single project, such as painting designs on props for a stage play or creating pictures to display in an art show Group work in therapy of this type facilitates socialization Thus art therapy can benefit patients socially as well as individually

Art therapy, like creative drama, is particularly useful for diagnostic purposes Oftentimes a patient will reveal an emotion in an art medium which he is not able to express verbally, or even to recognize in himself; therapists are skilled in the interpretation of these symbolic expressions Psychotic patients, in particular, frequently provide crucial diagnostic information through art work.

Recreational Therapy

Recreation can be used therapeutically rather than for the mere purpose of diversion. Ordinary recreational activities, such as games, sports, swimming, picnics, and trips encourage the patient to come out of himself, to enlarge his capacity for pleasure and relaxation, and to become more aware of the ways in which companionship and shared experiences are desirable and beneficial. The competitive aspect of sports can also have therapeutic effects, patients must be self-assertive within a larger cooperative structure For hospitalized patients, excursions outside the hospital often serve the secondary purpose of maintaining patient contact with the community at large. Camping is an activity which has proven to be useful in providing hospitalized patients with a new view of living. It has been an incentive for them to assume new responsibilities and additional degrees of independence while "roughing it." Camping has made patients more aware of their interdependence as they assume various assignments which are necessary and peculiar to the camping experience

Occupational and/or Vocational Therapies

Occupational Therapy

The objectives of occupational therapy are to increase self-esteem through more satisfactory working relationships with others; to promote ego strength through creative and goal-directed activities; and to increase the patient's capacity for effective functioning by introducing him to new skills which provide satisfaction and pleasure, and which might even lead to new occupational interests Activities include woodworking, painting, leatherworking, and ceramics, among others, instruction is usually provided in groups, so as to encourage social contact When a patient begins a new project and sees it through to completion, he increases his confidence and sense of accomplishment, and he develops an awareness of the range of skills which it is possible to learn

Vocational Rehabilitation/Therapy

Rehabilitation oftentimes represents an extension of therapy. Vocational rehabilitation provides the patient with counseling, training, and job placement services, the patient's vocational skills are evaluated, and efforts made to find him a job suited to his qualifications If the counselor finds that his client—whether a hospitalized patient or a participant in an outpatient program—is in need of vocational training, he will arrange for such training through the most convenient facility, hospitals often include their own training facilities Vocational rehabilitation counselors have become increasingly involved in followup services, such as supportive counseling after initial job placement, they also work with social workers in other areas of rehabilitation.

The patient's voluntary participation in a program designed to help him make an independent living is therapeutic and implies a recognition of certain determining realities in his life, involvement in training programs provides many of the same benefits as does occupational therapy The patient's self-esteem is strengthened as he becomes increasingly capable of functioning well, and of assuming practical responsibility for his life

Industrial Therapy

It is often possible to give the hospitalized patient a salaried job in one of the so-called hospital industries, such as the preparation and distribution of food, or the laundry and cleaning operations; or, if he has a particular skill, he may participate in a sheltered workshop which provides opportunities to exercise this skill for a remuneration The patient is thus able to accept some of the responsibilities of a work situation and to enjoy a degree of financial autonomy while simultaneously benefiting from the protected environment of the hospital, industrial therapy often serves as a transition to employment in the outside world Before the patient is placed in a job, he must be evaluated as to his suitability and his progress must be evaluated periodically

Educational Therapy

A patient with learning problems often requires a therapeutic setting in order to learn In educational therapy, the teacher/counselor establishes a close relationship with the patient which encourages communication and thus facilitates the learning process, the teacher may focus the communication on any subject which promises to be of interest and importance to the student The object of educational therapy is not so much to convey specific kinds of information or to teach skills as to raise the learning level of the patient, and to prepare him for achievement in other kinds of vocational and occupational therapies from which his learning problem excludes him

Somatic (Pharmacological and Physical) Therapies

Medication

Within the last 23 years, there have been revolutionary breakthroughs in pharmacological therapy, due to the discovery of a wide variety of tranquilizing and antidepressant drugs Many of these drugs are very effective in controlling psychotic states, and have to a large extent supplanted the use of physical therapies, such as electroconvulsive shock In many cases, drugs are also the most efficient means of reducing neurotic anxieties, so as to render patients responsive to psychotherapy, a highly anxious patient is too preoccupied with symptoms to think clearly Pharmacological therapy must be carefully controlled, since most drugs can produce undesirable side effects, and many are addictive, medication is usually an adjunct to other kinds of therapies and is regulated by the therapist according to the patient's need and rate of improvement These medications must be prescribed by a physician

Electroconvulsive Therapy (Shock)

The therapy that is popularly known as shock treatment produces convulsions by use of electricity, after each carefully regulated charge, the patient is rendered unconscious for about 5 minutes He has no memory of the convulsion, but may feel confused for some time after the treatment A frequent complication for patients who receive a series of treatments is temporary impairment of the memory, this may last for weeks or even months after the therapy has been terminated However, electroconvulsions as far as is known do not cause any permanent impairment of either memory or intellect

Shock therapy has been used primarily for patients suffering from depressive psychoses, usually over an extended period of time, and it has been highly successful with these illnesses Even now some depressive states are not responsive to drugs, protracted depression frequently leads to suicide Electroconvulsive therapy usually alleviates depressive symptoms rapidly, guilt and self-destructive impulses are markedly reduced Shock treatments are rarely used for psychoneuroses, though they are sometimes helpful in controlling extreme states of anxiety

Hydrotherapy

Hydrotherapy, or the treatment of disease by the external use of water, dates back to ancient times, like electroconvulsive therapy, it has been largely supplanted in the 20th century by the use of medications Water can have both sedating and stimulating effects, as we all know from such simple experiences as taking a warm bath or a cold shower Techniques used in hydrotherapy modify a patient's body temperature in an attempt to change his condition for example, the body of an individual who has been properly wrapped in a wet pack will generate a soothing heat over a period of time which will result in a general relaxation of anxiety, a whirlpool bath, in which a high temperature and strong current are maintained, also has a sedative effect—it is, in fact, a form of gentle massage Other hydrotherapeutic techniques are designed to act as tonics, or braces to the nervous system, and have been used with withdrawn or depressed patients Hydrotherapy still finds some use in many mental health facilities as an adjunct to pharmacological therapies

THE MHPD AT SAINT ELIZABETHS: 1963-1975

The use of many of the foregoing treatment modalities in the Mental Health Program for the Deaf (MHPD) has sometimes been problematic and always been challenging. However, before providing detailed accounts of a selection of illustrative cases, it is well to review briefly the history and development of the MHPD itself and its relationship to its sponsor institution, Saint Elizabeths Hospital

Saint Elizabeths, which provides both the setting and the resources for the MHPD, is a federally operated mental hospital which primarily serves residents of the District of Columbia but also serves several categories of Federal beneficiaries It has remained in the executive branch of Government since it was established by an act of Congress in 1855 and is now under the immediate supervision of the National Institute of Mental Health

Because many States have not yet developed mental health programs for deaf people, Saint Elizabeths makes such services available to deaf citizens of States around the country The financial support for this program has been a part of Saint Elizabeths' general operating budget since its inception, in this respect, the program is different from some others which started as research or demonstration projects subsidized by grants In general, the objectives of the MHPD reflect those of the hospital, with specific application to deaf people (1) to provide the most humane care and enlightened curative treatment of the mentally ill deaf through the use of special communication skills and the most effective therapeutic techniques, (2) to serve as a training resource for the development of skilled manpower in this important field, (3) to serve as a resource for research in mental health and deafness

The development of the program may be divided into three phases Phase one, beginning in winter 1963, or fiscal year 1964, resulted from my interest in languages, which led me to study sign language and fingerspelling at Gallaudet College in a course sponsored by the District of Columbia Association of the Deaf. During this same period, the hospital administration was arranging for the Association to sponsor sign language classes at the hospital for other employees, which provided an impetus to put my newly acquired skill to use by conducting group psychotherapy with deaf patients Accordingly, in October 1963, I requested a survey of the number of deaf patients in the hospital who communicated by sign language and fingerspelling. Since I was personally acquainted with most of these patients, I did not wait for the results of the survey before beginning therapeutic sessions with two deaf individuals on a once-a-week basis in December 1963 The group size rapidly increased to six members, which the survey later showed to be the total number of deaf patients skilled in manual communication in the hospital's total patient population of approximately 6,000 Since the deaf patients lived in various units around the hospital grounds, they came together at a central location for 50 minutes of group psychotherapy This phase of the program continued for 2½ years with occasional modifications, during which it became obvious that group psychotherapy was not sufficient to meet the needs of the patients

Expansion of the program got underway during the summer of 1966 when employees from several disciplines in the hospital were requested and encouraged to devote approximately 1½ hours each per week to the MHPD To help indoctrinate these employees in significant aspects of deafness, arrangements were made for them to attend orientation lectures for new faculty members at Gallaudet College on an informal basis, this marked the beginning of phase two By early 1967, at least 13 disciplines within the hospital were providing services in such areas as psychiatry, general medicine, clinical psychology, social service, nursing service, activity therapies, speech and hearing therapies, and religious ministry. As a result approximately 20 hours a week of multidisciplinary services were delivered to deaf patients Therapies were made available on both inpatient and outpatient bases, in addition, the program provided emergency, diagnostic, and consulting services, and it established research and training activities (to be described in chapter 4) The contributions of volunteers, both deaf and hearing, from within the community also played an important part in the delivery of services

During the first 7 years of the program's operation, most inpatient participants continued to live separated from one another in various wards throughout the hospital among hearing patients, rather than together in a single ward This arrangement left much to be desired in that many of the deaf patients had little access to one another It was not without its advantages, however, since it provided some opportunities for social intercourse between deaf and hearing patients, in addition, the participation of certain members of each ward in a hospital sponsored program helped educate other patients on the ward, and the staff as well, to the activities of the MHPD and the needs of deaf people.

In early 1968, the hospital hired its first full-time employee to coordinate the activities of MHPD and by fall of the same year, a second full-time employee was hired as program assistant. The MHPD also acquired additional office and program space in a second building. By 1969 and early 1970, increasing demands for services made it necessary to further reduce fragmentation and achieve closer coordination of the program. In order to arrive at these goals, the hospital leadership appointed a task force consisting of heads of the hospital's departments and staff members of MHPD. The consensus view of the task force supported the establishment of a separate unit for deaf patients and details of budgeting, staffing, facility, and equipment needs were worked out by the MHPD staff. In the meantime, three consultants with expertise in deafness had been hired representing the disciplines of psychiatry, psychology, and nursing respectively. The stage was set for the further indoctrination of department heads and prospective staff members in mental health and deafness. Blocks of time were set aside for lectures to be delivered by experts in the field of deafness. A complement of 11 additional full-time staff members was carefully selected and after careful intrahospital negotiations, a 30-bed building which also housed some hearing patients was assigned to the MHPD. Thus, on July 1, 1970, deaf patients and a full-time staff (both deaf and hearing) including a psychiatrist, clinical psychologist, community liaison and public education officer, rehabilitation, nursing, and clerical personnel were relocated to their "new" building. It was expected that the MHPD would continue to preserve some of the advantages of the former system by maintaining a fully integrated program of deaf and hearing patients. This move marked the beginning of phase three.

By its 10th anniversary, the MHPD had added a 40-bed inpatient ward and another building for program and office space. Eighty-one deaf patients were enrolled in the program 49 were outpatients, and 32 inpatients lived in the two special wards. Over the years the staff has grown considerably in contrast to the lack of full-time staff during the first 5 years of operation, the program now has approximately 40 full time members, 4 of whom are deaf or hard-of-hearing. Such expansion was necessary to keep up with the rapid increase in admissions to the MHPD in the seventies. Until fiscal year 1971, a total of 37 patients had been in the program, for the fiscal years 1971-1975 alone, 113 were admitted. Unfortunately, in spite of the rationale for integrating deaf and hearing patients, no satisfactory plan was worked out for maintaining an integrated structure, and steps were taken to phase out the hearing patients. It remains the author's opinion that a well planned and organized mental health program which integrates deaf and hearing patients is desirable.

It was apparent in the early phases of operation that the program had many positive treatment benefits for patients, and training benefits for those wishing to provide mental health services to patients, but it could not be all things to all people. As a consequence, some limits had to be set in keeping with the program's objectives and the available resources The MHPD was committed to providing optimum treatment to deaf patients rather than merely to keeping patients for custodial care Treatment was to be intensive, with the return of patients to their communities as rapidly as possible after they had achieved maximum benefit from hospitalization Therefore the following criteria for admission were established and are still in effect (1) the applicant should be willing and competent to apply voluntarily and cooperate in his or her treatment, (2) he or she should not be a serius managment problem, (3) he must have deafness as a lifestyle and possess skill at sign language and fingerspelling, (4) the referring source must agree to accept the patient, or provide for his acceptance, once he has achieved maximum benefit from hospitalization and is discharged In analyzing the statistical material at the end of this chapter, the reader should bear in mind that because of the imposition of these criteria, the total patient population in the MHPD at Saint Elizabeths is not necessarily a representative sample of the mentally ill among the deaf community

THE USE OF TREATMENT MODALITIES WITH DEAF PATIENTS IN THE MHPD: SELECTED CASES

All the treatment modalities described in the first part of this chapter have been used in the MHPD at Saint Elizabeths, with the exceptions of music therapy—which can be used with deaf patients, and may be sometime in the future at Saint Elizabeths—and electroconvulsive therapy (Robinson 1973) The adaptation of treatment modalities to deaf patients requires an innovative, highly skilled and flexible staff, as each therapist at Saint Elizabeths has become involved in the program, he or she has worked actively to discover the most successful modes of adaptation Just as the hospital pioneered in the use of dance therapy and psychodrama with hearing patients in the 1940's, it adapted these treatment modalities to deaf patients in the 1960's In addition, the MHPD was among pioneers in the use of group psychotherapy with the mentally ill deaf The following examples of the use of treatment modalities for deaf patients derive largely from my own experiences as Director of the MHPD from 1963, when I founded the program, until 1975, and since then as a consultant They illustrate some of the interesting ways in which therapies are adapted, and are not meant to be comprehensive

Individual Psychotherapy

Group Psychotherapy

Art Therapy

Social Service Case Work

Psychological Testing

Individual Counseling

Occupational Therapy

Dance Therapy

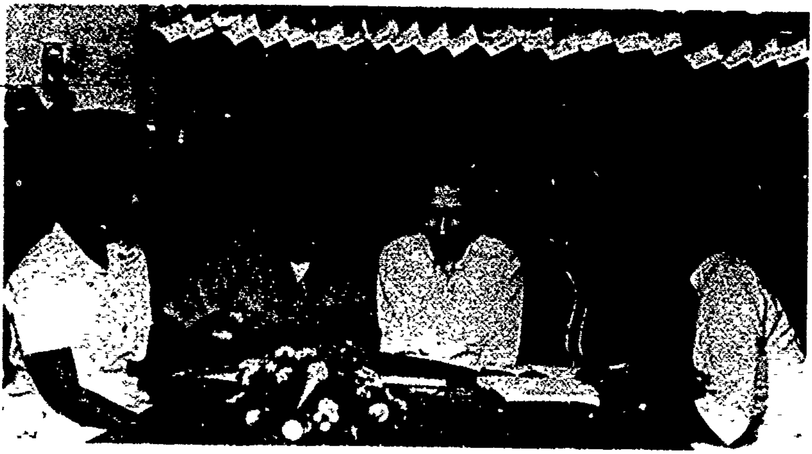
Psychodrama

Creative Drama

Nursing Personnel Learning Sign Language

Group Work Training

Recreational Therapy



Ward Staff Meeting

General Staff Meeting

80

Individual Psychotherapy and Individual Therapy

No patient in the MHPD has undergone formal psychoanalysis, however 57.3 percent of those treated during fiscal years 1964-1975 have participated in individual therapy, and 53.3 percent in individual psychotherapy (see table 4, p. 97). Therapeutic emphases have ranged from the psychodynamic to the supportive, given the communication problems that attend the use of individual psychotherapy with deaf patients, these figures reflect creditably on the training and skill of the staff. The specific difficulties in this area of therapy have long been of personal concern to me in my own work, and to those few of my fellow psychiatrists who have tried to deliver therapeutic services to the mentally ill deaf at other mental health facilities.

Perhaps the most obvious question raised in connection with individual psychotherapy for deaf patients is that of how the therapist and patient will communicate. Since it is generally accepted that lipreading at best misses about 30 percent of what is communicated orally and few deaf persons lipread well enough to allow for a free exchange of ideas, it is necessary either for the therapist to sign and fingerspell, or for an interpreter to be present in the room. When the therapist and patient communicate by means of the same language, rapport is facilitated. The staff members at Saint Elizabeths who conduct individual psychotherapy communicate directly with the patient, and find that his system works very well. However, attention should be called to the Registry of Interpreters for the Deaf, which has members specifically trained to interpret in mental health settings. Thus it is often possible for a patient to participate in indiviudal psychotherapy in the presence of an interpreter, Rainer et al. have found this method effective in New York. What is essential in any form of individual psychotherapy is that the lines of communication are open—that a comfortable milieu is established in which the patient feels free to express himself.

There is another, more complex problem in communication which proves troublesome, when a patient has serious deficiencies in language, and accompanying social retardation, the therapist is often confronted with an immaturity and inability to conceptualize which impede effective psychotherapy. Rainer discusses these difficulties and the related need of many deaf patients to depend excessively on therapists as parent figures in *Family and Mental Health Problems in a Deaf Population* (1969), in spite of the obstacles, however, Rainer and his colleagues have had some success in treating patients on an individual basis. My own efforts in this area have concentrated on patients who show aptitude for individual psychotherapy, that is, individuals whose communication and language skills are good, and who are able to examine problems conceptually.

A 34-year-old female patient, whom we shall refer to as Ms. K, is a case in point Ms K was an attractive person who was admitted to Saint Elizabeths Hosptial at the age of 22, some 11 years prior to receiving individual psychotherapy She had become deaf at the age of 3 and had been told that her deafness followed surgical removal of her adenoid glands She was able to hear some with the help of a hearing aid, but could not hear without it Ms K was a very good lip-reader, had excellent command of the English language, her speech was very intelligible, and she had excellent ability to use sign language and fingerspelling She was reared by her maternal grandparents in an urban environment where her mentally ill mother was a member of the household There were three other family members who had periods of mental illness She described her upbringing as very religious and strict She was a very bright person with an I Q of 103 with a probable potential in the superior range of intellectual ability Ms K graduated from an ungraded school and had met qualifications to enter Gallaudet College the year prior to her entering Saint Elizabeths Hospital During that intervening year, instead of enrolling in Gallaudet she accepted a job However, while at work one day, she began to experience her first overt symptoms of mental illness Thus, she began to hear imaginary sounds and to see an imaginary light which was very bright This was followed by bizarre posturing behavior at home and peculiar dressing habits which prompted her grandmother to seek hospitalization for her Upon admission to Saint Elizabeths Hospital, her condition was diagnosed as schizophrenic reaction, catatonic type During her 8 year period of hospitalization prior to her entering the MHPD, she continued to experience auditory hallucinations in the form of voices giving her conflicting advice She had a very stormy adjustment on the wards manifested by episodes of assaultive and destructive behavior, withdrawal and uncooperativeness There were also periods during which she displayed markedly decreased physical activity, standing in one place for prolonged periods and refusing to eat, which necessitated tube feeding She had received various forms of treatment over the years, including medications, without sustained improvement I had known her during most of her hospitalization and, at one period, prior to the establishment of the MHPD, had responsibility for her treatment She was a member of my group psychotherapy program when I offered her individual psychotherapy She readily accepted the offer Modest goals were set which included (1) to help relieve her of her hallucinations or help her become confortable with them, (2) to increase her self-esteem, (3) to improve interpersonal relationships Sessions were scheduled on a once-a-week basis for 45 minutes for each session It was my opinion at that time, which I have since changed, that a deaf patient could not tolerate longer sessions Rapport with her was established easily because of my previous working relationship with her For communication we used voice and sign language and fingerspelling During the later sessions, I used a technique which I borrowed from the late Benjamin Karpman, M.D., a psychoanalyst who worked for many years as chief psychotherapist at Saint Elizabeths prior to his death in 1962. He had introduced the technique to me during my period of psychiatric training about 10 years earlier. It consisted of the use of a large set of written questions—each set on a separate piece of paper. The questions covered a sequential development of a person's life from prenatal development through adulthood. A week prior to each session, the patient would be given a set of questions to respond to in writing. The patient would bring the written answers to the therapy session and these questions and answers would serve as a basis for discussion during the session. This method enhanced simultaneous data collection and evaluation and appeared to be an asset in cases where the patient was not spontaneous in the conversation. I had used it with a hearing patient and felt that the technique could be modified for a deaf person. A representative sample of the modified questions follow. (To conserve space in this book, the sets are not listed on separate pages.)

1. What have you been told about your birth? Your period of gestation? Your mother's state of health during that time? Did she have any diseases during that time? Was gestation full term or was your birth premature?
2. What else have you been told about your birth? Was labor difficult? Was delivery difficult? Was delivery by forceps, caesarean, or usual? Breech or head first? Anything unusual about your birth?
3. Were you born in a hospital or home? Was a physician, nurse, or other in attendance? Were there complications during your newborn period? Did your mother have any complications after your birth? What have you been told about your newborn period?
4. What have you been told about your infancy? Were you irritable? Did you cry much? Were you left alone frequently or for long periods? Were you held in arms often? Cuddled?
5. Were you breast fed or bottle fed? If both, do you know at what period you switched from one to the other? How old were you when you were weaned? Was weaning difficult?
6. What do you recall about your toilet training? What do you remember about your ideas on urine or feces? What do you remember about your thoughts or feelings about bladder or bowel function?
7. At what age did you become deaf? At what age was your deafness discovered? Do you know how your parents reacted at the time your deafness was discovered? How did your parents react to you? How did other relatives react to you?
8. At what age did you first realize that you could not hear? Did you ever feel you were different from other people? If yes, at what age did you begin to feel different? Do you now feel that you are the same as hearing people but for your absence of hearing?

Unfortunately, intervening priorities did not permit me to complete the development of these questions I still feel that the technique warrants further development to test its use with deaf patients

Both the new technique and the conventional methods of discussion worked well with Ms K She always looked forward to the sessions and was cooperative during them She was always neat and well groomed To summarize the account of the individual psychotherapeutic sessions, the patient reported her experiences at home as a little girl when she was very attentive to her ill mother who lived in the household She felt very sensitive to her mother's needs and tried to keep her comfortable She was the only deaf member of the family and when she became aware of her deafness, she hid in a closet and also hid behind a chair Her life was restricted and she was not permitted to go out in front of the house to play because of fear that her deafness would prevent her from hearing oncoming cars, placing herself in danger of being hit At the school for the deaf which she attended, she adjusted well but frequently felt some degree of jealousy or rivalry with other girls Some of this extended to adult life involving the same individuals She also reported how on the job she felt that often she was shunned as friendships developed among the girls She had strict religious training and when her symptoms of illness occurred on the job, she went immediately to a church where she had a very strange feeling Ms K discussed her frequent hostile encounters which occurred on the wards of the hospital, some recent and some long past, from the years when she lived among hearing patients and staff At times on the ward, she became violently assaultive requiring placement in a room separate from other patients It was interesting to note that she reported her auditory hallucinations freely in the individual psychotherapy sessions, but refrained from bringing up the subject during the group psychotherapy sessions As she discussed her relationships with boy friends in the hospital, it was noted that she frequently put herself into a position of rivalry with other girls and almost worshipped the male friend, sticking by him regardless of his behavior

After about 1 year of therapy, she developed a close companionship with a hearing female patient in whom she confided Her assaultiveness diminished and she became more cooperative on the ward In assessing the therapeutic process, I believe that the patient was able to gain an awareness of factors motivating her behavior and with the help of other therapeutic activities, including those of a social nature, and the use of medicine, she was able to modify her behavior toward improvement During the sessions, I did not encourage discussions of her hallucinations, but kept them in the background to avoid blocking more productive work Instead I concentrated on her self esteem, which was enhanced by the fact that she was one of the few patients in her building given the benefit of individual psychotherapy The major focus, however, was on her interpersonal relationships As she gained self-esteem, she was able to understand how she had been toying between the worlds of the deaf and the hearing, to which she brought a deep sensitivity and ambivalence that developed in early childhood Being the only deaf member in a hearing family surely entailed a great deal of rivalry with siblings and an attitude which she came to understand as operating in her future relationships with others Being a deaf patient in a hearing mental hospital was also seen as restricting, as she had experienced feelings of restrictions before in her home life as a deaf person As she became more aware of the relationship between her current behavior and past feelings, attitudes, and reactions, she was better able to deal with her day-to-day conflicts with others and refrain from using hostile assaultive tactics in dealing with them After working with her for 1½ years, I felt that significant progress had been made toward the pre-set goals A female therapist, who was deaf, became available and it appeared that the time was ripe for the patient to continue therapy with her The transition was made without difficulty

Taking another look at Ms K, it is interesting to note a few of her written accounts of her illness, hospitalization, and improvement

The following account was written 1 year prior to the beginning of individual psychotherapy

My Life and Experience in Saint Elizabeths

First I was admitted to D C General for observance of [illegible] I went through a long trial there They treated me in everything I did not respond in everything, and so the result was they thought I was insane and so I was transferred to Saint Elizabeths I did not know I was being sent to Saint Elizabeths I had no idea where I was going and when I arrived at W E I was delighted with the place—why? I don t know why I just liked it The long halls and the big dayroom I was placed on Ward 8 in W R It was supposed to be a ward for bad girls Most of the girls on Ward 8 were my age and I liked them For some reason on the very day I arrived, they put me in a cell and there I stayed for days They stripped me and threw me in the cell naked In the cell I made friends with the pigeons I fed them bread Maybe you all will be interested to know that at one time I was hearing voices which put me in a strange world of my own In the cell I heard noises Such as steel planks being dropped on the cell floor and bugs crawling all over me I could hear within my body voices speaking to me, but I could not make out what they were saying I remember very well the lights would bother me They would execute me and I often thought the crown of Jesus was up there in the blue light bulb Soon I got to know my voices They were Jesus Devil Bad Angels and Little Devil Yes I am a Catholic so you can understand that at that time my life was turning holy I was in religion for a very long time oh so very long How long God only knows!

My people would come to see me twice a week those days Now they come once a week Every Sunday Just seeing my people brought me around to reality My grandmother did get me a lawyer But she was of no avail She did not help me I have not seen her except that one time Do you know what she said she said What would you like to wear at your funeral? Did she think I was going to die? Small wonder cause I was always in bed

Well anyway, I got interested in going places I began taking an interest in life and I believe that's how I got back to reality Yes today I am just fine I am going to school and I am making all A's I hope to be working outside soon I am now on a better ward so the future looks bright for me I am happy Thank you

The next account was written 1 year after the beginning of individual psychotherapy

What Is It Like Being a Patient in Saint Elizabeths Hospital?

To be a patient in Saint Elizabeths Hospital is like being a prisoner within your own self First you were a prisoner of the make believe world You did things that were not normal or heard of in the World outside you (the World from which you came and the World to which you go back when you are completely cured) Then one day you were faced with reality You didn't know how to undergo reality you became excited and fear overwhelmed you but you tried and you made a stab at it Whoops—it worked The Wall which had enclosed you and was making you a prisoner on your own self has been knocked down You feel better and you think you are quite a Champion You are happy you made the first step to reality and it was successful So you try again You take a step farther, you succeed Then comes many more until you become strong and confident Your actions are better, you act faster and you find yourself happy

Now comes progress, you are faced with reality here, too Your concern for your body comes first You heard of vitality, you wonder just how to make progress in vitality You know it is one of the requests of the Hospital to have vitality You know with vitality of the body and soul you can be strong So what do you do? You go out and buy a Chocolate Malted Milkshake It gives you vitality, it makes you feel good and it is healthy to both mind, body and soul Now you know what vitality is, it is food and drink and much more Something that will nourish you and make you round, strong, and healthy—body wise and mind wise With vitality you seem much lighter You can walk and act faster You are happy here, too

Then second you think of a job You know without work you cannot make progress You ask your doctor to put you to work He does Your fear is over you are going to work There will be less sleeping and laziness will eventually go away The Make Believe World is shattered, you go to work You are facing up to reality At work you are first faced with many problems but you gradually succeed in overcoming them—one by one—but there are always many more to overcome By this you have learned and built your confidence to a much stronger height You are much stronger now to take a job outside in the World You tell the Doctor you feel you are ready to go He agrees Here too, your wall of dependency is shattered You have Hope and Faith in yourself I now anticipate the day when I might be able to leave the Hospital With the assurance and support of the Doctors, Nurses and Staff I have reached this goal There are doubts whether you're going to succeed or not You take the rein, you hope and feel sure you're going to make it because the first step was successful The Wall is broken through and you are free once more from yourself You are now thinking of becoming a Citizen out there making all kinds of progress and taking all kinds of steps You are back in the Community You report back in the Hospital periodically with the good news of your progress You are glad and happy all over You make an outstanding example to all the other Patients behind you You give them Hope

Also 1 year after the beginning of individual psychotherapy Ms K wrote the following list of advisory messages on mental health

My Advice to a Young Boy or Girl in Staying Out of the Hospital

1 Take an interest in people around you Whether it is in your own home or elsewhere
2 If you are deaf do not hide the fact that you are deaf Be open Show it And be brave
3 If you are deaf do not confine yourself completely in the Hearing World, or with the Deaf people, but mingle with both
4 Have friends and have a hobby It can be anything reading, writing, sport activities, or anything of the like
5 Be busy Keep your mind occupied at all times
6 Honor thy Father and Mother Be kind and understanding and tolerant to both old and young
7 Be interested in your Church Activities, Practice your religion
8 Avoid places that are indecent
9 Be decent and clean in all your actions
10 Develop the habit to use good manners and good grooming
11 Be well bred and be happy Be Healthy both in Mind and Body
12 Get plenty of outdoor air and sunshine Always have good hygiene

By these 12 rules, you can be sure you can avoid mental illness

I am happy to report that with the continuing therapeutic efforts of the staff of MHPD, including a one-to-one working relationship with a Nursing Assistant, Ms K is now living away from the hospital in a halfway house

Group Psychotherapy

As mentioned earlier, my first treatment experience with deaf patients in the MHPD was in group psychotherapy. This venture, accounts of which were published in 1965 and 1966, marked the beginning of the MHPD at Saint Elizabeths It is illustrative both of the successes and the problems encountered in this type of treatment

The group selected for this venture consisted of six patients who had the following general characteristics speech and hearing impairment ranging from severe to profound, varying levels of communication skills such as lipreading, writing, sign language, and fingerspelling Social isolation was a common characteristic manifested by withdrawal, dependency, inferiority feelings, attempts to overcompensate by acting out, and problems in interpersonal relationships During the course of their hospitalization, they had collectively shown symptoms of anxiety, such as chain-smoking, pacing, alterations in appetite, or psychotic symptoms such as catatonic stupor, urinary incontinence, delusions, and hallucinations with remissions and exacerbations

The group was started in one of the psychiatric units with a nucleus of two deaf patients, but new members were soon added After some turnover, the group settled down with six members, and continued with the same six members for over a year The age range was from 29 to 70 years with a mean age of 43 5 Periods of hospitalization ranged from 8 to 21 years with a mean of 16 years, there were two women and four men The group met with me once a week for a 50-minute period, established goals included allaying anxiety, alleviating inferiority feelings, improving interpersonal relationships, and expanding each patient's sphere of social interaction

At the beginning we established special rules Each member of the group had to be skilled in manual communication but was permitted to use other communication skills if he or she had them. Because communication among deaf people involves visual concentration, the therapy room was well illuminated and offered a minimum of visual distractions The seating arrangement was circular or semicircular to afford maximum visual contact among members Visitors were admitted only if they understood the communication techniques and had a special interest in the problems under discussion They were not observers, but were incorporated into the group For the several patient groups which have subsequently participated in group psychotherapy in MHPD, this type of structuring has continued for the most part

The personalities of the group members varied widely, as did the roles they assumed within the group structure Ms V, 32, had been hospitalized 8 years Her speech was only slightly impaired, she could lipread and hear fairly well with a hearing aid She was the most active member of the group, volunteering to interpret sign language when necessary On one occasion, she described how she had been slapped by another girl a few years before her hospitalization, she felt the girl had misinterpreted her deafness as snobbishness and retaliated with the slap Later, Ms V described a more recent ward experience in which she felt like slapping another patient, when reminded of the time she was slapped, she became extremely tense and anxious The group helped her deal with her hostility and anxiety by discussing the issue of why people slap or get slapped Although the question was not resolved, Ms V's anxiety subsided, and the benefit of the group interaction was clearly evident

Mr B was 29 and had been in the hospital for 18 years He had a moderate degree of speech and hearing impairment, but could lipread and communicate manually Although his ability to conceptualize was low, he was quite talkative and demonstrative, and sometimes carried pantomime to an extreme Mr B's acting-out problems had long been in evidence, at the time of our session, he had severely limited hospital privileges He was frequently disruptive The issue of Mr B's behavior was put before the group, over a period of time, group support and advice helped Mr B reduce his disruptive activities

Changes in Ms M, a profoundl, deaf patient of 50 who had been in the hospital over 20 years, were less obvious Ms M was not very active in discussions, but would respond relevantly when addressed directly, and was drawn out of herself sufficiently to occasionally smile, joke, tease, or touch Her progress was slow but definite, eventually, she was one of three patients in the group who was granted permission to walk about the hospital grounds unattended, she was able to keep her appointments and became more alert and sociable

Mr T, another profoundly deaf patient of nearly 70, had no intelligible speech, however, he was very active in the group, using manual communication almost exclusively He had a businesslike attitude and served as a mediator, keeping things in order, he was quite spontaneous in his communications and had animated interchanges with Ms V He was also free in showing hostility and opening up his emotions to the others About a month after the group began, he left the hospital to live with his sister Throughout the year he traveled unaccompanied by public transportation in order to attend group sessions

Mr D, age 50, and Mr H, age 30, had been in the hospital 21 and 8 years respectively, and were the least active members of the group Mr D was always pleasant and smiling, but never responded unless addressed directly, and nearly always fell asleep during the sessions He was, however, the only person gainfully employed At first, it was felt that Mr H s passivity was due to his difficulty comprehending sign language He was a chain-smoker Gradually he began to react to the activities and even to respond occasionally Over a period of time, his chain-smoking subsided

During group sessions there were sometimes hostile retaliatory responses to teasing and nonconforming behavior However, all the patients seemed to be genuinely concerned about one another's welfare, they frequently volunteered to do favors, or share possessions When one member became acutely ill with chest pains during a session, the others responded with an outpouring of sympathy Patients also expressed concern if one of their number was absent

One unique characteristic of this deaf group, not generally seen with hearing groups, was the openness and direct expression of affect Smiling, laughing, and touching occurred frequently, embracing, occasionally It was also observed that these patients were more sensitive to the introduction of new people than to changes in physical environment For example, when visitors took part in group sessions, patients became more expressive, describing hostility toward significant people outside the group, particularly authority figures such as parents or doctors On the other hand they responded minimally to changes in the meeting place or to the furnishings of the psychotherapy room and time schedule

In general, it can be said that gains made by patients during the total experience were modest but definite In addition, this experience brought to light certain factors which must be taken into account in conducting group psychotherapy with deaf members, for example, variations in sign language technique, particularly regional differences, sometimes require the therapist to be very active in helping to clarify communications In addition, transmitting and interpreting manual communications depend largely on the degree of sophistication and perceptiveness of the participants, which also varies After our group had been in session for several months, and some of these differences were apparent, attempts were made to test the patients' verbal concepts by having them write accounts of their Easter holiday experiences None had trouble with penmanship or spelling, but some had faulty sentence structure One patient wrote, "I had a good time for Easter basket and the color eggs I want to make all color Easter Monday" Another wrote, "None else in Easter Day" On the other hand, some of the patients used normal sentence structure and conventional verbal concepts These variations in levels of verbal and conceptual sophistication made it necessary for me, as therapist, to be very active in promoting the group interchange It would appear to be more efficient to work with individuals who are more compatible linguistically, though it is not always possible to assemble such a group at a given time, in any event, it should be borne in mind that broad differences create special problems

Observations were also made of patient reactions to the filming of one session, and to the taking of still photographs at another The group agreed to participate in these activities, although members experienced a variety of emotions in anticipation of the events Some were enthusiastic, others showed apprehension and anxiety However, their delight and amusement at viewing the pictures were fairly uniform, and it was possible to discuss their responses in the group, the comparison of self-image and screen image was of both interest and benefit to them The experience thus suggests the possible use of photographic devices as adjuncts to group psychotherapy, and/or as an aid to teaching the treatment procedure Video tapes and playback are used extensively for both treatment and training in other parts of the hospital with hearing people

In summary, then, my early venture in group psychotherapy proved the efficacy of this treatment method with deaf persons, the MHPD has continued to offer this therapy to large numbers of patients Ninety-eight individuals, or 65 3 percent of those in the program from 1964-1975, have participated in group psychotherapy sessions

Family Therapy

Early in the program, Olethia D Weathers, a social worker at Saint Elizabeths, and I collaborated in a therapeutic effort which may appropriately be called crisis intervention (a lengthy published account appeared in *American Annals of the Deaf*, June 1974) The crisis was a life threatening loss in a normal hearing 10-year-old boy suffering from anorexia nervosa, a syndrome marked by severe and prolonged refusal to eat Accompanying symptoms included fantasies in which the boy saw himself as a person of superhuman strength and power, learning difficulties, and shyness The patient, who shall be called Johnny S, was referred to the MHPD several months after he had undergone hospitalization to correct severe weight loss Though he had gained weight during his hospitalization, it was felt that it might not remain constant without psychiatric intervention and a change in family milieu However, the fact that Johnny's parents were deaf created a special problem they had not been able to communicate effectively with Johnny's pediatrician, and needed to talk to professionals who understood sign language and fingerspelling Prior to this time, the staff of the MHPD at Saint Elizabeths had not undertaken family therapy, although Johnny was hearing, the referral of his case provided an opportunity for working with a family with deaf members

According to the history, Johnny had begun eating poorly 7 months previously He started to lose weight and to act strangely, putting food in his mouth but not ingesting it and expressing much concern about body-building At school, he was having both learning and disciplinary problems After several months of weight loss, Johnny was admitted by the pediatrician treating him to a local children's hospital where he remained for approximately 1 month On admission, he weighed 41 pounds During the first week of hospitalization, he continued to lose weight, and was discovered to be hiding food in his clothes and in places around the room He was then fed intravenously, and eventually given a liquid diet supplement, which resulted in weight gain However, he continued to refuse to eat solid food, or to hide it During the course of Johnny's hospitalization, the family visited the patient regularly but seemed to avoid the pediatrician It was clear at Johnny's discharge that he and the family were both in need of professional counseling

In the interim between hospitalization and referral, the family sent Johnny, who refused to go to school, to live with an uncle and aunt, earlier in the year, Johnny had transferred from parochial to public school because of academic failure The family saw this move to the relatives as a panacea to Johnny's problems since the aunt and uncle could hear and hopefully offer Johnny adult supervision and advice However the arrangement was not successful, Johnny continued to refuse to attend school and to be preoccupied with his body and his weight By August, when family therapy began, he had returned to his family home

Initially the therapists gathered information from family members, and took note of their salient characteristics Mr and Mrs S, both 38 at the time had two children in addition to Johnny, another boy and a girl The family lived in a two-bedroom apartment in a semirural area of metropolitan Washington, D C Mr S worked at night and was at home most of the daytime hours He used part of his daytime hours for necessary sleep

Mr S was a short, stockily built man who usually dressed very casually, was generally pleasant in manner Mr S had become deaf at the age of 6 months from an illness he could not identify, his formative years were spent in a residential school for the deaf where he completed the ninth grade Subsequently, he received training which prepared him for his work as a printer

Mrs S, a short woman of medium build who wore glasses, had been a housewife during her 14-year marriage She appeared very interested in her family's problems, and cooperated as much as possible She had not become deaf until age 3 Mrs S had completed eight grades at a residential school for the deaf

The oldest child, Betty, age 12 at the time of the therapy sessions, appeared very alert, intelligent, and responsive to questions, it was soon apparent that Betty had assumed the role of parent surrogate in relation to the boys With adults, she behaved as it she were older than her actual age

Johnny, the identified patient, was very thin and shy he talked in monotones, and only in response to questions His lack of spontaneity, his tendency to withdraw into fantasy, and his recent history of academic failure reflected the emotional disturbance of a severe adjustment reaction of childhood Despite these disturbances in thinking, Johnny's I Q was normal (109) with bright normal potential

Six-year-old Billy, the youngest child, appeared to be a little small for his stated age, but was very active, talkative, and spontaneous, in marked contrast to Johnny He easily attracted the attention of the family and generally was successful in getting his wishes met He had recently started parochial school

Based on referral information and our initial impressions, the social worker and I set the following goals for the therapy (1) to redirect the focus from Johnny's eating habits and fantasies to the total family interaction, (2) to help alleviate acute symptoms in Johnny, (3) to keep pressure off Betty as the parental surrogate for the boys, and (4) to assist the parents in their roles as parents The decision was reached to meet with the family conjointly once a week for 50-minute sessions, we would use sign language and fingerspelling in conjunction with speech as the means of communication In case it proved necessary to divide the family into groups for separate counseling at any time in the therapy, arrangements were made for convenient facilities The therapy offices, connected by an all-purpose room, were comfortable, and within easy access of restrooms and a game room for the children

The first six meetings were conjoint family sessions, family interaction, which was quite revealing, confirmed many of our early impressions, and uncovered several contributing factors to Johnny's illness

The behaviors of Mr and Mrs S during the therapy sessions were very different from each other For the most part, he remained passive, interrupting occasionally to discipline the children by pointing a finger, frowning, or clapping his hands, sometimes he would volunteer information regarding Johnny's bizarre eating habits and fantasies in response to a question directed to Johnny This tended to keep the focus of the discussions on Johnny and away from questions which dealt with family problems in a broader context When confronted with those questions he deferred to his wife, who was much more actively and emotionally involved in the discussion, despite the fact that her manner was shy and sensitive She appeared to be the decision maker in the family, however, she delegated the responsibility for carrying out these decisions to the husband

Both Mr and Mrs S relied heavily on Betty, who willingly assumed the role of liaison between her brothers and parents, and tried to assume the same role between her parents and the therapists Her parents seemed to accept this as natural, and it became clear that at home Betty consistently mediated between members of the family, and between her parents and the hearing world The therapists called attention to Betty's difficult position very early and discontinued her role as the sole interpreter in the sessions, in instances where interpretation was necessary, all the children helped out The parents began to realize Betty's difficult position as a substitute parent As a result of this, it appeared to Mr and Mrs S that they understood that they should assume a more supervisory role over the sons and delegate less to Betty

The parents also were helped in dealing with Billy, whose attention-getting behavior they unwittingly encouraged Billy was usually very talkative speaking both for himself and Johnny, and he liked to be active – walking around the room, meddling with objects, or appealing directly to his parents for attention Mr and Mrs S frequently reinforced this behavior by responding to something Billy had done as cute or amusing, moreover, they left it to the therapists to set limits on Billy activities The parents' permissiveness toward Billy had a decided effect on Johnny, as was evident one day in the game room when the boys had a dispute over toys Mr S settled the dispute by summarily ordering Johnny to give up his toy to Billy, and come sit with him and his wife The therapist used this incident to discuss differences in the types of discipline the parents used for the two boys the possible inequities and the response of Johnny to these inequities The S's agreed to allow Johnny to return to the game, and to set certain rules for both boys regarding choice of toys and clean-up responsibilities in their future play

Johnny himself was the center of the most significant episode of the sessions which the therapists felt was the turning point in the therapeutic process During the fifth session, he burst out in anger, this outburst startled every member of his family and proved quite useful in helping them to understand how he felt For some time, the family therapy sessions focused on the subject of Johnny's behavior, despite the therapists' efforts to redirect the focus, often, in misdirected attempts to help Johnny, they freely offered him criticism Until this time, Johnny had remained relatively quiet, talking in monotones without looking directly at anyone, he had not protested when his father or younger brother interrupted him On this day, we were discussing with Johnny how he felt about his behavior being a continual subject of conversation, suddenly he began a verbal barrage of accusations He said he didn't like it, and that his parents were always talking to people about his behavior "They tell my grandparents,my uncle and aunts, and others" He ended in tears We asked the parents if they were aware that Johnny felt himself to be the subject of ridicule, when the father answered "yes," we asked why they had done nothing about it The S's seemed shocked by their confrontation with Johnny's feelings, and had no reply, the mother was weeping After a pause, we asked if Johnny ever did anything good Betty volunteered a list of chores that he carried out responsibly around the house Eventually, we were able to demonstrate that there were good points about Johnny which could be the subject of conversation with family members, friends, and neighbors, and that Johnny needed the reassurance of this kind of family support The parental response was positive, it was clear that this session had provided an important insight for them

Shortly after this episode, it was decided that my cotherapist, Ms Weathers, would meet with the parents separately from the children in order to discuss in greater detail their problems in handling the children Weaknesses in the disciplinary structure which continued to involve delegating parenting responsibilities to Betty were dealt with by lengthy discussions in responsible parenting

While the parents met with my cotherapist, the social worker, the children met with me in the game room Johnny was much more outgoing in this setting, he particularly liked to draw pictures of comic strip and cartoon characters He and Billy engaged in a great deal of horseplay during these sessions, Betty seemed torn between joining in the play, or assuming her more adult role Discussion of attitudes or problems depended on events in the children's play, for example, when they argued, the conflict was resolved through conversation Once again, care was taken not to focus specifically on the subject of Johnny's illness, when Johnny himself boasted of a weight gain on one occasion, I responded pleasantly but did not make an issue of it The children opened up in the freer, more permissive atmosphere, they confided readily in me and were more relaxed in their responses By the time the entire family unit was reassembled, the rapport had improved considerably

After a total of 11 sessions, the family felt it had passed the crisis and began to cancel appointments frequently The therapists decided to terminate and leave the balance of care and attention to the pediatrician who had been kept informed of the family's progress During the next year, we heard that Johnny had gained weight, was doing well in school, was no longer shy, and had ceased to talk about body fantasies We believe that these improvements were due primarily to the family's gaining a better understanding of the problem, the parents made greater efforts to communicate directly with their children, and to bolster Johnny's self-esteem, they also became less permissive with Billy and tried to relieve Betty of the adult parental role

The fact that family therapy has been used infrequently in the MHPD is partly because so many of the patients are from outside the District of Columbia, it is also true that local family members are not always able or willing to participate in therapy As the above description demonstrates, family therapy requires flexibility on the part of the family as well as the therapists, in addition, family therapy for the deaf usually presents problems in communication that are not present in group or individual psychotherapy In working with this family, for example, we found that the combination of Billy's hyperactivity, infantile language, and clumsy fingerspelling made it difficult for him to communicate effectively with the adults, he was also prone to exclude his parents by using his voice Since the families of deaf patients usually include hearing members, and most families include a wide range of ages, therapists must be very sensitive to these kinds of communication barriers, and skilled at dealing with them

Activity Therapies: Psychodrama and Dance Therapy

As might be expected, large numbers of patients in the MHPD take part in activity therapies designed especially for them (for statistics, see p table 4,) Patients with language problems are able to derive particular benefit from nonverbal forms of self-expression, such as dance therapy and art therapy, those who have suffered severe educational deprivations make good use of occupational and educational therapies, as well as vocational rehabilitation counseling In addition recreational activities in the MHPD are carefully planned to promote a sense of community and solidarity among the deaf population, for example, each summer, patients spend a week at a camp approximately 30 miles from Washington where they can enjoy all types of sports and outdoor activities They may also enjoy sports during the winter at the hospital, along with such special events as bus excursions and captioned films, this atmosphere contrasts markedly with the not so distant past when deaf patients in large mental hospitals were virtually neglected The emphasis in all the activity therapies is to reduce the isolation of deaf individuals, to provide them with as many modes of communication as possible, and to encourage the development of their confidence and self-esteem, psychodrama and dance therapy exemplify these efforts

Psychodrama

Psychodrama is one of the most popular and effective of the activity therapies (78 7 percent of all patients between 1964-1975 participated), and demonstrates well the manner in which a major treatment modality is adapted for deaf patients by the addition of sign language and fingerspelling to the standard techniques Psychodrama can be equally effective with deaf patients of both high and low verbal levels due to the fact that patients can supplement signed communications with pantomine and body actions, many deaf individuals are adept at these acting skills. Variations in sign language and fingerspelling, though frequently significant, are not as crucial as in many of the other forms of psychotherapy since even a patient whose sign language facility is slight, or highly dialectical, can act out a concrete illustration of a feeling or attitude When a withdrawn or low verbal patient finds that he can share his feelings through action, he frequently makes a greater effort to communicate through verbalization, thus psychodrama often provides the bridge to relationships with other people The experience of Mr R, a young man in one of our early psychodrama groups, is a case in point His response and that of other members of the group were described by Ms Lynette Clayton, one of the psychodramatists then at Saint Elizabeths, and me in 1971

When Mr R joined the group of about 18 members, he was extremely withdrawn and socially isolated, his most intimate relationships were with things—trees, balls, animals Mr R's view of the world was very narrow, as if he were looking through a distorted screen He spent a great deal of time in his own fantasy world, on occasion, in trying to act with the other patients, he would perceive them as monstrous forms ready to hurt or to mutilate him Since Mr R would not communicate verbally, it was decided to try to approach him through his own "language," that of his favorite objects

Mr R was asked to act out his feelings toward trees, balls, and animals, other patients, acting as auxiliary egos, responded to Mr R's impressions and contributed their own Gradually, the real-life equivalents of Mr R's symbolic language were uncovered, the auxiliaries helped Mr R to expand his perceptions For example, Mr R repeatedly pantomimed trees that were decrepit or damaged, sometimes the trees grew old and fell over, sometimes they were cut down by beavers and fell into a river (During this same period, Mr R was drawing pictures in which extremities were cut from the body) Gradually, the auxiliaries shifted the emphasis from trees to people and began to act out a skit showing people growing old and dying, people feeling helpless in the midst of things going on around, people being hurt and responding in anger. Mr. R was able to participate in this shift of emphasis; later when the group talked about the sequence, he was also willing to communicate verbally, if only in a limited way. Mr. R's gains in psychodrama were small, but significant. He was able to break away from his fantasies periodically in order to participate, and became more verbally expressive; most importantly, he formed relationships with some group members.

The role of protagonist is not always consciously assumed as in the case of Mr. R; sometimes spontaneous interaction between patients takes its own course from which a protagonist emerges. On another occasion, Ms. L, a group member, arrived at the warm-up session angry. Her emotion was apparent on her face; she refused to sign and was reluctant to join the group. Patients and staff were discussing job training with vocational rehabilitation; Ms. L was one of two patients in the group who had recently started this training, and she was not happy with it. One of the patients then accused Ms. L of stealing puzzles, which acted as the catalyst for her anger. She started to sign, saying that she did not like sorting dirty clothes at the service industry, would not continue job training, and wanted a good job with decent pay. As her excitement grew, she began to stamp the floor. The therapist then came forward with an empty chair with a cushion on it, which was placed in the center of the group; use of these objects is a psychodrama technique for channeling and focusing anger. Members of the group who were generally resentful of Ms. L's behavior were asked to assume roles as auxiliaries and act out their feelings about Ms. L's using the chair and cushion; Ms. L, the protagonist, was also allowed to act out her anger in the same way. Gradually the angry feelings subsided, and some patients made friendly overtures to Ms. L. However, one individual, still irritated, told her, "Stop all these things you are doing, they bother us!" which triggered another explosion in Ms. L, this time directed at the chair and cushion. When she reestablished control over her feelings—signified by her replacing chair and cushion in their proper places—the group began to comment on her action. Members admitted that Ms. L's habitual behavior bothered them, and that they had accused her of stealing as a way of showing disapproval, since they knew she didn't really take the puzzles. Eventually they recognized that Ms. L's anger was actually in response to group rejection, and that members of the group had contributed to that day's explosion. When asked what it was about Ms. L's behavior that was alienating, the patients said that her behavior was bizarre and reminded them of sickness. At this point, the psychodramatist directed that the rest of the session focus on demonstrating images of sickness and wellness—a way of helping the patients face those fears in themselves which Ms. L. seemed to represent. This very important theme emerged from the spontaneous interaction of the warm-up session; the entire episode was also very useful in reducing the friction between Ms. L and the rest of the group.

Oftentimes therapeutic effects in psychodrama are less perceptible and take place over a fairly extensive period of time. During 1969-1970 Ms. Clayton kept reports of psychodrama sessions in which she regularly participated with about 12 patients. Reading these records on a day-to-day basis, one finds many significant episodes like the ones just described: breakthroughs or unexpected insights. However, Ms. Clayton also kept records of changes in the climate of the group, especially in response to the loss of a familiar member and the introduction of an new one. Occasionally, the modification of the established group pattern proved to be the necessary impetus to action for some members, as this note of December 3, 1970, written approximately 1 year after the group was established, demonstrates: "Overall the change in this group has been quite marked as more people who are familiar with the community have been added. It has interested people like Ms. Z and Mr. N to respond in new ways which are not yet realistic and appropriate but show motivation to change." The unique chemistry of a psychodrama session is never predictable; just as the introduction of a new face can generate new interest in some, certain topics—often discovered by accident—may cause other formerly passive patients to respond. In addition, many patients take time to become acclimated to a social setting, and to loosen up enough to behave spontaneously. Thus the benefits of psychodrama for individual patients are not always immediately apparent; for some it is a long-range process.

Dance Therapy

Ms. I. is a 36-year-old congenitally deaf female who communicated by sign language and fingerspelling. She had good ability to use her voice in speech production, but she seldom did. The patient was admitted to the MHPD at Saint Elizabeths Hospital after 5 years of hospitalization in a State mental hospital.

She had a difficult childhood and when she was in her mid teens she was hospitalized because of extreme nervousness. Following her hospitalization, her adjustment was not good. She began to laugh without provocation for long periods of time and exercised poor judgment by becoming overly friendly with men in the neighborhood and constantly seeking their attention. The family was unable to control her because of her violent, destructive, assaultive and hyperactive behavior, withdrawal, bizarre drinking, and suicidal ideation. On admission to Saint Elizabeths Hospital's MHPD, she showed signs of infantile regression Her condition was diagnosed as schizophrenic reaction, chronic undifferentiated type On the ward her adjustment was characterized by absence of significant peer relationships and she spent most of her time napping, watching TV, or reading At times she would stand in one place on the ward for prolonged periods

She was encouraged to participate in a variety of therapeutic activities including dance therapy When special creative dance group was started for a selected group of patients, she was among them This was a small group of women who were selected by staff and the dance therapist because of their experience and therapeutic considerations The main goal of this special dance therapy group was to improve body image by improving coordination, rhythm, dance skills, flexibility, and concentration while at the same time improving self-confidence by facilitating self-acceptance To achieve a greater degree of freedom of movement and to get a better sense of body image and femininity, the patients wore leotards and tights This dance group was on a once-a-week basis, each session lasting about 1 hour The patients were permitted to introduce new movements and choreography Ms T participated in this group for about 3 years and showed periods of improvement Accordingly, she became more self confident and initiated new movements She also began to show more spontaneity in her behavior In spite of the effort in this procedure, together with many other forms of therapy, her improvement was not sustained The foregoing, however, is an example of how dance therapy is prescribed and carried out in an attempt to accomplish specific goals for individual patients whether done in small groups or larger groups or on an individual basis

Behavior Modification and Somatic Therapies

Behavior modification has been used very little in the MHPD, only 8 of 150 patients have participated in this aspect of the program The technique used was that of positive reinforcement through token economies that is, patients were provided tokens which could be exchanged for privileges or rewards if they continued to engage in desired behavior In most cases, changes involved the assumption of responsibilities for personal care and minimal ward duties (making one s bed, for example) It was hoped that the external stimulus would motivate the patient to come out of himself enough to change, after which he would be in a good position to continue the behavior as a result of internal motivations Several of the patients did show some significant progress in these areas

One hundred patients of the total MHPD patient population of 150 have received medication, this is the only somatic therapy that is administered regularly Electroconvulsive shock has never been used in the MHPD, hydrotherapy is prescribed only infrequently As was explained earlier, the move away from shock treatments and hydrotherapy in mental health facilities is general, and not restricted to the MHPD

Aural Rehabilitation

A special therapy offered to deaf patients by the Hearing and Speech Center of Saint Elizabeths in conjunction with the MHPD is aural rehabilitation The hearing of all deaf patients in the MHPD is tested by audiologists, thanks to sophisticated techniques, it is even possible to test a deaf psychotic who hallucinates that he hears voices, and to distinguish this patient from a hearing psychotic who is feigning deafness When evidence shows that a patient can be helped to hear by amplification, he is fitted with a hearing aid Aural rehabilitation is also helpful in determining the extent to which auditory stimuli, such as speech, or loud music for dancing, may be used in patient s treatment Thus, the work of audiologists in the MHPD is important both diagnostically and therapeutically

CHARACTERISTICS OF THE MHPD PATIENTS

As a way of summarizing the work and accomplishments of the MHPD, a variety of statistical evidence is presented regarding the characteristics of patients in the program through fiscal year 1975 and their most significant events Since its inception in late 1963, 150 patients have entered the MHPD The rate at which the MHPD gathered momentum in its later years is illustrated by the fact that until fiscal year 1971, only 37 patients had been in the program while 113 were admitted during the shorter period from 1971 through 1975

The MHPD patients are almost evenly distributed between males (74) and females (76) Slightly larger numbers of females than males are from the North East and North Central areas The median age for males (27 1) is 3 5 years less than that for females (30 6)

The youngest patient ever in the program is a youth from Maryland He was admitted to another division of the hospital in July 1974, slightly more than a month before his 11th birthday, and transferred to the MHPD the following June While one patient in the program was 77 years old at the end of 1975 and another died at age 80 that same year, the oldest at the time of admission was also a Marylander who was admitted at 55 years of age and discharged at 57

Well over 50 percent of all admissions to Saint Elizabeths are diagnosed as psychotic, and the bulk of those are schizophrenic The criteria for screening patients for the MHPD preclude the selection of a group which is representative of either a total deaf population or a total mentally ill population Yet it seems worth noting that although

40 of the 44 patients in the MHPD diagnosed as psychotic on first admission were schizophrenic, the entire psychotic group was only about 30 percent of the grand total And while situational disturbances account for about only 2 percent of all admissions to the hospital, they accounted for 35 percent of the diagnoses on first admission for MHPD patients

Noticeable also was that almost twice as many females as males in the program were diagnosed as neurotic, and more than 3 times as many males than females were considered having personality disorders This is true despite the fact that the total male to female ratio is almost 50 50

At the end of fiscal year 1975, 45 females compared to 33 males remained on the rolls And even though the median length of time on the rolls was 1 year more for females (2 7) than for males (1 7) 20 percent of the females had been on the rolls less than a year as compared to more than 36 percent of the males

While MHPD females stay on the rolls longer than males, the data show that one sex is about as likely as the other to get out of the hospital (by either discharge or convalescent leave placement) within 3 months after admission Forty-three males were in residence less than 3 months before their first discontinuation as opposed to 46 females These numbers are 57 percent and 61 percent respectively of the total males and females ever in the program However, since a larger number of males than females is released within 3 to 6 months, the percentages of first discontinuations in less than 6 months are reversed (70 percent for males and 66 percent for females)

Although some patients remain in residence for great lengths of time, others never become inpatients There are 36 MHPD patients who, at least for their first time on the rolls, went immediately to outpatient status without ever spending a night in the hospital Some of these patients had inhospital stays on later dates, either because they came in subsequently during that first enrollment period, or after a discharge and readmission But there are those who have been admitted as outpatients, were discharged from outpatient status, and still remain off the hospital rolls

Fifteen males and 18 females were in residence at the MHPD on June, 30, 1975 At that time two patients of each sex had been in residence continuously for 5 years or more One resident patient was admitted to Saint Elizabeths at the age of 28, long before the start of the MHPD She was transferred into the MHPD, but has been in residence continually since her admission in April 1943 In fact, her only time outside the hospital was 4 days temporary leave in 1968 The median age of males in residence (19 3) is in sharp contrast to the 32 5 years for females

There is a considerable difference, too, between the median age for the total resident patients (22 8) and that for total outpatient (31 0) at the end of fiscal year 1975 However, the difference in ages of male and female outpatients is not nearly so great (median 29 5 and 31 7 for males and females respectively), and there were only two males for every three females on outpatient status

MHPD patients have had 173 admissions, 23 of which were readmissions More than three out of four of those readmissions were males Since, as mentioned previously, females remain on the rolls about a year longer than males, one is led to wonder whether or not males might benefit from more time on the rolls

There has been a total of 90 discharges from the MHPD Although there have been two more females than males in the program, about 61 percent of all discharges were males The condition on discharge for 68 6 percent of the 35 female discharges was either recovered or improved, but only 54 5 percent of the 55 male discharges were judged to have done so well Again, questions are raised Are more males discharged as unimproved because they are less tolerant than females of the program and consequently more apt to leave against medical advice? Are more males discharged as unimproved because they have received maximum benefit from the program despite their unimproved condition? Perhaps neither of these is true and there is some other explanation for this phenomenon

The single most used treatment program is psychodrama One hundred eighteen of the total MHPD patients have had psychodrama at some time Recreational therapy, excluding art therapy, runs a close second with 117 patients having been involved The least used treatments by far are family therapy (16 patients) and behavior modification (8 patients) The geographic distance between many of the patients and their families may be the reason that family therapy is not used more extensively

The age at which 17 patients in the program became deaf is unknown Of the remaining 133, almost 59 percent were born deaf and more than 23 percent were deaf before the age of three Thus, about 82 percent of the patients who have been in the MHPD had the disadvantage of being not only deaf, but of being prelingually deaf as well

The great majority of the patients have no family history of deafness Here family is defined as including mother, father, and siblings only There are 42 patients for whom family history of deafness is unknown, but of the other 108, over 83 percent have no history Twelve patients have at least one deaf sibling, and three had mothers and fathers who both were deaf It probably is coincidental that more females than males had no history of deafness in the family

None of the patients less than 25 years old on first admission was married at that time Of the total patients, 30 had been married, but 12 were either separated or divorced and two were widowed Exactly four times as many females as males had been married, and not surprisingly, both those who were widowed were females

The highest level of education completed at the time of first admission is unknown for 20 patients of the program The record for the remaining 130 is impressive More than 50 percent of them had completed 12 grades of more Females were somewhat better educated than males This is illustrated by the fact that the median number of grades completed is more than one and one-half grades higher for them (11 8) than for males (10 2) In fact, almost 58 percent of the females had completed 12 grades or more compared to just over 42 percent for males

Tables 1-15 summarize these data on patients in the MHPD

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Table 1. Patients in the MHPD Fiscal Years 1964-1975 by Area of Residence, Age, and Sex

Age (years)	Total no. of patients	Area of residence					
		D.C.	North East	North Central	South	West	Unknown
All patients	*150*	*32*	*22*	*23*	*67*	*4*	*2*
Less than 13	3	1		-	2	-	
13-17	26	4	7	3	12	—	
18-44	108	21	15	20	48	3	1
45-64	13	6	—		5	1	1
65 & over			--	-		-	
Male	*74*	*17*	*9*	*10*	*34*	*2*	*2*
Less than 13	3	1			2		
13-17	17	3	3	2	9	-	-
18-44	48	10	6	8	21	2	1
45-64	6	3			2		1
65 & over	-				--		-
Female	*76*	*15*	*13*	*13*	*33*	*2*	-
Less than 13					-		
13-17	9	1	4	1	3	--	
18-44	60	11	9	12	27	1	
45-64	7	3	–		3	1	–
65 & over					-		

: Patient characteristics are those at time of first admission.

Table 2 Patients in the MHPD, Fiscal Years 1964-1975 by Period of First Admission and State of Residence

State of Residence*	Total patients		Period of first admission			
			Prior to F.Y. 1971		F.Y. 1971 thru F.Y. 1975	
	Number	Percent	Number	Percent	Number	Percent
All patients	*150*	*100.0*	*37*	*100.0*	*113*	*100.0*
D.C.	*32*	*21.3*	*20*	*54.1*	*12*	*10.6*
North East	*22*	*14.7*	*2*	*5.4*	*20*	*17.7*
Connecticut	1	0.7			1	0.9
Massachusetts	4	2.7			4	3.5
New Jersey	2	1.3			2	1.8
New York	4	2.7		-	4	3.5
Pennsylvania	11	7.3	2	5.4	9	8.0
North Central	*23*	*15.3*	*1*	*2.7*	*22*	*19.5*
Illinois	1	0.7			1	0.9
Indiana	3	2.0	-		3	2.7
Iowa	3	2.0			3	2.7
Kansas	1	0.7			1	0.9
Michigan	2	1.3	1	2.7	1	0.9
Nebraska	4	2.7	-		4	3.5
Ohio	8	5.2			8	7.0
Wisconsin	1	0.7			1	0.9
South	*67*	*44.7*	*12*	*32.4*	*55*	*48.7*
Delaware	1	0.7			1	0.9
Florida	2	1.3	1	2.7	1	0.9
Kentucky	1	0.7			1	0.9
Maryland	29	19.3	6	16.2	23	20.3
North Carolina	4	2.7			4	3.5
South Carolina	1	0.7			1	0.9
Tennessee	3	2.0	1	2.7	2	1.8
Texas	1	0.7			1	0.9
Virginia	22	14.6	4	10.8	18	15.9
West Virginia	3	2.0			3	2.7
West	*4*	*2.7*	-	-	*4*	*3.5*
California	1	0.7			1	0.9
Utah	1	0.7			1	0.9
Washington	2	1.3			2	1.8
Unknown	*2*	*1.3*	*2*	*5.4*	-	-

*At time of first admission.

Table 3. Patients in the MHPD, Fiscal Years 1964-1975 by Age, Diagnosis, and Sex

Most urgent diagnosis*	Total no. of patients	Age (years)				
		Under 13	13-17	18-44	45-64	65 & over
All patients	*150*	*3*	*26*	*108*	*13*	–
Psychosis	44	–	4	31	9	
Asso. with brain synd.	–	–	–			
Not asso. with brain synd	44†		4	31	9	
Neurosis	25		2	21	2	–
Personality disorder	9	–	–	8	1	–
Sex deviation	1	–		1		–
Transient situation disturbance	52	1	16	34	1	–
Behavioral dis. of childhood & adol.	2	1	1	–		
Mental retardation	2	–	1	1	–	–
All others	15	1	2	12		
Male	*74*	*3*	*17*	*48*	6	–
Psychosis	22		3	15	4	
Asso. with brain synd.				–		–
Not asso. with brain synd.	22		3	15	4	–
Neurosis	9	–	2	7		
Personality disorder	7			6	1	
Sex deviation	1	–	–	1		

(Continued on page 96)

Table 3. Patients in the MHPD, Fiscal Years 1964-1975 by Age, Diagnosis, and Sex–Continued

Most urgent diagnosis*	Total no. of patients	Age (years)				
		Under 13	13-17	18-44	45-64	65 & over
Transient situation disturbance	23	1	10	11	1	–
Behavioral dis. of childhood & adol.	1	1	–		–	–
Mental retardation	1		1	-		-
All others	10	1	1	8		
Female	*76*	–	*9*	*60*	*7*	–
Psychosis	22	-	1	16	5	–
Asso. with brain synd.	–		-			-
Not asso. with brain synd.	22	–	1	16	5	-
Neurosis	16	-	–	14	2	–
Personality disorder	2			2		-
Sex deviation	-					–
Transient situation disturbance	29	–	6	23		-
Behavioral dis. of childhood & adol.	1		1			–
Mental retardation	1			1	–	-
All others	5		1	4		

*Patient characteristics are those at time of first admission, diagnosis is the most urgent at that time

†Includes 40 schizophrenics, 10 of whom are paranoid type.

Table 4. Patients in the MHPD, Fiscal Years 1964-1975 by Use and Type of Treatment Program

Treatment program	Total patients		In at sometime		Never in		Unknown	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Individual therapy	150	100.0	86	57.3	61	40.7	3	2.0
Group therapy	150	100.0	56	37.3	91	60.7	3	2.0
Individual psychotherapy	150	100.0	80	53.3	67	44.7	3	2.0
Group psychotherapy	150	100.0	98	65.3	49	32.7	3	2.0
Family therapy	105	100.0	16	10.7	131	37.3	3	2.0
Aural rehabilitation	150	100.0	73	48.7	76	50.7	1	0.6
Educational therapy	150	100.0	64	42.7	84	56.0	2	1.3
Industrial therapy	150	100.0	49	32.7	99	66.0	2	1.3
Occupational therapy	150	100.0	91	60.7	56	37.3	3	2.0
Vocational rehabilitation	150	100.0	65	43.3	82	54.7	3	2.0
Psychodrama	150	100.0	118	78.7	29	19.3	3	2.0
Dance therapy	150	100.0	85	56.7	62	11.3	3	2.0
Art therapy	150	100.0	110	73.3	37	24.7	3	2.0
Other recreational therapy	150	100.0	117	78.0	30	20.0	3	2.0
Behavior modification	150	100.0	8	5.3	140	93.4	2	1.3
Medication	150	100.0	100	66.7	47	31.3	3	2.0
Other psychological therapy	150	100.0	80	53.4	68	45.3	2	1.3

Table 5. Patients in the MHPD Fiscal Years 1964-1975 by Age at Onset of Deafness, Family History, and Sex

		Patient age at onset of deafness						
Family history of deafness	Total no. of patients	Birth	Under 3 yr	3-5 yr.	6-11 yr.	12-18 yr.	19 yr. & over	Unknown
All patients	*150*	*78*	*31*	*14*	*5*	*3*	*2*	*17*
None	90	47	24	9	4	1	2	3
Mother	1	1						
Father	2	2						
Siblings	12	10				1		1
Mother & father	3	2						1
Mother & siblings								
Father & siblings								
Mother, father, & siblings								
Unknown	42	16	7	5	1	1		12
Male	*74*	*36*	*13*	*7*	*4*	*1*	*1*	*12*
None	37	17	11	3	3		1	2
Mother	1	1						
Father	2	2						

Siblings	7	6						1
Mother & father	2	1						1
Mother & siblings								
Father & siblings								
Mother, father, & siblings								
Unknown	25	9	2	4	1	1		8
Female	*76*	*42*	*18*	*7*	*1*	*2*	*1*	
None	53	30	13	6	1	1	1	1
Mother								
Father								
Siblings	5	4				1		
Mother & father	1	1						
Mother & siblings								
Father & siblings								
Mother, father & siblings								
Unknown	17	7	5	1				4

Table 6. Patients in the MHPD, Fiscal Years 1964-1975 by Marital Status, Family History, and Sex

Family history of deafness	Total no. of patients	Marital status				
		Single	Married	Separated/ Divorced	Widowed	Unknown
All patients	*150*	*116*	*16*	*12*	*2*	*4*
None	90	69	11	9	1	-
Mother	1	1				
Father	2	2				
Siblings	12	10	1			1
Mother & father	3	2	1			
Mother & siblings						
Father & siblings						
Mother, father, & siblings						-
Unknown	42	32	3	3	1	3
Male	*74*	*66*	*4*	*2*	–	*2*
None	37	32	3	2		
Mother	1	1				
Father	2	2				
Siblings	7	7				

Mother & father	2	2				–
Mother & siblings	–					
Father & siblings		–				–
Mother, father, & siblings				–	–	–
Unknown	25	22	1			2
Female	*76*	*50*	*12*	*10*	*2*	*2*
None	53	37	8	7	1	–
Mother						
Father					–	–
Siblings	5	3	1			1
Mother & father	1	–	1			
Mother & siblings						
Father & siblings	–	–				–
Mother, father, & siblings						
Unknown	17	10	2	3	1	1

Note Patient characteristics are those at time of first admission.

Table 7. Patients in the MHPD, Fiscal Years 1964-1975 by Marital Status, Age, and Sex

Age (years)	Total no. of patients	Marital status				
		Single	Married	Separated/ Divorced	Widowed	Unknown
All patients	*150*	*116*	*16*	*12*	*2*	*4*
Less than 18	29	29				
18-20	25	24				1
21-24	26	26				
25-34	35	22	5	6		2
35-44	22	9	7	4	1	1
45 & over	13	6	4	2	1	

Male	*74*	*66*	*4*	*2*	*–*	*2*
Less than 18	20	20	–			
18-20	15	15				
21-24	13	13	-		-	-
25-34	17	12	1	2		2
35-44	3	2	1			-
45 & over	6	4	2			
Female	*76*	*50*	*12*	*10*	*2*	*2*
Less than 18	9	9				
18-20	10	9				1
21-24	13	13				
25-34	18	10	4	4		
35-44	19	7	6	4	1	1
45 & over	7	2	2	2	1	

Note Patient characteristics are those at time of first admission

Table 8. Patients in the MHPD, Fiscal Years 1964-1975 by Education, Age, and Sex

Age (years)	Total no. of patients	Highest level of education: None Ungraded	Under 6th grade	Grades 6-8	Grade 9	Grades 10-11	Grade 12	Over grade 12	Unknown
All patients	*150*	*4*	*11*	*16*	*16*	*17*	*27*	*39*	*20*
Less than 13	3	1	2						
13-17	26	2	2	8	1	3	1		9
18-44	108		6	6	11	13	23	38	11
45-64	13	1	1	2	4	1	3	1	-
65 & over									-
Male	*74*	*3*	*9*	*7*	*8*	*7*	*8*	*17*	*15*
Less than 13	3	1	2						
13-17	17	1	1	6	1	1			7
18-44	48		6	1	4	5	8	16	8
45-64	6	1			3	1		1	
65 & over									
Female	*76*	*1*	*2*	*9*	*8*	*10*	*19*	*22*	*5*
Less than 13									
13-17	9	1	1	2		2	1		2
18-44	60			5	7	8	15	22	3
45-64	7		1	2	1		3		

Note: Patient characteristics are those at time of first admission.

Table 9. MHPD Patients on the Rolls June 30, 1975, by Sex and Time Since Last Admission

Time since last admission	All patients	Male	Female
All patients	*78*	*33*	*45*
Less than 6 months	18	10	8
6-11 months	3	2	1
1 year	16	7	9
2 years	8	2	6
3 years	12	4	8
4 years	6	1	5
5-9 years	9	5	4
10-14 years	1	--	1
15-19 years	1	1	-
20-24 years	1		1
25 years and over	3	1	2
Median years	*2.2*	*1.7*	*2.7*

Table 10. MHPD Patients in Residence June 30, 1975, by Age, Time in Residence, and Sex

Length of time in residence	Total no. of patients	Age (years) Under 18	18-24	25-44	45-64	65 & over
All patients	*33*	*9*	*10*	*7*	*6*	*1*
Under 6 months	18	5	8	3	2	—
6-11 months	3	1	—	—	2	-
1 year	5	2	-	3		
2 years	—	-		-		
3 years	2	1	1	-	-	
4 years	1			1	-	
5 years & over	1		1		2	1
Male	*15*	*6*	*6*	*2*	*1*	—
Under 6 months	9	3	5	1		—
6-11 months	1	1	-			

1 year	3	2		1	—	
2 years	—		—			
3 years			—			
4 years				—		—
5 years & over	2		1		1	—
Female	*18*	*3*	*4*	*5*	*5*	*1*
Under 6 months	9	2	3	2	2	
6-11 months	2				2	—
1 year	2			2		
2 years						
3 years	2	1	1	—		
4 years	1			1		—
5 years & over	2				1	1

Note Length of time is for the current residential stay only.

Table 11. MFPD Patients on Outpatient Status June 30, 1975, by Age, Time in Outpatient Status, and Sex

Length of time in outpatient status	Total no. of patients	Age (years)				
		Under 18	18-24	25-44	45-64	65 & over
All patients	*45*	*3*	*11*	*26*	*5*	–
Under 6 months	9		4	5		
6-11 months	6		3	3		
1 year	15	2	3	9	1	
2 years	9	1	1	7		–
3 years	4			1	3	
4 years	2			1	1	
5 years & over						–
Male	*18*	*3*	*4*	*8*	*3*	–
Under 6 months	3		2	1		
6-11 months	2		1	1		

1 year	4	2	-	1	1	-
2 years	5	1	1	3	-	—
3 years	2		—	1	1	—
4 years	2			1	1	—
5 years & over						—
Female	*27*	--	*7*	*18*	*2*	—
Under 6 months	6		2	4	-	--
6-11 months	4	-	2	2	-	
1 year	11		3	8		
2 years	4			4		
3 years	2				2	
4 years		-				-
5 years & over						

Note Length of time is for the current outpatient stay only

Table 12. MHPD Admissions by Fiscal Year Periods, Age, and Sex

Age* (years)	Total no. of patients	Fiscal Year Period of admission: Prior to 1964	1964 thru 1970	1971	1972	1973	1974	1975
All patients	*173*	*10*	*36*	*17*	*26*	*29*	*27*	*28*
Less than 13	3	1			1			1
13-17	27	1	2	1	6	5	7	5
18-44	123	5	24	12	18	24	19	21
45-64	20	3	10	4	1		1	1
65 & over								
Male	*92*	*7*	*22*	*7*	*13*	*15*	*12*	*16*
Less than 13	3	1			1			1
13-17	18	1	2	1	2	4	5	3
18-44	59	3	12	5	10	11	6	12
45-64	12	2	8	1	-		1	
65 & over								
Female	*81*	*3*	*14*	*10*	*13*	*14*	*15*	*12*
Less than 13								
13-17	9				1	1	2	2
18-44	64	2	12	7	8	13	13	9
45-64	8	1	2	3	1			1
65 & over								

t time of admission

Table 13. MHPD Discontinuations, Fiscal Years 1964-1975 by Age, Length of Stay, and Sex

Length of stay	Total no. of patients	Age at time of discontinuation: Under 13	13-17	18-44	45-64	65 & over
All patients	*115*	*2*	*15*	*87*	*11*	
Less than 3 months	89	1	11	69	8	
3 to 6 months	13		3	9	1	
6 months to 1 year	[illegible]		1	5	1	
1 to 2 years	1			1		
2 to 3 years						
3 to 4 years	1			1		
4 to 5 years	1			1		
5 years & over	3	1		1	1	
Male	[illegible]	*2*	*10*	*39*	*6*	
Less than 3 months	43	1	8	30	4	
3 to 6 months	9		2	6	1	

(Continued on next page)

Table 13. MHPD Discontinuations, Fiscal Years 1964-1975 by Age, Length of Stay, and Sex–Continued

Length of stay	Total no. of patients	Age at time of discontinuation				
		Under 13	13-17	18-41	45-64	65 & over
6 months to 1 year	1	-	-	1	–	–
1 to 2 years	–	–	–	–	–	–
2 to 3 years		–	-	–		–
3 to 4 years	1	–	–	1	–	-
4 to 5 years		–	–	–	-	–
5 years & over	3	1	–	1	1	–
Female	*58*	–	*5*	*48*	*5*	–
Less than 3 months	46		3	39	4	–
3 to 6 months	4	-	1	3	–	-
6 months to 1 year	6	–	1	4	1	–
1 to 2 years	1	-		1		–
2 to 3 years	-		-	-		-
3 to 4 years				–		
4 to 5 years	1	-	–	1	-	–
5 years & over	-	-	-		-	-

Note A discontinuation is a convalescent leave placement or a discharge from residence.

Table 14. MHPD Separations, Fiscal Years 1964-1975 by Type, Age, and Sex

Age* (years)	Total	Type of separation					
		Discharge			Death		
		All	From residence	From outpt. status	All	In residence	On outpt. status
All patients	*94*	*90*	*54*	*36*	*4*	*3*	*1*
Less than 13							
13-17	8	8	5	3			
18-44	71	68	42	26	3	2	1
45-64	14	14	7	7			
65 & over	1				1	1	
Male	*58*	*55*	*37*	*18*	*3*	*3*	
Less than 13							
13-17	5	5	2	3			
18-44	43	41	28	13	2	2	
45-64	9	9	7	2			
65 & over	1				1	1	
Female	*36*	*35*	*17*	*18*	*1*		*1*
Less than 13							
13-17	3	3	3				
18-44	28	27	14	13	1		1
45-64	5	5		5			
65 & over							

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* At time of separation

Table 15. MHPD Discharges, Fiscal Years 1964-1975 by Condition, Period, and Sex

Fiscal year period	Total no. of patients	Condition on discharge				
		Recovered*	Improved	Unimproved	No mental disorder	Unknown
All patients	*90*	*16*	*38*	*30*		*6*
1964-1966: Phase 1	2	2	1	-		
1967-1970 Phase 2	18	2	11	3		2
1971-1975. Phase 3	70	12	27	27		4
Male	55	*9*	*21*	*20*		5
1964-1966. Phase 1	2	2				
1967-1970 Phase 2	14	2	8	3		1
1971-1975 Phase 3	39	5	13	17		4
Female	*35*	*7*	*17*	*10*	–	*1*
1964-1966: Phase 1	1		1			
1967-1970. Phase 2	4		3			1
1971-1975 Phase 3	30	7	13	10		

ludes 1 socially recovered male in phase 3.

CHAPTER 4

Training and Research in Mental Health and Deafness

TRAINING PROGRAMS IN THE MHPD: 1963-1975

Those in the mental health field who plan to work in programs of prevention and treatment of mental health problems of deaf people should consider availing themselves of ample training. Not only should the prospective worker acquire appropriate communication skills, but he or she should also acquire knowledge of the lifestyle of deaf people and the psychosocial implications of deafness. In addition, he should obtain practical experience in dealing with mental health problems of deaf people under appropriate supervision. Of course appropriate indoctrination in the behavioral sciences is a prerequisite for any trainee embarking on training in the mental health aspects of deafness.

Training is an intrinsic part of the delivery of services in the mental health field. Accordingly one of the mandates of Saint Elizabeths Hospital is to provide training at the preservice and the inservice levels. The MHPD reflects the hospital's training role in preparing men and women to ~~work~~ with the mental health problems of deaf people. In order to describe the kinds of training provided by the MHPD, it is convenient to refer to five major categories of trainees, namely staff members of the hospital who decide to join the MHPD on a part- or full-time basis, hospital trainees who are participating in internships or residencies in specific disciplines such as psychodrama or psychiatry and who wish to learn to adapt their disciplines to the needs of deaf patients, college students who wish to satisfy the curriculum requirements of their respective institutions of higher learning through practicums, staffs of mental health facilities, State agencies, and schools who study and observe the MHPD as preparation for the establishment of similar programs at their respective home bases, or who wish to learn techniques of preventing mental illness in youths, and volunteers from the community who donate time in order to become actively involved in providing services to deaf individuals. The wide spectrum of training programs offered by the MHPD is de signed to promote growth in the field of mental health and deafness by attracting competent persons both deaf and hearing of diverse backgrounds and talents

Training the Staff at Saint Elizabeths

Since early 1964, special training facilities in sign language and fingerspelling have been provided for interested staff at Saint Elizabeths Hospital This training is available to staff at all levels, such as psychiatrists, social workers, nursing assistants, and personnel of other categories In some instances, training in cooperation with Gallaudet College is arranged Staff members take advantage of orientation lectures and/or course offerings at the college in order to acquaint themselves as fully as possible with the world of deaf people By the end of 1975, approximately 400 staff members had enrolled in training in manual communication at Saint Elizabeths

On-the-job training is sometimes concomitant with classes in sign language and fingerspelling, though it is more usual for a staff member to achieve at least a minimal level of competence before beginning work with deaf patients As chapter 3 demonstrated, there are special problems which attend the adaptation of regular treatment modalities to deaf individuals, on-the-job training allows workers to deal with these problems directly, and to learn therapeutic techniques already proven to be effective Some of the hospital staff members who volunteered early for the training program now work full time in the MHPD, other staff members contribute a certain number of hours each week to therapeutic work with deaf patients

Beyond this, staff members of MHPD may participate in a variety of inservice training programs of the hospital in accordance with their qualifications and needs

Training Interns and Psychiatric Residents

Some stipended trainees at Saint Elizabeths in disciplines as varied as psychiatry, clinical psychology, chaplaincy, psychodrama, dance therapy, recreational therapy, and occupational therapy have worked in the MHPD as a part of their training program Nonstipended trainees who worked in MHPD include students in social work, nursing, rehabilitation counseling, and other categories All of those in formal training at Saint Elizabeths must satisfy the training requirements of their respective disciplines For those who wish to learn to work with deaf patients while satisfying these requirements, the hospital s training division and the MHPD have been able to arrange jointly the trainees' schedules to allow a portion of the training period to be spent in MHPD In other words, training can be tailored to meet the needs of the trainee All such trainees are under the main supervision of staff of their primary disciplines in collaboration with the staff of the MHPD

The following is an account of a psychiatric resident's evaluation of a 1 year training experience in the conduct of psychotherapy with deaf patients

During the time in which I worked with the Deaf Patients here at Saint Elizabeths Hospital, I made the following general observations

(1) There was frequent usage of the lack of expertise on the part of the therapist as a weapon to ventilate hostility This was manifested by a tendency at times to fingerspell extremely rapidly or by refusal to use the voice as an adjunct during moments of overt anger In most instances, an acknowledgment of the obstacle to communication because of this factor resulted in an intensification of resistance Thus, it was learned eventually that this problem was best overcome by tacit approval of the patient's privilege to communicate in whatever manner he deemed appropriate during moments of stress

(2) There was greater difficulty in establishing rapport with male patients than with female patients The difference was even more striking when deaf males were compared with normal males Seemingly, not only did they view a female in the position of an authority figure as a threat, but the added attribute of her hearing ability tended to accentuate this threat This resulted in numerous discussions concerning marriage in which the deaf men usually voiced their preference for deaf women as potential mates Encouraging them to view the male-female relationship as being one in which the individuals support or complement each other rather than compete with each other was useful in alleviating to some degree the negative feelings in this area However, it was detrimental to the therapeutic process to mention the reality of the advantages to the team when at least one of the members is able to hear

(3) Fellow patients of lesser abilities, especially in the usage of fingerspelling and/or sign language, were often treated in a condescending manner This resulted at times in attempts by the more intelligent and versatile individuals to engage in discussions which excluded other group members It was then up to the therapist to bring the other members into the discussion This was done not by confronting those who attempted to exclude the others, but rather by asking those excluded to express their opinions or ideas about the subject matter which was being discussed

(4) I noticed in general a feeling of hopelessness which was more prevalent than that which I've observed in hearing patients with comparable illnesses It appeared that because the individuals had a tendency to view their emotional illness as being primarily related to deafness and the resulting obstacles in communicating,

their illness was deemed incurable Subsequently, there was far less of the usual enthusiasm to leave the hospital It was then helpful to point out the fact that one is not hospitalized here because of deafness but because of emotional problems It was then useful to encourage them to talk about their lives prior to their coming to the hospital in an attempt to have them evaluate their lives when only deafness was an important issue with them as opposed to the added problem of superimposed mental illness

(5) Because of the tendency to view deafness and its sequelae as the primary problem, the "hearing world" was viewed as a hostile enemy which meant that the patients often expressed the feeling that most of their misfortunes, including hospitalization, were the result of their handicap rather than their emotional illness Again, when appropriate, it was useful to have the patient talk about his experiences in life prior to the onset of overt emotional conflicts and subsequent hospitalization This served as a further reminder of the fact that deafness was compatible with a kind of life much different from that experienced in the hospital

(6) Understandably, the ready-made defense of deafness presents a major obstacle in attempting to encourage the patients to talk about their emotional conflicts which may or may not be related to their inability to hear Here also, by confronting them with the reality of the many deaf individuals who lead emotionally healthy and productive lives, they were gradually left to search for other reasons as being responsible for their illness and subsequent hospitalization

All trainees in the MHPD receive training ranging from classes in sign language and fingerspelling to experience in their specialities with deaf patients In order for a training program to warrant a stipend paid by the hospital, it must meet certain specific standards of the particular discipline and must be accredited or recognized by an appropriate organization However, nonstipended programs do not imply that the training is of a substandard nature Indeed, many of these programs are approved for the particular trainee by his college or university

The hospital is currently taking steps to develop stipended training programs in mental health in deafness as a separate discipline As more is learned about methods of effective treatment in this emerging field, additional programs can be developed and existing ones expanded It is essential that as many interested persons as possible are aware of the exciting career possibilities in working with deaf patients and of the great amount of work and research which are being done and remain to be done Developing and maintaining standards in training which would warrant stipends is one way of encouraging growth and of guaranteeing quality training for future leaders in the field

Practicums for College Students

The MHPD provides a variety of learning practicums for students both deaf and hearing, although most students come from Gallaudet College others come from metropolitan universities and institutions of higher learning in distant areas of the Nation The MHPD tries to accommodate any student whose curriculum requirements may be partially satisfied by a supervised learning experience at the hospital To give examples it provides practicums for students majoring in art, rehabilitation counseling, social work and seminary studies and provides special internships

A postmasters degree student served an 8-week internship in mental health aspects of deafness and recorded the following evaluation while the MHPD was preparing to enter its third phase of development with a separate full-time staff complement and a physical facility

1 Orientation to the following services
Speech and Hearing Clinic, Social Service, Vocational Rehabilitation Occupational Therapy, Sheltered Workshop—Rehabilitation Coordinator, Research Psychologist, Physical Therapy

2 Participation in the following unit programs
Physical Therapy Creative Drama, Psychodrama, Dance Therapy, Home Visit with the Program Assistant, Clinical Conferences, Group Psychotherapy, Sign Language Class, Religious Services, Sight-seeing Tour of Washington, D C , with deaf patient

3 Other
Gallaudet College – tour, Annual Medical Society Meeting of Saint Elizabeths Hospital, Regional Follow-up Meeting of Los Cruces, Convention—Area III Social and Rehabilitation Services Offices, Project Life Annual Conference, Council of Organizations Serving the Deaf

4 Comments
Any doubts that one might have regarding the efficacy of using sign language as the most important means of communicating with deaf patients certainly would be dispelled by an exposure to the Mental Health Program for the Deaf at Saint Elizabeths Hospital The comparison between deaf patients here and those unlucky enough to find themselves in a usual state hospital is dramatic testimony that without communication, there can be no treatment

The unique problems of deafness arise within that segment of the population who have never heard at all For those of us who have depended on our ears unconsciously for all of our lives, the possible amount of deprivation in language concept, principles and vocabulary patterns of a prelingually deaf person is not an easy concept to fully understand Even at Saint Elizabeths Hospital, there are some interested and sympathetic professionals who are not aware of the

> real lack of language present in much of the deaf population Therefore, there is a need for more orientation and training for staff of the hospital who are either marginally involved or outside the program I understand the Program Coordinator is planning to do this It is not enough to envision a treatment program confined only to the hospital if the goal for the patient is a return to the community Effective specialized evaluation and placement programs must be utilized or instituted outside the hospital S R S funds are available to qualified interested workshops Halfway houses and foster homes along with adequate professional supervision and followup must be secured so that the patient, upon moving out into the community, does not find himself in an alien, unfriendly environment
>
> Somehow the deaf community, itself, must be made more aware of the facilities at Saint Elizabeths Hospital so that they lose their fear of mental illness and do not wait until the situation with a mentally ill friend or relative becomes so intolerable that they turn to hospitalization as a last alternative Preventive psychiatry is as important to the deaf community as it is to the hearing community
>
> The liaison between Gallaudet College and Saint Elizabeths Hospital is excellent Not only does it provide an exposure for the students to the problems of the mentally ill, but also it may serve to direct more bright young individuals into the public health fields
>
> I am most appreciative of the opportunity to spend 8 weeks at Saint Elizabeths It has been an excellent learning experience, and the staff of the program has been most cordial and helpful I am only sorry that I can't be around for the physical opening of the unit This should offer a 24-hour treatment plan and cohesiveness impossible under the present arrangement

One of the major thrusts of the training programs is to promote interest in the problems of the deaf mentally ill among deaf youths, practicums are an effective means of doing this

A special project initiated in 1970 that has proven highly successful is the training program in social work for undergraduate deaf students of Gallaudet College The practicum experience was carefully planned in advance The sociology and psychology departments at Gallaudet and the staff of the MHPD worked jointly to determine such matters as selection criteria for students (generally, students are on the junior-senior level and have completed introductory courses in the behavioral sciences), arrangements for student accommodations, such as transportation to the hospital, office space, time schedules, a rating system for student performance, and a system through which school and hospital can remain in continuous contact during the field training of students (Hester 1972, Polakoff 1972) From the outset, it was decided that carefully planned, coordinated efforts between

Gallaudet and Saint Elizabeths would provide the best means both of structuring activities and of measuring results

Hester, in the article cited above, describes both the general and the specific educational goals which the program sets for its students

> The general education goals are 1) to broaden the student's liberal education, 2) to prepare the student to enter graduate and professional training, 3) to recruit new personnel into paraprofessional and professional employment, and 4) to provide useful services to patients while offering learning opportunities to the student
>
> The program seeks to assist the student in achieving the following objectives 1) greater knowledge and understanding of social and psychological problems of the mentally ill deaf and of the network of social welfare services in the hospital and community designed to reduce or eliminate such problems and meet human needs, 2) an awareness and understanding of such problems as deafness, social isolation, mental illness, family-breakdown, and the impact of these on individuals, families, and communities, 3) an integration of knowledge and theory derived from undergraduate, foundation courses with applicable field work experiences, 4) development of knowledge and a beginning application of some skills and techniques of social work practice such as interviewing, observation, fact-finding, analysis, and reporting, 5) some self-awareness and a sense of one's own value orientation, and 6) the ability to individualize the client according to his unique problems and needs (p 70)

The program for these social work students at Saint Elizabeths has remained essentially the same since its establishment, the following description of the schedule for the fall semester 1973 is representative of program activities At that time, four seniors visited Saint Elizabeths for their practicums on Tuesday and Thursday afternoons, the students spent 8 hours a week at the hospital for a total of 16 weeks

During orientation, the trainees were apprised of the expectations of the program, and introduced to hospital procedures and policies The issue of confidentiality was discussed, as were sick leave policies, and use of special keys, mailboxes, etc A tour of the hospital grounds followed a lecture on the hospital's administrative structure, the students were introduced to hospital staff during the tour

As soon as the group was oriented, each student was assigned two or more patients for whom he or she was to provide social work services, such as case history study, interviews, evaluation of needs and assessment of treatment programs In 1973, two social workers acted as supervisors for the group, they met weekly with the students on a formal basis and were also available to help out individual students with daily problems Students submitted written reports to the social workers together with evaluations and impressions, the supervisors provided guidance and corrections where necessary

Students also attended ward meetings, where they found opportunities to observe patients in interaction with other patients and staff Exposure to the milieu and operating procedures of the ward was useful in another respect that is it helped the trainees to learn the duties and functions of ward personnel such as doctor nurse, nursing assistant social worker therapist etc Perhaps most importantly, students could experience directly the ways in which various disciplines coordinated efforts in a group process

During the course of the semester efforts were made to introduce the students to as many of the treatment methods offered by the MHPD as possible Thus they attended sessions in such therapies as psychodrama and recreational therapy It is interesting to note in connection with psychodrama that it had been used (though not in 1973) as a part of student orientation to the socialwork program the objective was to rel[illegible]he students and to help with their initial understanding of the [illegible] relationships they would soon be forming with staff and patients

> Before the students went to the wards typical ward situations were set up and the students acted the roles of doctor, nursing assistant nurse and other staff They were also able to explore how a new person entering the ward might be seen and to try ways of relating to staff A second session explored a more viable role in relating to patients than friend" The professional aspects of the social worker role were brought into focus and discussed The process also gave the students a chance to try out interviewing skills These simulated experiences lessened the anxiety of students by structuring the situation they would find themselves in examining their role in it and providing some role training (Clayton and Robinson 1971 p 419)

Although attendance at therapeutic sessions is instructive there is much to be said for this kind of active participation in the treatment method as a learning experience

In the period from 1970 to 1975 40 students from Gallaudet College successfully completed the social work practicum at Saint Elizabeths Although we do not have information on the present status of all graduates it is known that at least four have gone on to do graduate work in the field one is currently employed in the MHPD, and at least five are employed in medical and social agencies serving the deaf The great need for more social workers in the field of mental health and deafness, and the particular advantages of training deaf individuals to help fill this need, were discussed in an earlier chapter it is hoped that the social work program jointly planned by Gallaudet College and the MHPD will continue to provide career opportunities for deaf youths

Training the Staffs of Mental Health Facilities, State Agencies, and Schools

Consultation services have been a feature of the MHPD since its inception The staffs of other mental health facilities often visit Saint Elizabeths in order to observe first-hand the structure and operating procedures of the MHPD, when requested, the MHPD staff provide instruction on how to begin similar programs elsewhere In some instances MHPD instructors visit mental health facilities in which programs are in the early stages of development to give consultations, through these services the MHPD has been instrumental in supporting the efforts to establish programs in such States as Pennsylvania, West Virginia Ohio Wisconsin and others

Nurses social workers rehabilitation workers, and other therapists also visit the MHPD whether they come individually, or as representatives of their agencies they are indoctrinated in mental health and deafness according to their needs and future plans In 1970-71, three short term training institutes were offered for rehabilitation counselors and other interested professionals The MHPD planned these 2-week institutes in cooperation with the Maryland State Department of Rehabilitation counselors at the department were able to attend the institutes as part of their inservice training Approximately 30 participants heard lectures on such subjects as the psychosocial aspects of deafness audiology and speech pathology, treatment modalities, and the role of the rehabilitation counselor in the field of mental health and deafness They were also given instruction in manual communication and taken on field trips to the Kendall Demonstration Elementary School the Model Secondary School for the Deaf, and Gallaudet College Participant response was most favorable (Goulder 1972)

Consulting staff from the MHPD often exchange visits with the faculty and staff of schools for the deaf, the objective of these collaborations is to help prevent the development of mental illness in children, and to diagnose and treat behavioral problems early (Dickens 1972) As was made clear in chapter 1, the faculty at deaf educational institutions have frequently been called upon to deal with behavioral problems in students which interfere with the teaching process It is not advisable to expect faculty to assume full responsibility for these problems, consultation with professionals in the field of mental health is a necessary support As the ties between the deaf educational establishments and mental health facilities such as the MHPD become stronger, collaborative programs of preventive action will do much to ensure the healthy psychological development of deaf children

Training Volunteers

Both deaf and hearing individuals frequently volunteer their services to the MHPD, orientation and training in mental health and deafness are given as needed. Hearing volunteers often attend classes in sign language and fingerspelling at Saint Elizabeths; most volunteers who are deaf, such as those from the Council of Churches of the Deaf or from Gallaudet College, are already fluent in manual communication. However, almost everyone is in need of some introduction to the problems of the deaf mentally ill, which is usually provided on an informal basis.

Volunteers perform a variety of functions. They visit with patients on the wards and accompany them on excursions; they arrange for parties and festivities (The Council of Churches of the Deaf has entertained deaf patients at Saint Elizabeths once a month for several years); they sometimes participate in certain therapeutic activities, and they act as sources of information about mental health and deafness in the community at large. From 1963-1975, approximately 50 volunteers of all ages were trained to work with deaf patients at Saint Elizabeths. In addition, several deaf adults volunteered to indoctrinate staff members in deafness, including the teaching of sign language.

NEW DIRECTIONS IN ACADEMIC TRAINING PROGRAMS

The comprehensive training programs described above provide opportunities for individuals of all ages, deaf and hearing, professional and nonprofessional, to take a part in helping the mentally ill deaf. However, in light of the great need for professional workers of different disciplines in mental health and deafness, it is necessary to develop continually innovative approaches to training in order to promote the entry of qualified personnel into this field. In recent years I have been intimately involved with proposals directed toward stimulating interest in young people, several of which will be reported here.

Proposed Curriculum in Mental Health and Deafness at Federal City College

Acting upon the request of community-minded people of Washington, D.C. for a mental health degree program at Federal City College, collaborative efforts were made in 1971 by the College, the D.C. Mental Health Administration, and the Federal mental health programs at Saint Elizabeths Hospital to establish such a program. As a result of these efforts, a basic mental health curriculum was formulated and endorsed by an appropriate committee. Subsequently, the administration of Saint Elizabeths appointed a second committee to develop a proposal in mental health and deafness which could be incorporated into the basic curriculum leading to an Associate of Arts degree. Committee members believed that the implementation of this program would significantly increase the number of mental health technicians and paraprofessional able to assist deaf patients and family groups and thus help alleviate the current shortage of workers Though the proposal was never implemented because of intervening priorities, it is still viable as a working model of a potential collaboration between an academic institution, the community, and a mental health facility, and is presented here for the consideration of interested parties

Three courses were proposed for the freshman year Mental Health and Illness in Deafness, to be taken the first quarter, Communication in Deafness I, for the second quarter, and Communication in Deafness II for the third quarter The introductory course acquainted students with environmental and developmental influences on deaf individuals, with current research on the manifestation of mental illness in deaf persons and with theories of prevention, treatment, and rehabilitation Students would be encouraged to explore their own attitudes toward the deaf mentally ill and the relationship of these attitudes to those of society Communication in Deafness I had both theoretical and practical objectives Students would study modes of communication, with emphasis on the transmission of thought through nonverbal means, such as body language, they would also be introduced to modern theories and methods of audiology The practical objective of this course was to prepare students for communication with deaf individuals through instruction in the fundamentals of sign language Communication in Deafness II was a seminar-practicum designed to further develop communication skills by providing students with opportunities to converse with normal deaf persons of various ages

There were two courses designed for the first and second quarters respectively of the sophomore year, each to be accompanied by a practicum In Orientation to and Causes of Deafness, students would acquire knowledge of the anatomy and physiology of the ear of the incidence and causes of deafness, both congenital and adventitious, and of ways of diagnosing and preventing the handicap They would also be introduced to some of the social aspects of deafness, which would be taken up in greater detail in the next course The accompanying practicum would concentrate on expanding the students contacts within the deaf community, and perfecting their sign language skills The last course Social and Cultural Aspects of Deafness, was designed to explore in depth the lifestyle within the deaf community, problems in deaf education and in vocational rehabilitation, the accomplishments of deaf individuals, and the psychological factors in the development of the deaf child In the practicum, students would work with the deaf mentally ill at Saint Elizabeths for the first time, both individually and in group situations During the third quarter of the sophomore year, students would continue field work with the deaf mentally ill along with projects in the deaf community, the last quarter would concentrate wholly on work with patients at Saint Elizabeths

When the planning of the original proposal was complete, 11 members of the staff at Saint Elizabeths volunteered to teach in the prospective program. the disciplines of psychiatry, clinical psychology, nursing, social work, and rehabilitation counseling were represented The allocation of faculty responsibilities in similar collaborations of this kind will, of course, vary according to the needs and resources of the academic institution

Currently Proposed Curriculum for Stipended Training in Mental Health and Deafness at Saint Elizabeths

Answering the increasing indications and demands for formal training in mental health and deafness, Saint Elizabeths Hospital proposes the establishment of a stipended training program to assist in the preparation of a local and national manpower pool which will enhance health delivery for a large and growing segment of American society who are tragically handicapped by the dual disabilities of mental illness and deafness The proposal is based on two principal considerations First, there is documented evidence of a need to provide training which meets the specialized treatment requirements of the mentally ill deaf, and second, Saint Elizabeths Hospital has the clinical resources training facilities, and educational expertise to launch a pioneer program of this type Hopefully, the Saint Elizabeths endeavor can serve as a model for other mental health training facilities which may wish to offer similar training opportunities

In proposing specialized training to work with the mentally ill deaf, the hospital's long-range goal is a three-track training program as follows

- Track 1 — Pre-baccalaureate or no formal education beyond the secondary level
- Track 2 — Graduate level students in the mental health core disciplines and other specialities 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 current proposal is limited to Track 3, the development of proposals for Tracks 1 and 2 is a part of the hospital's 5-year plan Track 3 is a proposed 12-month program operating in consonance with the fiscal year The proposal calls for introduction of this Track on October 1, 1978, with the first group of trainees scheduled to complete training on September 30, 1979

The training program in Mental Health and Deafness is designed for selected core mental-health professionals who have completed their professional training. The discipline of the trainee will be either psychiatry, psychology, social work, or nursing.

Preference for admission to the training program will be given to those who possess basic skills in manual communication. If an applicant otherwise meets admission requirements excepting basic skills in manual communication, and there are still vacant slots, he/she will be provided with a 2-week sign language program. Following the sign-language training, the applicant would then be evaluated for his/her potential for acquiring the skill and accepted or rejected at that point.

At completion of the training program the graduate will be able to provide direct psychiatric services to deaf clients, applying the tools of his/her disciplines. In addition, he/she will be able 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, administrative research, or program evaluation.

Each trainee will therefore be able to provide direct psychiatric clinical services to deaf clients and be able to assume one of the following roles: educator, researcher, consultant, administrator, or program evaluator.

The training program will have three concurrent components in which trainees will participate: (1) core didactic content relevant to understanding mental health and illness in deafness and psycho-socio-cultural-linguistical considerations in deafness, (2) supervised clinical experiences toward development of clinical competencies needed to relate to the specialized mental health needs and emotional problems of deaf clients, and (3) directed experiences toward development of competencies in a selected functional area.

The core content of the training program will cover the following topics:

I Orientation to Hearing and Deafness
  - Anatomy and physiology of the ear
  - Etiology of hearing impairment
  - Audiological assessment
  - Methods of treatment

II Communication in Deafness (basic class in manual communication)
  - Language development in those with communication disorders
  - Signed English and American Sign Language instruction

III Social and Cultural Aspects of Deafness
  - Characteristics of the deaf population (demographics)
  - Lifestyles in deafness
  - Manifestation of social deviancy in deafness

Attitudes toward deaf people (local, national, international)
The deaf community (schools, social life, vocational facilities (local and national)
Family dynamics in deafness
IV Psychology of Deafness
The psychological implications of the inability to hear (trauma of discovery, rejection, isolation, etc)
Dynamics of adjustment to deafness
Deafness and intellectual ability
Psycholinguistics and deafness
Implication and value of psychological tests for decision making—services and treatment
Psychological factors in the rehabilitation of deaf individuals
V Mental Health and Illness in Deafness
Mental health manifestations in deafness
Manifestations of mental illness in deafness
Diagnoses
Prevention
Treatment and rehabilitation of mental illness in deafness

The second component of the training program is the clinical practicum experiences which is really the major emphasis area. The needs, interest, educational background, and goals of the trainee will to an extent determine clinical practicum experiences

We would be interested in preparing students for a variety of changing roles and functions demanded by the legion of problems and needs presented by the deaf community Training will be offered in modal roles that should be functional in various work settings which find the deaf population in need of mental health services That is, having already acquired fundamental training as generalists in their respective disciplines, they must now acquire additional basic skills and knowledge that are needed in working with the deaf and in transcending specific problems associated with a particular type of deaf client

To that end the student will immerse him/herself in an intensive experience, for at least 16 hours a week, in a deaf milieu such as found in the Hospital's Mental Health Program for the Deaf This experience at MHPD will function to help the trainee understand milieu therapy and therapeutic community principles in working with deaf populations; to work with other mental health professionals with the deaf, to perceive the effects of different ward organizations and institutional policies on deaf patients, and to work with deaf patients individually, in families, and in groups

On the ward, trainees would be exposed to a therapeutic community, patient-staffing (including taking of detailed social histories), administrative decision making, and the general lifestyle of inpatients, as well as how the introduction of medication influences individual patient's ward life Attention will also be given to informal interaction with ward staff and patients

A major objective of this part of the program is to provide each trainee with a broad and thorough training in individual, group, and family therapy with a variety of deaf clients across different situations The curriculum-courses in supervision will be designed to provide a trainee with those theoretical, technical, and personal skills that will enable him to pursue his professional work with the deaf at the highest level of effectiveness Naturally assumed is that these trainees already possess some degree of clinical experience in psychotherapy The trainee will be expected to carry a sufficient number of diversity of cases, under different supervisors, to give him a range of therapeutic experiences and understanding In addition, there will be a seminar course which provides an ample opportunity for sharing of ideas and practical integration of case material and readings and discussion of theoretical issues and different treatment modalities with those people who are conversant with working with the deaf

It is also expected that the trainee will be seeing other deaf clients in treatment who are not at MHPD which allows for the development of psychotherapeutic skills in working with populations not represented at this Hospital in sufficient numbers to provide the depth and diversity of desired experiences For example, deaf parents of hearing children, hearing parent with deaf children, social and educational groups of deaf persons, deaf clients whose primary presenting problems are of alcoholism, addiction, etc This should account for another 4 to 6 hours per week

The third component is directed experiences in an elective of education research administration consultation, or program evaluation The didactic content of the elective will be determined by the background and needs of the trainees and will be offered in a seminar format The base for this experience would be either in the Hospital or somewhere within the metropolitan area This component could be arranged as "directed individual study" based upon the tutorial method which stresses the collegial relationship between a faculty member (within or without the Hospital) who has particular expertise in the chosen elective area and the student The time involved here would be between 4 and 8 hours per week

Finally, it is to be noted that while the intrapsychic dynamics or one-to-one elements in theoretical, assessment, or psychotherapy training should still be emphasized, training for the deaf needs to give equal stress to family social and cultural factors Further considerations include group dynamics and group psychotherapy theory and techniques the development of the use of community resources, development of skills in communicating with and teaching less highly educated mental health personnel and lay groups, making use of oneself in as therapeutic a way as possible in a variety of situations, the assessment of the patient's problems by using information from a variety of sources, and the active involvement of relatives in the patient's treatment

In summary, the trainee will be spending his 44 hours per week as follows 6 hours core didactic content, 6 hours supervision (including one overall evaluative preceptor) 6 hours elective (including supervision) 16 hours clinical practicum experiences on MHPD (exclusive of supervision) 6 hours (4-8) other clinical practicum experiences, and 4 hours individual study peer group discussion, etc

Prospectus for a Course for Medical Students in Psychiatry at George Washington University

Since many deaf persons have particular difficulty finding doctors who understand their life circumstances and are able to communicate with them, the training of medical students in major medical centers should include an introduction to the implications of deafness together with opportunities for direct involvement with deaf persons Accordingly, in 1975, as Clinical Associate Professor of Psychiatry at George Washington University Medical Center, I developed a prospectus (subsequently adopted and implemented) for an elective for freshman and sophomore medical students entitled Mental Health Issues in Deaf People The arrangement of the prospectus is chronological, and proceeds as follows (1) Implications of Deafness (congenital or early acquired versus late acquired, the silent world and social isolation, deaf people as a subculture, attitudes of the hearing society toward deaf people, character and implications of dreams of deaf people mental health issues), (2) Growth and Development of the Deaf Child (the deaf child in his family, language acquisition, the deaf child among deaf peers, the deaf child among hearing peers, the deaf child in the community, thinking and learning, behavior—normal versus abnormal) (3) The Period of Transition—From Childhood to Adolescence (psychosexual development, bridging the gap), (4) The Deaf Adolescent (search for maturity, identity crisis, therapeutic considerations) and (5) The Deaf Adult (as citizen as parent, as achiever, approaches to mental health and illness in deaf people) The suggested teaching method combines lectures and group discussion so as to allow for a free exchange of ideas The use of appropriate films, such as one prepared by the staff at Saint Elizabeths on the history and treatment facilities of the MHPD program, is suggested as a supplementary source of information In order to introduce students directly to the deaf community, the syllabus also suggests field trips to educational institutions such as Gallaudet College, and to mental health facilities such as Saint Elizabeths

Most medical schools have easy access to mental health facilities, many of which now have special programs for deaf patients It is time that psychiatric students are apprised during their training of career opportunities in this important field, and that medical schools in general take more responsibility in exposing their students to the needs of deaf people

Courses Designed for Deaf Students at Gallaudet College

A Seminar in Human Reactions

My professional association with Gallaudet College has always been enjoyable, and I have particularly appreciated its willingness to open its doors to me and to the staff of Saint Elizabeths in the interests of helping deaf people As a way of reciprocating and of broadening my understanding of deaf people, I offered to teach a course in 1968 which I had originated The course was based on my philosophy that learning about human reactions would be more meaningful to the students if they studied their own day-to-day reactions or the reactions of others close to them, rather than read printed materials which describe other people's behavior

The course had the following objectives (1) to provide an understanding of the psychodynamics of human behavior (2) to help students form an integrated cognitive and affective awareness of their everyday emotional reactions, (3) to aid progress in general adjustment, growth, and ways of coping Although students of all academic levels enrolled in 1968 (and in subsequent semesters), the majority were juniors and seniors, hearing impairments ranged from congenitally deaf to hard-of-hearing Educational backgrounds were similarly diverse, students had attended residential institutions, oral schools, day classes in public schools, and regular public schools Some were transfer students from other colleges and universities The simultaneous method of communication was used in the classroom, as might be expected, skill in sign language and fingerspelling varied widely

The course was designed to cover such emotional reactions as separation anxiety, grief, shame and guilt, inferiority feelings, and what could be termed normal' reactions to problem situations, with the expectation that interest in additional subjects would develop Accordingly, later topics included loneliness, death, defense mechanisms, homosexuality, love and hate, inhibitions, stigmas and stereotypes, reactions to disability, and mental hospitals The fundamentals of psychodynamics were explained as appropriate topics arose Often the question of possible differences between the emotional reactions of deaf and hearing people was examined

A special feature of the course required each student to write a commentary after the examination and discussion of a specific topic, giving his or her own definition of the emotional reactions discussed, and including examples from personal experience The aim of this exercise was twofold to increase feedback and to check individual understanding, and to accumulate over a period of time enough meaningful material to compile a reference book available to future classes The reference book was never assembled, due to time and work pressures, however, the pedagogical device of writing commentaries was quite useful in its own right

The reaction of the initial class was particularly interesting In the beginning, students were skeptical and suspicious of my motives They felt insulted by the strict rules concerning attendance, tardiness and participation, and disturbed by the fact that no text was used and no formal lectures given It was difficult for many of them to understand how progress could be measured without these traditional tools We decided to discuss these issues openly in a meeting, during which students gained an understanding of the methods, principles, and goals of the course Subsequently, anxiety lessened as they began to cooperate in the group process and discovered that others had similar feelings, attitudes toward hearing loss, and emotional experiences Eventually, the class evolved into a comfortable forum for the expression of feelings, even negative or frightening ones Several students who were reluctant to admit suicidal impulses during class discussions did report these feelings in their writings and were relieved to discover that they were not alone It was clear by the end of the semester that the students were able to understand the psychodynamics of human behavior more fully and meaningfully when they were encouraged to relate the concepts directly to what they knew, and that in the absence of printed materials which deal specifically with the experiences of deaf persons, a classroom forum of this kind was quite beneficial

In several subsequent semesters, heavy enrollments reflected positive student attitude toward the course and necessitated the addition of a second teacher I had 5 years of experience teaching the course on a night-time basis, sometimes with a coteacher, one such coteacher Jean Mulrooney and I published a paper on our joint experiences in 1972 The course is now taught on a daytime basis at Gallaudet and continues to attract students Courses of this kind can be most helpful in disarming that defensiveness toward the subject of mental health which was mentioned in the second chapter as characteristic of many persons, it can also stimulate deaf youth to investigate career possibilities in the mental health field

Course on the Nature of Mental Illness and Mental Health Programs for the Deaf

After the Seminar in Human Reactions was firmly established as a two-credit course in the psychology curriculum at Gallaudet, I was asked by the head of the department in 1974 to develop a course dealing with serious mental disturbances, and with mental health programs for the deaf The course which I designed focuses on definitions of illnesses and their symptoms, methods of detection, incidence among deaf and hearing people, causative and preventive factors, and special techniques of interviewing, treating, and rehabilitating the mentally ill deaf

The course is presented in several stages During the first 3 weeks, students begin building a vocabulary of psychiatric terminology Throughout this period, they are encouraged to learn to regard the mentally ill as persons with human dignity, deserving of respect This is accomplished by introducing the students to the interview procedure, and having them practice one-to-one interviews among themselves In this way, students learn to appreciate what it is like to interview and to be interviewed in an atmosphere of mutual respect They are also asked to interview me, so that I can get a better appreciation of the degree of guidance individual students will need when they begin their practical experience interviewing mentally ill patients later in the course

From the third through the ninth weeks, students are given reading assignments on mental illness, its concepts, and diagnostic categories, from selected reference works in psychology and psychiatry Recently, I have introduced a pedagogical device which is designed to illustrate some of these theoretical concepts in a directly meaningful way Although the students have studied abnormal psychology as a prerequisite to this course, few of them have actually talked with or seen a person who has been diagnosed as mentally ill, nor have they witnessed actual symptoms, such as expressions of or responses to distorted perceptions Consequently, in order to make the description of symptoms more vivid, I arranged for a psychodramatist trained in manual communication from Saint Elizabeths to visit my class in 1976 and act out the role of a mentally ill person The script for the psychodramatist was prepared according to my specifications to demonstrate specific behavior and symptomatology Students were informed as to the nature and purpose of the demonstration, and several of them were given the opportunity to interview the patient Open discussion followed the interview, in general, students felt that the exercise was a valuable learning experience

A special and regular feature of this course is the viewing of a film documentary of the MHPD at Saint Elizabeths, followed by a field trip to the program's facilities Students give oral and written reports of their field trips (as well as their reading assignments) in appropriate class periods

During the final weeks of the semester, students are given assignments to interview patients at Saint Elizabeths They are thoroughly informed of the need for confidentiality in interviewing patients No patient is obligated to participate in the interview and may do so only on a voluntary basis The deaf students are required to conduct interviews with hearing patients as well as deaf patients, so that they can have a broader exposure to the reality of mental illness and the ways in which it affects both deaf and hearing people They can also compare symptoms and dispel the notion that deafness of itself is the cause of all mental health problems in deaf people After the interviews, case conferences are held to clarify problems and answer student questions

I have found the procedures described above to be very effective in teaching undergraduate deaf college students about mental illness At the end of the course students have a better knowledge of the nature of mental illness and its implications in deafness, they are also more alert to signs and symptoms and have a healthier attitude toward mentally ill individuals Both class exercises and practicums acquaint students with methods of prevention, treatment and care, hospital and community programs, the availability of services for deaf people, and the categories of mental health workers and training required

The Admission of Deaf Men and Women to Medical Schools

Is it possible for a deaf person to become a medical doctor? This question was asked of me by Mrs Edna Adler of the Department of Health, Education, and Welfare in April 1967 My affirmative answer at that time has been well borne out by my subsequent experience in teaching and training deaf health care workers, and by my contacts with deaf professionals Deaf people who have been given the opportunity to pursue higher education on the graduate level in the larger colleges and universities have measured up to the task More and more deaf persons are earning degrees at the masters and doctorate levels and are working in positions commensurate with their training These achievements attest to their academic abilities and should suggest their readiness to pursue careers in medicine and other health and mental health professions

It has been my pleasure to be personally involved in paving the way for deaf students to enter medical school and become doctors of medicine One student and friend whose progress I followed closely was hard-of-hearing and educated in schools for the deaf, he achieved his goal by entering Rutgers University Medical School in 1972 and graduating with the degree of Doctor of Medicine in 1976 This accomplishment should be an inspiration to other such students, as well as to deaf youth who are congenitally or prelingually deaf If supports are needed for students with profound hearing loss, they could include, but not be limited to, visual aids (slides, films, and video tapes with captions or overhead transparencies), electronic devices with visual indicators, interpreter services, hearing study mates, transcribed tape recordings of classroom lectures, counseling services, and financial aid

Our educational climate is now one of innovation and change, with particular emphasis on the handicapped The time is ripe for deaf persons to capitalize on these changes and to take full advantages of the opportunities which they afford for medical education By the mid 1980 s deaf men and women should be taking their places among the ranks of the medical profession However, they will need the support of training facilities and the community at large to do so

NEW DIRECTIONS IN RESEARCH

As has been pointed out, interest in mental health problems of deaf people is a phenomenon of the last half of the 20th century Much research in many areas has already been undertaken, such as the social and genetic studies of Rainer, Altshuler, and Kallmann (1969), studies in the thinking processes of deaf people by Furth (1966), studies in emotional adjustment of deaf children by Schlesinger and Meadow (1972), and attempts to develop psychological tests to meet the specific conditions of deafness by Vernon and Brown (1964), and Vernon (1967, 1968) Nonetheless, much more needs to be done, as the following suggestions make clear

The knowledge which has been gained about the nature of mental illness has been accumulated from studies of hearing persons who have full use of their five senses However, because persons who are congenitally and profoundly deaf have never had use of the hearing sense the study of mental illness in them should offer much to the understanding of mental illness in general In particular, the production and amelioration of hallucinations in deaf persons, including so-called auditory hallucinations are important subjects of future research There is also a need to study more thoroughly the degree to which psychoanalytic concepts of the development of personality and the causes of illness can be applied to deaf people

It is generally known that hormones have a significant influence on psychosocial development and behavior, again studies of hearing patients have established this fact Research is needed to determine if there are significant differences in the hormonal levels of deaf people as compared to hearing people, if deaf children reach puberty at the same age as hearing children, or if deaf girls reach menarche at approximately the same age as hearing girls Studies of hormonal levels in the deaf might well shed light on the incidence of mental illness in both deaf and hearing populations

In *Family and Mental Health in a Deaf Population* (1969) Rainer suggests that research is needed in the area of pharmacology and deafness Deaf patients have now had the use of psychotropic drugs over the past 20 years, along with hearing patients It would be inter esting to have comparative statistics about the specific modes of action of these drugs in both deaf and hearing patients

Rainer has also called for more research into the benefits of group psychotherapy for deaf people (1969), an area which has been of particular interest to me for some time When I started my work in group psychotherapy with deaf patients in 1963, I had no knowledge of any previous work using this method As was made clear in chapter 3, my observations revealed certain behaviors which appeared to occur more frequently in this group than in groups of hearing patients, such as laughing, smiling, frowning, touching, and occasional embracing It is well known that nonverbal communication is common to all human beings, it would be of particular interest to collect data comparing the frequencies of types of nonverbal communication among the deaf and hearing populations These data, in turn, should help in the examination of the effectiveness of group psychotherapy for both deaf and hearing people

One aspect of deafness which has always raised questions in my mind is the sleep-dream phenomenon Because sound so frequently serves as an arousal stimulus in the sleeping states of persons with normal hearing, the study of sleep in the deaf might establish connections between sleep patterns and the absence of auditory stimulus Several studies of this subject are already available Max, 1935, 1937, Stoyva, 1965, Robinson and Dawson, 1975 This kind of exploration could open up avenues for better understanding the relationship of mental health to deafness

Another area in which additional knowledge is needed is sexual behaviors and problems in deaf people My own exploration in this area in 1975 was by means of a 21-item questionnaire distributed to 15 mental health professionals in the Washington area who work with deaf people The items included the following sexual behaviors and dysfunctions impotence, premature ejaculation, delayed ejaculation, anorgasmia, dyspareunia, vaginismus, homosexuality, bisexuality, masturbation prostitution, excessive sex urge, oral-genital sex, sexual refusal in marriage, incest, exhibitionism, fetishism, transvestism, sadomasochism, sex acts with animals, voyeurism, pedophilia The questionnaire was meant to be a cursory survey and not a scientific study Twelve of the 15 mental health professionals receiving the questionnaire responded They reported cases of all of the problems and behaviors mentioned above except sexual refusal in marriage, voyeurism, and sex acts with animals The behavior appearing with the greatest frequency in males as well as females was masturbation It should be stated here that the sexual dysfunctions mentioned above viz impotence, premature ejaculation, delayed ejaculation, vaginismus, anorgasmia, and dyspareunia have rarely been studied in deaf people This survey suggests that more rigorous study should be done in human sexuality and deafness

An Orthopsychiatric Workshop on Deafness was held at Saint Elizabeths in May 1975. Participants representing State programs from around the country determined that training in mental health and deafness was one of their highest priorities in providing mental health services. This action has particular application to the needs of mentally and emotionally disturbed deaf children, who currently have no inpatient treatment facilities. Much research is needed if such training programs are to be developed; once established, these programs would themselves further stimulate research endeavors.

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Afterword

It is gratifying to think that the last two decades have opened up a new era in mental health facilities for deaf people, but as in all developments of this kind, exploration and progress result in the constant identification of new needs. The success of programs in New York, Chicago, San Francisco, and Washington, D C , has spotlighted the lack of such services in many parts of the country, growth in this regard has been steady (programs have begun in Pennsylvania, Ohio, Minnesota, Virginia, Wisconsin, Colorado, North Carolina, West Virginia, and Indiana, among others), but we still have a long way to go if adequate mental health facilities are to be readily available to all deaf people who need them In addition, existing facilities, are in a more or less continual process of testing and improving their services There is a consensus among those involved in such facilities that they could do more in serving the mental health needs of deaf people Accordingly, more placement facilities such as halfway houses should be created for deaf patients to serve as a transitional step between hospital and community, or, in some cases, to serve as an alternative to hospitalization One such example of a functioning halfway house is the one operated in Washington, D C , by the National Health Care Foundation for the Deaf In association with houses like these, or apart from them, more social and rehabilitation services for the mentally improved deaf person could be established and much more consultation and guidance and other outreach programs could be provided There are pressing needs for programs to serve deaf children, the mentally retarded deaf, as well as those with serious behavioral disorders Quality training is needed to prepare personnel to provide quality services These are but a few ways in which professionals in the field of mental health and deafness continue to scrutinize themselves, their accomplishments. and their goals in the interest of continued growth

However, preventive action is most important of all since it is always easier to forestall psychological damage than to undo it The problems in communication discussed in chapter 1 must be met squarely, both at home and in the educational institutions a great many behavioral disorders in deaf individuals could clearly be averted if all parents knew how to deal with deafness realistically, and all children were provided with the proper opportunities for the development of communicative skills We should also try to introduce social workers, psychologists, and medical consultants into the school systems to help in the early detection of emotional difficulties, to provide treatment where necessary and to join with teachers and administrators on such matters as the development of educational programs in human sexuality—currently a pressing need And perhaps most significantly, we have a responsibility to create a community climate in which persons with emotional problems are not shunned, but helped, in which the family and friends of emotionally disturbed individuals know how to make best use of the community facilities, and in which hearing and deaf people work together to promote mental health for everyone

During the last half century we have seen a new trend in the delivery of mental health services and other programs The treatment emphasis has been on prevention, early detection, reduction of the mental hospital inpatient population, and community based mental health services Long-term hospitalization often had detrimental effects on patients it imposed what we call chronicity, or the indefinite extension of the illness The longer the person was isolated from the mainstream of life and society, the more difficult it was for him or her to return similar difficulties in adjustment were often experienced by the families of patients returned home after long absences Today mental health facilities try to get patients back into the mainstream of society as soon as possible, where they may continue treatment on an outpatient basis if necessary However, such efforts fail if the community itself does not lend support to the patient when he needs it, this support may take both direct and indirect forms Intensive involvement of family and relatives—sometimes in a patient's therapy, almost always in his recuperation—is one kind of support, the acceptance of a person who has suffered an emotional illness by the average citizen is another It is very sad when an individual who has recovered from the critical phase of a mental disorder finds that he must contend with prejudice and social stigma as his price of readmission into society Yet these attitudes will not change until more people understand the nature of mental illness, and the importance of social climate in the promotion of mental health

Citizen responsibility to the mentally ill deaf is, perhaps, even greater, since the emotionally disturbed deaf person is likely to encounter prejudice against both his deafness and his disturbance, if he has a language deficiency, and would have difficulty communicating with the hearing world under the best of circumstances, his isolation may indeed be terrible The community must lend a helping hand, perhaps the most obvious way in which this can be done is through institutions—businesses and schools offering jobs and rehabilitative education But the individual citizen has many choices also he or she can do volunteer work in connection with hospitals or mental health agencies, promote adult education programs in mental health, support through political action allocation of adequate community resources for care and rehabilitation of emotionally disturbed persons and share, whenever possible, the facts about mental illness and about deafness with family and friends who are uninformed Through therapy, professionals in the field of mental health can help a patient establish, or reestablish, the faculty of accommodation—that ability to adapt to the changing realities of experience—which is basic to a happy and healthy life, however, if the individuals environment imposes inordinately heavy pressures, and forces him immediately into a new series of stressful situations, much of the progress accomplished in therapy may be undone That is one of the reasons why mental health is everyone's responsibility, and why the mental health of deaf people, in particular, demands the attention and concern of an enlightened and involved community The advances of the last 20 years are heartening, and the prognosis for quality mental health services in the future optimistic, but much of what will assure the maintenance of sound minds in the deaf population will depend on the establishment of a social milieu in which deaf persons find complete acceptance and support

INDEX

(Note Page numbers for illustrations are italicized)

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