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Patrick K. Best
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A REVIEW OF DEAFNESS AND MENTAL HEALTH: A DEVELOPMENTAL APPROACH

PATRICK K. BEST

The introduction to this study focuses on the importance of communication for mental health. Many important theories on mental disorder are based on the fact that deep frustration occurs when an individual's felt need is not met for gratifying communication with significant others in his environment. Other broader theories rely heavily on the importance of interpersonal communications as a primary explanatory concept in general human development. Cognitive retardation and psychological maladaptation remain frequent among deaf children and adults. The core of these difficulties may be in the absence of gratifying reciprocal communication within the family during the deaf child's early years.

The problem is serious: 1) the deaf student suffers from a three to four year lag in educational achievement compared with his hearing counterpart, 2) the average deaf adult reads at the fifth grade level or below, 3) only 12% of deaf adults achieve linguistic competence, 4) only 4% become proficient speechreaders or speakers.

It is suggested that the absence of early auditory stimulation, feedback and communication might be the source of many common problems among people who are deaf: emotional immaturity, ego-centricity, easy irritability, impulsiveness, suggestibility, lack of caring for others, lack of empathy, gross coercive dependency, and absence of thoughtful introspection.

This study does not intend to belabor the nature-nurture controversy, but rather examine plans for optimal adjustment throughout the life cycle. The authors encourage us to look at the early environment and make it

Mr. Best is Assistant Office Supervisor, Michigan Vocational Rehabilitation Services.

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optimally effective as a learning environment. The earliest years are also crucial from the standpoint of preventive mental health planning. Parents are often filled with anguish on the one hand, and inflated with hopes for the future on the other. The developmental problems of deafness differ at each age level and often hinge on communicative competence. The primary method of study, therefore, in this thesis is the developmental approach.

The ensuing chapters seek a unifying theory to explain the persistent discrepancy between the normal potential and the depressed achievement of the Deaf. Dr. Schlesinger states that she is seeking to understand the interaction between the environment and the deaf individual by building a developmental framework.

The L.P.N.I. Study is based on Erikson's epigenetic scheme. In this scheme the whole life cycle is divided into "the eight stages of Man." The human being goes through a sequence of critical phases in what is an integrated psycho-social developmental plan of nature. The successful solution of any crisis depends on its difficulty and the resources available.

1. Basic Trust vs. Mistrust: (Infancy)

The infant establishes a sense of trust in the world. The infant conveys the message, "I am what I am given." Piaget especially has emphasized the importance of the environment in early perceptual and cognitive experience.

The impact of deafness: The mother suffers guilt, sorrow, mourning, and anger which interfere with her warm relationship with the baby. Parents usually feel let down by the professionals at diagnostic time, and so they go shopping. Deaf parents are more accepting of the diagnosis. Some solutions to the problem at this stage are: sophisticated hearing aids and a greater variety of visual stimuli. Dr. Schlesinger concludes the discussion of this stage by stating that it is unclear how much the infant suffers. The parents certainly suffer and if their anxieties are not properly resolved, the child will accordingly suffer.

2. Autonomy vs. Shame and Doubt: (Early Childhood 18 months to 3 years)

The goal of this stage is to develop autonomy and separateness. The child conveys, "I am what I will." If a child isn't helped to be autonomous he will always require minute and stubborn control.

The impact of deafness: Words can be used as weapons in the battle for childhood autonomy. Words can be held or let go at will. A child can self-destructively win the word battle just as he can win the battle of the potty. Some mutism therefore is psychological. Deaf children show a delayed resolution of the autonomy crisis. Parents routinely do not let their children have the same independence as their hearing siblings. Speech seems to be the area of importance to most parents. The child may see the

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insistence as punitive and react with rebellious mutism. Many deaf children go through this stage with negativism, because negativism is the only way he can bring about his independence. If he habitually loses these battles of independence, he becomes hostile.

3. Initiative vs. Guilt: (Childhood 3-6 years)

During this stage the child is saying, "I am what I can imagine." The child identifies with the plumber and the fireman, etc. Parents need to let the child pursue his locomotor quests. Parents teach their children by good example at this stage.

The impact of deafness: Deaf children are exuberant only in their actions. They are inhibited by numerous safety regulations. Schools for the deaf place a premium on immobility. Optimal teaching situations are hard to achieve. Deaf children are deprived of contact with successful deaf adults.

4. Industry vs. Inferiority: (6-11 years)

The child is saying, "I am what I can learn." His basic task is to develop a sense of industry with an accompanying sense of mastery.

The impact of deafness: Society is not usually kind to its "exceptional" members. There is still, for example, pervasive disapproval of one of the most potentially useful coping mechanisms of deafness – the American sign language. Deafness, more than other disabilities, frightens the uninitiated into a "shock – withdrawal – paralysis" reaction on their first exposure. Teachers of the deaf have a sense of provincialism and despair about them which reinforces underachievement in deaf students. No tests of verbal competency have been given in the language of signs, even though this is the language spoken by 80% of deaf adults.

5. Identity vs. Identity Diffusion: (Adolescence)

Adolescence brings with it problems of emancipation, independence, personal and social purpose. Adolescents who have successfully resolved previous crises of trust, will, imagination, and competency are prepared for the encounter with adolescence. Parents who have resolved their own crises of generativity and care are best prepared for meeting problems of adolescence with flexibility.

The impact of deafness: The typical deaf adolescent approaches the crisis with a delayed resolution of the previous crises. Society idolizes a normalcy he cannot achieve instead of cultivating his unique areas of competency. Many parents are no longer able to deny the encompassing effects of deafness on some of their cherished goals. Some adolescents solve the identity crisis by entering "the deaf world" and excluding, temporarily, "the hearing world." Those who do the opposite, and try to "pass" for a hearing person, often suffer pathological consequences.

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6. Intimacy vs. Isolation: (Young Adulthood)

The successful resolution of the problems of love and work entails a successful resolution of the identity crisis of adolescence. Those who are not sure of their identity dare not commit themselves to work and personal intimacy for fear of being submerged by institutions and for fear of losing their fragile sense of self.

The impact of deafness: Many young deaf adults give evidence of identity diffusion. In this period they become separated from the protective settings of school. They find the world quite different. Many have not achieved internalized controls and motivations. Often there is regression to impulsivity and dependency. If maturity has not been achieved, intimacy will be replaced by isolation or frantic, superficial relationships. Work may take the form of frequent change of jobs, or be replaced by total avoidance and consequent non-gratification. Work paralysis (a deep sense of inadequacy) often sets in.

7. Generativity vs. Stagnation: (Parenthood)

There is a direct relationship between receiving early adequate mothering and being able later in life to become an adequate mother.

The impact of deafness: Individuals who still demand coercive gratification of their own needs will have difficulty in receiving a child in trust and postponing their own narcissistic needs. Some immature deaf parents have felt so incompetent in the task of child-rearing that they have entrusted the care of their infants to others. Dr. Rainer and his associates at New York Psychiatric Institute find that deaf parents do better with their deaf than with their hearing children. Many deaf parents use their hearing children as messengers with the hearing world.

8. Integrity vs. Despair: (Old Age)

The ability to remain productive, or to accept decreased productivity, enables the old to view their own life cycle benevolently.

The impact of deafness: Dr. Schlesinger admits "we simply do not know the effect that deafness has on the crisis of old age." She postulates that the impact could be devastating or it could be relatively easy since the deaf person has been equipped for this adjustment by a life of deprivation.

Since there has been little research on the incidence of mental health problems among the deaf, Dr. Meadow undertook such a study at the California School for the Deaf (Berkeley). Dr. Rainer and his associates at N.Y.P.I. in 1963 had found that there was no higher incidence of schizophrenia among the deaf than the hearing. However, their "problems of

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living" were higher.

Dr. Meadow's survey of teachers and counselors at the California School for the Deaf showed that 11.6% of the students suffered severe emotional disturbance and 19.6% had serious behavior problems. She compared this with a study of hearing students in the Los Angeles public schools where it was found that 2.4% had severe emotional disturbances and 7.3% had serious behavior problems.

Some of the significant findings are as follows:

- 1) the diagnoses of teachers and psychiatrist usually agree;
- 2) one-half of the emotionally disturbed children came from non-intact families;
- 3) a large proportion of the disturbed children came from small families;
- 4) 61% of the disturbed children had I.Q.'s below 100;
- 5) 55% of the disturbed children had unknown etiologies;
- 6) girls comprised 55% of the E.D. group. Measurements of extreme passive behavior were used as well as measurement of aggressive behavior. This method revised certain previous theses that boys outnumbered girls in emotionally disturbed classifications.

The report of their clinical experiences emphasizes that mental health intervention among the deaf must have a preventive orientation. Three stages of prevention are noted:

- 1) primary prevention – counteracting harmful circumstances before they have had a chance to produce illness;
- 2) secondary prevention – working with patients with incipient or mild disorders;
- 3) tertiary prevention – rehabilitating those with psychiatric disorders.

During the four years of the study, 215 patients were identified; 28% of these were found to be seriously disturbed. During the early years of the project 40% of the patients were adults (21 and older). In the last year, 75% were under 21. The change occurred largely because the staff found they had much greater success with the under 21 group and consequently became selective at intake.

The procedures followed were: referral, intake, diagnostic study, brief or long term therapy (more than six months), collaboration and case consultation.

25% of the cases were treated by consultation with other agencies. Consultation was received only at the diagnostic stage and included: clinical testing, speech and language evaluation, educational and medical evaluation. The service team used no hard and fast eligibility criteria, other than "how and who can we serve?" The policy was to consider any and all referrals and to render in each case an appropriate professional decision.

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Sign language was employed by the therapist when appropriate. Interestingly it was not the use of sign language but the accepting attitude toward it that facilitated successful therapy.

A distribution of the caseload was given by APA diagnostic categories.

psychoses	19%
neuroses	4%
personality disorders	15%
special symptoms	2%
transient situational	16%
behavioral disorders	27%
social maladjustment	4%
mental retardation	7%

It was not felt, however, that diagnostic labels said very much about the practical therapeutic problems that were encountered and the ways in which the therapists dealt with them. Therefore, case examples were given using each of Erickson's eight stages of man to illustrate the major types of problems treated. For example, the case of Ruth, a young deaf adult was explained within the framework of "intimacy vs. isolation." She showed a very immature conscience. As a job applicant she was asked to fill out a personnel form. She deluded herself into thinking that a youthful indiscretion gave her a "criminal record," and so she withdrew from the task of looking for a job. The therapist set about bolstering up her confidence by empathetic listening, suggesting insights to explain her behavior, suggesting practical steps, and accompanying her at job interviews.

The clinic team defined success as: "forward movement in terms of behavioral change and/or situational change that reduced the presenting problems." With such criteria, the treatment outcome was successful in 82% of the cases of those under 21, and 57% of the cases of those over 21. The prognosis was found to be correct in 97% of the cases.

In a discussion of the preventive aspects of community psychiatry, Dr. Schlesinger maintains that mental health professionals are not the prime promoters of mental health. They can only provide corrective experiences to the individuals who have lacked them. She found that her most useful contribution to the community was as a consultant.

Consultation with teachers at the California School for the Deaf at Berkeley involved helping them out of their provincialism and despair of achievement. Teachers and counselors were encouraged to bring their feelings on manualism vs. oralism out in the open. The result was mutual respect and not polarization. It was observed that there are good results when parents and teachers are emotionally close.

Consultation with teachers and parents in a city school system for the deaf was related to helping solve discipline problems and distinguishing between acceptable and unacceptable aggressive behavior. Professionals in other agencies also sought the expertise of the L.P.N.I. team. Dr. Schlesinger found that "the shock – withdrawal – paralysis" results from professionals

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being more concerned about not being understood than not understanding. In the process of bringing some light to the oral-manual controversy, Dr. Schlesinger developed the following criteria: "Sign language is generally helpful in the development of deaf children when it is used with positive affect, without conflict, is accompanied by speech and auditory training, and is used before a feeling of communicative impotence occurs between mother and child."

One of the chapters examined the differences between deaf children in day schools and those in residential schools. It was found that deaf children of deaf parents had a better self-image than deaf children of hearing parents regardless of the type of school – day or residential. Regarding social and personal adjustment, it was found that maturity, responsibility and independence decline as the level of family stability declines. Day school children are more influenced by family climate. Many residential school placements were due solely to the parents' inability to cope. Lack of sex role identity is not caused by factors inherent in residential school living, but by lack of a parent model. The knowledge of manual communication did not impede the acquisition of spoken English. The child with the greatest school achievement is the deaf child of hearing parents who studies in a day school by means of the total communication method.

In a very significant chapter dealing with the development of communicative competence, it was found that the young deaf child's social and personal adjustment are positively related to his communicative competence. Also relating to communicative competence are: parents' communicative skills, self-esteem, flexibility, warmth, creativity, relaxed manner, enjoyment of child, and approval of child.

Regarding the effects of communication deficit on early childhood socialization, mothers with hearing children were found to be more permissive, creative, flexible, approving, non-intrusive, and non-didactic. Mothers of deaf and hearing children appear to be the same regarding their effectiveness in achieving the child's cooperation, relaxed comfortable manner, use of body language, and enjoyment of interaction with the child.

Clausen has stated; "It is the parents task to provide the physical nurturance for the child; it is the child's task to accept it." Dr. Schlesinger concludes: "The nature of deafness, because of the effect on the parent-child communication, is the physical handicap with the most far reaching influence on both the child's development and the parents' socialization behavior."

Another important conclusion is that "there are more significant differences between the mothers than between the children."

Dr. Schlesinger offered studies and personal observations to show that manual communication would enhance the growth of the deaf child to mature adulthood. Studies of deafness, neurology, ethnocentrism and bilingualism, cultural disadvantagedness, and psychiatry were used to support her thesis. Some interesting observations were: deaf children of deaf

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parents do better in every area of academia, even lip reading and speech; the deaf use sign language with their peers but speech with hearing people, which in many ways reflects the American prejudice against other languages; the literature on ghetto children bears curious similarities to literature on deafness; highly verbal parents can inhibit the speech of children; dialogue modeling is better than expansion and correction, and both are better than non-treatment.

The final chapter summarizes the study and proposes a model that will incorporate the findings of this study in the form of policy recommendations for community psychiatry for the deaf.