

# MEETING THE PSYCHIATRIC NEED OF THE DEAF

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Some thirteen years ago the late Dr. Franz J. Kallmann organized our research team to explore the mental health needs of the deaf. We had become drawn to the field because in our experience as psychiatrists and as marriage and parent-hood counselors, we had met deaf families with personal problems which we knew very little about. We were also interested in the many unanswered research questions regarding the cause and aggravation of mental illness, and we felt that much could be learned by working with the deaf. When we started, we were immediately struck by a total lack of information about the deaf and the little concern with this group on the part of all the mental health professionals. Not even the number and distribution and family structure of the deaf were properly documented. To be sure, rehabilitation specialists and particularly educators had known for a long time that early deafness caused special problems in adjustment. Psychologists had already devised better and better ways to measure the intelligence, thinking and maturity of the deaf and they were beginning to tackle the emotional aspects as well. But the pathway to good psychiatric diagnosis and care, either on an individual or group basis, was completely blocked by formidable communication obstacles.

These shortcomings were something we had not expected. It was indeed surprising to find that a group of persons who

needed help so badly in an area which had so many unsolved problems was neglected by psychiatry. Probably it was not just ordinary disinterest or laziness, for the soundless world of the deaf has for many people an unconscious association with the absence of life, with impenetrability, and with no hope of meaningful contact. These more subtle anxieties must have contributed to keep people from the field.

In retrospect, this attitude seems hard to believe. How different in these thirteen years of work with the deaf has been the experience of all of our team who have ventured to explore this difficult territory. In the early visits to wards in our State hospitals, it was necessary to move from building to building looking for deaf patients, many of whom were there for decades. Although our skills at manual communication were elementary at that time, we were as inspired as the patients by the awakening contact, the opportunity they had for real communication for the first time in years. All of those connected with our program, from physicians to ward attendants, developed a dedication, a fascination, and a loyalty which could not have been predicted. These feelings were possibly aroused by the inherent interest in the problems of the work, possibly by meeting the challenge of doing the impossible and possibly by the gratification of success. Perhaps these feelings were stimulated by some special emotional satisfaction in reaching the deaf. In any event, the inspiration brought about through feeling privileged to do the job is a type of staff dedication that bodes well for future work with the deaf by any group that attempts the task.

Our project for the deaf has moved through two distinct phases since 1955 and is now in its third phase. These may be described in sequence.

Little was known at the outset of the program in 1955, so we made our first task that of obtaining a broad and first-hand knowledge of the deaf in all their areas of life performance, as well as the extent of their psychiatric problems. We combined a program of psychiatric guidance in the form of an outpatient clinic with an extensive research program.

Preparing lists of names, addresses, ages and family relationships of all deaf persons that we could find in New York State, we made trips to all areas of the State and interviewed a sample of 300 deaf families. Deafness was described as a stress-producing hearing loss from birth or early childhood, rendering a person incapable of effecting substantial auditory contact with the environment. Through our efforts we built up a list of nearly 12,000 names and addresses of deaf persons over the age of 12.

In our interviews we were looking for data on education, on preparation for life, family living, for job achievement, and for patterns of community socialization. The results of these researches have been published in the book *Family and Mental Health Problems in a Deaf Population*, and only a few of them may be summarized here. Educational findings indicated that all of the deaf persons who were interviewed had had some formal education; almost 4% had more than a high school education, but about 16% had left school-without graduating-before the age of 16. The findings in the area of preparation for family life were less satisfactory. Of the women questioned, fewer than 20% had happy dating experiences during their school years and over half of them had no experiences which could be described as dates at all. Most of the deaf parents admitted problems in rearing their children, especially their hearing children.

When it came to evaluating emotional disturbances and mental illness among the deaf, delinquency and crime covered the same categories as found in the hearing population. As with hearing, many of the lawbreakers among the deaf were from lower socioeconomic levels and were unemployed. It is interesting in view of our general findings in the area of personality that many of the offenses were of the impulsive, immature, and irresponsible nature. There were absolutely no special treatment facilities to deal with these problems.

In the psychiatric realm proper we obtained our material during that first phase in three ways: First, the continuous survey of deaf patients who were in New York State mental

hospitals; secondly, the evaluation and treatment of neurotic and psychotic individuals who came to our outpatient clinic for the deaf; and third, interviewing the families of many of our deaf patients.

In our outpatient clinic we saw over 200 persons during that first seven-and-a-half-year program. A good many of them were in the late adolescent group or early adult age. They were referred by schools, by the Division of Vocational Rehabilitation, by agencies and organizations for the deaf, by private physicians, and, as the project became better known, through families, friends or self. Almost every psychiatric disorder was seen, including psychotic, neurotic, and behavior syndromes. The job of making a psychiatric diagnosis in the deaf proved to be much harder than we thought, requiring a great deal of time, experience with the communication methods of the deaf, and prolonged observation to uncover various clues of mood, attention span, and thinking.

Various methods of psychotherapy were modified for the deaf and applied according to the motivation of the individual patient, and we soon learned that psychotherapy was ineffective unless it was coupled with opportunities for social and vocational rehabilitation and family cooperation.

In the hospitals, the number of patients found on our initial surveys was surprisingly large, about 230 in all, or about twice as many as one would expect for the same-sized hearing population. The diagnostic distribution of these patients was similar to that for the hearing population, including about half with a diagnosis of schizophrenia. Many hospitalized cases were diagnosed "psychosis with mental deficiency", but we found that a good number of these were not actually retarded but had poor communication skills and some other emotional disturbance. In some cases there was retardation and deafness, both of which derived from the same early illness. It was interesting that neither alcoholism or severe depressions were common among the deaf, a finding that we came to feel had to do with a certain limited emotional involvement with their parents in early life which tended to protect

them against the usual depressive reaction to losses later on. Another finding was that paranoid symptomatology, suspiciousness, was not a prime finding among deaf patients. Actually, persons with early total deafness seemed to us in many cases to be very trusting, in contrast to persons deafened later in life who may show a tendency toward oversensitivity.

Among the deaf the length of hospitalization at that time showed a substantial increase compared to the hearing, and there were a large number who were in hospitals for more than five years, some even for longer than twenty years. In 1962, therefore, as the first phase of our work drew to a close, we felt that the most important need was for a more comprehensive psychiatric program, which would combine both inpatient and outpatient facilities. We needed a ward where deaf persons requiring hospitalization would not be lost to us but would receive further treatment under our direction. With recommendations by ourselves, by our advisory council, and by a large group of deaf leaders in the State, the Department of Mental Hygiene set aside for our use a large ward at Rockland State Hospital. Situated some 20 miles from New York City, this institution is one with excellent clinical and research facilities and access to community health services both of suburban Rockland County and of New York City. The ward itself was completely remodeled to house 30 deaf patients, 15 male and 15 female patients, and was designed as a model, self-contained unit for intensive psychiatric care and rehabilitation for the deaf. The original staff of the project was supplemented by a full-time psychologist, by social service and guidance counselors, by an occupational therapy worker and a teacher of the deaf, and by a complete nursing staff - a head nurse, a practical nurse and 14 ward attendants, and all were trained in manual language.

We chose our first patients by reviewing carefully our list of deaf persons at other hospitals; finally we requested the transfer of five female patients whom we felt could be treated with some degree of success. These patients were soon supplemented by other female patients, and by the end of the year - after ward remodeling had been completed and the

staff had been well tuned to their new tasks - the male patients were admitted. Any deaf patient in a State hospital was eligible for admission to this ward after screening by one of our staff. Arrangements were also officially made for any patient to be returned to his original hospital if no further improvement could be expected, so as to make way for newer patients with a better prognosis. In the course of the first three years of the project however, only two patients had to be so transferred back.

With individual psychotherapy and drug treatment, day-by-day problems to handle, and relatives visiting twice a week with special questions, the ward program developed rapidly. One of the most exciting developments has been the group therapy program for the deaf, begun soon after the ward opened. At first the patients brought up in group sessions only day to day problems and minor complaints of a concrete nature. They found it hard to see their own role in these problems, but then gradually they began to talk about each other and then about themselves. After a few months they requested the sessions to be increased from once to twice and then to three times a week. As its members began to show greater awareness of each other, to be interested in one another and to recognize illness and change in themselves and in their fellow patients, the group became a genuine dynamic force for improvement. Patients acted one upon the other. They interacted. They showed transference reactions towards the group therapist. For a while they even set up a kind of ward government which was short lived only because it was too easily dominated by patients with a psychopathic bent. The concept of group therapy was so successful that it was later extended to patients' relatives on visiting days.

Along with the individual and group therapy and other forms of psychiatric treatment, a special program of occupational therapy and rehabilitation was set up for each patient from the time he was admitted until the time he was discharged. The rehabilitation counselor obtained as much information as possible about the patient's potentials, interests,

and abilities, and the occupational therapy workshop was used as a place to motivate him to work. Many patients graduated to other vocational shops in the hospital and some patients were found jobs after discharge who had not worked for many, many years.

The results of the three years of the pilot program in this ward, coupled with the continuation of the outpatient clinic and provision of aftercare outpatient treatment to discharged patients, are documented in the second volume put out by the project entitled *Comprehensive Mental Health Services for the Deaf*. This book describes how the inpatient service rotated 50 patients through its 30-bed ward during its first three years of operation. Of these, 22 were discharged and only two of the discharged patients had to return to the ward. During that same three year period about 120 new patients applied to the outpatient clinic and about one quarter to one third of them showed definite improvement in spite of a dismal prognosis.

A very heart-warming outcome of the hospital program was the genuinely growing interest of the deaf community in mental health. In 1958 while doing our original research, we had encountered a certain amount of concern and suspicion by members of the deaf community in New York who felt that they were being labeled as mentally ill and that attempts were being made to pry into their personal lives. At that time we invited a large group of deaf leaders to New York for a one-day conference in which the purposes of the whole program were explained; it was also certainly indicated that we did not feel that the deaf had more mental problems than anyone else, but probably had just as many without any recourse for help. A greater understanding was shown by many deaf people after this meeting, but it was not until our ward was under way for a year that a Mental Health Association of the Deaf was formed comprising deaf volunteers who visited the ward at regular intervals, gave parties and presents to the patients, took some of the patients on outings and so on. This Mental Health Association of the Deaf has even run a number of instructional programs in New York at which -

turning the tables from the early days - the deaf community invited us to speak, and themselves staged dramatic productions depicting the return of mental patients to the community and making every effort to dissipate the stigma of mental illness.

We are presently in the third phase of our work, the phase of rehabilitation and prevention. The clinical demonstration program just discussed was taken over by the State as part of its permanent mental hygiene facilities, a historic development both for psychiatry and for the deaf. But in our work we saw a great further need to extend the principles of mental hygiene from the patient back into the schools and families and forward into the areas of rehabilitation and social service. Therefore in April 1966 our current project began, built upon the research and the clinical facilities of the previous work. In the preventive area, it provides for the demonstration of methods of consultation, case finding, early diagnosis and preventive group therapy for pupils in schools for the deaf, and for group and individual family guidance for parents of these pupils and discussions with teachers and house parents regarding emotional development and behavioral problems. It also includes lectures, conferences and group discussions with deaf leaders and organizations of the deaf and with the psychiatric community at large. Two national workshops have been held at which the organization, methods and early highlights of this work have been reported, one for psychiatrists and one for other professional groups in mental health.

In the rehabilitation sphere, the current program provides for exploration of halfway house and day care programs, for more effective and specialized vocational rehabilitation and for more personalized guidance of family, vocational and community adjustment, for all deaf patients. So far this program seems to have justified our early hopes. By adding halfway house and day care services, and improving our liaison with vocational rehabilitation services, we have been able to even better our earlier results. Considerations of space prevent a detailed report, but after two years we can



say that of 63 patients who ordinarily would be expected to remain hospitalized for life or live outside only briefly, 32 have so far achieved good or fair results; all but three of these 32 are out of the hospital, for the most part working or in training or homemaking programs. This demonstration of continued success we hope will enable New York State to add the preventive and rehabilitative aspects of our work to its permanent mental hygiene program in the near future.

Thus it is clear that the picture has changed considerably from those dark and early days when we were approached to do something about the psychiatric needs of the deaf. Our own work is well on its way to becoming a total psychiatric program. Though still too few, other groups have sprung up over the country and in other parts of the world. There is now the confident feeling that a firm foundation has been laid and that progress in this field should snowball, as the great human importance of this work and its intrinsic interest is recognized at last.

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