

**THE PSYCHOLOGICAL HEALTH AND WELL-BEING  
OF DEAF PEOPLE IN THE COMMUNITY**

**A thesis submitted to the University of Manchester  
for the degree of Doctor of Philosophy  
in the Faculty of Science**

**1998  
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## **ABSTRACT**

The relationship between attitudes, feelings of identity and the psychological health and well-being of Deaf people in the community is examined.

The incidence of psychological distress in this sample ( $n = 102$ , mean age = 41, range = 17-65) is examined using the General Health Questionnaire (Goldberg, 1972) and the Attitude and Identity Questionnaire (ATIQ) designed for this study. Both were presented in British Sign Language. An interview questionnaire was also used to gather information about the participant. The participants' experience of sexual and physical abuse is also investigated and related to health and well-being.

Information was collected using British Sign Language in face-to-face interviews. The processes of translation into English and the back translation procedure is described. Thirty-eight percent of the sample was found to suffer psychological ill-health. A high incidence of sexual abuse was found and this was significantly related to psychological ill health ( $p = 0.047$ ). The relationship between psychological ill health and the Attitude and Identity Questionnaire was found to be highly significant ( $p = 0.002$ ). The Attitude and Identity Questionnaire was designed to measure attitudes towards deaf people; the self-perception of deafness; and provide a measure of self-esteem. The questionnaire also measures the degree individuals identify with the Deaf community. The implications for developing strategies for the mental health and well-being of deaf children and adults are discussed. The implications of the findings for education are also discussed.

## **DECLARATION**

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## **PREFACE**

### **Statement of Education and Research Experience**

BA (Hon) Psychology and Sociology - University of Sunderland, 1980.

MSc Applied Social Sciences - Regents Park College, University of London, 1985.

Research Experience - (PhD Thesis for this study), University of Manchester, 1991.

# CHAPTER ONE

## THE NATURE OF DEAFNESS

### Introduction

The usual way to write about deaf people is to focus on the fact that they do not hear.

In this context everything becomes interpreted using the norms of non-deaf hearing people. Examples of how deaf children view the world gives some insight into the nature of deafness.

This is Sam's story as taken from Padden and Humphries (1988).

"Sam, a young Deaf boy, noticed a girl next door who seemed to be about his age. After a few tentative encounters, they became friends. She was a satisfactory playmate, but there was the problem of her "strangeness". He could not talk with her as he could with his older brothers and his parents. She seemed to have extreme difficulty understanding even the simplest of gestures. They developed a way to interact with each other and he was content to accommodate to their peculiar needs"

Padden continues:

"One day, Sam remembers vividly, he finally understood that his friend was indeed odd. They were playing in her home, when suddenly her mother walked up to them and animatedly began to move her mouth. As if by magic, the girl picked up a dolls house and moved it to another place. Sam was mystified and went home to ask his mother about exactly what kind of affliction the girl next door had.

His mother explained that the little girl was hearing and because of this did not know how to sign; instead she and her mother talk, they move their mouths to communicate with each other. Sam then asked if this girl and her family were the only ones "like that". His mother explained that no, in fact, nearly everyone else was like the neighbours".

(p.15)

Deaf people have long believed they are different to hearing people. Deafness has demographic, linguistic, political, psychological and sociological dimensions. Deafness is often interpreted and researched, as if a homogeneous group, in relation to numbers of deaf people, and also by adding partially deaf (hard of hearing or hearing impaired) and deafened people altogether with those who are deaf from an early age. Throughout this thesis the uppercase 'D' is used to distinguish those culturally Deaf people who are members of the Deaf community and whose first or preferred language is usually Sign Language. The lower case 'd' is used as an audiological term to describe deaf people who are usually not considered subjectively and objectively, to be members of the Deaf community, who include, for example, those with acquired deafness or partial hearing, hard of hearing people and deafened people. This is a convention proposed by Woodward (1972) and is seen to be increasingly used in the literature.

The following is an excerpt from an interview conducted with two young deaf sisters, Vicki and Helen (Padden and Humphries, 1988). Carol Padden is the interviewer:

Vicki: "My friend Michael gave it to me".  
Helen: "Michael's her boyfriend". (Giggles)  
Vicki: "Michael is not! Anyway Michael is deaf".  
Helen: "No! Michael is hearing!"  
Vicki: (Confused but not convinced) "Michael is deaf!"  
Helen: "You're wrong! I know! Michael is hearing".  
Carol: "Well, which is he? Deaf or hearing?"  
Vicki: (Pauses) "I don't know".  
Carol: What do you think?  
Vicki: Both! Michael is deaf and hearing.

Helen, Vicki's older sister, was aghast! No one is ever both deaf and hearing at the same time. One is either deaf or hearing (Padden and Humphries, 1988, p.13).



This dialogue shows that the younger sister (Vicki) had said Michael was deaf because he signed. She emphasised this because she had already learned that in conversations about people, one has to refer to the person's hearing status. The hearing people she had met did not sign but Michael did. The older sister (Helen) had learnt that it is not just knowing signs that determines one's cultural affiliation to the Deaf community. It has many other aspects: It is also about Deaf humour, Deaf poetry and Deaf norms and values. It is about 'knowing', instinctively, about cultural affiliation, through the experience of seeing native and fluent signers and somehow 'observing' those who have learnt the language, like Michael.

### The Deaf Community

The community of Deaf people of which this study is concerned, form a group who share a language, British Sign Language (BSL), and use it as the primary means of communication between each other. They hold particular beliefs about themselves and how they relate to the larger society (Padden and Humphries, 1988; Lawson, 1989; Reed, 1994). These people are different from those who lose their hearing through age, illness or trauma. Over 17% (8.4 million RNID 1995) of the British population have some degree of hearing loss, most of whom do not identify with the Deaf community and therefore do not have different linguistic or cultural needs to most of the hearing population. However, deterioration in hearing or sudden loss of hearing, either partial or complete, can result in profound psychological and emotional trauma. The mental health needs of this population who require a range of skills, resources and therapies, is quite different to that of the needs of those born Deaf, or who became Deaf at an early age, which is the group that the present study

is concerned with. Deterioration in hearing in later life and its accompanying psychological distress can be seen to fit in with non-Deaf models of care and therapy.

Although audilogically not hearing, deafened people do not usually identify with the ways, manners, values and beliefs that are practised and held by culturally Deaf people. The essential issue is that deafened people function as hearing people whereas culturally Deaf people do not. Culturally Deaf people refers to those who share similar values and beliefs and who identify with other Deaf people in terms of their history, cultural values, behaviour and mannerisms. Deaf people "achieve" cultural status through identifying with the Deaf world, having shared experiences, and being involved with other members of the Deaf community.

There are deaf children from hearing families who meet deaf peers and perhaps deaf adult role models, encounter and internalise Deaf culture outside their families and so develop a Deaf cultural identity. There are deaf adults who spend a large part of their lives away from other Deaf people and who join the community of Deaf people later in their lives. They may have attended mainstream schools or partially hearing units. Characteristics of deaf people who are culturally 'hearing' and those who are not often overlap, especially in areas of identity and the shared perception of the lack of understanding displayed by the wider culture of hearing people. There are also hearing children from deaf families who may have acquired the culture and language of culturally Deaf people yet, are also hearing people seen as bilingual and bicultural members of the Deaf community.

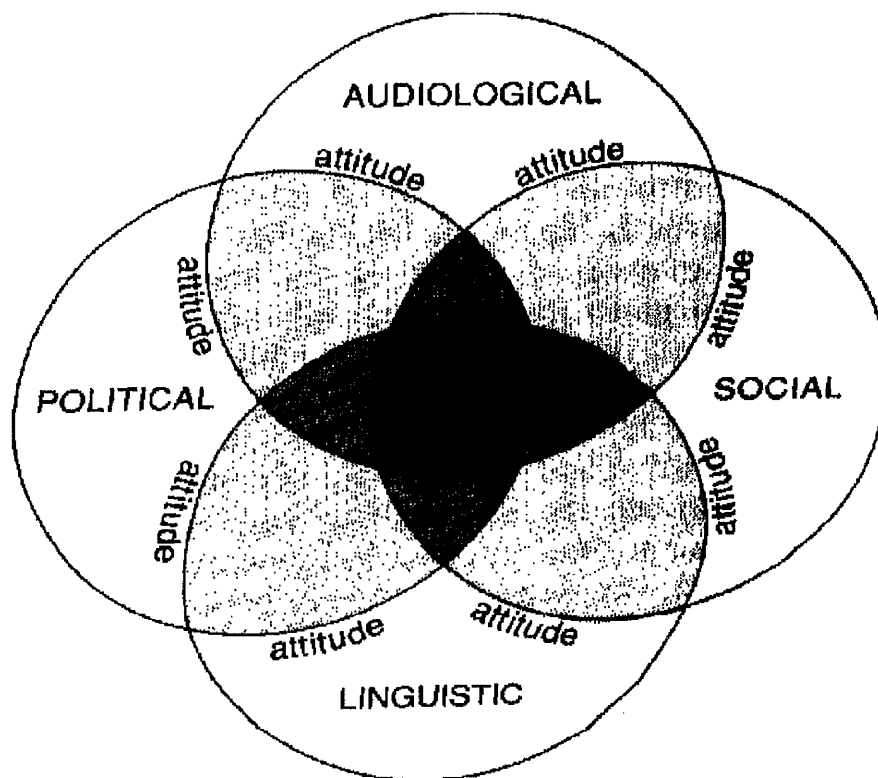
There are many cultures of Deaf people as there are for non-deaf people. In every country there are communities of Deaf people who use Sign Language to communicate (World Federation of the Deaf, 1991). Each country has its own national Sign Language, likewise, spoken language varies from country to country and dialects vary from region to region as do regional sign variations. Some countries with more than one official spoken language will also have more than one Sign Language.

Within each community of Deaf people, there are further distinctions based on their profession or job, race, ethnicity or class. There are various Deaf groups; for example, Gay Deaf groups and Deaf Asian groups. These groups share similar characteristics and essentially use British Sign Language. Between 11-30% of deaf children inherit their deafness and between 10-12% are born to parents who are also deaf (Marschack, 1993, p.14). The uniqueness of culturally Deaf populations is highlighted by the fact that the great majority do not join the Deaf community at birth. This uniqueness gives the community its distinctive feature, in that for most deaf people, access to their 'mother tongue', comes later in life. For the first few years of life deaf children are often treated by their hearing parents in the same way as hearing children. Childhood years are often spent in isolation, away from meaningful and purposeful interaction within the nuclear and extended family. Meaningful and purposeful interaction refers to conversations beyond the simple natural gesture used by many families. The use of other more visual channels are often denied because of lack of appropriate guidance, information and knowledge during and after discovering deafness.

Padden (1980) uses the term culturally Deaf to create a distinction between deaf and non-deaf people who work towards promoting the goals of Deaf people and who might be considered part of the Deaf community, sharing beliefs, not only about themselves but also about those who are not deaf.

Baker and Cokeley (1980) devised the pie chart, Sign Language Continuum, illustrated in Figure 1.1 which shows four different ways deaf people may be Deaf community members.

**Figure 1.1: Avenues to Membership in the Deaf Community**



*Source: C. Baker and D. Cokely (1980) American Sign Language: A Teachers Resource Text on Grammar and Culture. Silverspring, M.D.*

Baker and Padden (1978) put forward the idea which appears to be a compromise, that whilst the Deaf community shares common language experiences and values, it is the **attitude** that appears to determine membership (Baker and Padden, 1978).

The multicultural concept is probably a useful way of describing culturally Deaf people. The term multicultural is often used in describing a social model of society, where in Britain, for example, we encounter people from many different parts of the world and who speak their native languages. The term multicultural is used to describe some of the phenomena that emerge when different cultures meet. Sometimes, the term has a blanket effect when used in that context and is seen to be something non-deaf people are asked to adjust themselves to in everyday life. The concept is new to the (hearing) world and having been borne of various cities, is moving towards urban and eventually, rural use. However, it is not a new concept for Deaf people. Deaf people in Britain represent a population whose major need is one of communication development in at least two languages, the visual-spatial natural language of British Sign Language and the auditory and written language of English.

### Culture and Community - The Fight for Recognition

Political obstacles have prevented the official recognition by the British Government of British Sign Language as Britain's fourth indigenous language (McWhinney, 1996). The first native language is English, second Welsh and third Gaelic. A number of political issues surround issues of deafness and deaf people. Controversy surrounds the question of who has right of membership of the Deaf Community, for example. Some of these arguments can be seen as cultural arguments. There are

also arguments as to whether or not Deaf people are to be described as disabled people, eligible for disability benefits from the Department of Social Security and for other benefits such as free or subsidised bus and rail travel. Most of those who debate such issues do not acknowledge the possibility of dual membership of both Deaf and Disability groups but see the distinction as a choice. This may be viewed as a purely cultural argument. Sometimes this relates to the self-image of the Deaf person - the more negative the self-esteem, the less proud the Deaf person feels about their Deafness. There are several factors that influence this process and this will be seen throughout the thesis. Those attending the European Day of Disabled Persons (1996) support the view that Sign Language is the natural and preferred language for deaf people and that culturally Deaf people have the right to access information in Sign Language. Such recognition has been given by The United Nations Standard Rules for Equalisation of Opportunities (1993) and the UNESCO Salamanca Statement (1993). Various external influences determine when and how Deaf people become part of their own potential community, through affiliation with other Deaf people, by attending Deaf clubs, Deaf centres and national and regional activities and events.

Reference to deaf people has been made at various times throughout history (Hodgson, 1954) and it is highly likely that where a gesturing or signing deaf person is referred to, that he or she will have known another deaf person to communicate with in Sign Language. There have probably always been deaf individuals, and possibly small communities, although little has been recorded until the eighteenth century. There appears to have been a reference to a deaf person in 63 BC, a member of the family of Pedius, at the time Julius Caesar was alive, who could paint

very well "even though he was deaf" (Wright, 1969). A group of brothers who Signed was observed and noticed by a monk, as far back as 352 AD (Augustine).

### The Medical Model

There have, from a medical point of view, been various preoccupations with Deaf people. Most of our earliest information about medical deafness comes from Egypt where priests would attempt to cure deafness by using parts of animals, herbs and other fluids. Deaf people continued to be subject to some horrifying attempts to make them be 'hearing' (Dimmock, 1993; Lane, 1993). Examples from Dimmock (1993) include forcing various chemicals or insects into the ear. The sense of hearing has been seen as necessary for the development of language (Pintner and Paterson, 1916). Language has, until very recently, been seen to mean spoken language. Evidence of such beliefs can be found in various articles including older editions of the Journal of the British Association of Teachers of the Deaf, American Annals of the Deaf and Dumb and the Volta Review.

### Minority Groups and Culture

Deaf communities, whose concerns and mistreatment have been highlighted over the world, compare with no other group in terms of general public misunderstanding and lack of awareness. Cultural Identity for minorities is seen to be intimately related to racism and oppression, from the dominant and controlling culture (Hall, Cross and Freedle, 1972; Jackson, 1975; Parham and Helms, 1981, 1985; Parham, 1989). The existence of Black ghettos, for example the Bronx, is seen by some writers to be a result of racism. To provide an insight into some of the issues faced by deaf

people, a comparison is made with American rioters of the late 1970's, who presented as better educated, better 'integrated' into the social and political aspects of society, holding more positive attitudes towards Black history and culture (racial pride) and were seen not to be 'alienated' from themselves, than those black people not involved in riots. This evidence indicated that the 'rioters' probably had more healthy scores on measurements of mental health (Caplan, 1970). By comparison there is evidence that Deaf people are becoming more conscious of their own Deaf cultural identities regardless of nationality (Padden and Humphries, 1988; Gregory and Bishop, 1991) and are increasingly comparable with other minority groups in terms of perceived oppression and discriminatory experiences. Deaf activists such as Lee, (1992) and Dimmock (1993) present as holding positive attitudes towards Deaf history and culture and are seen to be well educated and aware of the socio-political aspects of society. These features provide a positive sense of well-being and hence a healthy mental state. This thesis hypothesizes that deaf people with Deaf identities will have better psychological and mental health.

Deaf people define some social issues differently and behave in a way that can be misunderstood by many non-deaf people. For example, etiquette and table manners. It is a Deaf norm to eat noisily or continue conversation whilst eating. Deaf styles tend, when viewed from a hearing cultural perspective, to be high-keyed, animated and confrontational and perhaps inter-personal. A Deaf person may also be perceived by hearing people as being irrational or angry, due to misperceptions of non-verbal communications and might be seen as emotional. In another comparison with Black cultural groups, the Reverend Jesse Jackson's key note address at a Democratic



Convention in the 1980's was described as 'moving', "coming from the heart" and "indicative of his sincerity and honesty" but was also described by white TV presenters as being an address more appropriate for a "Baptists revival meeting" and was also described as being "too emotional" (Sue and Sue, 1990). This interpretation is comparable to how deaf people are perceived in society. Deaf people have been described as aggressive and impulsive (Basilier, 1956) and attributed many negative traits comparable to those suffered by black cultural groups (Lane, 1988). Through interaction, misinterpretation and misunderstanding between deaf and non-deaf people occur everyday in various situations.

### The Disability Model

One common hearing view of how best to describe, educate and rehabilitate deaf children and adults is based on the view that deaf people are disabled.

Lane (1992) describes three different perspectives which hearing people tend to adopt in terms of their view of how to deal with deafness:

- a)     imagine themselves as deaf and base their views on this  
       or
- b)     assume "John understands me when I talk to him" so deaf people can lipread.  
       or
- c)     a social identity model which shares attributes which are part of the  
         mainstream culture

These assumptions can lead hearing people to misconceptions about deafness. Other misconceptions found in the following myths drawn from my observation and comments in the literature:

- a) Deaf people lipread well and can hear with hearing aids.
- b) Deafness is a major physical disability.
- c) Deaf people lead isolated and socially impoverished lives.
- d) Deaf parents usually have Deaf children.
- e) Deaf people think in concrete terms and cannot engage in abstract thinking.
- f) Sign Language is universal.
- g) Early use of Sign Language interferes with acquisition of good English skills.

Literature reviews reveal many interpretations of Deaf people which also use a long list of pathological terms. Deaf people have been described most commonly as linguistically deficient, aggressive, immature, labile, uninhibited and rigid (Evans, 1982; Lane, 1989). Sexually promiscuous was another characteristic attributed to deaf people. The clinical (or pathological view), such as that portrayed by Myklebust (1964) further adds to negative views of deafness. Paul and Jackson (1993) see these as value judgements, somewhat avoiding the issue of cultural and linguistic group status. Moores (1987) and Rodda and Grove (1987) have written extensively on the topic of deaf people, who are caught within a mainstream framework that values attempting to learn to speak, read and write. What seems to be a common assumption seen in the literature is that Deaf cultural norms do not include the ability to read and write (Arnold, 1993). Further details can be found in Vestberg (1991) who describes a number of studies of deaf people which have been inappropriate and poor in quality.

## Deaf Well Being

Members of the Deaf community, like people generally, present with mental health, physical health and general care needs, perhaps even more so because of the failure of society to understand the unique differences within their value systems and beliefs which separate deaf people from their non-deaf peers. It is this lack of recognition and lack of awareness of the factors involved in deafness and the use of Sign Language and communication which has resulted in the emerging history of misdiagnosis and inappropriate treatment, based on a lack of awareness or interest in deafness, on the part of mental health professionals. This has resulted in deaf people being placed in psychiatric hospitals for much longer than their non-deaf peers (Adams, 1990; Timmermans, 1988). In addition, deaf people who use mental health services may face additional negative stereotyping. Kailes (1982) asserts this is the situation generally with disabled people who have mental health needs. There is a higher incidence of problems in mental health in the deaf population generally. Alberdi (1996) suggests that 1.9 - 2.8% of Deaf people are receiving specialized psychiatric treatment in Denmark. Kyle and Griggs (1996) suggest that the number of young deaf referrals to one of the specialist deaf units is much higher than for the mainstream population. This figure emanates from a cohort (n=573) of deaf people now aged 35-37 who were initially assessed in 1974-76 (Conrad, 1979). Conrad's study provided evidence that a large number of children educated orally were underachieving. The median reading age found was 9 years. Coates and McClelland (1996) identified 17% of the 16-65 year old deaf population in Northern Ireland as having ongoing mental health problems. Jacob et al., (1991) in the Netherlands, suggest that 20-35 % of deaf people consult specialist welfare services for deaf people.

These figures suggest a higher incidence of mental health problems amongst the Deaf population compared to the mainstream population, an increase that is approximately 6½ times more frequent than within the hearing population. The Health of the Nation (1995) package produced by the Department of Health states that approximately one person in ten suffers from mental health problems significant enough to cause some impairment in usual functioning (Royal College of Psychiatrists, 1995) and of which 4% will develop a psychotic illness. This includes anxiety, phobias, depression, manic-depressive illness, schizophrenia and dementia. Ninety-one million working days were lost in 1990/91 due to sickness absence certified as mental disorder.

### Language

Deaf people are not simply hearing people who cannot hear, which is a commonly held misconception. Some deaf people, mainly those born of Deaf heritage or to non-deaf parents who learnt to sign, acquire a Deaf identity and a positive self-concept from a young age and acquire the ability to develop their natural first language, British Sign Language (BSL). The latter group is growing in numbers. Gregory (1995) identifies a 25% increase in the number of parents who express an interest in learning Sign Language once the diagnosis is made that their child is deaf. The opposition of oral educationalists to bilingual teaching (BSL and English) is partly based on the belief that if a deaf child is allowed to sign, then he or she will not learn to talk. As the majority of deaf children are born into hearing families (Phoenix, 1988) "speaking" is, of course, valued by their parents. Conrad's (1979) cohort study on deaf school leavers who had been educated by Oral/Aural methods were

found to have a normal distribution of intelligence although a poor reading age, of approximately 8½ years. Poor competence in speech and speechreading were also found. Gregory's cohort study (n=91) indicates that 17% of the participants had so little language, spoken or signed, that they could not be interviewed (Gregory, 1995), nor could their responses be appropriately analysed. Poor self-esteem, poor Deaf identity and limited or restricted communication are significantly related (Gregory, 1995).

Conrad's (1979) study indicated the extent the issue of gaining spoken English language had been emphasised together with achievement in his study. Thoutenhoofd (1998) suggests that the results of Conrad's study, and of many studies since then, indicates that the type of placement has very little effect on the educational achievement of deaf pupils. In some ways it was from Conrad's findings that the development of Total Communication took place in the U.K. and more recently Bilingual programmes. A project at the Centre for Deaf Studies, Bristol, (Sutherland, 1993), instigated a programme involving very young deaf children, their families and nursery staff and Deaf mentors who were consultant role models. A number of interesting findings were made. The ability of hearing parents to jointly refer to objects with their deaf children was very poor, compared to deaf mothers. Similar findings were made in the mother-child "babytalk" interaction between deaf mothers compared to non-deaf mothers (Sutherland, 1993). Also, other skills such as turn taking was found to occur much more easily and naturally in deaf mother and deaf child interaction than in hearing mother and deaf child interaction. What these studies suggest is that the earlier Deaf 'mentors' are introduced into families that are not deaf

centred, the better the opportunities for hearing parents to carry out the tasks and functions to meet the deaf child's needs. This will, in the long term, reduce possible anxieties that hearing parents may initially feel when coping with what they may see as a child from another culture.

### The development of Sign Language

Signs emerge around twelve months (Acredolo and Goodwin, 1989). Bonvillain, Orlansky and Novak, (1983) and Harris, Clibbens, Tibbets and Chasin, (1987) report findings which suggest signs emerge a few months earlier and a few months later respectively. The first signs are object signs (Ackerman et al., 1990), gradually moving to combinations of signs and then use of signs in appropriate sign grammar. Research conducted by Acredolo (1989) found signs emerge naturally in all hearing children of hearing parentage, prior to learning how to speak and then simultaneously, with signs gradually being replaced by speech. From these studies, emphasis is given to Bilingualism in deaf education as being a more appropriate means of educating deaf children. The methodology debate does continue however and it does sometimes seem to lose sight of the main issue for Deaf people which is about language use.

However, there are difficulties involved when, in effect, a family is required to "change" their mother tongue. For many families this will be too stressful or a source of pressure that might be felt as excessive. Davies (1991) suggests that this does not have to mean discouragement but bringing in a deaf adult to fulfil the child's need for a comprehensive model of his or her language is contributory to a positive role model of Deafness and what being a deaf adult means. Svatholm (1993) argues

that this helps parents to enjoy more relaxed communicating relationships with their deaf children.

Sign Languages change over time, as with all languages. There are differences in the way users use the language depending upon age and sex, and this is found for both spoken and signed languages. The scientific study of the linguistic status of Signed Languages (Stokoe, 1972; Ahlgren and Bergman, 1980; Brennan Colville and Lawson, 1980; Deuchar, 1981; Petitto, 1983; Kyle and Woll, 1985) has shown that human languages are not restricted to the speech channel with Signed Languages possessing the linguistic features that have been identified as being essential universal features of the world's spoken languages (Petitto, 1983). Deaf children who are exposed to Signed Languages from birth acquire these languages at the same maturation time as non-Deaf children acquiring spoken language and they reach the same linguistic milestones at the same developmental age. The ability to acquire language does not appear to be differentiated between spoken or signed language input and processes appear to be similar (Petitto, 1994). Twenty years of research on the development of Sign Language in deaf children of deaf parents shows language acquisition in deaf children occurs at the same stages and milestones of spoken languages, with the same capacities for complex linguistic systems. The young deaf child has therefore two things to achieve in his or her sign language development. This means spatial perception, memory and spatial transformation, as well as processing grammatical structure, in Sign Language, all in one time regarding the same visual stimuli. Much has been learnt from the structure of brain organisation from studies of visual-spatial language and studies of brain-damaged deaf signers have

helped to understand the cognitive functions, in particular, the relation between left or right hemisphere lesions, (damage) and language (Bellugi, 1991). For example, deaf people with right hemisphere damage were not impaired in their production of Sign Language grammar. Those with left hemisphere damage were seen to be aphasic for Sign Language, typical as for the ungrammatical way a hearing person with damage to the left hemisphere would produce spoken language (Bellugi, 1991). However, there is as yet more to be researched particularly in the area of right hemisphere damage because these signers' production of Sign Language did have spatial deficits but not related to language production.

#### Young Deaf People: Education and Health

The incidental information hearing children have in mainstream schools are often not accessible to deaf children. The 'indirect messages' (incidental learning), of awareness of feelings, attitudes, social skills and awareness of choice is often absent in Deaf children, simply because of inappropriate approaches to living and working with Deafness, mainly due to the poor communication and language skills the children have accessed. This means that conditions of social and emotional growth are often poor and consequently a set of behaviour strategies may develop which can appear negative. In view of these difficulties the deaf child often grows in fear and uncertainty, fear of indicating the wrong things, fear of not understanding others and fear of failure. The result is a set of coping strategies inherited from early childhood which although adaptive at the time in the face of external stressors may become maladaptive and negative during adolescence and early adulthood. As mentioned earlier, 88% of deaf children come from hearing families, very few of whom will



learn any Sign Language although recent research by Gregory (1993) indicates that more non-deaf parents of deaf children are beginning to understand the issues needed to learn Sign Language. Throughout the 1980's and 1990's a great deal of attention appears to have been given to the subject of how to teach deaf children. Implications for self-image and inferiority feelings such as feeling a nuisance value, can be long lasting, resulting in a negative self concept if parental guidance is inappropriate. In the employment sector 80% of deaf people in employment remain in unskilled labour and only approximately 56% of deaf people are in employment (Phoenix, 1988). Deaf people in employment are usually in non-deaf environments, often work alone and as such, are often exposed to rejection, loneliness and isolation from their work colleagues who tend to lack understanding and awareness of Deafness. Being marginalised is an important factor in the mental distress many Deaf people suffer during their working lives, with 70% of deaf people (in this study) reporting significant problems in communication in their working environments. The same is true of difficulties in accessing the wider community since deaf people do not have the same pathways to obtaining information as hearing people. For example, information about public events often do not reach Deaf people, its presentation is usually written or provided through hearing media channels such as newspapers and radio, accessible mainly to those with adequate understanding of English. An examination of the literature on general health services shows that there are many problems faced by deaf people in accessing the health services (Deaf Health in Scotland, 1996; Jackson, 1986; Phoenix, 1988; Schein and Delk, 1974). The main problem appears to be that of communication and not being able to understand what is said. The Cheshire Survey (Cheshire Deaf Women's Health, 1995) revealed that

only 7% of deaf women interviewed said they felt they fully understood their General Practitioner. Deaf people can be seen to be at risk in health settings due to potential misunderstanding and misinterpretation in communication. Mohay and Kleinig's (1991) study of deaf people's access to medical care needs in Australia concludes that health care knowledge is particularly restricted, showing a lack of understanding not only of medical terminology but even common names for body parts (Mohay and Kleinig, 1991). A survey (Gowing, 1996) undertaken by a Social Service department in Derbyshire identified 16% of its young deaf population who should have been offered referral to a counselling service but for whom no service was available. The major need for counselling was identified as during transition period from school to college and vocational training for young deaf people aged 16-25, who made up approximately 10% of the total deaf population. Acute dysfunctioning either during transition or in adult life was experienced by nearly 50% of this group. Presenting problems included relationship difficulties, coping with stress and medical situations. Also self harm, victimization abuse and identity crises.

Research has revealed that most Deaf young people, upon leaving school, aged between 15 and 16, had attained a reading age of 8½ years (Conrad, 1979; Lane, 1995). However, half of the children tested, using the Brimer Wide Span Test were in fact unable to read at all. A minimum reading age of 13 years is generally necessary to read tabloid newspapers, such as the Daily Mirror and Sun (Arnold, 1993). Many deaf children leave school with few or no qualifications, academic or vocational (Phoenix, 1988). The implications are far reaching and extend beyond every day communication issues. The implications of poor reading skills are

difficulty reading letters, difficulty understanding advertising which often use idiomatic English expressions; difficulty communicating with hearing people in writing (using written English), and difficulty using textphone systems now in operation. The introduction of sub-titles on television has done little to help improve access to information for this minority group, which probably benefit mostly deafened or partially deaf people who have English as a first language.

Most of today's deaf adults over the age of 50 attended residential schools which catered for young deaf children up to high school age. Many of them have now closed and some of those remaining have further education colleges attached, e.g. Doncaster College for Deaf People. There is a considerable amount of evidence to suggest that life was sometimes cruel and punitive for deaf children attending the older residential schools from the background information gathered from a number of clients referred to the National Centre for Mental Health and Deafness. This is often seen in those who appear to have developed poor internal controls and who have suffered emotional abuse and neglect from otherwise well meaning carers. This might include making the child look at the speakers lips, who is more often than not using words of which the speech reader has no prior knowledge. It also includes the obvious frustration and strain of family life, when a deaf child is involved and whose family do not communicate. The child is exposed to non-verbal cues in response to his or her demands, which may take the form of frowns, sighing, annoyance or impatience. Additionally carers may often 'give in' to the child's wants. Deaf children are not given access to information concerning appropriate and inappropriate behaviour and in Freudian terms the super ego may develop late, indicating a high

demand for anger management therapy for example. A somewhat egocentric view of the world and self may therefore develop as has been seen to be quite common amongst the client population at National Centre for Mental Health and Deafness, although the actual reasons for referral to the centre vary.

**A young married Deaf couple, caring for their very young baby, sat down at the table to eat. The visual alarm began to flash, indicating their hearing baby was crying. The couple decided to continue eating and supported this action by saying that the baby had to learn to wait. The baby was seven weeks old. Neither of the couple have any learning difficulties or mental illness.**

*(Example from author's clinical practice)*

Often a poor level of insight is achieved and it is difficult to instill further learning or develop insight into rigidly held beliefs once early childhood has passed and the developmental milestones have begun to form.

A further example is seen in the way many Deaf clients seen respond to external stimulus in a suspicious manner. For example, mistakenly thinking two non-deaf people having a conversation are talking about them because eye-contact was made. To further illustrate, in interpreting situations, it is difficult for some deaf people to understand how to use an interpreter appropriately despite repeated explanations. Transference is probably placed onto the interpreter from, for example, a social worker. This might be viewed as a form of dependency on the part of Deaf people which has been learnt and internalised so that it is hard to develop a degree of independency in thinking. Some of these issues can be seen in Erikson (1950), in which problems rooted in "the basic trust versus mistrust" stage are not successfully worked through. Myklebust (1964) claimed that there is a difference in the behaviour

and personality of deaf people and attributed this difference as being directly due to different life experiences of deafness and claims social immaturity as a result. Mykelbust's assertion may be seen as correct, although for different reasons. Differences as perceived by Myklebust are likely due to deprivation of language, access to information and interaction. Deaf children appear to have always managed to learn about Deafness, Deaf culture and language from each other (Kyle and Woll, 1985). Many have spent years of their lives with other deaf children and also, more recently, with deaf adults who work at the schools. These schools become like a beehive, the centre of the surrounding Deaf communities. Today's multicultural environment places emphasis on integration and mainstreaming. This is seen in The Warnock Report, (1978), The Education Reform Act, (1988) and The Childrens' Act, (1989) and means for some deaf children attachment and belonging to the Deaf community comes later in life, often at the expense of their emotional and mental well-being. Chapter 7 in this study describes the link found between indications of psychological distress on the General Health Questionnaire (Goldberg, 1972) and the Attitude and Identity Questionnaire (ATIQ) designed for this study. Jones (National Deaf Childrens Society Development Officer, 1994) has campaigned for the needs of those deaf children educated in a mainstream setting and has established a support group called DEX (Deaf ex-mainstreamers) in order to try and establish a self help group for those who are sometimes referred to as survivors of the system.

Consequently some deaf people internalise hearing (non-deaf) values and feel ashamed to be seen using signs. Oralist factions of Deaf people have existed for a century or so and have an antagonistic attitude towards Deaf users of Sign Languages

(Dimmock, 1993), although many of them do possess and share some cultural features of members of the Deaf community. A French publication "Le Sourd Parlant" (The Speaking Deaf) was launched in the early twentieth century to try and establish a group of deaf oralists but according to Dimmock (1986), its life was short, attributable to the lack of reading skills deaf people possessed (Dimmock, 1986).

Some schools are now using policies which encourage social and academic integration, using biculturalism. The Royal School for Deaf Children, Derby is an example. Research has provided evidence of progress in terms of early language development, both in their native Sign Language and in the country's native spoken language as being undifferentiated cognitively (Petitto, 1994). This would, for a deaf U.K. citizen, mean British Sign Language and English.

### Mental Health Services and Deaf Issues

If a Deaf Sign Language user has a physical problem requiring medical intervention, there are usually difficulties in communicating with professionals. These problems are further compounded if that person has mental health needs. Much of the early literature concentrated on the mental health implications of communication deprivation on the psychological development of the deaf person. Some studies suggested to the possibility of mental health problems arising because of "failed" oralism (Vernon, 1969; Schlesinger and Meadow, 1972). Specialist mental health services for deaf people exist to address Deaf people's particular needs. There are three mental health centres for deaf people in Great Britain. These three centres are The National Centre

for Mental Health and Deafness, Manchester, The Central England Service, Birmingham and National Deaf Services, London. All three centres offer a variety of inpatient facilities as well as day client care and outpatient consultation. One aspect of these services is the recognition of the need for essential and culturally appropriate environmental services for Deaf people with mental health difficulties. The importance of Deaf people being trained in mental health awareness and increasing the number of deaf people involved in service provision is considered vital by all centres yet their practice does not reflect this. Deaf professionals provide positive role models to a range of clients many of whom have suffered adverse life experiences and have poorly developed self-concepts and self-esteem.

Traditionally support networks for those from Deaf communities experiencing mental distress come from the voluntary sector and social workers, often unqualified, attached to pastoral care institutes. Apart from this there has been very little other support available. Psychiatry as a discipline has extremely limited understanding of Deafness or Deaf issues. Mainstream services have probably felt obliged to meet their statutory responsibilities but unfortunately find that in the process their practice has probably resulted in further mental distress (British Deaf Association and National Schizophrenia Fellowship Report, 1996). There are many examples of misdiagnosis and inappropriate treatment of Deaf people (Adams, 1990; Denmark, 1994; Monteiro, 1990; Timmermans, 1989) which continues to the present day.

**Case example: Gordon, a 40 year old Deaf man was referred for an assessment of his cognitive functioning. His social worker suspected he was not capable of managing his affairs, in particular, financial matters. She gave the reason as being because he was withdrawing large amounts**

of his savings, accrued over the years, and apparently giving money to Deaf friends, who were, she believed, taking advantage of his vulnerability. Gordon revealed a history of incarceration. A reading of his medical notes revealed that when he was in his late 20s he had been arrested following an argument with his mother and sister and subsequently referred for a psychiatric assessment. Following this, he was placed on a ward, a nurse observed his 'waving his hands in the air' and concluded he was probably delusional. The consultant psychiatrist in charge confirmed a diagnosis of a psychotic illness. Several years later, after having been subject to course after course of psychotropic medication, several Electro Convulsive Treatment (ECT) courses and a lobotomy, Gordon was rehoused into a community independent housing. It was hardly surprising that Gordon should present as appearing unsure of his affairs. Gordon communicated using Sign and finger spelling. None of the doctors or nurses used Sign communication with him and from what could be ascertained from the medical notes, an interpreter nor even any Signer, a person with communication skills, had ever been used.

*(Example from writer's clinical practice)*

This example provides an insight into the dangers deaf people have faced in the Mental Health System - at risk and unsafe. Such examples are not as few and far between as we might envisage.

In another example;

Case Example: Mary, a 52 year old culturally Deaf woman who presented as feeling depressed, was diagnosed as having a 'Receptive Language Disorder' by the local consultant psychiatrist. Mary communicated fluently in British Sign Language, and like many Deaf people who had been subject to English speechreading throughout her school years she had poor English skills - about the level of a ten year old. An interpreter was not used for any of the consultations she had with various locum psychiatrists, who would regularly see her for reviews, at least one of whom confirmed the earlier diagnosis of a 'receptive language disorder'.

*(Example from writers clinical practice)*



The referral was received in 1995 and Mary was eventually seen by a Deaf counsellor, after several overdose attempts, who assessed her and offered counselling for depression. There was a marked improvement after a few weeks.

It is only recently in the late 1970's that studies began to look at mental illness and implications of cultural diversity. Numerous studies have examined minority groups and this is discussed further in Chapter 9. The concept of culture-bound syndromes emerged and were highlighted in the early 90s (Beiser, 1987; Kleinman, 1987). Philip Rack's book 'Race, Culture and Mental Disorder' (1982) was one of the first book to directly address what he described as pitfalls in the recognition of various mental illnesses amongst ethnic minorities. Fernando (1986) wrote extensively on ethnic minority groups and misconceptions of Western psychiatry in using their own tools, (the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R), 1987, and International Classification of Diseases (ICD-10), 1992) to diagnose and treat all clients in the same manner based on the assumption that signs of illness are the same for every culture. A later publication challenges what may appear to be seen as mental illness amongst ethnic minorities as possibly being expressed distress (Beliappa, 1991). The most recent contribution to this field of transcultural psychiatry or multicultural mental health (Fernando, 1995) provides practical multi-disciplinary ways of working. In none of these books is Deaf culture referred to. Mention is made of an increased incidence of deafness amongst Asian families (Rack, 1982) which might lead to an incorrect diagnosis of mental handicap or behaviour disorders. It has been thought the higher incidence of deafness in this population might be due to poor antenatal care and lack of education (Rack, 1982). Deaf culture

is not referred to in the literature on transcultural psychiatry or in mental health in ethnic minority and multi-ethnic groups, and as yet are not referred to in the literature in any discussion concerning mental health and culture. Examining cultural variations of mental illness indicates the need to look at the way symptoms are reported, possibly misinterpreted and misdiagnosed by the psychiatric profession. Since 1968 when the first centre opened at Whittingham Hospital, Preston, (now the National Centre for Mental Health and Deafness (NCMHD), Manchester), there has been little improvement in the level of awareness amongst the psychiatric profession as a whole. Some disillusionment exists about the controlling aspects of the deaf psychiatric services in the community as a whole. This is addressed in the Health Advisory Service Thematic Review of Mental Health Services to Deaf People (1997). The issue is raised as to the future direction of development of services to Deaf people in this area and an emphasis is placed on the preferable structure of decentralisation. Deaf people continue to be disadvantaged in their access to appropriate mental health services. It seems strange to many people to be discussing Deaf people as a cultural group. There is a belief which continues in many societies, that a person who does not hear is a person with a deficit, an impairment. Such a person would not be seen as a member of a separate cultural group.

It is not very long since deafness was seen in only medical terms and it is not much longer since deafness was viewed as a learning disability in itself or an indicator of inability to acquire language. The experience of living with a 'stigmatised' identity has been studied by Coyle (1993) who found that this experience contributes to lower levels of psychological well-being than in the general population. There are many

professionals 'treating' people for their deafness and many more who although they know there is no 'treatment' to cure deafness, believe that deafness is not 'normal' or is a disability. Some believe deafness has tragic consequences (Ashley, 1994). Numerous other references exist supporting this perspective although it is mostly in connection with a later in life trauma of deafness that a 'tragedy' is described.

There is an increasing number of mental health professionals who feel that deafness does not have to be seen as a pathological condition but lack information to contradict the prejudices and images of deaf people they will have learned from everyday life, or perhaps from their own training.

Many of the present difficulties are rooted in the education of medical professionals, psychologists, teachers, social workers and in fact any one concerned with the development and well being of deaf people of all ages, who will have been exposed to material and resources which have been borne out of common misconceptions about deafness. The position in this respect is very similar, as previously mentioned, to that of the various perceptions held about black (Afro-Caribbean) people (Lane, 1989). Research has shown the number of black people have been, and continue to be, over representative within the British mental health services (Fernando, 1991; MIND, 1995; Rack, 1982).

In the field of mental health, deaf people continue to suffer a unique disadvantage. Cultural features of deaf people have been, and continue to be, described as aggressive, egocentric, immature, and rigid (Rainer and Altshuler, 1968). Denmark

(1972) went as far as describing Deaf people as having explosive personalities. Although these dates appear to have been sometime ago, the research papers and articles remain easily available and accessible and therefore continue to provide readers with misleading information. This again provides further evidence of the imposition of one culture onto another. For example, Denmark uses his own values and norms and compares the differences presented by culturally Deaf people as, not only deviance, but indicating various forms of personality disorder. In diagnostic terms, assessment, treatment and therapy have presented serious disadvantages for deaf people in view of the inappropriateness of measuring (psychometrics, for example) with use of hearing norms and values as criteria. This includes direct use of psychiatric measures such as the Present State Examination and Clinical Interview Schedule. The result has been a high proportion of Deaf people diagnosed either incorrectly or mental disorder being missed altogether. Sometimes when mental distress has been missed, the difficulties have been attributed to the cultural features of Deaf people, interpreted as deviance rather than different. Research analysed in this study has revealed a threefold increase in the incidence of depression and anxiety in a population of Deaf people compared to that of non-deaf people. The results are described in the Chapter 7. The results of the research in this study also show that Deaf people are three times more likely to have suffered sexual abuse than hearing people. A number of risk factors are identified, including early language deprivation, poor communication at home and at school, lack of access to information and poor self image. The internalisation of a negative self concept continues to contribute to the increase in life stresses suffered by young Deaf people which result in the

disproportionate number who complain of psychological distress. Evidently many deaf people develop negative coping strategies.

Misconceptions of deaf people throughout the centuries continue at many levels, largely due to misunderstandings and perpetuation of commonly held myths. Oppression and discrimination emerge in the form of continuing lack of access to information, lack of opportunity in the field of further and higher education and lack of opportunity in employment. Deaf people continue to be discriminated against widely in all avenues of society (British Deaf News articles; Padden and Humphries, 1988; Lane, 1992). The European Parliament has referred to the adverse situation of people with disabilities and the discrimination experienced. In its Resolution 83-580/93 (April, 1993), following the United Nations General Assembly resolution, the Commission set up forums to investigate further (Commission on Equality of Opportunity for People with Disabilities - COM (96) July 1996). It was found that exclusion and discrimination existed and was against various universal human rights (Article F.2 of Treaty on European Union). The European Union for the Deaf is included in the Commission, representing thirteen major European Deaf Organisations (NGO's).

The history of misdiagnosis and mistreatment, and inappropriate access or lack of access to proper services provide evidence of the need to not only re-educate ourselves but ensure that local and central services are accessible, are appropriate and are Deaf 'friendly'. The first task, therefore, is to inform you about the nature of deafness. This section has presented the issues of deafness from within.

## **CHAPTER TWO**

### **MENTAL HEALTH ISSUES AND DEAF PEOPLE: AN EXAMINATION OF THE LITERATURE**

Deaf people in Britain who suffer from mental health problems are frequently over-, under-, or misdiagnosed. Their care is undertaken with what might be called a 'hearocentric' bias which often leads to ineffective and culturally insensitive treatment.

There is increasing concern about the way in which mental health services in hospitals, general practice and community settings appear to omit meeting the mental health needs of deaf people from care planning programmes, at all levels of service provision. Furthermore, deaf people are often placed into categories of conduct or emotional disorders because they do not seem to fit anywhere else. This raises a concern that conditions or symptoms of deaf people, are lumped together which sometimes happens because we do not have well established alternative ways of assessing deaf people who present with mental health problems. Deaf people who are not well understood by hearing professionals are likely to be at risk of misdiagnosis.

Poor communication may lead to misunderstanding or the misinterpretation of symptoms. There can exist, on the part of the health professional, a reluctance to take the deaf individual seriously. This risk remains even in the presence of a Sign Language interpreter, who may lack understanding and awareness of mental health issues and who may misinterpret the client's meanings.

Much of this appears to stem from a failure to recognise that most of the difficulties deaf children experience within their non-deaf families are due to a number of external factors such as inappropriate, or lack of, guidelines; lack of support and access to Deaf awareness; lack of access to Deaf community and culture and to Deaf role models. Research has shown that non-deaf parents can be willing to learn about their deaf child's culture and language and thus develop close relationships and positive attachment and bonding with their deaf children (Lederberg and Mobley, 1990; Sutherland, 1993).

Past suggestions of the social construction of a 'Deaf personality' have had a powerful influence in the literature. This continues despite Lane's (1988) identification in the literature, regarding the views and traits white people (Europeans during the age of colonialism) held of Africans which are almost identical with the many traits, all negative, attributed to deaf people (1988). Lane (1988) argued that this is the result of paternalistic attitudes and ethnocentricity on the part of white Westernised Europeans. This reinforces the need to consider behaviours and emotions within an appropriate cultural and experiential context (Miller and Rose, 1986).

The Department of Health (1995) produced a fact sheet for its 'Health of the Nation' series, suggesting that about one out of every six or seven people will suffer from mental health problems and that of these mental health difficulties experienced, about 4% will experience a more serious illness such as schizophrenia, paranoia or an affective psychosis, including short term psychotic episodes in depression. These are the figures for the whole population. However, research evidence and experience

suggests the incidence of mental health difficulties, experienced by deaf people is significantly higher than for the non-deaf population. The Office of Population Censuses and Surveys (in Britain) carried out a survey of almost 10,000 (non-deaf) adults and found 16% to have a psychotic or neurotic disorder of some kind (1996). This kind of information has also contributed to the view that there is a separate psychology of deaf people and which may be based on the idea that deaf people are seen to experience things differently but to the extent that their particular difficulties and presentation of problems are different. Basilier (1956) in Sweden suggested the need for the creation of a new diagnostic criteria which he termed 'Surdophrenia' and which was used to describe deaf people who seemed to fit his version of what he saw as 'emotional and conduct disorders'. The term surophrenia (deaf mind) is not used much now in the U.K. and is rejected by the European Society for Mental Health and Deafness, as a somewhat derogatory term and has been replaced by 'emotional and conduct' disorders (Swan-Joha, 1988). The term Primitive Personality Disorder, a synonym of surdophrenia, continues to be used in some literature, for example in a recent article by Vernon and Rich (1997) on deaf paedophiles.

Several studies have been conducted to examine the prevalence of mental health problems and disorders in the deaf population. Deaf people are as likely as non-deaf people to develop mental health problems both during childhood and later. Literature in the field of deafness and mental health originally tended to focus on the implications of not having any language, or what was seen as no language and how this affected psychological development of the deaf person. Earlier studies (Vernon, 1969; Schlesinger and Meadow, 1972) were based, more or less, on the premise that



some mental health problems actually developed because of the use of aural/oral and speechreading methods in schools for deaf children. Deaf education is usually part of a larger discipline termed special education. The main drive of special education since the early 1960s when it was first introduced in the USA, Canada and gradually in Europe and the U.K., (Education Act, 1981), has been a focus on integration or mainstreaming. The mainstream movement seems to have gained its initial momentum from the field of learning difficulties and deaf education (Stoker and Spear, 1984). Studies have suggested that resources are not available to accomplish an integrative objective for all deaf children (Stoker and Spear, 1984). The trend continues to place an emphasis on mainstreaming despite the strong counter-argument from many educators, both deaf and hearing, who state that deaf people are a minority group and need access to their peers in order to develop relationships and interpersonal skills and so achieve appropriate developmental milestones. This issue has attracted a great deal of debate (Kannapell, 1980; Baker and Battison, 1980; Bienvenue, 1988; Padden and Humphries, 1989). The Special Education Needs (SEN - Green Paper, November 1997) has provoked an angry response from the Deaf community in the U.K. The SEN paper does not indicate recognition of Deaf people's culture, community and language and appears to describe all deafness as being hearing impaired. However, little research has been done concerning the implications of mainstreaming. It is likely that the accessibility of communication used and the presence of deaf peers will be more significant than the type of setting. These issues are referred to here because they highlight a need for research to be directed at what happens in the socialization processes both in and out of school in integrative settings. The dynamics, from a psychological perspective, of social

interaction between deaf and hearing children at pre-school level is seen as an essential factor in determining early intervention programmes for deaf children (MacDougal, 1991). Such intervention, when appropriate, can serve to reduce the risks of psychological distress in later life. In this respect the Special School has been seen to have a role in the well-being and psychological development of deaf children regardless of the language used in communication with educators, because of access to interaction with their peer group. The Special School thus appears to have a useful role in the education of deaf children (Jordon, Gustason and Rosen, 1979; Padden 1980; and Greenberg and Kusche, 1993). However, the level of academic achievement has been poor.

### **Aetiology of Deafness**

To remind the reader of the population referred to here, it is deaf people who are usually defined as prelingually deaf, prior to spoken language development. The term prelingual may be seen as a somewhat odd way to describe deaf people who are deaf from an early age, because all babies are born 'prelingual', regardless of hearing status and furthermore, the term contradicts itself since the awareness that Sign Language is a language in itself, and therefore equivalent to spoken language.

The ratio of this group of deafness in the population is approximately 1:1500 (Department of Health, 1985). Past figures were higher, approximately 1:1000 and have now reduced due to increased inoculation against infections such as Rubella. Rainer and Altshuler (1971) show that about 90% of those born with early or congenital deafness are born to hearing parents. In addition, over 200 genetic

syndromes have been identified which are related to deafness (Kent, 1997). This will cause a pro-rata raise in the numbers of deaf people likely to have difficulties, perhaps behavioural or learning difficulties, when compared to the non-deaf population. Medically, childhood deafness can be linked to certain phases in pregnancy, aetiology (genetic, infection, metabolic or traumatic for example) or to the audiological mechanism (glue ear for example, which may cause conductive deafness). Changes have taken place, reflected for example, by the generally lowered incidence of deafness caused by such infections as measles, meningitis and congenital rubella. Martin's (1982) study of 8 year old deaf children in the European Commission included information on causes of deafness for 3,462 children. The questionnaires were completed mainly by medical officers. Forty two percent reported no specifically known causes, 16% were congenital rubella syndrome, 12% from genetic disorders, 6% meningitis and 12% birth difficulties. The main problem with the figures is that information was gathered concerning deaf children with deafness levels greater than 50 db which does not indicate specifically what differences aetiology there are in those with greater levels of deafness, if any differences at all.

### **Prevalence of Mental Health Difficulties**

Denmark (1985) studied a total of 250 patients referred to a Department of Education for the Deaf in Whittingham, Preston. A table of diagnoses, shows a large proportion of clients as mentally handicapped. Fifty-three were shown as having problems related to their deafness, defined as behaviour and maladjustment problems. Three people were shown as suffering from depression due to acquired deafness and one

person from alcoholism which was attributed to the onset of acquired deafness. One hundred and four were diagnosed as mentally ill. Of the 104, fourteen were described as having an affective disorder and twenty-six were seen to present neurosis and personality disorders. This has implications for the prevalence of mental health problems. Table 2.1 lists the results of studies which have examined the prevalence of mental health problems within a deaf population.

There are three specialist centres in the U.K.. These are the National Centre for Mental Health and Deafness, Manchester; Mental Health Services for Deaf People, Birmingham; and The National Deaf Service, London. Apart from these services which go some way towards providing Deaf Centred services, with some skilled staff who can communicate in Sign Language, there are no other established services, locally or regionally which can help to meet the mental health needs of deaf people, although some areas are considering the possibility of having their own satellite clinic and some deaf people wish to take up training in counselling. Although this will go some way towards alleviating the present situation, there will nevertheless be difficulties in obtaining funding for such initiatives. The majority of mental health professionals have little or no knowledge or awareness of the language and culture of Deaf people. There has been some attention given in the literature to the difficulties faced by those in a range of disciplines who attempted to formulate an understanding of a culturally Deaf person without appropriate knowledge and understanding of deafness (Denmark, 1969; Schlesinger and Meadow, 1972; Adams, 1990; Kitson and Fry, 1990). These problems are partly those which any practitioner would experience with clients from another culture and who use another

language but are also due to the difficulties that arise from the poverty of access people have to information about mental health.

**Table 2.1: Studies of the Incidence of Mental Disorder in Deaf Populations**

Authors	Study Population	Most Common Disorders (% of total)
<u>United States</u> Altshuler et al., (1971)	217 Outpatients	46 (21.2) Schizophrenia 34 (15.7) Passive-aggressive personality disorders 19 ( 8.8) Homosexual 15 ( 6.9) Mental Deficiency
Vernon (1968)	121 Outpatients  31 Inpatients	27 (22.3) School Situational Reactions 17 (14.0) Schizophrenia 9 ( 7.4) Inadequate Personality 9 ( 7.4) Antisocial Reaction 26 (83.9) Schizophrenia 3 ( 9.7) Inadequate Personality 3 ( 9.7) Depressive Reaction
Altshuler and Rainer 1970	230 Psychotic Inpatients  92,409 Hearing Inpatients	120(52.2) Schizophrenia 42 (18.3) Psychosis with Mental Deficiency 17 ( 7.4) Senile/Arteriosclerotic Psychosis 16 ( 6.9) Other Organic Psychosis (56.5) Schizophrenia (16.2) Senile/Arteriosclerotic Psychosis (12.0) Other Organic Psychosis ( 8.0) Cycloid and Involutional Psychoses
Altshuler et al., (1971)	171 Inpatients	81 (47.4) Schizophrenia 17 ( 9.9) Personality Disorder 17 ( 9.9) Adjustment Reaction 11 ( 6.4) Psychotic Organic Brain Syndrome
Robinson (1973)	150 Inpatients	40 (26.7) Psychosis Unassociated with Brain Syndrome 35 (23.3) Transient Situational Disturbance 23 (15.3) Neurosis
<u>Europe</u> Denmark and Eldridge (1969)	170 Outpatients and Inpatients	66 (38.8) Behavioural problems/maladjustment 26 (21.2) Schizophrenia 9 ( 5.3) Deafness with Subnormality
Denmark (1985)	28 Inpatients	<i>Author's Diagnoses</i>  14 (50.0) Schizophrenia 12 (42.9) Undiagnosed Psychiatric Disorder  <i>Other's Diagnoses</i>  10 (35.7) Mental Retardation 7 (25.0) Schizophrenia 4 (14.3) Manic-Depressive Illness 3 (10.7) Undiagnosed Psychiatric Disorder
Denmark and Warren (1972)	109 Inpatients	47 (43.1) Schizophrenia 34 (31.2) Behaviour Problems/Maladjustment
Remvig (1969)	30 Inpatients  10,390 Hearing Inpatients	6 (20.0) Schizophrenia 6 (20.0) Unclassifiable Psychosis 5 (16.7) Behavioural Disorders 3 (10.0) Organic Brain Syndrome with Retinitis Pigmentosa (59.5) Schizophrenia (8.2) Manic-Depressive Psychosis (7.4) Presenile Psychosis (5.4) Other Organic Psychosis

*Taken from Health Advisory Service Thematic Review (1997)*

Several studies have been conducted to examine the issues involved in mental health assessments of people from different cultures (Ekman and Friesen, 1968; Grant, 1970; Leff, 1973; World Health Organisation, 1973). Issues in diagnosis do not only emerge in cross-cultural studies, (Miller and Rose, 1986; Littlewood, 1990), some studies concerning class distinctions (Bernstein, 1958; Crandell and Dohrenwend, 1967) have revealed differences in the way people verbalise their feelings. Leff (1973) has raised the question about culture in developed countries and the way emotions tend to be differentiated more in some cultures than in others. Influences probably stem from where importance is emphasised for example, in individualization or groups, extended family or immediate family values or those of the tribe for example. These influence the way the culture is formed and created, the way people relate to each other, their values and beliefs. Likewise, the Deaf community has its culture based on a set of beliefs and values. The ability to judge a person's *mood* depends on observation of non-verbal behaviour as well as what the person is saying, which can be very different in its expression and presentation from culture to culture (Leff, 1973; Rack, 1980). Cross cultural differences can be powerful in the area of mental health and the culture of Deaf people will be exposed to as many of the dangers and risks of misdiagnosis and misunderstanding, if not considerably more so, than between ethnic cultural groups. The strongest influence on a child's development of language is its parents' use of language (Leff, 1973). Deaf children, the large majority of whom are born of non-deaf parents, are thus usually without immediate access to the parental language.

These studies later attracted attention to the field of cross cultural psychiatry. The World Health Organisation conducted a major study (The International Pilot Study of Schizophrenia, 1973) (IPSS) involving nine countries in order to discover links between a particular culture and the relevant verbal aspects of its language. Studies focused on the issue of how we express ourselves, and the origin of our expression and thinking. The IPSS study predicted that significant variation between countries in emotional differentiation would be found, expecting developed countries to show greater differentiation. Although the study had several weaknesses, it did establish there was a strong link between the availability of appropriate terms for different emotions and how easily people could express themselves.

The translation of the instruments used (Present State Examination (PSE); Wing, Burley, Cooper, Graham and Isacss, 1967) presented difficulties rather like those described later in this study. Conclusions of this and other studies (Beliappa, 1991; Fernando, 1991; 1995) indicate strongly that cultural factors must be considered prior to any interview for assessing mental state. Cultural influences can determine the difference between a diagnosis of schizophrenia or no diagnosis at all. Several studies have researched into this area. The Department of Health have raised concerns about the disproportionate numbers of Black people who have been given such diagnosis when in fact it has been an imposition of one culture onto another. This undoubtedly was the turned stone which generated interest and research in transcultural issues but still there was no reference to Deaf people, their culture and linguistic recognition.

Coates and McClelland (1995), in their survey, reveal a high number of deaf people who are experiencing mental health problems, 17% of the 16-65 year old deaf population in Northern Ireland. Jacob et al., (1991) in their study in the Netherlands show 20-35% of deaf people are in contact with their social workers due to experiencing mental health problems. Kyle (1996) claims 1.92% of deaf people aged 31-35 years are referred to the mental health services in the U.K. Phoenix (1988) found a high proportion of deaf people were unemployed compared to non-deaf people. Coates and McClelland, (1997) have also found that 30% of deaf adults were unemployed (more than three times the rate for the hearing population); 10.5% of the population interviewed had a physical disability and 9.3% had some degree of learning disability. In the present study the population sample shows that 37% of deaf people were unemployed at the time of interview and of those who were employed, 73% were unhappy at work, due specifically to communication issues. These figures contribute to the limitations in deaf people's lives and will affect the deaf persons well-being, powerful influence from in their educational experiences. Seventy-five percent of the sample reported that they felt their teachers did not understand them and 61% reported being unable to understand their teachers at school. These figures are considered to be representative of deaf people throughout the U.K. and continue to be the case in schools that use oral/aural methods or what is known as "Total Communication", which is a philosophy of communication that encourages educators to use the best suited method of learning for deaf children. The BATOD (1994) review of educational services for deaf children in the U.K. show there are a large number of establishments who continue to use what is called a Total Communication approach. The philosophy has been somewhat diluted and most



practitioners tend to see it as meaning sign and spoken language simultaneously (Manually Coded English) (MCE). This has caused some difficulties in the management of language acquisition for deaf children who continue to be confused between the two languages, BSL and signed English (Signed Supported English).

Many adults today were educated by the oral/aural methods and although the numbers of deaf young people who are educated using some form of Sign is now increasing, it is still not possible to obtain a more accurate picture of how much of the possible presented mental health difficulties are attributable to inadequate educational methods or how much is due to other factors, such as genetic or organic factors. There does seem to be a concentration of emphasis on the method (language) of communication used with deaf children and little emphasis on a range of other factors such as environmental exposure, cultural awareness, knowledge of Deaf history, arts and Deaf literature, norms, values and beliefs, gained mainly from exposure and interaction with other deaf people.

The measurement of mental illness and mental health depends to a large extent upon the norms, values and beliefs of the society being "measured" or assessed. Mental health is associated with the ability to relate to others, develop insight, empathy and attachment to others. Deaf people who have been deprived of experience which would have otherwise have provided them with healthy mind states are vulnerable to being seen as unwell. Deaf people are often cut off, from birth, from their peers (deaf peers). They are also not functioning as hearing members of a hearing society. Most attempts to measure ill-health are based on hearing society which includes its

cultures values and norms, so that even when translated into Sign Language, deaf people are unintentionally still subject to measurement based on hearing cultural values and attitudes. The issue of appropriate translation of material between various cultures is discussed further in a Chapter Four 'Issues in Translation'.

In the field of mental health the orientation of an individual's feelings, thought patterns and attention, and affective state, are measured by questions focusing on the mental state. Together with gathering background information, a classification of mental functioning is made. Information from the client is also included in the collection of data concerning the history. This indicates immediately the difference between physical state examinations and Mental State Examinations (MSE), where the latter clearly relies upon communication with the client to reach a conclusion from an assessment. Assessors need to be aware of the different ways deafness is experienced and of how this shapes the cognitive functioning process, developmental patterns, social relationships and family interactions. Whatever shape the MSE takes, the deafness must be seen and recognized and the interview Deaf centred. Furthermore the way language is used or distorted is often a key to the type of disorder being examined. The clinician therefore not only needs to be able to communicate fluently in Sign Language, but also needs an in-depth knowledge of the linguistics of that language. At this time, none of the clinicians engaged in working with deaf people using Sign Language as their first language have any expertise in the linguistics of Sign, hence would likely be unable to properly assess persons with language disorders. The difficulty is complicated by "normal for deafness" linguistic and cultural styles, (Stokoe and Battison, 1981) which are attributed to deaf clients.

These approaches can confuse, distort or 'bury' psychological difficulties being experienced by the client (Evans and Elliott, 1981). Issues involve poor interpretation of the written language of deaf clients which might lead to misdiagnosis. The language might be seen as concrete and primitive (Evans and Elliott, 1981). Kitson and Fry, (1990) have also commented on this. Rainer and Altshuler (1968) and Baroff (1963) warned that there could be difficulties in assessing thinking disorders and dissociative states in deaf people without appropriate knowledge and expertise, however, not for the same reasons this is now pointed out (Kitson and Fry, 1991), which is, that deaf people's written English cannot be characterised nor used as a basis on which to determine deviation, regardless of expertise and skills of the practitioner.

In the same way, showing of affective states, feelings and affect, and considered 'appropriateness' or the inappropriateness of the language are difficult for hearing cultured persons to appreciate in deaf people and therefore this will cause difficulty in empathising, particularly concerning feelings. The area of weakness which may be the most troublesome, is in the restriction placed on the expression of sign language nuances, regardless of how fluently the assessor signs. It can be difficult to discern anxiety or the level of one's depressed state when the client is not only in an unfamiliar situation but also subject to exploring new language. This is why the gathering of background information is of added importance in any assessment of deaf persons. A culturally depressed deaf person may convey a level of anxiety that is due to the situation of being interviewed and this could be seen as the major concern. In

another example, an anxious person may present situationally provoked behaviour in relation to his anxiety but which may have an emotional base.

In the field of psychological testing, it is of particular importance for any evaluation to be carried out on the basis of a battery and not a single test (Pollio and Pollio, 1991). There are a number of issues related to thinking and language and deaf people, which have been explored by several researchers (Furth, 1966; 1973; Vernon, 1967; Schlesinger and Meadow, 1976; Martin, 1991; Marschark, 1993; Paul and Jackson, 1993). Thought processes that may seem pathological in a Mental State Examination might be due to the deaf person's difficulty in understanding the interviewer or it may be due to pathological difficulties. Meadow (1980) suggests that difficulties in communication are linked to thinking and implies deaf children therefore must lack an ability to think, because they are without the tools to use thinking skills.

There are other issues which hearing culturally bound mental state examinations raise. Hesitation in a deaf client might equally be due to difficulty in producing language the client hopes the interviewer will understand. This is an issue that many deaf people tend to take on responsibility for themselves, knowing that interviewers are usually, and still are, culturally hearing persons unlikely to be fluent in the first or preferred language, or at worst, unlikely to understand deaf people, their ways, norms and values. At the time of writing, none of the specialist psychiatrists working with deaf people are fluent in British Sign Language although some have advanced level certificates (level III) awarded by the (Council for Advancement of

Communication with Deaf People C.A.C.D.P. Appendix 2). These certificates provide evidence of a level of meaningful communication that can take place between deaf and hearing persons but do not indicate fluency in that language. This really challenges present practice even where the interviewer has an advanced level certificate (level III) because if the starting point were the advanced interpreter level, this would indicate a much better breadth and level of understanding of deaf persons than presently takes place in mental state examinations. Deaf clients have often commented on the stress they feel in Mental State Examination interviews. Apart from what one would consider to be a usual level of anxiety in such interviews, Deaf clients have also borne an extra burden - that of actually *taking on* the responsibility to enable communication and the facilitation of such communication to take place. This is something many deaf people have "habitually" done since childhood and internalization of this extra 'burden' is a necessity that becomes crucial in mental health settings. Historically, the view was that doctors attempting to make diagnoses had to teach their patients to sign to make a more accurate diagnosis (Rainer, 1966).

In assessment of possible thought disorders in Mental State Examinations, interviewers need to be aware that the presentation of Sign Language, or spoken English at whatever level of aural clarity, is being presented for the hearing person, and may not be a natural production. The same applies to assessing other thought processes such as appropriateness in responding to questions - the possibility of misunderstandings are raised particularly if relying on means that are not necessarily the client's preference but out of necessity. Assessment of abstract thinking processes is probably one of the hardest parts to assess. In order to think in abstract terms, to

translate and produce requires a degree of fluency and essentially, ease in communication, whichever language is being used. Abstract thinking is very much culturally bound, to the white western approach to psychiatric thinking, and will contain profoundly hearing norms, expressions and metaphors.

Another area where a large degree of misdiagnosis takes place is in information and intelligence assessment. Psychological testing is geared towards culturally hearing persons. Alterations can be made to some extent, although what usually happens is that parts are omitted, such as parts involving spelling or those involving speech or comprehension of English, and the rest are made "to do". Many deaf people have been mistakenly diagnosed as having learning difficulties due to inappropriate, or lack of, awareness of issues involving deaf people. Mis-spelt words, poor grammar and syntax, may be regarded as evidence of intellectual impairment (Monteiro, 1994). Several psychologists have raised issues related to the use of tests standardised on hearing persons (Levine, 1974; Sachs, 1977; Zieziula, 1982; Elliott, Glass and Evans, 1987; Orr, DeMatteo, Heller, Lee and Nguyen, 1987). Zieziula (1982) claims that some scales used to assess deaf people have altered instructions through using demonstration/mime and gesture and probably sign too (Halgin and McEntee, 1986).

Personality measures such as the Minnesota Multiphasic Personality Inventory (MMPI) and the California Personality Inventory (CPI) are usually not considered appropriate for deaf people because of the verbal loading and the need for good reading skills (Halgin et al., 1986). Brauer (1988) has performed a translation of

the MMPI with a reasonable reliability and validity. However, as pointed out by Thomas (1984), the MMPI does contain a lot of hearing cultural norms as reflected in questions such as "I am quite often not in on the gossip and talk of the group" or "I dislike having people about me".

On the other hand, learning disabilities have been missed because the interviewer has only acknowledged the deafness. This has been supported by Moores (1978) and Funderberg (1981). Funderberg (1981) suggests the number of learning disabled deaf youngsters is around 40% of the deaf population (American study in 1981). There are also difficulties in assessing psychotic experiences - such as a range of hallucinations or illusions. A great deal of interest is usually shown in this area which raises the fundamental question "Do people who are deaf actually 'hear' voices or do they 'think' they do"? If deaf people "think" they do - is this based on the abilities of the imagination or is the terminology used by the deaf person, containing the phrase 'hear' an internalization of the way people talk to each other? "Have you heard about ..." is a typical example of phrases deaf people frequently use, in whichever language they are communicating. Remvig (1969); Evans and Elliott (1981); Denmark (1994) and Monteiro (1994) have created awareness of these issues in the literature. Auditory hallucinations among deaf people have been noted as far back as 1886 (Stearns, 1886). Stearns wrote a paper containing a case history of a "deaf mute" woman who experienced auditory hallucinations. Altshuler (1968) wrote about a man, from the age of 13 months, who heard God's voice. Altshuler's client drew a picture of *vibrations* entering his body and ears, through wires. Remvig (1969), who did a more extensive review, found the first report to be in 1867 and he

also reported four deaf clients of his who experienced auditory hallucinations and also vibrations as puffs of air. Altshuler (1971) raised the question not of *how* deaf people experience auditory hallucinations but *why* they should experience this. It was Evans and Elliott (1981) who concluded that those clients who experienced auditory hallucinations had in fact been born hearing or who in any case, had already experienced sound.

An imaging study of auditory hallucinations in profoundly prelingually deaf clients with schizophrenia has been conducted to define brain areas which are active during deaf people's experience of auditory hallucinations (Kitson and Robertson, 1997). In hearing schizophrenic clients, an increase in blood flow to the left anterior brain regions, which are involved in language production and perception, was found and was caused by the experience of auditory hallucinations. Of interest, no brain areas were active when profoundly deaf clients with schizophrenia experienced auditory hallucinations. One theory is that the auditory hallucinations arise due to failure to monitor "inner speech" production which is then seen as "alien". The incidence of schizophrenia in the deaf population is considered to be the same as in the mainstream (Monteiro, 1994) and in support of this, Mendlewicz (1980) found that relatives of deaf people with schizophrenia also experienced schizophrenia in the same way as non-deaf people. Of on-going interest in the literature, is that the hallucinatory experiences of deaf people were seen to be different to those of hearing people (Critchley, Denmark, Warren and Wilson, 1981). Haptic hallucinations, passivity phenomena and delusions (paranoia) have a similar rate of frequency as in non-deaf people. Visual hallucinations (rare in non-deaf people) were reported in ten out of



twelve deaf clients experiencing a psychotic illness (Monteiro and Critchley, 1994). Generally, within the mainstream population, between 2-4% of psychotic hearing people will experience visual hallucinations.

Clearly, it is necessary to obtain answers by asking questions in a manner which provides examples for the interviewee but without actually giving or "feeding" information. Many deaf people have said their pseudo-auditory experiences do not involve Sign Language or speechreading and yet have been unable to explain how they could 'hear'. The underlying question is whether or not deaf people with schizophrenia and other psychotic illnesses have the same symptoms as hearing people. de Feu (1996) considers the answer to be yes, and suggests this is supported by evidence that 75% of cases of schizophrenia in deaf people present with auditory hallucinations. This figure does not seem to correlate with Monteiro and Critchley's (1994) findings which suggest that ten out of twelve deaf clients report visual hallucinations. Fraunhofer and Kitson (1991) consider that similar clinical symptoms checklists used for non-deaf people - (Schneider's First Rank Symptoms for example) can be used to correctly diagnose deaf people with schizophrenia by straightforward translation. This is, however, debatable. Evans and Elliott (1981) felt that symptoms of schizophrenia such as 'vagueness' and 'poor rapport' would be difficult to establish due to the fact that any deaf person trying to communicate with non-deaf people might present this. de Feu (1996) considers the importance of these symptoms to be minimal so as not to warrant concern. However, all symptoms listed, in any mental state assessment are important in any diagnosis and particularly so in assessing a possible psychosis.

In taking this further, Asian patients with depression or anxiety will usually present with somatic symptoms and may not admit to having a depressed mood even if they are asked directly (Rack, 1981). This example shows that symptoms are crucial in diagnosing mental disorder. Rack (1981) points out that the presentation of paranoia is misleading in immigrants who might have reasons to feel suspicious and can also present as a result of their suspicions, paranoid delusion, together with hallucinations, and that this may not at all mean a diagnosis of schizophrenia. In another example to illustrate the problems of using Western psychiatric diagnostic criteria upon another culture, Rack (1982) shows how Afro-Caribbeans could present with symptoms of endogenous mania when in fact they are reactively very excited about something and are really displaying a psychotic type of stress reaction. These examples are the reasons that the mental health professions need to ensure sufficient awareness and knowledge of ethnic minority groups and their cultural differences should be known to the mental health professional.

The mental health profession in the U.K. is more aware of these issues and the previous mistreatment of many ethnic minority group members because of lack of understanding and awareness and because of the inappropriate imposition of a dominant group's cultural values imposed upon another. There is no reason to suppose that deaf people do not present with similar differences in presentation of symptoms, perhaps in subtle ways. Furthermore, any mental health professional whose work brings them into contact with culturally Deaf people 'has a duty to acquaint himself with the cultural background and current predicament of such groups' (Rack, 1981).

Psychological testing has not incorporated the need for transcultural considerations regarding deaf people and furthermore, Maclachlan and Carr (1997) have asserted that psychology's lifeblood depends on a cross fertilization between cultures. Much of the common psychological approaches are not culture-free and thus difficulties in assessing deaf persons are doubled.

### Mental Health Issues and Young Deaf People

Several studies have been conducted to look at mental health problems and disorders in the young deaf population. A number of research studies in the area of mental health difficulties in deaf children have been carried out although there are a number of possibly confusing variables such as the degree of deafness, type of school and communication used, both at school and at home. In addition, some deaf children will have disabilities such as neurological or learning disabilities. The absence of standardized testing and interview schedules for deaf young people add further problems to the validity and reliability of research in this field, which has many conflicting factors. It was previously believed that deaf children had inferior intelligence (Pintner, Eisenson and Stanton, 1941) and it was commonly believed that deaf children were about three years behind their hearing peers in tests not involving language, for example, the Pintner Non-Language Mental Test (Myklebust and Bruton, 1953). Furth (1966) created a stepping stone for deaf people, recognizing that some 'testing' may put deaf people at a disadvantage if the tests were laden with spoken language. It was Rosenstein (1961) who insisted that there were no differences between deaf and hearing people's performances in conception and providing one used the matching language level of the deaf person. He did not mean

Sign Language but nevertheless it was a pointer towards a more appropriate direction. Furthermore, Rosenstein (1961) challenged the then held belief that deaf people could not think in abstract terms by asserting deaf people *can* think in abstract terms. McConnell (1970) suggested that deafness caused deaf children to be isolated and remote, and caused crying and tantrums when they could not get what they want with words (1970).

Some studies of deaf children now show that 40-50% of deaf children have emotional or behavioural problems, or sometimes both. This compares with 25% for the general child population (Health Advisory Service, "Together We Stand", 1995). A number of studies have also been conducted on deaf families, where parents and children are deaf. Useful information has been gathered from these studies which relate to these deaf children having higher self-esteem, positive self concept and a higher level of achievement in schools. These children have also been seen to be more socially mature than when compared to deaf children of non-deaf families (Meadows, 1976; Chess and Fernandez, 1980). Many deaf children are seen to be immature but it is not an innate cause of deafness (Meadows, 1978). Most of the 40-50% identified as having mental health problems (Hindley, Hill and Bond, 1994), which include emotional difficulties, behaviour disorders and mental illness, will not need specialist intervention. They will not require being seen by a psychiatrist. However, many would probably benefit from involvement from other professionals who might be able to advise or work with the family to meet the deaf child's mental

health needs. An approach that takes the view the family's needs must be taken as a whole is acceptable as long as the individual deaf child's needs are not compromised.

The Health Advisory Service report referred to earlier, shows in their breakdown of the 25% prevalence rate, that around 8.5% of children will experience severe problems and approximately 2.1% will have disabling problems. Hindley (1997) suggests that adjusting these figures for a higher prevalence in the deaf young population would give a figure of 20,000 who would need a specialist mental health service. The figure is dubious and is likely to be much lower. Hindley suggests that around 11-16% of deaf children would have severe problems and 3.4% would have disabling problems, suggesting a 650-3,200 per year case load. Thirty to forty percent of the total U.S. school age deaf population has multiple disabilities (Schildroth and Motto, 1996). Aetiology is important due to the fact that some deaf people have one or more disabilities. Twenty-five percent of the deaf population fall into this group (Gentile and McCarthy, 1973). In addition, children with deafness of unknown origin seem to be more likely to experience behaviour problems (Schlesinger and Meadow, 1972). In addition, many of the *causes* of deafness (prematurity, meningitis, Rh incompatibility and maternal rubella are examples although the incidence of maternal rubella and meningitis has decreased more recently) are reasons for learning difficulties (brain damage) (Vernon, 1969). Freeman, Carbin and Hastings, (1975) studied 117 deaf children aged 5-15 years in Vancouver, Canada, and found 26 from genetic causes, 18 from rubella, 2 premature, 2 drugs, 4 anoxia, 2 trauma and 51 of unknown causes. The purpose of showing

these figures is to provide us with some knowledge of the incidence of brain damage in deaf children from central nervous system disorders which is approximately 9-10% of deaf children. Chess and Fernandez (1980) studied children affected specifically by Rubella, and found in deaf children there is a high degree of impulsivity and difficulty in actually discriminating their own behaviour in order to learn how to control themselves.

Of interest is the increasing number of drugs and chemicals which are associated with ototoxicities (a chemical substance that can damage ear mechanisms). Over 130 such possible ototoxicities have been identified (D'Arcy and Griffin, 1979-1983; Lien, Lipsett and Lien, 1983 and Jawetz, 1984). The incidence of hearing loss of idiopathic (unknown) origin and iatrogenic (physician-caused) origin appears to be on the increase (Elliott et al., 1987). Autism occurs in 4-20 per 10,000 children (Steffenburg and Gillberg, 1986) and the occurrence of autism and congenital deafness is extremely low, 1:5 million according to Hindley (1997) although as Hindley (1997) and Monteiro (1997) suggest, there is a higher incidence than expected. Ten percent of deaf children referred to a deaf child and family service in London have autism and this suggests there may be a common neurology causing both autism and deafness together rather than seeing them as two separate occurrences. Simons and Hindley (1997) suggest detailed clinical assessments to estimate the prevalence as the only study conducted so far revealed a 4% incidence of autism and deafness (June, Rapin and Tuchman, 1991).

Schlesinger and Meadow (1972) estimate the rate of behaviour problems being 3-5 times higher than for non-deaf children. They estimate in an analysis of the prevalence of behaviour problems in a population of deaf school children, as 12% to be emotionally disturbed (5 times greater than the general school population) and 20% mildly disturbed (3 times greater than the non-deaf population for school aged children). These figures are from a U.S. population in 1972. Aplin (1985, 1987) used the Rutter B(2) parent questionnaire (Rutter, Tizard and Whitmore, 1970) to examine the incidence of behaviour problems in deaf children and a group of both deaf and hearing impaired children (N=61 and N=42), the latter group attending mainstream school. It is not clear if this refers to mainstream with or without Sign Language provision. Aplin found a 36% prevalence rate for the children in the deaf school and 16.7% prevalence in the deaf children attending mainstream school. Although the children were not interviewed themselves, as often found in these studies, the prevalence rates are at least double for the deaf school group. A number of factors may contribute to this such as the actual degree of hearing loss and how much this becomes a barrier to acquisition of a Deaf identity or a hearing identity, which is expected in a population of children who are hard of hearing (not very deaf audilogically). The extent to which anticipated difficulties is reversed is quite high, especially when compared to other studies such as Hindley (1997), which suggests children attending schools for deaf children produce a lower prevalence rate of psychiatric disorder than do children in other schools, such as mainstream or Partially Hearing Units (PHUs).

More recent figures seem to reflect an increase in these numbers. Fundudis, Kolvin and Garside (1979) in their study used teacher questionnaires and parent interviews to look at a range of children with varying degrees of deafness, found a prevalence rate of 54% of deaf children who were considered disturbed and 28% for hearing impaired children considered disturbed. The trend of hearing impaired children as suffering fewer psychological problems than deaf children is reversed in Hindley's study (Hindley et al., 1994), which shows a prevalence rate of 60.9% in the hearing impaired children attending a PHU and 42.4% attending a deaf school. Hindley et al., (1994) view this as the prevalence rate of psychiatric disorder in the deaf population. A number of weaknesses exist throughout this study however. Hindley performs part of his assessment of the children's communicative ability by using the assessment of teachers (Hindley, 1994). Most teachers do not sign and those who do, often use manually coded English (MCE) rather than the child's natural first language (even if the child's sign language is restricted - for various reasons). It is dubious therefore to accept the teacher's own identification of what language the child used when most do not appreciate the difference between BSL or MCE (a difference between two languages). As in other studies, parents were interviewed, most of whom were probably not fluent in Sign Language and therefore not as involved in the child's life as non-deaf parents are with non-deaf children. The Child Assessment Schedule (Hodges, 1987) was used to create DSM diagnoses (both DSM -IIIR and DSM IV) through translation of questions, which were designed for hearing children who are culturally hearing, into British Sign Language. Different interviewers were assessed for effect. There was one deaf person involved in interviewing in this study who was trained to conduct the interviews (Hindley, Hill and Bond, 1993), who



consistently elicited fewer symptoms thus no positive diagnoses. Hindley et al., (1993) attribute this to insufficient training for the deaf person. Hindley's (1993, 1994, 1997) studies suggest that communication is important for interviewing yet fails to recognize the importance of cultural congruency as probably being of equal importance in interviewing as is fluency in Sign Language in interviewees. The more positive image of self seen within the deaf school is not necessarily attributable to being able to communicate with peers but to sharing similar culture values and beliefs. Being deaf is not only about Sign Language as Hindley appears to indicate. The attitude towards the deafness is of particular importance in such studies into mental health, probably more so than in socio-demographic studies and negative implications are conveyed by terms such as psychiatric *consequences* of hearing impairment which many writers have conveyed, such as Myklebust, (1964), Altshuler, (1971), Levine, (1980), Swaans-Joha, (1990), and (Hindley, 1997). Powerful influences such as titles of articles, for example, 'Psychiatric Aspects of Hearing Impairments', (Hindley, 1997), which can affect the views of those, in particular, mental health professionals who may come into contact with deaf children, giving a prejudiced notion that hearing impairment carries with it psychiatric consequences. We know that this is not the case. Deafness itself does not create pathological behaviour deviations (Chess and Fernandez, 1980). Deaf children may bear increased risk of experiencing behavioural and emotional difficulties due to either or both, aetiology of the deafness or environmental factors, such as deprivation of language skills but not to the deafness itself.

## Development of Personality

Early childhood deafness has a whole range of issues to which it relates: cognitive, sociological, psychological and linguistic. Any child assessment where deafness is experienced needs to consider all those issues. Meadows, (1980) suggested that deaf children experience 'developmental deviations'. There is a tendency to blame resulting developmental problems onto the deafness. The experience of deafness may affect early parent-child bonding and reciprocity thus leading to influence separation and individuation (Stahlecker, Hansen and Krentz, 1985). Vernon (1969) studied 413 deaf children evaluated for entering a school for deaf children and found 225 classified as having severe emotional problems. This study led on to other studies being conducted, namely, Altshuler, (1971); Schlesinger and Meadow, (1972); Chess and Fernandez, (1980); Freeman, Carbin and Boese, (1981) and Langholtz and Heller, (1988). All these studies seem to indicate a greater incidence of personality and behaviour disorders within a deaf population compared to non-deaf peers and furthermore, that the prevalence of neuroses (depression, anxiety or neurotic type disorders) in deaf people are much the same as for the non-deaf population. These studies concluded that if a deaf person has difficulty expressing themselves either in Sign or spoken language, anger (eruption) results. Altshuler (1971) went so far as to suggest audiological facilities were necessary and used, for children to learn to develop internal controls, thus suggesting use of hearing as necessary to control impulsivity and aggression. Impulsivity has come to be seen as a common psychiatric 'disorder in the deaf population' (Langholtz and Heller, 1988). Contrary to Altshuler's (1964) data on the incidence of depression in a deaf client population, and contrary to much of the research printed in the literature until

recently, depression *is* common in the deaf population. This study (Ridgeway) shows a prevalence rate of 37.3% of deaf people who scored positive on the General Health Questionnaire (1972) a screening instrument which detects anxiety and depression. This is almost a 3-fold increase compared to the prevalence rates in a non-deaf population (12-17%). Depression is even more common in deaf people who were hearing and became deaf (Glass, 1988), which is often related to grieving for the 'loss' of hearing (Luey, 1983). This group of people are not the focus of this study. Readers can refer to Jones, Kyle and Wood (1987), and Thomas, (1981), for further details and references to the literature.

In conclusion, there are a number of issues concerning deaf children and adults which previous research has focused on involving organic factors (aetiology), learning difficulty and disabilities, difficulties in 'temperament', behavioural difficulties, the prevalence of emotional disorders (neuroses such as anxiety), and the level of delay in psycho-social development. All of these issues are important towards understanding deafness. Different studies may place a different emphasis on factors depending upon the orientation of the interviewer or researcher involved. By orientation, this means approach taken towards deafness and the basic perception of the term deaf and its values. A person without appreciation of linguistic and cultural status of deaf persons and Sign Language is unlikely to produce valid conclusions in research with deaf people and will emphasize aetiology and probably attribute non-organic developmental delays to the deafness rather than to external influences such as access to communication, language and culture. Conrad (1979) suggested that oral

approaches in education failed to educate deaf children and atrophy occurred as a result of the prevention of signed languages reaching the deaf child's brain (Arnold, 1993).

It seems likely that the prevalence of learning disorders and disabilities and behavioural difficulties are greater in the deaf population and are likely due to organic factors. The greater incidence is in addition to reasons presented in the population as a whole, which includes non-deaf children. Difficulties in behaviour can arise from external factors such as inappropriate familial integration, attachment and bonding, but can also be attributable to organic factors such as rubella. In this case, it becomes a complex area to look at causes of difficulties that sometimes emerge. Quite often the causes are attributable to environmental factors. Research trends show now that problems deaf children experience are not due to the *deafness* itself although some of the material presented and published today does tend to reflect the opposite and therefore inaccurate view, which depends very much on the actual *view* and perception of the deafness. The prevalence of emotionally based disorders, such as depression, anxiety and other 'neurotic' type disorders have been, until recently, considered to be much the same as for the general mainstream population. Earlier studies tended to emphasize that depression was much lower in a deaf population, having based this in the belief that deaf people have difficulties in developing insight or in learning empathy. Such ideas probably stemmed from the view that concreteness in thinking and lack of ability to abstract meant that deaf people were less likely to develop disorders other than behavioural since the lack of ability to

develop insight would have been seen as leading to a reduction in emotionally based disorders.

However, this study has shown that far from assuming the incidence of depression and anxiety to be the same as for the mainstream, the prevalence is almost three times higher. A number of reasons for this are discussed in the concluding chapter.

## **CHAPTER THREE**

### **A DEAF PERSONALITY**

#### **Introduction**

The idea of a 'Deaf Personality' has been, and continues to be, of interest to professionals involved in work with deaf people. The issue of whether or not there is a psychology of deafness and deaf people relates to this debate and it appears that those who think there is a psychology of deafness are those who tend to embrace the medical or clinical model, whilst those who suggest there is no such psychology favour the cultural and linguistic model of deafness. A rather similar debate applies to other cultural groups such as Afro-Caribbean or hispanic populations who are usually not given a label which suggests a special psychology.

This chapter explores the term 'Deaf Personality'. Identity issues for deaf people are discussed as are mental health issues. A model of identity formation is described based on the principles of Cass' (1979) interactionist model. It is argued that a similar model can be used to describe the process of the acquisition of a Deaf identity. The interactionist model proposes that this process depends upon our interactions with other people, both Deaf and non-deaf. Interaction experienced between other members of society and ourselves changes our values and beliefs. The use of the term deaf is here based on the premise that all deaf children who are so deaf that they tend not acquire spoken language through aural means will naturally develop to become culturally Deaf young people. However, such growth can be rechannelled or diverted. A number of external factors influence the process of

acquisition of Deaf identity. Prevention processes might include continuous immersion in culturally hearing environments and includes lack of access awareness of Deaf issues, Deaf history, language and lack of contact with culturally Deaf peers to facilitate positive role model interaction. External influences will include the process from the point of identification of deafness, exposure to deaf peers, interaction with young deaf people and adults, knowledge and awareness of Deaf community issues, Sign Language, culture and history.

Some deaf children, including late deafened children, will not grow into culturally Deaf young people and may function in a meaningful way in the non-deaf world. There are children who acquire bicultural hearing status identity, deaf and non-deaf. A number of deaf children will have ethnic minority status and may acquire cultural attachment to their ethnic backgrounds as well as to their Deaf heritage. The term prelingual is avoided since it undoubtedly describes both deaf and hearing people at birth. Audiological measures are not considered meaningful in this context. Research in the field of education often concentrated upon *methods* of communication used in the teaching of children and has forgotten that there is a range of other factors, which emerge within the external environment and form a number of important variables. The focus of this paper will be on those who will naturally develop a culturally Deaf identity given the appropriate external environment growth factors.

Culturally Deaf individuals accept the values, attitudes, beliefs and norms of Deaf cultures and will usually behave in line with these characteristics. Furthermore, deaf

people with a range of experiences of deafness can participate in the non-deaf community.

Identification with the Deaf community and culture is influenced by several factors, one of the most important seems to be linked to the attitude towards the deafness as in 'attitudinal Deafness' (Baker and Cokely, 1980). This useful term describes individuals who, *regardless* of audiological status, behave as culturally Deaf people, seeking association with like-minded others, with similar values and attitudes. The term describes a healthy culmination of a process that may be fraught with conflict for the individual struggling with internal and external dynamics, throughout the history of that individual's identity development, which begins with the immediate family and level of interaction.

The development of personality, which refers to our behaviour, characteristics and our 'dispositions' is how we begin to perceive our 'self' and of others (Allport, 1961).

The process of personality development evolves from our cognitive and social interactions. The cognitive basis for the development of personality is the information we receive about our interactions with others. In this way we organise the information we receive about our relationships. A knowledge structure develops classifying information received. This is similar to Kelly's (1967) theory of attribution and attributional bias. The process of organising information we receive leads to the development of all our interpretations and the construction of abstract



psychological interpretations based on our attributions and self-reflection (Hoffman, 1981). Jackson (1991) argues that it is the emotional aspects of development that play an important role in our behaviour. He sees emotions as regulating behaviour and thus our ability to express our feelings, affected by the quality of our social interaction. Maslow's (1967) theory focuses upon our instinctual behaviours and drives (desires for food, warmth and care), which creates our emotions and social behaviour upon which we learn. Most personality theorists do not dispute the link between emotions and drives (arousal systems) although there are differences in their view of the process. Does the emotion relate to arousal (Lewis and Michaelson, 1983) or does the emotion lead to a *response* that is influenced by inter- and intrapersonal processes? This includes effect, exposure and influence of culture.

### Behaviour and Emotional Development

Jackson (1991) argues that emotions are adaptive processes which an individual 'retreats' from if desired, and that curiosity, exploration and selective response to social situations and persons which develop to protect and maintain independence are *shaped* by emotions.

The consensus view of affective processes is that it is the *development* of emotions, which are usually covert, and not the *intensity* of the emotions, which shapes social-cognitive development and well-being. Growing up and learning to regulate or monitor our affective states enables control over behaviour and interpersonal reactions. What this means is that on the assumption that emotions are both

biological and socially constructed we all experience a range of emotions and that these emotions are modified by learning and our social interaction.

How is this applied to deaf infants and children? Most research has focused on babies (Scherer, 1982) and their aural skills to assess emotion and responses and how children learn to modify or express emotions by taking into account others' reactions. Children begin to learn to appropriately suppress or display their emotions from the expressions of significant others (Campos, Barrett, Lamb, Goldsmith and Sternberg, 1983; Lewis, Stranger, Sullivan and Barone, 1989). This suggests an ability to 'self-reflect' rather like the internal locus of control (Rogers, 1957). Our ability to regulate our interpersonal behaviour is dependent on our 'role-taking' skills, as well as our previous knowledge. For deaf children, this will develop mainly by what is felt and thus used as a reference point for behaviour that is considered to be acceptable.

Psychologists such as Schlesinger and Meadow (1972) and Meadow-Orlans (1990) suggest that deaf people have poor empathy skills because of deprivation of communication skills, reinforced by inappropriate parental tendencies to communicate information to the deaf child in more concrete ways. This means information received tends to be short and 'sharp'. Carers tend to 'show' them through actions or pantomime what to do and children will depend on this. Jackson (1991) suggests that as a result, the external locus of control is allocated to the carer. The external locus of control indicates a level of awareness of what others think of one and awareness of how others perceive one. With a poor development of the external

locus of control (Rogers, 1957), aspects of emotional and social development such as autonomy (Erikson, 1968), may remain undeveloped. These studies suggest that deaf children are not able to express a wide range of emotions and have difficulty differentiating emotional responses in social relationships. Arnold, (1993b) states that there is no scientific evidence to suggest that deaf people are different to non-deaf people in terms of prosocial and sociomoral behaviours. However, much of the literature focuses on the difficulties deaf people have compared to their non-deaf peers.

This has not been seen to the same extent in situations where the carers are also deaf (Rodda and Grove, 1987; Meadow, 1988). Deaf children of Deaf heritage (deaf parents), tend to have a better level of development in psychosocial areas, relating to social skills, turntaking, role shifting and in identifying emotions and their expressions. Reasons include, access to the natural first language from birth, positive role model exposure and a more positive self concept. Weisel (1985) studied two groups of adults, a deaf group and a non-deaf group who were asked to observe faces displaying a range of emotions. The differences found in the ability to perceive and interpret the emotional facial expressions did not appear to be significant except in the case of happiness and surprise, which the non-deaf group had difficulty with. The deaf group had difficulty distinguishing faces showing disgust or sadness.

Weisel's (1985) findings have been interpreted to mean that hearing people experience difficulties with positive emotions while deaf people have difficulty with negative emotions. Another possible interpretation of these findings lies in the fact that the

expressions are fairly similar in terms of particular facial features used, for example, raised eyebrows indicates surprise or glee. Fluent signers who are linguistically aware, are more likely to be able to translate the expression into the counterpart language. Weisel's study merely validates the view that gesture is commonly used worldwide and is easily recognisable within similarly orientated cultures ,but not by those with a different cultural orientation. For example, raised eyebrows in Greece indicates 'yes' or 'acknowledgement' but is interpreted differently in more western parts of Europe.

### Baby Signs

Acredolo and Goodwyn (1996) have found in their ten year study that babies, regardless of hearing status, pick up signs naturally. Opening the mouth wide and holding the head back, for example, will indicate a hippopotamus, in the context of the conversation. This is how very young deaf children may sign hippopotamus, in this unsophisticated sign form. Other signs, for 'hot', 'big' and 'all gone' are easily conveyed iconically, although the sign for 'hot' varies depending upon the context, and the sign for 'scared' comes from the chest, by a hand tapping the chest to indicate a beating heart for example. This is particularly interesting in that it indicates emotions are linked to the chest area and children seem to use this themselves from a young age. In their studies Acredolo and Goodwyn, (1990, 1996) have found that hearing children gradually, independently, replace their sign vocabulary with vocalizations when they have learnt to say the word, by hearing others talk, perhaps using both modes, (sign and vocal) during the period of transition. The more the child signs, the more the word is heard by the adult

repeating it. Parents are told to vocalize words once the baby has the sign, in order to alleviate fears many of the parents have that their baby won't learn to talk or will continue to use signs. These studies could suggest that visual-spatial and creative skills develop early in very young children and development is usually on-going for deaf children but not for the hearing children, possibly in part due to environmental restriction or inhibition towards continuing to use manual skills.

The developing attribution and references learnt will determine for the children who are not deaf how far to go with signs. Some deaf children will react in a similar way at some time during their development, depending on environmental factors, and might 'reject' their deafness and try to 'behave' as those who can hear. The writer has seen this in the behaviour of many deaf children. The children go through a period where the behaviour of hearing people is 'copied', for example, a torrent of unintelligible 'words' from the mouth and will adopt various hearing status positions (i.e. hands on hips), looking through the window and the turning round to talk to those in the room using their mouth. This particular behaviour could be interpreted in different ways; it could, for example, be seen as 'normal'. Children growing up and in play, or a deaf child's expression of wanting to be seen as the same as the apparent majority (developing awareness of difference), an attempt to 'show-off' - (I'm clever), or perhaps a 'tease' towards hearing people, depending on the level of self-reflection and attribution acquired. Deaf people have suggested this may be due to inferiority feelings on the part of the deaf child (Woodward, 1995).

Several studies showed that deafness influences and changes psychosocial development, resulting in negative traits (Altshuler et al., 1976; Levine, 1976; Chess and Fernandez, 1980; Meadow-Orlans, 1990). Later studies showed more deaf children than hearing children were seen to have emotional difficulties. This was noticed by Conrad (1979) and Rodda and Grove (1987) but this was not manifested in adult deaf people (Rainer et al., 1966). The 'identified' problem behaviours were then considered to be attributable to the emphasis on perception by deaf children. This means that because a reliance on visual means in order to perceive (anything at all), this influences the way attention and information is obtained and processed. Eventually, other studies brought in important factors which are externally attributable to the difficulties identified in deaf populations, that is mainly language (linguistic) issues. Other studies emphasised the parental relationship (Bowlby, 1973 and Parke and Tinsley, 1987) and some considered the personality style of the child as being most influential (Farrugia and Austin, 1980). However, the most powerful variable is likely to relate to lack of access to learning language and acquisition of communication skills.

### The Development of Cognitive Skills

Linguistic information is used to develop a sense of self (Erikson, 1959) and reflection skills to process information. If these skills are not learnt in an appropriate way, it is likely to result in poor self-awareness and reflecting skills, which is why many deaf people have been seen to be 'impulsive', one of the many traits which have been given to the emotion of the 'deaf personality'. Some psychologists (Myklebust, 1964) consider the deafness as restricting the possible level of cognitive

achievement. Aside from certain aetiology, such as rubella, which appears to have a link with poorly developed cognitive skills (Chess, and Fernandez, 1980), it can almost safely be said that deprivation of access to appropriate communicating skills results in poorly developed cognitive skills.

Some findings suggested that language and communication as well as social-economic variables affect the level of cognitive development (Vernon, 1967). These variables have psychological affects from social and family circumstances.

### Self Awareness and Attachment

A person who is field-dependent has difficulties in distinguishing objects in embedded backgrounds (Jackson, 1991). Field Independence or dependence relates to an individual's ability to differentiate objects from their backgrounds. If difficulty in differentiation is experienced this indicates they are field-dependent. Tests of reading and language skills usually provide information measures of field-independence gathered from the contextual parameters used (Davey and Lasasso, 1985). This means using external resources (external locus of control reference point) as the reference point and becoming focused (rigid) in the information being targeted. This leads to the idea that deaf people have difficulty with abstract thinking processes because these studies indicated that deaf people had problems in attentional control over the information received and how it was processed. The most likely result has been difficulty in developing awareness of the self-concept and boundaries between objects and self. It is likely that being able to distinguish boundaries develops identity awareness at the same time. Of interest, is that deaf individuals who have

developed field-independency abilities have better memory 'coding' skills where associated with reading. Bowlby's studies (1973) suggest that parental attachment influences childrens' emotional and cognitive development and links this with the consequential ability to explore self-knowledge limits (Campos et al., 1983). However, doubts have been expressed about this. Attachment does not create cognitive development skills which essentially grow from language and communicating. It is possible to be attached to a significant carer, *without* communication skills except instinctual and basic communication. Crying when hungry is an example of this. Comments from several of the sample population of this study suggest that initially, attachment and affection was prominently felt in the early children - but that later, particularly for those who attended residential schooling, attachment wore away.

It is likely that both interpersonal interactions and the way we perceive ourselves creates emotional development and awareness of self in relation to those people we experience in our external frame of reference. The fact that many deaf people do have emotional difficulties and inappropriate behaviour is seen as indicative of poor familial relations and poor quality attachments in early life. Deaf people have described (reported in this study) initial feelings of closeness and affectionate relations with their carers with whom there is no linguistic communication but many still experience emotional difficulties and may exhibit poor internal behavioural controls. Attachment to the carer does not necessarily, as Bowlby claims, lead to the development of initiative, autonomy and self-reliance (Bowlby, 1973). Nevertheless, personality development begins *very* early indeed and it is the very early experiences



that shape personality growth. In this respect, it is therefore more important for deaf children to access appropriate communication in order to develop the skills needed to live in and to deal with society. Greenberg and Marvin (1979) studied deaf children using oral methods and Total Communication, (a philosophy which advocates use of whatever method of communication or language suits the child, which in this case appeared to mean Signed English) and found that competence communication was essential to self-dependence and social development.

Further exploration of attachment of the carer and deaf child has found similar identified factors such as low self-esteem or poor imaginative skills possessed by deaf children to be linked to the carer being more controlling, less flexible and less 'approving' than carers in the mainstream child population, tending to take a directive role instead of allowing 'external' controls to develop. The latter two factors are caused by poor communication but this is not generally seen to be the case in the views of researchers such as Schlesinger and Meadow (1972) and Greenberg, (1980). The results of studies of deaf children and deaf carers show the display of the same skills, emotional development and communicative interactions as hearing carers of hearing children (Meadow et al., 1980), thus indicating poor communication is a crucial factor in deaf child development. This view has been supported by Spencer and Gutfreund (1990) who found a negative relationship between the carer being directive and the child's language development. Interpreted, this probably indicates non-deaf parents are disappointed at their child's deafness so on an unconscious level, do not really try to learn how to communicate with their deaf child who, in turn, will internalise the depressed position, resulting in insecure child attachment and

consequential psychological development in the deaf child. Several interesting accounts given by families of deaf young people can be found in Gregory et al., (1995).

**Table 3.1:** The extent to which parents in Gregory's study attributed the particular characteristics of egocentricity and immaturity to their deaf children

	Yes		Varies		No	
	Number %		Number %		Number %	
Immature	40	49	2	2	40	49
Egocentric	35	43	2	2	45	55
Will admit when in the wrong	29	35	27	33	26	32
Will take a joke against self	36	44	15	18	31	38

*Taken from "Deaf Young People and their Families" - Gregory et al., (1995) pp.226*

**Table 3.2:** A more detailed breakdown of personality characteristics attributed by parents to their deaf offspring

	Yes		Varies		No	
	Number %		Number %		Number %	
Calm	35	43	15	18	32	39
Anxious	29	35	11	13	42	51
Easily bored	43	52	4	5	35	43
Affectionate	51	62	10	12	21	27
Generally happy	51	62	23	28	8	10
Bad tempered	26	32	11	13	45	55
Aggressive	14	17	4	5	64	78

*From "Deaf Young People and their Families" - Gregory et al., (1995) pp.224*

These questions were asked in relation to the way parents had responded to questions concerning the issues the deafness raised for the family, relationships between them and the effects of the deafness on the relationships within the family.

The search for a Deaf personality probably began when psychologists became interested in the possibilities of learning more about their own personality theories and child psychology through acquiring an understanding of personality formation and issues in deafness. Pintner (1941) began such investigations and at that time, expressed caution that use of non-deaf norms and standards in inventories and assessments of deaf children would be unfair and lead to false conclusions. His other comments, however, did a disservice to what otherwise would have been a remarkably insightful advancement at that time. Pintner (1917) believed that deaf children were emotionally unstable, introverted and immature in reasoning and social skills. This view was later reinforced by Meyer (1921) who suggested deaf people were unsocial, morose and suspicious. Some of these characteristics were seen as a result of deafness, and some were seen as being attributed to the cause of deafness, possibly with neurological links. Heider and Heider (1941) introduced the view that hearing personality tests were inappropriate for use on deaf people but the popular interest in deaf people as being psychologically disturbed, by virtue of their deafness, was far too interesting to ignore. Levine (1956) described deaf women as particularly egocentric, irritable and impulsive, with an external locus of control. One of the key terms often used to describe deaf people's difficulties and which continues to be, is adjustment. Many questions linked to how deaf people 'adjust' have been explored and in the field of mental health, the diagnosis of adjustment disorder was and continues to frequently be applied to deaf individuals who express various difficulties including behavioural and emotional. Cross cultural research has shown that minority group members are likely to suffer from discrimination and oppression throughout childhood, which will include inappropriate environmental circumstances,

influences and lack of access to information. More importantly, cross-cultural (transcultural) research awareness developed the idea that dominant cultural beliefs and values are not appropriately applied to minority groups hence the general enlightened awareness and caution amongst health and educational professionals working with minority group members.

Deaf children from ethnic, linguistic and racial minority backgrounds tend to have lower levels of achievement, compared to white deaf children. The differences are significant as is seen in an American study of Black and hispanic deaf children, which includes Afro-American, Asian, West Indian and African (Cohen et al., 1990). It is likely that access and knowledge of ethnic background, language and culture is appropriate for them and yet often only 'bits' are picked up on the way to adulthood, either because the deafness has been pathologised, has been given primary focus or the child has had to choose. The more multicultural assessment teams and service providers are, the more positively this can reinforce the deaf child's self image, crucial to identity formation, and in particular, towards developing bicultural identity awareness. Having minority role models for minority group children helps to strengthen and enhance self-identity (Sue and Sue, 1990). A survey of professionals in deaf education programmes in the USA in 1993 (Andrews and Jordan 1993), found that about 10.4% were of minority group status, and furthermore, only 11.7% of these were deaf.

Many culturally Deaf people use, or grow to use Sign Language as their natural first language even though many do not acquire fluency in Sign Language until their later

years. Another term that is often used to describe the needs of deaf people is rehabilitation. This term is probably contentious in that many deaf people may require their appropriate habilitation needs to be provided rather than be rehabilitated following unsuccessful or inappropriate earlier educational experiences.

### Identity Formation

There are many theories which contribute to ideas on the development of personality and of identity formation. Erikson (1950) was one of the first theorists to examine comparatively the alleged effects of deafness on personality development. Piaget (1967) observed that language enabled 'inner life' to be communicated - meaning that once the child becomes aware of his/her thoughts and once this was a conscious process then the child can communicate his/her thinking. Whichever way round one perceives the development of language, it is universally agreed language is necessary to communicate and furthermore, communication is necessary for mental health (Rainer, 1969). It follows that communication and mental health need to develop from birth.

Identity development and the study of personality structures has therefore been of great interest to educationalists, psychologists, mental health service providers and researchers. The identification of an emerging Deaf culture and the establishment of Deaf Studies programmes has resulted in an increase in interest in Deaf identity issues. Identity is a complex construct and individuals can have more than one identity. Understanding Deaf and hearing identity constructs can be helpful in understanding identity development in others who experience deafness such as

partially deaf (or partially hearing), deafened young people and may also be of use in understanding children of deaf parentage and others who may have varying hearing status. Identity influences rites of passage in life and identity influences belonging and choices. The process of how is important for educational practitioners, who are undoubtedly at the forefront of mental health issues in deaf children.

A model of Deaf identity formation is described shortly, based on similar principles outlined by the interactionist model provided by Cass (1979). The process of acquisition of a Deaf identity depends upon interactional experiences with others, both Deaf and non-deaf. This interaction experienced with society and ourselves creates development and change in our values and beliefs. Many Deaf people refer to themselves as part of a cultural and linguistic minority group. This is an important self-defining statement, resulting in a move away from medical pathology. Some Deaf people will continue to prefer to call themselves "deaf and dumb", as reflected in the sign. Although many have dropped the latter part of the sign, translated as 'dumb' in English, many choose to keep or begin to use the sign, as an attempt to challenge or conform to stigma or stereotype images. This raises an important aspect of the *language* Deaf people use (Bahan, 1997). The sign is sometimes seen as a way of affirming the Deaf community, the apparent 'deficit' becoming a strength (de Monteflores, 1986). Some deaf people may see themselves as deaf but dislike the idea of the self-identity in their view, in case it cuts them away from opportunities and interaction with members of the non-deaf mainstream community. This group of people are more likely to develop a negative self-identity, which can be accompanied by, or lead to, dislike of self. If this is not acknowledged or resolved,

psychological problems may develop. Some deaf people might express a wish to change their hearing status and try to interact mostly with non-deaf people (Bat-chava, Robbins and Lim, 1992). In a sample of 267 deaf adults Bat-chava (1993) found that the ecological context in which group members live affects identification with their group and that group identification has a positive effect on members' self-esteem.

**Case Example:** Adrian, (34), works for a large clothing company. He has some Deaf friends who he sees at regular intervals. He enjoys attending the occasional national rally for Deaf people but he does not like to be seen associating with a Deaf colleague at his place of work. Adrian explained that he does not want his hearing colleagues at work to think he is one of the Deaf people who have to sign. He prefers to use his voice, use pen and paper or speech read wherever possible. Adrian confided that he did feel quite left out and occasionally was made a mockery of, and was teased, about his Deafness but that he tolerated this because he felt he humoured them so he was not totally forgotten about like the other Deaf person was. It appeared that Adrian felt that tolerating his work colleagues' abuse and teasing was a way for them to like him. In this manner, Adrian appears to identify with his aggressor.  
(Ridgeway, 1992)

There are several defence mechanisms (Kovel, 1976; Brown and Pedder, 1979) and one frequently seen amongst minority group individuals is the tendency to identify with the aggressor. In Adrian's case, the aggressors are the non-deaf people who discriminate against him. This brings us to the issue of hearing teachers who in transference from pupil to teacher, might be seen as 'the good parent' particularly if the deaf child's non-deaf family are experiencing difficulties in working with their deaf child. The teacher's role may be seen as providing more than structured tuition within the school classroom and this transference is also placed upon the role of deaf assistants and co-workers which is another issue this highlights.

There are six stages in the Cass model (1979) which can be seen as a process towards formation of identity. These are: identity confusion; comparison; tolerance; acceptance; pride and finally the synthesis of identity.

Identity confusion refers to the period when the deaf individual begins to feel, or realise, there is a difference between them and the rest of society and that they are different from their non-deaf families, perhaps recognising the demands their deafness places upon their carers and perhaps experiencing feelings of alienation. Although this period usually takes place during their childhood years, it can occur much later, depending on educational circumstances and exposure to mainstream society. Young individual deaf children might, on meeting another deaf child, for example, upon being placed in an educational setting with other deaf children, may reject the others similarity. Deaf children ill prepared for such an experience may experience disturbing thoughts, feel uncomfortable and may reject the deafness. Deaf young people might reject deaf teachers for example, preferring to identify with non-deaf teachers. This may be seen in psychodynamic terms as identifying with the 'aggressor' as illustrated by the case example of Adrian, shown earlier, which is used to describe the process of affiliating to what is seen as the dominant culture in favour of rejecting the minority or 'weaker' cultural group, thus interjecting mainstream values which are 'picked up' from a very young age. This can be linked to the development of poor self-image and a negative self-concept. Lack of self-confidence also presents problems particularly in asserting or expressing feelings.



**Case Example:** An example from Leigh (1991) illustrates this. A deaf client was seen by Leigh, who is a Deaf psychotherapist. It was important for the client (who will be called Marlon) to be "just like everyone else" and who struggled to look "normal". Marlon did not wish to be seen by a deaf therapist (Leigh) whom he perceived as having a "speech impediment". Of interest is that it was not until Leigh's third session with Marlon that Leigh revealed her Deafness and up until then, there had been no difficulties in understanding each other. This example illustrates what low self-esteem and image might look like in later years.

The process can be seen at various stages throughout the child's life, where interaction with others is expected. Selecting hearing partners may be a way of expressing a rejection of Deafness and of attempting to join the mainstream or to 'normalise'. Toleration of identity might follow this stage, whereby deaf individuals start to do 'Deaf' things, refer to Deaf issues more and might feel a need to 'prove' they are Deaf. In this way, the deaf person might begin to feel more "detached" from the mainstream and more in contact with other Deaf people, thus selecting Deaf friends and perhaps avoiding contact with hearing people who might cause feelings of discomfort.

There are different directions that deaf people might move in. Perhaps move on and accept and confirm their own deaf identity by themselves. Alternatively, whilst acknowledging their deafness and some affiliation to the Deafness experience, do not wish for a Deaf identity and so will behave in ways that will give the deafness occasional 'special case' acknowledgement that will make them "feel better" - like a compromise, or they might pretend not to be aware of Deaf cultural issues. Gradually, Deaf individuals move out of this stage, develop supportive relationships with other Deaf people and will make links with organisations and centres for Deaf

people. This stage is probably one of the most vulnerable in terms of future progress as it sensitizes to the influence of other Deaf people. Whether or not obvious association with other deaf people displaying cultural features and behaviour is made known or covert to the mainstream is also determined at this stage.

Identity Pride, the next stage, is where the individual starts to feel that it is acceptable to be deaf and begins to show that they are Deaf, and not be embarrassed at displaying Deaf behaviours and cultural mannerisms, and to be more open about their cultural affiliation. The Deaf individual feels a sense of belonging as a cultural group and develops pride in his identity, which is felt to be affirmed. Society may, at this stage, be seen as divided into two groups; people who are in support of the Deaf cultural experience and those who are not. The latter might include those who support DELTA activities, (formerly National Aural Group who are opposed to the encouragement of Sign Language development). Speech therapists and audiologists who work with Deaf people may also be seen as antagonists.

Such perception reinforces the attractiveness of 'belonging' and deaf individuals will often submerge themselves into all things 'Deaf', like having a Deaf house with flashing or visual aids, a Deaf car, with a rear window mirror on the dashboard in order for the driver to communicate with passengers without having to turn to the side, Deaf style furniture (positioning furniture in Deaf friendly ways) and choosing a text telephone without a portable hand set are other ways of stating culturally Deaf feelings. Anger, resentment and bitterness might be expressed towards those responsible for negative feelings that may have been experienced, including feelings

of alienation from mainstream society and feelings of devaluation, borne of oppression and discrimination. The Deaf person becomes more congruent as various aspects of the 'self' begin to synthesise. What usually follows is the realisation that not all of certain groups in the mainstream are against the values and beliefs of culturally Deaf groups and deaf individuals. For example, some hearing people are involved in work to promote the cultural and linguistic aspects of Deafness and Deaf communities. Although such non-deaf people may be accused by Deaf people of earnings based on a 'Deaf-wage', nevertheless they are seen to help raise the profile and value of Deafness. Teachers of deaf children who learn to sign and may visit Deaf centres and take part in deaf-related activities help contribute towards the growing congruence and integration of the individual deaf person and his/her fitting in a diverse society.

The description of this process takes place all through life. A whole intra-psyche and interpersonal developmental process is involved and which does not stop at any particular stage and will very often extend well beyond teenage and adolescent years. Recognition of the process brings out the issue of deafness as often being stigmatised by society and the stigmatisation of being culturally Deaf.

A major factor in the process of identity formation is language. There has been much debate over the difficulties inherent in 'communication matching' which stem from a variety of manual coded English systems (MCE) in use in various schools and educational settings in the U.K. These include Signed English, Makaton, normally used for people with learning difficulties, Signed Exact English, Pidgin English and

probably other varieties based on the English Language in terms of structure, grammar, morphology and syntax, in addition to British Sign Language.

Communication matching refers to matching the communication requirements of deaf children with the various communication styles and skills of teachers. Here is an example to illustrate the particular issues which may arise, although in a different setting.

**Case Example:** A deaf therapist received a referral to see a young Deaf man, Mike, for counselling for sexuality issues and exploration of concerns. The deaf therapist, who was not culturally Deaf, found it difficult to establish an alliance with Mike and attributed this to what he saw as Mike's poor language skills. The therapist could not effectively communicate using British Sign Language, which Mike used, with very little oral English. This led the therapist to make the assumption that Mike, who was from another county in England, was using only regional signs and thus could not be understood except by those from the same school or local area. This expression of an incorrect presumption on the part of the therapist led Mike to develop further problems with his self-image. It also conveys inappropriate beliefs about Sign Language. The therapist used good Sign Supported English and considered this was sufficient to communicate with any signing deaf person. The therapist held misconceptions about sign vocabulary and structure and also did not appreciate that only 20% of British Sign Language vocabulary is regionalised. (Herd, 1996)

*(Example from writer's personal communication)*

Some deaf people believe that a non-deaf person is more 'clever' and able, and so attribute what they perceive to their own 'shortcomings' to "oh well, it's because they're hearing". Deaf children do not always understand the meaning of the words deaf and hearing, except perhaps from an audiological perspective. Gregory, Bishop and Sheldon (1995) found about one third of deaf young people had, as children, thought they would grow up to be hearing. In another study (Gregory, Smith and Wells, 1997) deaf children aged 7-11 were asked a series of questions which looked

at experiences and attitudes towards schools, home and Deaf issues. The answer to the question "what does 'deaf' mean?" gathered a number of responses within the context of not hearing although many did refer to the use of Sign Language. The question "what does 'hearing' mean?" also gathered a number of responses in the context of not being able to hear. A third question, asking whether deaf or hearing people were more clever also attracted responses conveying what deaf people were seen as being unable to do. There were, however, a number of responses to this question which reflected positive and non-rejecting attitudes towards their experience of deafness. The aim of the questions was to gain some insight into the deaf children's understanding of the differences between hearing and deaf people.

The research shows that the use of a bilingual bicultural model provides evidence to the contribution of a positive self-identity. A high percentage of deaf people have been found to have a poor self-concept (Brauer, 1992) and negative self-esteem which cannot be over emphasised. For some Deaf people, internalisation of a degree of oppression results in other defence mechanisms such as rationalisation and reaction formation. By the latter, this might refer to a Deaf person who presents as so introvertedly deaf as to appear to practise a form of discrimination reversed. Such culturally Deaf people might refuse to interact with non-deaf people, may avoid eye contact with and might feel hostility towards non-deaf people. Self-esteem of minority group members is enhanced by strong identification with their group. Crocker and Major (1989) suggest, in their model of social stigma and self-esteem, that group membership helps to protect their self-esteem, and that this is done through different psychological processes. The process identified by Crocker and Major

(1989) are; comparing their performance with others in their group; interpreting negative prejudice by those outside their group; emphasizing the positive aspects of their group and giving little recognition to aspects where their group appears to be weak. Although research on self-esteem of minority group members has focused on transcultural matters, involving ethnic minorities, similar issues apply to Deaf people and identification with the Deaf community.

**Case Example:** Edward, a 44 year old culturally Deaf man, who lives with his deaf wife and her deaf parents, displays an almost exaggerated image of his pride at being Deaf that he considers himself to be actually better than non-deaf people altogether. This might be interpreted as a defence mechanism for what *may* be perceived as a more difficult life.  
*(Example from writer's clinical practice)*

Another example illustrates aspects of use of defence mechanisms.

**Case Example:** Martin and Jane, a deaf couple, who have lived together for seven years, use only Sign Language with each other, do not socialise or mix in the Deaf community or Deaf scene. They have one or two non-deaf friends with whom communication is minimal and is through speech-reading. One of those friends referred to was a man at the local newsagents who waved and smiled at them when they visited the shop. They appear to have no contact or interest in Deaf activities or other Deaf individuals.

*(Example from writer's clinical practice)*

In this sense, it is almost as if the couple do not want to show their deafness and are saying indirectly that they are the same as their non-deaf friends yet share many cultural features with members of the Deaf community with whom they appear to have estranged themselves. There are a number of issues related to culture and this next example illustrates some of these in the context of one individual's experience of cultural incongruence.

**Case Example:** David, (27) a bilingual partially deaf person from a Deaf family was feeling that he was losing control of himself and felt he was being troubled by "outside" pressures. He was born into a Deaf family and considered himself a fully integrated culturally Deaf member of his Deaf family and had incorporated Deaf cultural values, norms and beliefs. He attended first a Deaf School and later attended a Partially Hearing Unit (PHU). He felt he had not learnt much about non-deaf culture and values until he went to the PHU. In some ways David felt that the therapist (the writer), represented the "traditional culture" (the culturally Deaf culture), whilst he wanted to develop the hearing part of his identity. It was as if wanting to be in the hearing world was a trend - a fashion. David could, because of his dual functioning, enter either world he wished. The two cultures were in conflict and there was tension within his own relationship with his partner Morgan, who was non-deaf. David frequently projected his angry feelings onto Morgan. The situation that emerged was that David identified *with* Morgan, his partner, who was also part of a minority group facing oppression from anti-gay attitudes in the wider society. Gradually as the therapeutic alliance progressed, David discovered how in his social world he had been extremely close to his family, who appeared to be dependent on him to meet some of their communication needs. This resulted in David later wanting to break away, in irritation, with what he now perceived as having too many demands placed upon him during his teenage years. David felt he had not considered his own needs and was, in one way, rebelling against what he saw as the family 'morals', values, and beliefs by, for example, *being* hearing and having a non-deaf partner. Once this anger had been addressed David could see how his attempts to integrate into another culture had led him to believe he had actually adopted many of the non-deaf cultural values and norms although it was on a superficial level, hence feelings of external conflict arose as a result of internal conflict over values he had tried to reject. He had 'decided' which culture he wanted to adopt but found he could not "shake off" his Deaf culture as he then wished to. Gaining insight in therapy helped him to move forwards and begin to look at bicultural issues as a way of dealing with his identity development and the cross-cultural conflicts he had been experiencing.

*(Example from writer's clinical practice)*

These examples are used to illustrate a range of issues, all of which have implications for the mental health and well-being of deaf people - the process of which begins at a very early age. Difficulties most often start to develop or there are 'signs' of difficulties during the middle school years onwards.

The attitudes and expectations of non-deaf and deaf teachers are vital to this process which until recently has not been given sufficient recognition by many professionals involved in the health and educational field with an interest in Deafness. Rather than see the development of a Deaf personality as such, the field of transcultural models has provided a stepping stone to the non-pathologization of deafness, in much the same way Black people are not necessarily of a separate psychology but do have separate cultural entities, including, for example, different languages, behaviours and norms. Attitudes and expectations in some ways can be much more influential and instrumental to deaf children's well-being than perfect linguistic matching. For example, the following points taken from a transcultural model (d'Ardenne and Mahtani, 1989) will initiate practical consideration and self-exploration regardless of hearing status.

- How your cultural or racial background affects your attitude to the deaf individual.
- Whether or not you see the deaf person's culture as part of the solution to the present problem.
- Whether or not you can accept, acknowledge and understand the Deaf culture.
- Whether or not your expectation about the Deaf culture affects the outcome of the service being provided.
- Whether or not cultural prejudice experienced by you has a bearing on the educational and teaching relationship.



## Mental Health Issues

The issue of ego development in deaf children has been of interest in relation to language development. This is seen as linked with interaction in the environment, with others and with cognitive development. On the subject of the ego in personality development theory, it is interesting to observe the thinking that since the ego is believed to be shaped by speech and hearing and because it is seen as a vocal and auditory mechanism, the ego has often been seen to be weak in deaf children. Previous research, particularly psychiatric studies from the mid twentieth century until now has tended to apply various characteristics to deaf children. This led to the thinking and belief that deaf children's personality formation was thus characterised by a 'fragile ego'.

Past suggestions leading to the "creation" of a Deaf personality have had a powerful influence in the literature and in practice and continue to do so despite Lane's examination and challenge of the literature on the views and traits white people (Europeans during the age of colonialism) held of Africans which compared almost identically with the many traits, all negative, attributed to deaf people (Lane, 1988). This kind of research information provides evidence of the particular need to consider behaviours and emotions within an appropriate cultural and experiential context. Deaf people have experienced many of these factors of oppression and discrimination in the attempt to 'create' a deaf personality. Interestingly a study of a group of people serving life sentences for various serious criminal offences looked at impulsivity, rigidity and concrete thinking, and found a significant link between these cognitive deficits and deprivation in childhood -referring to limited opportunities for language

acquisition (Laurie, 1996). Although quite different to issues this paper addresses, this does give some weakness to the development of the idea of a Deaf Personality and thus, of a Deaf Psychology.

The Department of Health (1995) produced a fact sheet for its 'Health of the Nation' series, suggesting that about one out of every six or seven people will suffer from mental health problems and that of these mental health difficulties experienced, about 0.4% will experience a more serious illness such as schizophrenia, paranoia or an affective psychosis, which includes short term psychotic episodes in depression. These are figures for the mainstream population. However, research evidence in this thesis shows the incidence of mental health difficulties experienced by deaf people is significantly higher than for the non-deaf population. Thirty-eight percent of deaf people indicate psychological difficulties. There is a view that there is a separate psychology for deaf people, which may be based on the idea that deaf people experience things differently (undoubtedly true) but to the extent that their particular difficulties and presentation of problems are different. For example, Basilier (1964) suggested the creation of a new diagnostic criteria, which he had termed surdophrenia to describe deaf people who seemed to (frequently) fit his version of what he saw as emotional and conduct disorders. The term surdophrenia (deaf mind) is seemingly not used in the U.K. and is rejected by the European Society for mental Health and Deafness as a somewhat derogatory term, replaced by the term emotional and conduct disorders (Swanns-Joha, 1988). Deaf people's presentation of psychotic illness, for example, is not seen to differ from those of non-deaf people (Kitson and Fry, 1990; de Feu, 1996). These beliefs have not necessarily disappeared into oblivion. In a

research article in 1997, Vernon uses the term Primitive Personality Disorder and Surdophrenia which was taken from Basilier (1964) to mean Deaf personality. There have been significant advances by other disciplines, nevertheless, including the teaching professions in the recognition that language, as we now know, is not only vocally and auditorily based. This has helped to shape present thinking and understanding and enabled the re-writing of much of the learning from previously assumed incorrect but powerful beliefs which permeated the field of studies in Deafness.

#### Mental Distress - Deaf People in the Community

Depression and anxiety states were seen as rare in Deaf people. Historically, a particularly high percentage of deaf people were seen as suffering behavioural disorders. Diagnoses such as adjustment reaction, situational disturbance, school situational reactions and inadequate personality have been used, some of which continue to be used by both specialist and non-specialist medical practitioners in the field of mental health and deafness. With better understanding of deafness and cultural issues, better assessments have resulted. The prevalence of mental disorders in a deaf population is similar to that of the mainstream, and this applied to mental illnesses such as schizophrenia (Kitson and Fry, 1990; Monteiro and Critchley, 1993). However, apart from the continued likelihood of deaf people presenting with higher prevalence of behavioural difficulties, where this is linked to aetiology, there appears to be some evidence that deaf people suffer a higher incidence of depression and anxiety states. The writer found, for this study, a prevalence rate of

psychological distress of 38.1% (compared to 10-15% in the mainstream), taken from a random sample of Deaf people in the community, none of whom were part of the client group of the mental health centre. This is described in more detail in a later chapter of the thesis, as is detail about the General Health Questionnaire (Goldberg, 1978), the screening instrument used in this study for detecting anxiety and depression. These include a range of illnesses classified as neuroses (International Classification of Diseases - IC-10, 1995) which have traditionally been referred to as including depressive neuroses, affective disorders, obsessional compulsive disorders, phobias and anxiety states. The figure, 38.1% provides evidence of the hidden needs of Deaf people in the community most of whom may not require specific psychiatric help, but do need support, therapy, counselling or befriending. For example, some of this group have difficulties relating to isolation, relationships and identity problems. Some experienced psychological difficulties linked to experiences of abuse, and in particular, sexual abuse (40% of the sample reported experiencing sexual abuse). A significant statistical relationship between psychological problems and sexual abuse was not found. Several of the sample expressed anxiety and panic states. Many were unaware that they could be helped and were also unaware that help could facilitate change or improvement to their mental state and well-being.

### Young Deaf People and Mental Health

A number of research studies have been conducted to look at mental health problems and disorders in the young deaf population. There are variables which need to be considered such as the degree of deafness, type of school and communication used,

both at school and at home. In addition, a larger number of deaf children have disabilities such as neurological or learning difficulties when compared to the mainstream. The absence of standardised testing and interview schedules for deaf young people add further problems to the validity and reliability of research in this field, which has many conflicting factors. It was previously believed that deaf children had inferior intelligence and commonly believed that deaf children were about three years behind their hearing peers in tests not involving language, for example, the Pintner Non-Language Mental Test (Myklebust and Bruton, 1953). Furth (1966) created a stepping stone for deaf people, by recognising that some testing may put deaf people at a disadvantage if the tests were laden with spoken language. It was Rosenstein (1961) who insisted that there were no differences between deaf and hearing people's performances in conception, providing one used the matching language level of the deaf person. He did not mean Sign Language but nevertheless it was a pointer in a more appropriate direction. Furthermore, Rosenstein (1961) challenged the then held belief that Deaf people could not think in abstract terms by asserting Deaf people could think in abstract terms.

Some studies of deaf children show that 40-50% of deaf children have emotional or behavioural problems, or sometimes both. This compares with 25% for the general child population (Health Advisory Service, "Together We Stand", 1995). At least 30% of the total U.S.A. school age deaf population has multiple disabilities (Schildroth and Motto, 1995). In this aspect, aetiology is important as some deaf people have more than one disability. Many of the causes of deafness, such as prematurity, meningitis, Rh incompatibility and maternal rubella, are reasons for

learning difficulties. The incidence of brain damage in deaf children, due to central nervous system disorders is approximately 9-10% of deaf children (Fremen et al., 1975). The only study to examine the incidence of autism in deaf children has revealed a 4% prevalence of autism **and** deafness (June et al., 1991). Hindley suggests the figure is nearer 10% as seen in his clinical practice, although this is not the same as would be found in a community sample. Autism occurs in 4-20 per 10,000 children in the mainstream population.

Schlesinger and Meadow (1972), in their analysis of a U.S.A. deaf school population, estimate behaviour problems comprising of emotionally disturbed as being 12% and mildly disturbed being 20%. A number of studies have also been conducted on deaf families, where parents and children are deaf. Useful information has been gathered from these studies which relate to these deaf children having higher self-esteem, positive self-concept and a higher level of achievement in schools. These children have also been seen to be more socially mature than when compared to deaf children of non-deaf families (Meadows, 1976; Chess and Ferdinandz, 1980). Most of the 40-50% identified as having mental health problems (Hindley et al., 1994), which include emotional difficulties, behaviour disorders and mental illness, will not need specialist intervention. They will not require being seen by a psychiatrist. However, many would probably benefit from involvement from other professionals in particular, those in educational and related disciplines, who might be able to work with or provide advice and guidance for the family to meet the deaf child's mental health needs. An approach that takes the view the family's needs must be taken as a whole is acceptable as long as the individual deaf child's needs are not compromised.

What these studies seem to suggest is that there is a higher prevalence of psychological disturbance in deaf children and young people; neurological factors may account for only some of the difficulties, particularly where aetiology of deafness has an influence. This weakens the argument for a personality of deafness. The tendency has been to blame psycho-social developmental problems on the deafness. For example Meadow (1980) suggests that deaf children experience developmental deviations. Deafness does not create pathological deviations (Chess and Fernandez, 1980). However, deaf children and youth are more vulnerable when compared to their non-deaf peers, and this vulnerability results from stressors in the external environment produced by communication issues and conflicts, lack of, or inappropriate interaction and liaison with the external environment. There are a whole range of issues which this area relates to; cognitive, sociological, psychological and linguistic.

The search for a Deaf personality appears to have brought us back to the original questions of the psychological characteristics of deaf people. The answer is to be found in the environment and not within any biological or innate characteristics of the deaf child.

### Deaf Centred Approaches

Therapeutic services to deaf people, especially counselling, benefits from the use of a Deaf Centred Approach (Ridgeway, 1995). At present, there are very few available services in the community focused on deaf people's well-being and unless a referral is made to a specialist Mental Health Centre for Deaf People, then little

other help is available. The situation differs in the mainstream, where community clinics exist in almost every town and a wide range of NHS mental health services are available. For the deaf person to request access to these services, the needs must be known. Deaf well-being depends upon the skills and experiences of qualified and trained deaf people, who can provide a range of skills and expertise to help meet the various educational and mental health needs of our deaf population. There is no reason why the field of mental health cannot follow the footsteps of the educational profession, where access for deaf people is gradually being made and increasing focus placed upon use of transcultural models as models of good practice. Although there are examples of bad or inappropriate practice in some mainstream settings, and within PHUs, the numbers of those striving to provide appropriate deaf centred educational services are undoubtedly increasing, and it is on this positive note that this chapter ends.

### Conclusion

Much of the emphasis on the view that there is a psychology of Deafness, probably stems from a failure to recognise that most of the difficulties deaf children experience within their non-deaf and deaf families are due to a number of external factors such as inappropriate, or lack of, guidance and support, lack of access to awareness of Deaf issues, Deaf community, culture and Deaf role models. It appears to be a unique human experience to have a biologically related child who has a belonging to another cultural and linguistic group from that of its hearing parents. Ninety percent of deaf children are born to non-deaf parents (Reagan, 1985; Pheonix, 1988). Research has shown, however, that non-deaf parents are often willing to learn about



their deaf child's culture and language and thus develop close relationships and positive attachment and bonding with each other (Lederberg and Mobley, 1990; Sutherland, 1993) than anticipated. This process is initiated by appropriate contact, interaction with deaf people, both culturally and non-culturally deaf, and access to information, knowledge and awareness.

## CHAPTER FOUR

### ISSUES IN TRANSLATION

#### Translating Written Material into Sign Language

There are a number of weaknesses to be found in any study that uses written questionnaires to gather information from deaf people. Face to face contact is probably the most appropriate situation to interview most deaf people. Using British Sign Language (BSL) videotape is an alternative way of interviewing, and is comparable to giving written English questionnaires to those with English Language skills. Apart from BSL being the preferred language of culturally Deaf people, visual and face to face contact is often also preferred by a number of other groups of deaf people who may not have the ability to use Sign Language but who may prefer to speech read or use a combination of channels in which to communicate. These channels can include written communication and may also include other manual communication systems, such as Makaton, (a sign system used mainly with learning disabled people), based on the English language, which, like Signed Supported English, uses a *vocabulary* of signs borrowed from British Sign Language, but not the structure, syntax, grammar and morphology of BSL), Paget Gorman, Signed Supported English, Signed Exact English or Cued Speech, all of which are based on English. The difficulties of using written English for deaf people, is that the participant does not usually have an opportunity to query any of the questions and often does not have access to the ability to make immediate clarification on a spontaneous level. This refers to the researchers or practitioners who are often non-deaf and without fluency in the use of Sign Language. This is comparable to poor

performance related influence that Black students can feel when the examiner is white (d'Ardenne and Mahtani, 1989). There is also the issue of having a 'third party' present (an interpreter for example) which might add to the participant's anxiety or concern. Young deaf people tend to develop coping strategies at an early age and quickly learn to cover up any inadequacies seen or felt by observation. For example, a child's response to a teacher's question can often be guided by looking at their facial expressions and body language as to whether a negative or a positive response to their teacher's question is required. These strategies are used in various situations and well into adult life. It is often much easier to feign understanding and comprehension because of anxiety felt on the part of the deaf person, when asking the hearing person to repeat their question. Observing the facial expression impatience or inconvenience, is distressing. This is particularly apparent in younger deaf people who may begin to acquire a negative self concept. This suggests that many deaf people whose first language is British Sign Language will tend, as they grow into adulthood, to suppress their queries, and perhaps feel embarrassed to ask for clarification even if help were immediately accessible.

The results of studies which use spoken or written questionnaires for the deaf population are questionable in their validity, appropriateness and accuracy and raise many issues. Some of these issues are discussed here. The issue of making written English easier, or more 'simple' (for example, by shortening sentences), for deaf people to read, has features that may be seen as patronising and this has caused offence to members of the Deaf community as it would appear to suggest that deaf people are not very 'bright' or by nature not very good at reading. No-one would

suggest, for example, that if a non-deaf English speaking person could not understand Dutch, that he is not good at reading Dutch (unless his position or career indicated he ought to be). English is often a usually poorly developed second language, the average reading ages for deaf school leavers are found to be low. Conrad (1979) found an average reading age of 8 to 9 years was attained by deaf school leavers. This reading age has probably improved over recent years with increased use of signing in schools. Bi-lingualism, whereby English is taught using Sign Language has been found to be productive in facilitating deaf people's understanding and comprehension of written English (Gregory, 1995; Head, 1995; Pickersgill and Gregory, 1998). The British Deaf Association, (BDA), the U.K.'s leading organisation representing the interests of the Deaf community advocate a bi-lingual approach, whereby deaf children are taught various subjects, including Mathematics and English, through British Sign Language (BDA Education Policy, 1996). Such approaches tend to concentrate on the level of comprehension of written language for reading and writing and not for spoken abilities (speaking functions) although speech therapy is offered.

### The Modification of Written Questionnaires for a Deaf Population

Issues raised in the translation of questionnaires designed for a culturally hearing population into versions acceptable for culturally Deaf people will now be discussed. The Beck Depression Inventory (BDI), devised by Beck (1967), is a written questionnaire which has been translated into simple written English for use with a deaf population (Leigh, Robins and Welkowitz, 1988). The translation was designed to ensure easy readability and suitability for college-level deaf populations in

America, a large percentage of whom it was assumed, will have received somewhat limited exposure to American Sign Language during their lives before entering college. The researchers did not say why this is an assumed background variable. The translation was made into what was considered simpler written English and this is referred to as the Revised Beck Depression Inventory (1988). The authors concluded that there were problems with the internal consistency in the test-retest process used in the translation, and recommended that further work needed to be done in the validation and utility of these screening questionnaires within a deaf population.

The deaf sample were selected from a college population at the National Technical Institute for the Deaf, (N.T.I.D.), in 1983-1984. The items in the original BDI were given to a non-deaf (hearing) high school teacher who was given the task of identifying the written items she considered to be too difficult for the deaf participants in this study. The items were revised into easier English which requires a lower level of reading ability. Care was taken to ensure that the meaning of the revised items still corresponded as closely as possible to the meanings of the original BDI written English version. This process was supported by the inclusion of matched possible college applicants who were not deaf, (with the actual college participants) who volunteered to assess each item for meaning and comprehensibility. The items were further revised as necessary. The revised and simplified version of the BDI, however, does not appear to be clear and simple. For example, in the revised version, Question 8 (a) reads "I feel I am not worse than other people", which forces the interviewee to visually lose placement of the subject because of the complexity

of the sentence. The sentence might more easily read, "I am the same as other people". The original version was "I do not feel like a failure".

Another example statement in the revised version of Question 11 (b) is "I felt less bothered in the past. I am more easily bothered now". Again, this does not appear to be expressed in a Deaf-friendly linguistic form and might more appropriately read "I am more quickly upset compared to before". However, the original version was "It takes extra effort to get started at doing something". Not only does the revised version appear to be linguistically distorted but it is different in meaning. The revised BDI also, in places, seems to complicate concepts, for example, the original question 18 (a) reads "My appetite is not as good as it used to be". The revised version reads "Now my appetite is not as good as before". A more clear translation might read "My appetite before was better". I would suggest from the original that the translation would more appropriately be conveyed as "I have to work hard to do something", or "I have to work hard to be active", thus retaining its meaning. The translation of the BDI, by a hearing high school teacher, without any proper test of appropriateness in translation and a linguistic matching, is an example of the issues highlighted in this chapter.

There are 21 items that make up the BDI. These are listed in Appendix 1. The revised version is also listed in Appendix 1. The revised version was administered to both deaf and hearing samples and the original version was shown to another all hearing sample only. Among the hearing participants, the results of the revised and original versions of the BDI presented were comparable in internal consistency, both

comparing well with the 0.86 which Beck had found. A group of 112 hearing students and 102 deaf students took part in the study at the NTID. The study used three instruments, all of which had been revised into what was considered a suitable format for the adult deaf population. The three instruments were the Beck Depression Inventory, (BDI - revised version), (1988), the Parental Bonding Instrument (PBI) (1979) and the Sociotropy-Autonomy Scales (SAS) (1983). The other psychological questionnaires were revised in a similar way as the Beck Depression Inventory. These items were selected as part of a larger study (Leigh et al., 1988) on the relationships of personality and parental-child relationships, to depression in deaf and hearing individuals.

The Sociotropy-Autonomy Scale (SAS), (1983) consists of two 30 item self report scales of Sociotropy, (described below) and Autonomy (Beck, Epstein, Harrison and Emery, 1983). The students interviewed were asked to respond on a five point scale by giving a score of 0-4 on how much they felt each statement applied to them. The Sociotropy-Autonomy scale (SAS) was revised for use with deaf populations. The rewriting process also involved translating the original written items into a lower grade vocabulary level, in order to minimise any problems deaf students might encounter in reading the questionnaire. Robins (1988) reported that in a sample of 424 undergraduates, a .90 internal consistency for sociotropy was obtained. The Sociotrophy, Autonomy Scale (SAS) measures concern about feelings of disapproval, attachment, (towards others, for example, including parents and pleasing others), and a .80 internal consistency was found for the items measuring autonomy.

Factor analysis of this part of the scale generates three factors which can be described as; freedom from control; achievement; and preference for solitude.

The Parental Bonding Instrument (PBI), (Parker, Tupling and Brown, 1979), is a 25 item scale containing descriptions of parental behaviours and attitudes and to which, again, students were required to respond in the same way as for the Sociotropy, Autonomy Scale, by rating statements on a 4 point scale according to their recollection of their parents when they were children. This scale looks at issues of parental care and overprotection. Parker et al., (1979), recorded split half reliabilities of 0.88 and 0.74 and test-retest stabilities of 0.79 and 0.63 for the work involved in translating the Parental Bonding Instrument.

Half of the hearing group were asked to complete questions in their original form and the other half, along with the group of deaf students, completed the revised versions. The researchers aimed to address whether or not deaf people present with different symptomatology for depression than hearing people, and also how, if any, relationship is found, do the personality characteristics of sociotropy and autonomy compared with perceptions of parental characteristics, and if this was at all related to presentation of depressive symptoms. The results are shown in Table 4.1.



**Table 4.1: Internal Consistencies of Original and Revised Psychological Instruments**

Instrument	Original Author	Hearing Original N=56	Hearing Revised N=56	Deaf Revised N=102
Parental Bonding Instrument				
Care	.88a	.90	.93	.85
Overprotection	.74a	.89	.80	.75
SAS				
Sociotropy	.90	.92	.85	.84
Autonomy	.83	.83	.76	.78
Beck Depression Inventory	.87a	.89	.87	.66

a = Split-half Pearson correlation coefficients.  
All others are Cronbach's alpha.

Taken from Leigh, Robins and Welkowitz (1988)

The researchers, Leigh et al., (1988), are suggesting that the derived internal consistencies in participants' responses can be gauged by comparing the hearing (revised) responses to the original, and the hearing (original) responses to the revised versions. They imply that if the revised instrument has an acceptable (comparable) level of consistency to the original, then it must be a valid comparison. However, what the authors have overlooked are the cultural issues. The results of hearing people's responses to a 'revised' or, to put it more accurately a "simplified" version of the same questionnaire cannot be taken as a measure of successful validity for translation except perhaps for application to a younger age group of hearing people. Although the suggestion, as can be seen in Table 4.1, which is that the revised versions, when compared with deaf and hearing results, did not differ on measures

significantly, it nevertheless cannot be assumed that this does not merit further analysis and consideration, in particular, with relation to the cultural and linguistic aspects of deaf people and the deaf population interviewed. Table 4.1 shows that the only significant item was for overprotection on the Parental Bonding Inventory, which shows a significant difference between the hearing original (0.89) and the hearing revised (0.80). The results of this study shows that more deaf people were depressed, when compared to non-deaf people but that this only appeared in the case of mildly depressive states. Deaf people did not score higher than non-deaf people for moderate or severe depressions.

The authors of this research (Leigh et al., 1988) concluded that depressive states were not related to deafness but that deafness seemed to increase vulnerability to mildly depressive states. The differences between the depressive states described here relate to degree of severity. Severe depressions may include those who were comatose or who were experiencing an affective psychosis related to a depression. There are different views on what may be considered mild, moderate or severe - a guideline would be the degree of risk of harm a person presented either to himself or others. A Major Depressive Syndrome, (DSM-III-R, 1987), is defined by a number of symptoms present during a two week period and is further categorised into mild (symptoms resulting in only a minor degree of interference in occupational functioning or usual social activities and relationships), moderate (functional impairment between 'mild' and 'severe') and severe (without psychotic features) which indicate significant interference in both occupational and social functioning and relationships with others.

These results raise the possibility of a greater number of stress factors that might affect a deaf person's emotional stability compared to non-deaf people and the implications of this in examining the mental health needs of deaf people. Deaf students scored higher on the personality dimensions of sociotropy and autonomy. The researchers suggest this might be due to deaf people feeling a greater need to 'prove' themselves and conclude that this is a 'healthy "adjustment"' to deafness. It is not clear what is meant by their use of the concept of 'adjustment' in relation to this study. The term 'adjustment' when applied to deaf people seems to refer to their ability to adjust to their deafness **from** what is seen as a normal state of what might be called "hearingness". The writer views the term 'adjustment' as not being appropriately used, for example, deaf people who from an early age, have **not** had to 'adjust' - as opposed to the term being applied to deafened people (hearing people who have **become** audiolgically deaf). The term would, therefore, appear to be seen to have a patronising and disabling effect when used upon culturally Deaf people who use Sign Language as their first or preferred language.

Leigh et al.'s study (1988) suggested that the expected relationship between sociotropy (characteristics of dependency), and a lack of maternal care and attention did not appear as statistically significant for deaf people as it is for non-deaf people. The authors, however, assume that for deaf people, lack of parental care does not lead to dependency. This, however, does raise issues in translations with regard to cultural and linguistic awareness. For example, deaf participants may not be aware that parents have been lacking in caring skills and might just think or have come to expect and believe, that their particular experience of growing up in a hearing family

was usual or normal, either because of their deafness, because of lack of communication with members of the family, because of lack of access to information or a combination of factors.

The scores of both hearing groups did not differ significantly in the mean BDI scores attained, compared to the revised versions of BDI. This, according to the researchers, (Leigh et al., 1988), suggests that the revision did not alter the measurement characteristics of the instrument. The deaf sample scored significantly higher on the revised BDI than the hearing sample. We do not know if this is to do with the language in which the test was presented (written English) or with the effect of a translation into what the researchers term simple English from a more sophisticated version of the same language. Nevertheless, the prevalence of depression in this particular population of deaf students was significantly higher than the prevalence of depression within the non-deaf population. Of interest is that the deaf people selected for this sample had to meet a criteria which meant that they had to have a hearing loss greater than 80 decibels and onset of deafness was to have been prior to the age of two. They had to be of hearing parentage and without any handicaps, or disabilities as is usually the preferred term in Britain. Such individuals meeting this criteria would usually come to develop Sign Language as their first and or preferred language once exposure to Sign Language was initiated or facilitated. The writer suggests that although the results of internal consistencies appear satisfactory, they cannot be used to be representative of deaf people. Hearing (non-deaf) norms are still, in this situation, being imposed upon deaf people. It would be preferable and more appropriate to devise scales which originate in Sign Language.

Translation from Sign Language into English may be equally difficult in terms of issues linked to cultural mediation. However, scales which originate in Sign Language versions would enable and facilitate better translation into less sophisticated Sign Language, for example, for those deaf people who have limited language (sign vocabulary), in much the same way non-deaf tests can alter language for age suitability instead of for 'simplicity' for deaf people. The creation of new scales and questionnaires, which originate in British Sign Language has not appeared in various literature searches.

### The Translation of Instruments into Sign Language - Cultural Issues

The reasons for the need to translate instruments into Sign Language are due to a number of factors. The most obvious one has to be the facility of ease and comfort in which a deaf person can be interviewed and assessed. Usually this means in Sign Language as it is a visual language and an obvious medium of communication for deaf people in which to learn and to communicate in as natural a way as possible. One reason for the interest in developing instruments in Sign Language has occurred by default because the often poorly developed English skills of deaf students in schools and colleges. Research has revealed low reading ages (Conrad, 1979; Wolk and Allen, 1984; Paul 1987). The median reading score for deaf students at the age of 20 years or more has been found to correspond to a fourth year grade (Allen, 1986; Paul, 1988). This would be equal to children aged 8-9 years old .

In other American studies, it was concluded that only 10% of deaf 18 year olds, across the nation, could score at 8th-grade or more (Brauer, 1993). Eighth grade

refers to the equivalent of high school age of 12-13 years. It continues to be the case that many deaf students remain functionally illiterate for comprehension and understanding of English as their second language when leaving school. Functionally includes being unable to read tabloid newspapers, follow subtitled news or read a set of instructions for example. A number of writers have also pointed out the lack of success of Orally based education systems which result in continuing poor levels of English (Lane, 1984; Kyle and Woll, 1985; Denmark, 1985 and Brauer, 1992). Nester, (1993) has stated that the only possible use of verbal tests is to measure verbal abilities and that this means deaf people are prevented from indicating their abilities in any other field when a written test is used. The implication here is that any form of written test is, therefore, inappropriate for use on a deaf population and this is so regardless of signing skills and or English skills since the purpose of the test is lost in the effort of the interviewee to comprehend the English in the first place.

Research has often used written or spoken (speechreading) methods to interview deaf participants. Research using a video camera to record Sign Language and recruiting deaf people to provide Sign Language to use in interviews does provide a means of interviewing which appears more suited to deaf people than the use of non-deaf signing researchers. Research on members of the Deaf community will involve complex social psychosocial and cultural processes from which, where a non-deaf researcher is involved, parallels can be drawn with issues which will emerge in similar intercultural contact, for example, a Western white person conducting research interviews within an Afro-Caribbean population sample. White examiners being used in situations where groups of Black students were taking exams have been found to

produce poorer results than if the examiners were also Black (Katz, 1978; d'Ardenne and Mahtani, 1989).

Several research articles, (Thomas and Sillen, 1972; Greene, 1985 and Sue and Sue, 1990), have been written on this subject and as there appears to be some parallels to be made with non-deaf people interviewing deaf people, it is likely that similar issues will emerge.

Research has examined how deaf people are seen by hearing people and therefore reflects their perception of behaviour amongst deaf people, usually from a cultural perspective. Hearing researchers interviewing deaf people will, therefore, impose features of their own non-Deaf culture, onto aspects of the behaviour of culturally Deaf people and thus may arrive at a set of their own however inappropriate conclusions. Such situations are described by Vestberg (1988) and Lane (1988). Ethnographers (Hammersley and Atkinson, 1983) have also drawn attention to the problems of researchers who perhaps unintentionally create 'social constructions', about a group of people, from their own perspective. Obviously the very nature of research tends to place the interviewer in a position of power relative to the interviewee. Contact between deaf and non-deaf people may sometimes be problematic, rather similar to when ethnic groups come into contact with those from another group. The differences and the potential areas of conflict may not necessarily reflect ignorance or even lack of awareness on the part of either group, but may reflect intrinsic differences which cannot be 'watered down' or empathised with. Furthermore, the cultural identification shared by members of the same group affords

a way of 'protecting' themselves from the 'outsiders' or 'invaders'. Cultural affiliation offers a way to use their resources to defend against assumptions of the hearing world (Padden and Humphries 1988). Deaf cultural identification can also offer a way of gaining and maintaining psychological and social well being.

The process of acculturation - (process of cultural contact and change between two social groups) happens within mixed groups and probably within mixed interactions between deaf and non-deaf people. This applies to non-deaf people working with Deaf people, who will face the problems of cross-cultural interaction. Cultural norms within a culture include ways of attracting others - such as waving the hand in front of the deaf person's face or touching. Each has its level of intensity. Sometimes it is appropriate to tap on the shoulder and at another time it is not and this may give off unintentional signals of alarm. There is also the issue of pre-interview etiquette - which involves the need to partly socialise, or what appears as engaging in general conversation, prior to taking on board the beginning of the interview process. It is often the case, however, that non-deaf people conducting research interviews themselves are 'misled' into believing their Sign Language skills are better than they actually are, through the pleasant surprise that some deaf people experience when meeting a hearing person, other than a social worker, who has sign skills. By this, reference is made to the fact that as so few hearing people do take the trouble to learn to sign at least well enough to be able to conduct some basic conversation, it is a pleasure and often enhances the self-esteem of the deaf individual to see Sign Language being used. The hearing researcher might have only basic level 1 in signing skills, and therefore might be led into a false sense of belief that their signing



is better than they thought. The non-deaf interviewer might then believe he/she is accepted as a member of the Deaf community when this is not so.

On the other hand, there are a number of perceptions deaf people tend to hold of non-deaf people. The 'Deaf Comedians' is a well known comic group of comedians who are all deaf, have spent many years performing comic sketches, some of which have become internationally famous, of hearing people - mocking and making fun of hearing values and norms. An extract from Bahan (1989):

**"On Halloween Night at about 8.30 the doorbell flashed for about the hundredth time. I groaned and wondered who was sending their kids out this late? I got some sweets and went to the door wondering what costume this kid would be wearing; so far, the scariest one was a kid with a Ronald Reagan mask. As I opened the door and glanced down at the kid, I couldn't believe my eyes. I screamed, dropped the bowl and ran back into the house bolting the door shut behind me. The kid was dressed like a hearing person".**

*Bahan, (1989, p.17)*

Other humorous perceptions include the tendency for non-deaf people to be seen as 'stiff' (hence - 'the stiff upper lip') and formal in appearance and body language. There are obviously specific ways one needs to consider when approaching hearing people - making a complaint in an immediately abrupt manner would be unacceptable whereas a general planning of intervention might be more the norm for non-deaf people - who tend to be a little inhibited generally, compared to deaf people. They may also be seen as 'cold' and unexpressive and thus have such characteristics assigned to them.

These are examples of some quite essential cultural factors which differentiate and separate deaf and non-deaf people and their distinct cultural affiliation or characteristics. These issues suggest therefore that there is an element of risk involved in the translation processes from language into another, if the translator, or the interviewer as in this discussion, does not have sufficient facility and awareness of both cultures and linguistic familiarity.

**"The task of being responsible for the contents of the written version of a signed statement can be daunting, even for a qualified interpreter. The potential for error that such statements are based upon the interpretations of non-qualified people, is frightening".**

*Reed, (1996) Deaf Worlds Issue 1, Vol. 12, p.17.*

Apart from the issue of language and cultural mediation, there is the fact that there are few professionals working in the range of disciplines to which non-deaf people access, who have a reasonable degree of signing skills or any basic Deaf awareness. On a visit to a German Psychiatric Unit for deaf people in 1996, a staff nurse informed me, in response to my query regarding the lack of visual alerts, that there was no need to adapt the environment to meet the needs of deaf people as the hearing staff would inform the deaf patients when they were wanted. There were no visual aids or visual alarm systems of any kind throughout the 60 bedded unit which was occupied solely by deaf people suffering from a wide variety of mental health difficulties.

Deaf people are rarely given access to training in this field and where engaged, it is usually in a voluntary capacity, perhaps working alone and without supervision (Report to WFD Commission on Psychology and Psychiatry Workshop; 'Deaf

Professionals in Mental Health Care' - (Ridgeway, S) Austria, 1995). Research by Johnson, Liddell and Erting (1989) have found evidence of the poverty of Deaf awareness and Sign Language communication skills of hearing people within services to deaf people and furthermore, in a study involving 195 psychological centres which provide services operating at schools and clinics and rehabilitation centres across a total of 48 states in the USA, ninety percent had no staff who could communicate effectively with clients who use American Sign Language. This has implications on any therapeutic work that clients may require which involves interpersonal relations. This caused such concern that in 1974 a separate Society for psychologists interested in working with deaf people was formed within the mainstream psychology services in America, for those psychologists who either worked with deaf people already or who wished to work with deaf people, becoming recognized as an area of work in itself. To date no such group exists in the U.K.. Although a special interest group was established for a short time, the group was not accepted by the British Psychological Society as a recognised Special Interest Group, (due to a stipulation that there must be fifty members first before any group can call itself a special interest group of the BPS), which is further evidence of the lack of recognition, understanding or interest in Britain on matters concerning deaf people and their linguistic and cultural issues and challenges.

The Special Interest Group was established in the summer of 1992 and was active until its second workshop in 1994. Larner (1993) has provided further evidence of the small numbers of psychologists with any kind of understanding of Deaf issues. Indeed, it appears that in the U.K. there are only three clinical psychologists, all of

whom are hearing, presently working with deaf people, who have any degree of competency in Sign Language, and none of them at this time hold the Advanced Level three Certificate in Sign Language with deaf people. This suggests that there is even more of a pressing need to create Deaf awareness amongst professionals in the field of psychology and especially to apply this knowledge prior to any kind of psychological testing, so as to prevent the large number of errors and misdiagnosis of deaf peoples' psychological problems. Mistakes and errors occur regularly, however, based on myths or ill-informed and badly conducted research. Only recently in clinical practice, an Educational Psychologist, who has over twenty years' experience working with deaf people, assessed a young deaf girl using the WISC-111 (Wechler Intelligence Scale for Children) and concluded that the deaf child was exhibiting difficulties in abstract conceptualising hence a low score on the performance scale section of the WISC-111. The Psychologist wrote; "... like many deaf students, Jane (not real name), found it difficult to understand the concept of 'what is missing?' despite several demonstrations". This suggests that the Psychologist believed that deaf people usually have difficulty with abstract concepts. This lack of awareness and understanding on the part of an established educational psychologist working with deaf people is a reflection of the numbers of professionals who are working on premises derived by badly performed and conducted research which has drawn out not only generalised negative traits about deaf people but has also reached a number of incorrect conclusions and suggestions.

A reading of Vestberg (1988) and Lane (1993) provides a number of points to support this. Harlan Lane has drawn parallels between the way white people stereotype black

people with the way non-deaf people see deaf people and has written several articles on this (1988, 1984, 1994). Vestberg's (1988) paper draws on the way non-deaf people see the impact of deafness and the subsequent affect of the individual's personality and the personality characteristics that might be seen to 'emerge' simply as a result of the way deaf people have been treated at home and at school. Vestberg does this by reviewing a number of studies of deaf adults and deaf children conducted during the twentieth century and comments on studies that tended to attempt to reinforce the stereotypical views of deaf people and which, in his opinion, were mainly linked to the biased views of the researcher, rather than the actual results of the research itself. Vestberg also makes the point that the researchers own views, or opinions, on communication issues and deaf children in education (the philosophy of the researcher) can actually cause researchers to miss, or fail to see, some of the implications of their research results.

#### Sign Language Translations of English Based Psychological Questionnaires

There is very little research that has been done concerning the *effects* of translating written psychiatric and psychological instruments into Sign Language and on the maintenance of linguistic equivalency in validation and reliability of such translations. Researchers, namely, Brauer, (1980) and Tweney and Hoemann, (1976), have suggested that the issues would be just the same as for translations of any assessment instruments which involve the translation of one spoken and written language into another spoken and written language. The head of a translating company based in the U.K. has suggested that the issues for translating Sign Language into spoken or written form and vice versa will present much the same issues as for translations of

any spoken language into another spoken language and therefore suggests that there are no particular difficulties specific to Sign Language itself (Eurocom, 1996).

The translations that many researchers think about might refer to translation work done at conferences where a number of different spoken language interpreters are operating at the same time. Cultural mediation is seen as an issue for any interpreter, whatever languages are being translated, and therefore, perhaps unfortunately, is often not considered as any more of an issue for deaf people than for hearing people. Previous translations of psychological instruments into Sign Language have been attempted, but this appears to have been mainly with using the Minnesota Multiphasic Personality Inventory (MMPI) (Rosen, 1967; Brauer, 1993).

Prior to the translation of the MMPI, which is described shortly, another instrument was translated into American Sign Language. This was a small ten item unnamed intelligence test which was translated into ASL by an interpreter in a study conducted by Hoemann (Hoemann, 1972). The items which were in written English, were to be translated into ASL but Hoemann found particular problems in translating the test into ASL because the interpreter, although fluent in ASL, still used English words, syntax and morphology in the test and tried to translate the words themselves. This resulted in a Sign Language version which is not satisfactory. Hoemann felt the translation result was awkward in style and garbled. Examples of the difficulties in the use of interpreters who are attempting to interpret in situations where the language (subject, context or terminology) is not familiar, tend to illustrate the unconscious 'dependency' (to fall back) on English. Such illustrations do present a danger to

onlookers, listening to a voice over translation, of thinking that Sign Language is inferior to English. The interpreter, in unfamiliar linguistic environments, might lose sight of what is the 'topic' or placement and direction of subject or verb, and spontaneously resort to English structure in Sign presentation, hence the 'awkward' effect described by Hoemann. Dwyer and Wincenciak (1977), also found similar difficulties when attempting to translate the Intelligence Test into ASL.

One of the implications of translations is that they may themselves grow through the process of being translated **into** the other (target) language. It seems that the English versions are often held onto by non-deaf interpreters, without letting go of the grammar and the structure instead of concentrating upon the meaning of what is to be translated. Often the signed translations from English, in many areas of research conducted so far, tend to be lengthier, and may contain examples, to illustrate the meaning of what is being conveyed in the originating language, English. Well known examples involving interviewing clients for psychotic illness might involve questions which use abstract ideas. Some questions might aim to try and elicit the pattern of the deaf participant's thinking. Many psychiatrists have found themselves in difficult situations, with an interpreter, when performing a psychiatric assessment and having to resort to examples and thus 'feed' answers or responses for example. "Do you feel any outside influences" is often not going to be understood if translated literally but the interpreter usually starts to feel the need to provide examples to illustrate the concept by giving the client ideas such as 'the moon', computer or television, and if a 'positive' answer is not received, the result is usually a misdiagnosis. A client who feels influence from another source may not actually volunteer this information, either

because he or she does not wish to or because the meaning of what is being asked is not clear, or because he might not necessarily be conscious of this. Better interpreting training now means this is less likely to happen but the interviewer, instead, feels pressure to provide the examples even though this is deemed inappropriate practice amongst researchers and practitioners within the medical profession in relation to psychiatric interviews.

Other questions such as "what is it like when you worry?" (Present State Examination Medical Research Council, 1974), or "Do you feel on edge or keyed up or mentally tense?" or "Do you find that a lot of noise upsets you?" or "Do you find that a lot of noise goes through your head?" are unlikely to be Deaf friendly. For example, terms such as 'on edge' or 'keyed up' are not used by culturally deaf people, and are culturally hearing terms. Asking questions about noises going through one's head need to be carefully considered and it is useful to seek clarification of positive responses as to whether the noises are 'seen' (visual - for example, signing or felt (vibration) or possibly Tinnitus). However, what interpreters without mental health awareness training and knowledge tend to do is to give examples together with the questions instead of literally translating the **meaning** of the sentence.

"Can you think clearly or is there any interference with your thoughts?" is the sort of question that might be asked to elicit information about thinking and to detect psychotic states but as referred to previously, a translation by a non-native signing professional may prove to be inappropriate. The question "Do you like to stay away from other people?" was interpreted by a Sign Language interpreter as "If someone



came home would you open the door for them?". This was witnessed by the writer during a clinical interview in 1997. A further example shows difficulty in assessing a person's confidence - and an interpreter suggested, adding the following "if you are given the wrong change would you go back?" as being a sufficient way of measuring a deaf person's self-confidence. As commented earlier, such translations might appear awkward or 'garbled'.

The same method was used to translate the Counselor Rating Form (Freeman and Conoley, 1986). In this study items were translated quite successfully, probably due to the use of a native Sign Language user being recruited to be one of the researchers conducting the testing. Brauer (1993), emphasises the need to have 'native' psychologists engaged in all translation attempts, as does Butcher and Pancheri (1976) and Westermeyer (1987). The meaning of the term 'native' psychologist is not described but presumably means a qualified and practising culturally Deaf psychologist. This kind of stipulation is probably not always practical although a 'native' or a 'qualified' psychologist could review procedure and evaluate progress. The importance of employing native Sign Language users both for research itself and for the placing of translations onto video tape cannot be overestimated. Of particular significance is that Sign Language is often compared to, or placed alongside, those ingredients that make up the term 'manual communication' or 'manual methods'. Sign Language **and** various English based manual modes of communication can be seen on a continuum. The continuum swings across many regional variations of sign, particular to or within a given country, degrees of sophistication in sign vocabulary use, different syntaxes and also the degree of English 'features' such as oral English

mouth pattern and English word ordering (grammatical structure). These points are made to provide support to the evidence that regardless of discipline, researchers must be native Sign Language users, or as near native as a non-deaf person could be as it is the native Sign Language user who will most likely have the fluency, or the proficiency required to communicate with deaf people at any point of the continuum in which the deaf person lies.

What seems to be emerging now is that as the use of Sign Language is becoming more acceptable and recognized as a language, deaf people may be more readily accepted as being part of teams conducting research projects into the use of sign in translation of instruments in psychological as well as other fields.

The Multiphasic Minnesota Personality Inventory (MMPI) was translated into American Sign Language via a back-translation procedure and was recorded on video tape (Brauer, 1993). The MMPI is a well established instrument which can be conducted in a range of settings including rehabilitation and clinical settings and also has been used within all sectors of the non-deaf society. One of the first attempts to translate the MMPI into ASL (American Sign Language), was made by Myklebust (1964), and later by Rosen (1967). Rosen's study resulted in a large number of students presenting with a psychotic type of personality. This study was conducted on a number of academic deaf college students who demonstrated no signs of mental illness and had never been referred for mental health assistance. The tests had been administered directly in their original standardised written form and the students reading ability was of the 7th grade level (11 year old equivalent) and had been

deemed sufficient for understanding of the MMPI in its unaltered unadapted form. However, a number of the students did not understand many of the MMPI items. The MMPI contains idiomatic expressions and deaf people without sufficient understanding of English hearing culture would do poorly on this. Despite these difficulties in obtaining a valid and reliable estimate of deaf peoples' personality profiles, by means of a psychological assessment measure, such as the MMPI, the use of the MMPI has been deemed to be not recommended by psychologists at the University of California Centre on Deafness (Orr, DeMatteo, Heller, Lee and Nguyen 1987).

Harlan Lane (1988) has strongly stated that this specific test should "never be used with this population" (Lane, 1988, p.15). Lane refutes the use of the MMPI on a deaf population because of its lack of cultural appropriateness. The MMPI is a culturally hearing test aimed at culturally hearing people, and this probably supports Lane's (1988) assertion. Brauer (1993), attempts to move away from the present disagreements and conflicts in the field of psychological testing and deaf people, by taking a look at the field of cross-cultural psychology to see if there are any possibilities in borrowing their own testing approaches. A number of assessment techniques have been devised which enable the successful transferring of tests for use on one group to be used on another, by following criteria to be met (Butcher, 1987). The techniques include criteria for valid translations, translating and back-translation processes and also include the need to consider such variables as the translator's characteristics, as well as for the need for proper reliability and validity assessment and evaluation. Brauer developed the Sign Language version of the MMPI based on

the fact that the MMPI had been translated into several languages already and that the use of the MMPI had already been demonstrated in several different cultures internationally. The process Brauer used to translate the MMPI was to aim for linguistic equivalency first. This was seen as the most important stage in the translation process to be followed by psychological and conceptual equivalency. Linguistic equivalency is achieved if the entire context matches for meaning and can produce, upon presentation, similar concepts being described. Particular **meanings** of a given concept which may have more than one interpretation, need to be explored and presented as culturally appropriate.

Modifications were kept to a minimum and that meant to try and keep down the number of words which might need to be substituted and to try and keep the MMPI in its original form as far as possible. Brauer followed the rationale for translating instruments as presented by Butcher and Pancheri (1976) which is used for foreign language translations. Presumably, Brauer is referring to **spoken** foreign language translations although does not actually say so. This omission is in itself quite remarkable since the essence of Brauer's work is the intention to provide accessibility to psychological testing for deaf people in their first language, which is usually Sign Language, and the essence of that reasoning is the recognition that language can be presented in other forms apart from spoken and written. The criteria specifies that the instrument has to be universally appropriate and relevant for psychiatric assessment, the implication being that the items might function in different cultures in similar ways and therefore might be successfully used on deaf Americans since the MMPI was designed in America. For cross-cultural comparison, a minimum number

of items of the MMPI were to be substituted for the ASL version. Brauer goes on to make the following comment, however, which appears confusing and raises questions as to what culture she is examining:

**"If the ASL (American Sign Language) version of the MMPI could be shown to perform in the Deaf American culture in a way similar to the way the original English version performs in the United States, then future research with the ASL versions of the MMPI could be easily tied to the extensive construct validity of the MMPI. Extensive item substitution may make this accessibility impossible".**

*Brauer, (1993), p.250.*

Here it becomes clear that the dominant culture is undoubtedly the non-deaf hearing culture and the implication is that differences presented by deaf people could be interpreted as deviance, as was the case in Rosen's earlier attempt to use the MMPI, in 1967, although not in Sign Language form. Much of what shapes an approach to the field of psychological testing of deaf people is the perception of whether or not a Deaf culture exists and if it does, then does this culture offer some differing psychological aspects when compared to non-deaf people. Brauer appears to be saying that we cannot find out if this hypotheses holds unless we attempt to verify the adequacy or inadequacy of items in the MMPI in a cross-cultural comparison. A cross-cultural comparison nevertheless is still a comparison with scores held by non-deaf people who have produced non-deaf norms.

The procedure of translating the MMPI into an American Sign Language version used by Brauer involved three stages, as recommended by Brislin (1980). The first stage involved three deaf people who were bilingual, in English and in ASL, translating the MMPI, first on an individual basis and then together as a committee of three persons,

in order to reduce the numbers of differences when translating from English into ASL. The Signer of the ASL 566 item questionnaire was a deaf native signer from a deaf family. The signer had a degree in linguistics and used a 'pure' form of American Sign Language. By pure, the term refers to the lesser emphasis on English mouth pattern and English grammatical features are not used. The signer referred to 'I' items as 'you' (second person singular), in the translation and as found in other studies, there was no interference or distortion of the meaning as within the original standard test (Dahlstrom, 1993).

The next stage involved recruiting three non-deaf bilingual people who were not familiar with the contents of the MMPI, to translate the ASL items back into English. Two deaf people who were bilingual professionals compared the back-translations with the original written English version of the MMPI item list. Any differences that were found indicated that the ASL translations that had been used had to be revised. The third stage involved actually conducting the MMPI test and this was to check for linguistic equivalency.

Other procedures that have been used to check for adequacy of translation have used this test-retest technique (Butcher and Pancheri, 1976). Brauer found the total time to conduct the MMPI test, using all 566 items was nearly three hours, hence the 399 item revised MMPI was used. The time to complete this test was then about two hours. A group of 12 deaf volunteers who were bilingual, took the MMPI in its English format and then two weeks later sat for the same test instrument in ASL; another group of bilingual deaf volunteers took the test in reverse order, first in ASL

then secondly, in written English. Analyses performed to check for linguistic adequacy is shown in Table 4.2, showing comparisons of mean and standard deviation of each of the MMPI scales between the administration of both tests.

**Table 4.2: Comparison of Means and Standard Deviations of MMPI Scale Scores without K-Correction Between Two Test Administrations**

MMPI Scale	ASL		English	
	M	SD	M	SD
L	53.75	9.1	53.75	9.7
F	74.54	13.4	67.61	14.2
K	55.64	7.8	52.75	10.5
Hs	52.39	9.1	53.14	12.1
D	51.61	10.7	51.43	8.2
Hy	57.46	10.2	55.29	8.1
Pd	62.46	14.1	59.18	13.1
Mf	53.78	8.6	52.57	8.7
Pa	64.57	8.5	65.11	11.5
Pt	53.68	10.7	53.96	12.6
Sc	63.89	13.3	63.07	15.0
Ma	65.32	9.3	65.96	9.0
Si	47.18	5.3	48.79	7.6

Source: Brauer (1993)

Comparisons were made with the Hebrew to English translations of the MMPI. The scores produced similarity in relation to foreign language translations on several of the 13 scales that make up the MMPI. The comparison of MMPI Test Re-test correlations between ASL-English Bilinguals, Hebrew-English Bilinguals and English-English subjects is shown in Table 4.3.

**Table 4.3: Comparison of MMPI Test Re-test Correlations Between ASL-English Bilinguals, Hebrew-English Bilinguals and English-English Subjects**

MMPI Scale	ASL-English (N=28)		Hebrew-English <sup>a</sup> (N=28)	Composite of nine studies English-English <sup>b</sup>
	<i>r</i>	<i>r</i>	<i>r</i>	<i>r</i>
L	.85	.85	.71	.66
F	.69	.77	.64	.71
K	.56	.60	.88	.69
Hs	.73	.75	.51	.59
D	.58	.60	.72	.74
Hy	.59	.62	.62	.62
Pd	.61	.62	.65	.71
Mf	.54	.54	.86	.80
Pa	.39	.40	.65	.61
Pt	.85	.86	.88	.77
Sc	.87	.88	.88	.63
Ma	.50	.49	.72	.70
Si	.51	.55	.91	-

<sup>a</sup> From Butcher and Gur (1974)

<sup>b</sup> Composite obtained by averaging weighted Z transformations of *r* in studies of normal subjects reported in Dahlstrom and Welsh (1960)

So far these results suggest that there is some linguistic equivalency but not conceptual equivalency which need to be tested further to see if both of the tests, are measuring the same construct. The current translation work is incorporating more (American) Pidgin Signed English, because it is felt that more deaf people across the USA want this instead of just ASL (Brauer, 1993). This may unwittingly have the effect of 'watering down' ASL due to a matter of what might be seen as a political issue and also what might be seen as a reflection of the negative self concept and esteem that many deaf people suffer, and which is often reflected in their possible lack of pride in using Sign Language and also, in embarrassment of the use of Sign



Language. Of interest is that when subject to video-taped interviews, culturally Deaf people will tend to switch to a more English version of British Sign Language, using more English word orders and even lesser facial expressive features, almost as if the camera is a hearing person who is not fluent in Sign Language. Research work using these procedures is nevertheless still using national 'hearing' cultural norms as opposed to creating, from scratch, new norms based on Deaf values and Deaf culture and Deaf beliefs.

The MMPI-2 has since the time of Brauer's research outlined above, been devised, and new 'national (hearing) norms' are being used in respect of this. The national (hearing) norms are considered to be more representative of the current population in America. The changes which have resulted in the new revised version of the MMPI, now known as the MMPI-2 include more updated content and has modified items that were previously seen as sexist in the original MMPI (Butcher, Dahlstrom, Graham and Tellgen, 1988). The MMPI has been translated into over 50 languages. French researchers wanted to use French norms instead of the standard Minnesota norms. Dahlstrom was critical of the French decision to use their own norms and suggested this caused confusion in comparative studies across the world using the MMPI-2 (Personal Correspondence with Brauer, 1993). Dahlstrom, Lachar and Dahlstrom (1986), also highlighted particular issues using norms derived from a Black population and suggested that diagnostic accuracy was reduced when not using the norms that were standardized. This might be seen by some groups as the oppression of one culture upon another.

The best way of securing the most reliable information is probably using face to face interviews where a number of non-verbal cues can be seen and considered (Jones and Pullen, 1992). Doubts in any part of any question asked, which may be due to even the slightest of concerns, can be clarified immediately. This is probably particularly true for the deaf population. The face to face interview or the video questionnaire, which records British Sign Language on video cassette, is probably a safe and reliable method since it ascertains and enables questions to be presented in the natural language of the deaf person.

There are, however, some issues to consider concerning the use of a signer on video. Non-verbal cues given by signers, non-objectivity or possible non-neutrality, may indicate an existence of a signer effect. The signer effect in Sign Language is a way of describing what might be interpreted as spoken non-verbal cues, the passing and intercepting of information and communicating it in covert and overt form. Research involving two video tapes of an American Sign Language translation of the Minnesota Multiphasic Personality Inventory (MMPI, 1990), using two different Sign Language interpreters have not, however, revealed a significant signer effect (Brauer, 1992).

The signer effect is described here. Brauer (1980), tested the hypothesis that the MMPI performance of deaf subjects taking the test might be affected, or compromised, by a 'signer' effect due to the signer's body language, facial expression, style of signing and personality type of the signer. Thirty eight items were taken from the MMPI. Two different signers translated the items into ASL - one signer translated the items into the order presented on the MMPI and the other

signer was given the items in randomized item order. The purpose of this was to ensure participants did not memorize the items too easily. The two signers were matched for gender, both were deaf, of Deaf heritage, were from residential schooling backgrounds and were college graduates. A group of deaf people responded to both videos, given a gap of 30 minutes. There were 19 people in one group and 16 in the other, making a total of 35 subjects. The participants were volunteers who had come from a variety of professionally skilled occupations. Females comprised 80 percent of the group and males 20 percent. Ages ranged from 23 to 65 years of age. Each of the participants had 'self-rated' themselves for their Sign Language skills first, and most considered themselves highly competent in their understanding of ASL (Brauer, 1992). Eighty four percent of the items ( $n=32$ ) were agreed. This means 32 out of 38 found the same level of comprehension to each question as presented by the two different signers. There were no significant mean differences in the t-tests between the two signers except on four items. Sixty percent of between signer correlations were significant at the 0.01 level, which indicates significant similarities in the expression of over half of the items even when the questions had been presented by the two entirely different signers.

Further investigation looking at the 6 items with a lower percent agreement, showed these were related to the manner of the signing. For example, if the subject was 'sensitive' to the participant, then the response might be 'coloured'. The participant might 'perceive' something that is not there and might reply 'defensively'. There was also a need for more translation 'refinements' (Brauer 1992). The refinements,

although not clarified, appear to refer to sign translations and re-taping various parts of questions so as to ensure maximum neutrality.

Brauer concludes that as long as items are presented in a psychologically professional manner, there is no significant evidence of a 'signer' effect. The study was based on a community sample which thus does not support the hypothesis that there is a signer effect of the MMPI performance, the subjects responding to the signed text and not to the signer.

Another study (Hindley, Hill and Bond 1993) looks at the possibility of an "interviewer effect" from the 'interview' in terms of a range of symptoms elicited, using the Child Assessment Schedule (CAS) (Hodges, 1987). The CAS is a clinical interview schedule used for diagnostic purposes and was carried out on a group of 12 deaf children and young people, using various combinations of the three interviewers and interpreter who were conducting the interviews. There were two hearing psychiatrists, a deaf care worker and a qualified interpreter. Neither the deaf care worker nor interpreter had any particular expertise in mental health issues. The researchers wished to investigate the influence of the interviewers signing ability and cultural status on the outcome of psychiatric assessments. The study concluded that discrepancies between the range of symptoms elicited by the different interviewers were due to unfamiliarity with the language which posed problems for both the child interviewed and the clinician.

The preliminary findings suggested that linguistic competency of the interviewer had a significant effect on the range of symptoms elicited at interview and that poor competency leads to the masking of a child's emotional difficulties. This is already clearly supported by the evidence we have that one cannot interview a client unless using a commonly understood language. Hobson (1992) identifies this in his book "Forms of Feeling". He states:

**'The skill of the therapist is to learn the language of the client and help create a mutual language - a personal conversation' (p.46)**

In one of the interviews carried out, the clinician who had limited Sign Language skills failed to gather certain symptoms, which were present in a particular child he had interviewed. The study suggests that this was due to the positive non-verbal behaviour displayed by the particular interviewer during the interview. This undoubtedly is true for any kind of interview, whether with deaf or hearing individuals, who might be somewhat emotionally 'blocked' or prevented from indicting, or exploring their feelings, (affective state), due to the overly positive manner and friendliness of the interviewer. This would be in much the same way that a hearing interviewer, conducting an assessment interview on a hearing child smiles and laughs in a jolly manner and might even crack a joke about the weather or something similar whilst engaging the child in an interview containing questions about his or her emotional state. Interviewers operating in this fashion are possibly nervous or anxious (perhaps if unskilled, or deskilled, or inexperienced) or are perhaps engaging another defence mechanism. The reason for failing to elicit certain symptoms appears to be due to the lack of Sign Language skills and therefore lack of Cultural familiarity. The writers also suggest that the deaf person, despite being

given 'training' in theoretical aspects of mental health, had 'failed' to elicit symptoms in those children who were found to have symptoms when interviewed by a clinician (with minimal Sign Language skills and an interpreter). This might be seen as an unreasonable expectation of someone without clinical training, although similar hearing status with the interviewee would probably at least facilitate the development of empathy.

The study (Hindley et al., 1993) does not produce any new findings but reinforces and states what we already know, that linguistic and cultural competency is essential for properly conducted research involving deaf people who use Sign Language as their first or preferred language. A skilled clinician with fluency and proficiency in BSL will be able to detect subtle cues in sign inflexion, non-verbal communication and other responses such as ambiguity and expressed emotional cues, presented by the subject being interviewed. Their study suggests only the highly skilled hearing interpreter had been able to perform this task. However, again, this is due to the inexperience and lack of cultural and linguistic understanding and expertise of those conducting the study itself. The authors are all non-deaf. Signers, (interpreters) do need to be well trained and knowledgeable concerning the subject matter in which they are doing the translation work, from one language into another. The signer (interpreter) also needs to be aware of issues related to cultural mediation. Any interaction or act of translation is open to misunderstanding and an interpreter's presence may increase the chances of this happening. Issues regarding the perceptions that are made by the users towards the interpreter also apply to the interpreters themselves. The interpreter has her own 'cultural baggage' and

everything that they receive will be 'coloured' by their own experiences. An interpreter may also be seen as an active participator because of the overt participation on which she operates. The very fact that often different cultures are coming together in the process of interpreting and translating in order to communicate means that the risk of misunderstanding taking place may increase.

**"The interpreter is engaged in a constant process in which a range of components influencing the participants and the Sign Language message must be assessed and in which the effect of any influencing component be accurately and appropriately accounted for in the target language message".**

*Cokely, 1992, p.19.*

Cokely, in his book *"Interpretation: A Sociolinguistic Model"* (1992), further goes on to say:

**"In examining the components that effect any communicative behaviour (and, thus, those components that the interpreter must be aware of), it is possible to identify components that pertain to the context within which the interaction occurs and components that pertain to the nature of the communicative message itself".**

*Cokely, p.19.*

A sociolinguistically sensitive and appropriate translation model can be based on this. Interpretation can, therefore, also be seen as a form of mediation. The degree of explanation involved in interpretation depends on the mutually shared knowledge of the 'speaker' and the 'listener', the frequency of contact with each other's cultures and their being able to understand each other.

Danica Seleskovitch, (1978) in her book *"Interpreting for International Conferences"*, states that:

**"To try to ignore the contribution of the interpreter would be tantamount to ignoring the international nature of conferences". (p.114).**

The position is much the same for observing interpreters (deaf or non-deaf) in a video questionnaire, where one cannot avoid taking in and internalising the interpreter's own values and contributions which are overt and ubiquitous. These points are highlighted here because of the increasing use of Sign Language translations of written English text by an interpreter, who is usually hearing orientated. Interpreters are usually hearing and will have had access mostly to hearing culture although some interpreters are of Deaf heritage (of a deaf family), and may be made aware of both deaf and hearing cultural orientation. Another term for this is bi-cultural identity. It is assumed, however, that most non-deaf interpreters are culturally profoundly hearing.

It is useful to be aware of these issues when translating between cultures as these issues apply also when translating between written text from one language into another, and applies to written translation of Sign Language according to the requirements of the target audience.

British Sign Language, the first language of most of the subjects in this study, is usually described as visual. Some research work is being carried out to examine the possibilities of translating British Sign Language (BSL) into written format, probably scripts. The script format is still being researched. The potential for a BSL script and its use is still not established. It is possible that deaf people would resist the idea of a translation of BSL into a script formula for writing purposes because it then carries



a hearing orientation and it would mean the learning of a written language which although it would be a written interpretation of what is being signed, would not be able to capture the very essence of what BSL is renowned for, its beauty and expression and the fact that the slightest movement upon the face or brow conveys subtleties in communication that cannot be met by many spoken languages. The translation of BSL into written script would probably find most use in an academic setting where more specific specialist sorts of information and knowledge can be gathered and recorded instantaneously, for example, lectures. The academic setting is thus probably the most beneficial way of initiating continuing development of BSL script.

As far as the published literature review tells us, other tests have not been translated into Sign Language for clinical use or use as a screening instrument in a deaf population. There appears to be no material in a literature search for any instruments that may have been designed from Sign Language as its originating language.

### Summary

Although internal consistency of translation work on psychological questionnaires might be improved with more research work, this will not necessarily indicate better understanding and comprehension of English than the level of comprehension that deaf people have now. It remains an issue that psychological testing and screening for psychopathology in deaf people appears to be examined from a non-deaf perspective. All instruments used for screening and detection of psychological difficulties are rooted in the values, beliefs and norms of a non-deaf culture. Culture

free tests' are perhaps a contradiction in terms since the act of writing down spoken language becomes culturally embedded in hearing values. The rationale that many researchers hold, who are interested in devising scales for deaf people, translated from a written format, into Sign Language, often fails to grasp this point. Instead of appreciating the naturalness of Sign Language and its linguistic and cultural difference to spoken language as a starting point from which to create scales accessible in Sign Language, researchers tend to start from the perspective of how can we adjust already created scales into simple or easily written language, and in a somewhat misguided or misplaced, often patronising manner, blaming the need to do this at all as being due to the effects of oralism and poor acquisition of English skills. The issue does not seem to be the level of comprehension a deaf individual has of written language but rather, the need to access testing instruments by the most natural and preferred route, regardless of fluency in written language. Furthermore, many researchers tend to translate written questionnaires for hearing people in a way which focuses on wanting to simplify, instead of concentrating on the way of presentation and the **meaning** of what is being translated. The more recent recognition of the need to provide access to deaf people of questionnaires and testing in Sign Language, has helped to shift focus away from constantly seeing deaf people as having poor English. The reasons are still considered to be because of the lack of comprehension of written English rather than seeing that the main justification of producing Sign Language questionnaires is inevitably for the same reason that non-deaf people use written language questionnaires, because it is a preferred method of providing information and not because the need is seen as a reflection or a 'shortfall' or lack of ability to comprehend what is produced in another language.

The issue of cultural mediation is of special interest particularly in this field of translation of material designed in one language into another. It is not possible to produce translations without the language suffering effects of the process. This is a recognised factor which many translators have to cope with and this itself appears to suggest that it would be useful to merge the two fields to see what could be reasonably achieved and appreciated in terms of the adequacy and appropriateness of translating written questionnaires into Sign Language questionnaires. Moreover, indications are that most psychologists tend to pick up knowledge about deafness through a 'trial and error' process. To illustrate this point, many non-deaf professionals, with skills in a range of professions related to mental health and other disciplines, such as the caring professions including social workers, nurses, occupational therapists, medical officers and psychologists will apply for positions of employment which involve the assessment, care and treatment of deaf people, a population of whom applicants frequently have no prior knowledge of or experience. At interview, members of the panel will consider whoever mentions an intention to learn Sign Language. Out of a number of short listed applicants, it is the one who appears the most interested in deafness who will be given the post. This might be judged even on the basis that an applicant can demonstrate he knows the needs of his grandmother, who suffers from acquired deafness is different to the needs of those deaf from an early age.

Inevitably, successful applicants, or unlucky applicants as the case may be, find themselves having been 'dropped in the ocean', having to wade their way through misconceptions previously held and never challenged or working on the basis of false

perception and premises which render them deskilled, frequently resented (by both deaf and hearing people), either because they have walked into a more senior position in relation to their usually also non-deaf colleagues, (who often have good Sign Language communication skills) and yet cannot sign, or feel rejected and criticised outright by deaf clients and deaf staff who become frustrated with having to communicate with somewhat primitive communication tools such as using facial expression and gesture. Such applicants may become unhappy in their work. A high turnover of staff, which frequents the nursing professions, are exaggerated by these factors. These factors are evidenced by Levine (1981). In the present climate, such a situation would be rejected by those who are working with minority groups such as ethnic minorities, whose users have a say in who serves to meet their mental health needs and a criteria would be set down whereby applicants for posts working with ethnic groups must demonstrate a knowledge, awareness and understanding of issues presented by the particular minority group with which they were applying to work. No such situation exists for deaf people, who continue to be presented with risks to their well-being and self esteem, which is afforded by employing culturally appropriate surroundings, deaf role models and culturally friendly staff. However, in all fairness, this is often due to a lack of appropriately skilled and qualified pool of applicants which tends to cause employers to 'make do' rather than to try and look at ways of improvising the situation on a regional level or planning appropriate induction programmes and deaf awareness programmes.

Misassumptions of deaf people have occurred from as far back as we can recall in any of the published literature written about deafness and deaf people, although many

of the original attitudes and ideas and misconceptions were mainly due to non-deaf people not understanding issues of deafness. However, this cannot be presented as the case today for we have gathered much information on deafness, Deaf culture, values, beliefs and norms, that for such paternalism to continue, must only be in the guise of denial or blindness to the issues of deaf people who present as a linguistic minority group.

## CHAPTER FIVE

### GENERAL HEALTH QUESTIONNAIRE

#### Design and Purpose of the Questionnaire

The General Health Questionnaire is described, the rationale for its use, and the reason it has been selected for the study of the deaf population in the North West of England are given.

The General Health Questionnaire (GHQ) was designed by David Goldberg (1972). It is a self-administered screening test to detect psychiatric disorders and psychological distress. It is designed to distinguish between psychologically healthy states and psychologically unwell states.

The original motivation for the production of the General Health Questionnaire arose from Goldberg's concern that most available psychiatric questionnaires appeared to concentrate on psychotic illness. The proportion of people in the general population with a psychotic illness is small relative to the spectrum of non-psychotic psychiatric illnesses. Non-psychotic psychiatric illnesses include a range of emotionally based problems, of what is usually termed as neurotic, (although this term is becoming less popular due to its somewhat stereo-typical image and lack of recognition of other **emotionally** based psychological disorders), such as obsessions, phobias, non-psychotic depression, anxiety and addictive behaviours. The epidemiological interest was not previously focused on identifying these in the non-psychotic group, hence the development of Goldberg's screening questionnaire. It is important to remember that

in the past most epidemiological research focused on psychotic illnesses, but common sense suggests that most people with psychosis were probably already known to other family members or other significant persons, and in particular were probably already known to the local psychiatric services.

### Aims of the Questionnaire

Non-psychotic illness includes a range of the illnesses classified as neuroses in the International Classification of Diseases (ICD-10) (1995), (Code 300). The neuroses are traditionally referred to as the 'depressive neuroses', 'obsessional compulsive disorders', 'phobias' and 'anxiety'. However, medical and related professions tend to use the term "neuroses" in different contexts and it does not have a clear and consistent meaning. For example, some psychiatrists will use the term to describe certain personality disorders. The "neurotic personality" is one such example. This is why Goldberg chose the term non-psychotic disorders, as it appeared to be more neutral than the possibly dubious practise of labelling a whole range of different disorders as neurotic. There is a concern by many professionals that it might not be possible to separate the psychotic and the non-psychotic disorders easily and clearly. The tradition of seeing psychiatric disturbance as being on a single axis continuum appears to be rejected by Goldberg because of the subjective nature of defining the border between normality and severe disturbance (Goldberg, 1972).

Severe abnormality, which would include dementia and mania are also not detected or considered by the questionnaire because it was originally intended to be a self-administered test and it was assumed by Goldberg that clients in these populations

would be unable to complete it. Goldberg also stated that he did not want the questionnaire to be too long which was another reason for excluding questions on psychotic illness. The more lengthy a questionnaire is the less inclined or motivated participants may be to complete it as it might appear tiring and stressful. The GHQ has been criticised on the grounds that it may fail to detect **chronic** neurotic illnesses (Finlay-Jones and Murphy, 1979). A questionnaire which aims to detect neurotic illnesses does need to take into account both chronic and acute illness and chronicity might be hidden by the person completing the questionnaire having become "used to" their condition and its consequences for their way of life. Goodchild and Duncan-Jones (1985) have suggested this may possibly arise due to the wording of the answer categories for some of the items and this will be discussed later in further detail.

The prevalence of significant levels of 'strain', which means significant distress or stressors, [positive cases], that is, those who can be considered to be suffering from psychological distress, in the community at any one time appears to be about 14% (Reeler 1991). This percentage has been found in community samples although it is much higher in clinical settings such as General Practitioner clinics for which Reeler (1991) suggests a figure of 35%. Neurotic conditions seem to outweigh psychotic conditions in these clinics by a ratio of four to one (Reeler, 1991). However, the number of emotionally based disorders could produce a much higher ratio because of often hidden psychological problems that can be present at any time. These might include depression, mild or severe, anxiety, emotional and mental abuse symptoms and often eating disorders, such as bulimia, which can go undetected for a long time.



Essentially, the GHQ aims to focus on how the usual or 'normal' everyday coping strategies, in the everyday life of the person being interviewed, may be disturbed. This is done by examining any problems in carrying out one's usual everyday functions or by identifying any new areas of concern such as, for example, difficulty in sleeping. The test items also focus on recent changes or difficulties rather than long term products.

### Previous Studies Using the GHQ

The General Health Questionnaire has been translated into a number of European, Asian and other languages and has been administered in about 38 languages (Goldberg and Williams, 1988) and over 90 independent validity studies have been published (NFER Nelson, 1991). The GHQ has been tested and validated in a large number of different languages (Harding, 1976; Munoz et al., 1978; Chan and Chan, 1983). Many conceptual and practical problems can arise when instruments designed and constructed in one culture are translated and used in another. Despite these problems, the GHQ appears to perform well in a variety of cultural settings.

It has been argued that psychological distress has some common features within different cultures. Goldberg (1972), suggests that the items relating to 'worrying', 'feeling under strain', 'being unable to sleep', 'unable to concentrate' or 'unable to face up to one's problems' are specific to the human condition rather than to any particular culture, and so assumes that there are common perceptions and diagnosis of symptoms by mental health workers. Superstitions and magical beliefs are other factors that may, however, confuse presentation of mental illness or hide the

psychological distress experienced. There is evidence that Afro-Caribbean patients are more likely to be admitted to hospital unwillingly for example, or with the 'aid' of the police (Kellecher and Copeland, 1972; Rwegellera, 1977). Studies in Leicester and Bradford (where there are large populations of Asian people), have found that the issue of increased likelihood of forced admission to hospital, does not appear to apply to Asian cultures (Hitch and Clegg, 1980; Shaikh and Bhate, 1980).

The languages in which the GHQ has been translated include Chinese, Dutch, French and Greek, all of which reflect quite different cultures. The GHQ was designed in London and was aimed to be culture specific to the British population in London, originally intended to be used in the community population and not for use in a clinical population. The community population refers to the community of individuals at large which are drawn in a random style for research samples. In other words, those people who do not require to access consulting settings. Clinical populations are usually drawn from a sample of attendees at a mental health clinic or from a list of those people in the population who are at that time receiving treatment for mental health problems from a General Practitioner (GP) or consultant.

There may be some disagreement as to what properly constitutes a community and for the purposes of the present discussion, community refers to those individuals who are living in the community and who are not residents in a psychiatric unit or any other similar institution.

## Review of the Literature

A review of the literature on case identification, during the period before Goldberg devised his questionnaire, reveals a range of conflicting reports which depended on the definitions used and whether symptoms selected were deemed to be acute or chronic. Figures from community studies have shown measures from 13.1% for neurosis, 1.7% for psychosis and 1.2% for mental deficiency (Hagnall, 1968). The earliest psychiatric survey by a general practitioner was by Johan Bremer (1951), who reported on an isolated community of 1,000 people in the northern part of Norway. He carried out his own psychiatric interview schedule and suggested 25% of the population, whom he knew well, had psychiatric problems. The interviews were conducted during World War II which might be the partial cause of what appears to be a higher ratio of psychological problems than is usually found. Another early study of a group of North American immigrants, members of a sect of Anabaptists referred to as Hutterites, showed a prevalence of mental disorder of 16.7 per 1,000 people in the population suffered from psychological distress at any one time (Eaton and Weil, 1955). Cole, Branch and Shaw's (1957) survey in Salt Lake City found a prevalence of 333 per 1,000 people in the population. This figure is higher than the general war time norms (World War II) that were found. A later study by Hagnall (1969) showed a much higher percentage for the incidence of neurosis as he was then using the definitions devised by Leighton (1959) in America. A survey of psychiatric morbidity in forty six London general practices (Shepherd, 1966) found that individual doctors varied in their estimates of psychiatric morbidity in their practices, from as few as 37.8 per 1,000 (3.8%) to 323 per 1,000 (32%) people at risk in the population. This difference of nearly nine times, between the two figures,

probably illustrates how influential variables such as who is interviewing and the variation between particular practices can have on results. The doctors involved in these surveys have usually either instigated the study themselves or have particular interests. For example, a doctor who has an interest in psychotherapy will probably find he has more emotionally based difficulties to deal with and this may be because people recommend doctors to others and talk about how 'good' or 'bad' their doctor is at listening to them or at spending time with them. In addition, views on diagnosis, and standardization of classification varied widely which is another reason for the wide range of psychiatric morbidity found as well as the fact that different ways were being used to measure morbidity. The different rates being computed also indicated that populations were not demographically similar. These issues led to increasing concern and need for a research instrument to assess psychiatric morbidity regardless of interviewers or observers standards. Taylor (1954) visited 30 English GP practices while collecting information for a book entitled, 'Good General Practice' (1954) and comments that it was rare for even a GP with knowledge of mental health issues, to be able to diagnose neurotic illnesses. Taylor (1954) found that patients with organic illness, who understandably react with some anxiety, might be mistakenly thought by their GP to be suffering from a neurosis. During this time, the common view of neurotic illness was that it was usually chronic although we now know that this should not be assumed. Littlewood and Lipsedge (1982) have suggested that psychiatric abnormality is often seen against the background of beliefs about normality which are themselves cultural. The presence and type of expression for the distress is seemingly variable and probably has some determinism which will relate to that society and culture at that time.

A number of factors may influence why some of the General Practitioner practices reported higher rates of clients at risk than did others. These can be possibly attributed to the GP's own personality. One General Practitioner may be more approachable than another and so attract more patients who are suffering from emotional type disorders because he or she is prepared to give them more time and listen to them in an empathetic manner. These issues demonstrate the kind of difficulties in producing accurate prevalence rate figures in any given population. The need to have standardised questions; guidelines on questioning; trained interviewers; and awareness of cultural features and implications are added dimensions of importance in any study or survey. The threshold which is selected and used as a cut off point for caseness (the point at which an interviewee scores beyond the predetermined minimum threshold before being deemed to be an identified case), is of the most significant importance in determining prevalence rates.

Goldberg (1981) has pointed out that the collection of information which might lead to a diagnosis of neurosis appears to have a strong link with the degree of rigidity of the questions asked. Rigidity here refers to the lack of flexibility in the examination of background information and observation of behaviour which could contribute towards a better understanding of the client and difficulties being experienced. It is probably easier to identify a psychotic illness by the use of a standardized list of consistent questions than to identify a neurosis where there is possibly a higher risk of misdiagnosis if one uses a standard set of questions only. A questionnaire which asks questions in a way in which the "better" answer is obvious, will tend to gather less obviously troubled responses from participants who may be embarrassed or

unhappy or concerned about their feelings and therefore might try to hide them. This means the interview cannot be guided only by the responses to the questionnaire alone. A number of other factors must be taken into account before any conclusions can be made as to whether or not the person has been properly screened for mental disorder. This might include gathering background information from the interviewee and sometimes, where appropriate and where the interviewee is able to give informed consent, from significant others. Another major factor is the interviewer's training. The length of experience and time spent dealing with the questions and queries and sufficient understanding of what is being asked and what is being looked out for is essentially important as this applies both to lay interviewers and psychiatrists (Robins, Helzer and Croughan, 1979).

There has been a large amount of literature concerning self reporting type questionnaires and their disadvantages. The advantages are probably obvious. For example, a large number of a given population can be approached and tested quickly. In fact, costs will also be affected and become less expensive, as investigators can interview a whole section of the community by post. It also means there are no problems in standardising interviews. The self-reporting questionnaires used ask for 'objective' responses which assists in encouraging less subjective and possibly emotional involvement. For example, they may be seen as a list of 'complaints' or 'symptoms' and people are simply asked to tick which relates to them. However, this also carries negative consequences in that unless matching for participants is done well, then there maybe a tendency to attract more cases than intended because of the morbidity contained within the questions. The morbidity is often perceived in the

absence usually of any explanation as to the nature of the research and usually without any comprehensive explanations of what the concepts used mean. Usually, explanations are brief and minimal for the sake of simplicity. Obviously, if there was a long section to read first before completing the questionnaire, which would explain the nature and purpose of the whole study, this creates the risk that many people may be put off completing the questionnaire because of the need to read the material. One of the major disadvantages is that questionnaires lead people to tend to respond with what they see to be the most 'appropriate' answer. This may produce a distortion in the reported number of cases identified. The rationale behind individuals who complete questionnaires 'untruthfully' or misleadingly, is usually because the participant wishes to obtain what they may perceive as a 'normal' score in order to avoid being seen as having mental health difficulties. The wide differences in prevalence rates reported in various community surveys are obviously due, to some extent, to the differences used in the method for case identification as well as to the different types of questions asked.

Theoretically, the General Health Questionnaire is more likely to miss very long standing disorders, due to the nature of the choice in the response scale. An example to illustrate this point is to take the choice answer 'same as usual', which a person might indicate for a long standing illness and thus so for the symptoms which they might be experiencing. For example, responding 'no more than usual' to the question 'have you been having restless, disturbed nights' or 'have you been feeling unhappy or depressed' which might indicate a chronic illness. People who respond 'as usual' in this way may be just as ill as those responding 'more than usual' though with a

chronic (not episodic or acute) condition. However, it has been noted that the loss of ability to detect long standing disorders is not as obvious as one might have thought due to the fact that many people do tend to still have a concept of their 'usual self', that being a self without symptoms even after a lengthy period of time of experiencing illness (Goldberg and Williams, 1988).

The best way of securing the most reliable information is probably by face to face interview where a number of non verbal cues may be observed. Doubts in any part of any question asked, which may be due to even the slightest of concerns, can be clarified immediately. This is probably particularly true for the deaf population. The face to face interview or the video questionnaire, which records British Sign Language on video cassette, is probably the most safe and reliable method since it ascertains and obviously enables questions to be presented in the first or preferred language of the deaf person.

### **The General Health Questionnaire - GHQ-12**

#### **Reason For Its Use In This Study**

The GHQ has been produced in three different shortened versions. The original GHQ-60 (1972) has been shortened into the GHQ-36 (1972); GHQ-30 (1978) and a GHQ-12 (1978) version. The GHQ-12 is used in the present study and appears to be as reliable as a case detector as the longer and most popular GHQ-30 (Goldberg and Williams, 1988). The GHQ-12 appears to be an effective and simple measure of



'strain' or mental health distress, (i.e. anxiety and depression). It has become more popular in recent years because of the increasing number of validations being carried out.

The GHQ has also some positive (case identification), predictive value which will vary with the prevalence of cases. This means the higher the prevalence within a number of people interviewed the higher the likelihood of gaining a positive predictive value. Its use as a predictive questionnaire has not been intended because it was to be used to assess the participant's present mental state rather than to look at certain traits which lend themselves to the development of mental disorder. The studies which have been done looking at predictive values with positive findings have related mainly to the difficulties linked to physical health problems and subsequent psychological distress. It is quite possible that this type of questionnaire would have a use in predicting morbidity in a deaf population. However, this is not the subject of further discussion here but would be useful in further research.

### Scoring Methods and Interpretation of the GHQ

As is standard, community studies have used a binomial classification to establish 'caseness' and 'normals'. Obviously this is only giving a probability estimate of a person being a psychiatric 'case' but it is an indicator that psychologically the person is not feeling the same as he or she usually does, identifying changes in sleeping patterns or difficulty in concentrating, worrying more or feeling that life is more of a strain than usual are examples of situations the GHQ identifies and that he or she is reporting negative symptoms related to anxiety and depression which is what the

GHQ is designed to look at. Later, as will be seen in this study, the scores have been put into three groups and we will look at 'caseness', 'bordercases', and 'normals' and see what identifying features may be shared by the separate groups. The higher the score, the more the psychological distress is being experienced (Goodchild and Duncan-Jones, 1985). Further information on scoring systems can be obtained from the manual which accompanies the GHQ (Goldberg, 1978).

Goodchild and Duncan-Jones' (1985) scoring method, known as the CGHQ, increases the sensitivity of the GHQ scoring method by making it more likely to detect long standing disorders. This is done by dividing the test items into negative items (for example 'do you feel constantly under strain?'), and positive items such as 'do you enjoy day to day activities?'. The positive items indicate health and the negative items indicate illness. The CGHQ therefore provides a score for what would otherwise have been missed negative items.

**Table 5.1: Various Scoring Methods for use with the General Health Questionnaire**

Scoring method	Not at all	Same as usual	Rather more than usual	Much more than usual
GHQ Scoring	0	0	1	1
CGHQ scoring				
negative items	0	1	1	1
positive items	0	0	1	1
<b>Other ways of scoring whilst using the GHQ:</b>				
Likert scoring (simple Likert)	0	1	2	3
Modified Likert	0	0	1	2

The CGHQ scoring has more sensitivity (84.0% sensitivity compared to 73.5% when using the GHQ scoring (0, 0, 1, 1 for all items). The CGHQ scoring method assigns 0, 1, 1, 1, to negative items and 0, 0, 1, 1, to positive items. There are 6 items classified as negative (questions 1, 2, 7, 10, 11 and 12) and 6 items classified as positive (questions 3, 4, 5, 6, 8 and 9). In addition, the CGHQ provides more evenly distributed scores and fewer people will respond with a score of zero.

A comparison of the scoring methods are shown in Table 5.1.

**Table 5.2: Comparison of Sensitivity and Specificity in GHQ and CGHQ Scoring Methods**

	<b>Sensitivity (%)</b>	<b>Specificity (%)</b>	<b>Correlation with total PSE score</b>
GHQ scoring	73.5	76.4	+0.52
CGHQ scoring	84.0	80.2	+0.58

As can be seen in Table 5.2, the CGHQ scoring method gives better validity coefficients for prevalence of cases as against that provided by the Present State Examination. The Present State Examination (PSE) is a clinical interview schedule designed for psychiatric interviews by Wing, Cooper and Sartorius (1974). For the purposes of this particular study within a deaf population, the method of scoring deemed to be the most appropriate will be the CGHQ scoring method.

Foulds and Bedford (1975) suggest that most psychiatric disorders have a disturbance at the lowest level of what might be seen as a hierarchy of psychological disorders beginning with those that interfere the 'least' with daily functioning, for example, dysthymic disorders, (a chronic mood disorder involving a depressed mood of two years duration DSM III-R(300.40) 1987), in a type of pyramid going upwards, representing more severe disorders. Surtees and Kendall, (1978) tested Fould's hierarchy theory on a sample of 400 patients which had been admitted to hospitals and found that 80 percent conformed with this model.

This provides extra support for the use of the GHQ, as a detector of mental health and psychological distress in the present study of the deaf population.

In conclusion, the GHQ does not make clinical diagnoses but it serves as a very useful identifier of the number of possible cases within any given population at any one time. It has been validated in many studies and is used worldwide. It is a good estimate of psychiatric illness and also picks out the hidden cases one would not usually find in a psychiatric setting. It also picks up cases that would tend to 'cure' themselves after a time and so merge back into the 'normals' group without any treatment. If a clinical diagnosis is required it would be usual to interview identified 'cases' by use of a Clinical Interview Schedule (CIS) (Goldberg, 1970) or the Present State Examination (PSE) (Wing et al., 1974). The GHQ is not a detector of long standing problems related to psychiatric distress but measures the changes or new features (states) in a person suffering from mental distress. The GHQ-28 or GHQ-30 are the versions to use if scaled symptoms are required but this is not particularly the focus of interest in the present study.

#### Other Studies Using the GHQ with a Deaf Population

Dr. Ken Checinski, Research Fellow of the Royal National Institute for the Deaf, London, initiated a research project using the GHQ-30 in a deaf population in the London boroughs of Sutton and Wandsworth. He was attempting to estimate the level of psychiatric disorder in a pre-lingually deaf population of adults living in the community. He translated the GHQ-30 into 'simple' English and posted the questionnaire to deaf people together with an explanation of the study. A financial

reward was offered to people who agreed to be interviewed, twenty pounds for coming to the office and ten pounds for agreeing to a home visit. Checinski approached the local GP practices and local Social Service Departments in order to find his sample population. The letter he sent out was accompanied by a cover letter from the local Social Service Departments' requesting them to complete the form (questionnaire) and give their agreement. A copy of the written 'simple' English version of the questionnaire is in Appendix 2. Of the one hundred and fifty one profoundly deaf adults interviewed, fifty were found to have a recognised mental health problem (as defined in the Diagnostic and Statistical Manual of Mental Disorders DSM-III-R, 1987). These problems were mostly those of depression and or anxiety. Checinski also found in his study that the level of major illness such as schizophrenia or major affective disorder such as manic depression was not higher amongst the deaf population than anticipated, when compared to a non-deaf population. Of particular interest is that the GHQ was found to be most effective at identifying those participants who had mental health problems. This was seen by the results of interviewing the same participants using a standard semi-structured interview, the Clinical Interview Schedule (CIS) (Goldberg, 1970). The C.I.S. interviews were conducted by a psychiatrist who did not have prior knowledge of the results of the GHQ questionnaires.

To date the GHQ is being used in two other studies. The Sign Campaign for Deaf People who have obtained a Section 64 grant (1995), from the Department of Health to look at the rehabilitation needs of deaf people and the General Health Questionnaire is also being used as part of a project at the Centre for Deaf Studies,

University of Bristol, following up Conrad's earlier study of deaf people to ascertain the level of psychiatric disturbance within a deaf population. These studies will provide further material for validation and reliability in the use of a British Sign Language version of the GHQ in a culturally Deaf population.

## **CHAPTER SIX**

### **DESCRIPTION OF ATTITUDE AND IDENTITY QUESTIONNAIRE (ATIQ)**

#### **Purpose of the Questionnaire**

##### **Introduction**

The relationship between Deaf identity and prevalence of psychological distress among Deaf linguistic minority group members is of interest for several reasons. Health status could be related to the formation of cultural and linguistic aspects of identity, that is those with a higher risk of illness may be less likely to have formed any cultural and linguistic features of Deaf identity. This study hypothesizes that the development of a Deaf identity facilitates the growth of positive self-esteem and self-image, thus acting as a protective factor against the emergence of psychological ill-health. It is possible that the social and environmental factors that lead to psychological distress and mental illness might be different among Deaf and deaf minority group members. We know, as described in Chapter 2, research that uses assessments of psychological distress and mental illness based on non-Deaf psychiatric practice may fail to accurately identify those from Deaf cultures who are distressed or ill. This is probably a consequence of translation difficulties and also a consequence of culturally determined differences in the experience and expression of emotion and illness. The Attitude and Identity Questionnaire (ATIQ) is an attempt to gain a clearer idea of a person's cultural affiliation and feelings towards their own hearing status and those of others.



The object of designing the Attitude and Identity Questionnaire (ATIQ) and its use in this study is to identify the attitudes of deaf people, in particular their perception of statements that might be construed as being a measure of Deaf identity. The questionnaire items explore attitudes towards the deafness; towards hearing; Deaf people; anxiety; confidence and esteem in relation to being deaf. Questions also examine Deaf perceptions of the hearing community towards deaf people.

The questionnaire was devised by the author to provide some guidelines as to the belief systems constituting an identity of being Deaf, as perceived by members of the Deaf community.

### Description of the Literature

There is little reference in the literature to the use of questionnaires designed to assess the degree and extent of identification that Deaf people may have with each other or deaf people's attitudes towards deafness and 'hearingness'. Bronfenbrenner (1940) devised a hearing attitude scale for use with hard of hearing people. This population is usually defined as those who have impaired hearing and who benefit from use of amplification. Members of this group usually feel part of the mainstream non-deaf (hearing) population. This unpublished scale was based on the Psychological Program in the Army Centre at Boston General Hospital (USA). There does not appear to be any scoring instructions or details of any data collected nor were any results analysed. The copy of the scale was obtained by the writer from Appendix E in 'Ecology of Early Deafness (Levine, 1980) and appears in Appendix 3.

Bronfenbrenner's efforts represent a rare attempt to create a scale to examine the individual's attitude towards their own hearing status. Bronfenbrenner's scale has 100 items, which are statements the reader can agree or disagree with. A literature search revealed no other attitude scale or instrument consistent with the focus of this section of the thesis. Most references in the literature relate to the attitudes of non-deaf or non-disabled people towards those considered to have disabilities (Melgoza, 1980; Cambra, 1996). Greene (1985) examined issues involved in the treatment of Black clients who were in therapy with White therapists. Other studies (Melrick, 1976; Greene, 1985; Ridley, 1988; Kareem, 1992) have looked at members of a group of people who identify with each other and their attitude towards other groups. There have been few attempts to investigate the attitudes of hearing people towards deaf people but none on the attitudes of deaf people towards their own deafness or towards non-deaf people. The literature contains little reference to research investigating the level of attachment and identification deaf people have with the Deaf community, Deaf Centres, social activities and national events which are cultural features of Deaf people.

Glickman and Carey (1993) developed a Deaf Identity Development Scale (DIDS) (Appendix 4) in an attempt to measure how deaf people identify with the Deaf community and Deaf culture. An identity development model with four different cultural orientations, relating to the deaf community, formed the basis of the scale. The source language of the 60 item instrument was English, translated from English into American Sign Language on videotape by a native Deaf signer. This referred to a Deaf person from a Deaf family who acquired British Sign Language from birth.

A person from the American Registry of Interpreters for the Deaf was employed to perform a back translation of the videotape, into English. Presumably the interpreter was hearing, although Glickman does not specify. Following this a bilingual consultant 'reviewed' both versions. Again, it is not specified whether this person was deaf or hearing. As a result of discrepancies, modifications were made to the English version, as well as to the signed videotape version. The DIDS measures what Glickman identified as four different cultural orientations in deaf people. Basing his work on cultural and social identity development theories (Helms, 1990; Sue and Sue, 1990), Glickman's model proposes four kinds of deaf cultural identities and presumes they are developmentally related. The four identities are culturally hearing, (those who see their deafness as pathology or disability and communicate 'orally' and function in the non-deaf (world); culturally marginal (those who feel 'in-between' the two worlds of Deafness and hearingness); immersion (those who 'reject' the non-deaf world and uncritically identify with other Deaf people); bicultural (those who function comfortably in Deaf and hearing settings whilst retaining a sense of Deaf pride).

Glickman's sample is drawn from two sources - 105 Deaf students from Gallaudet University and 56 members of the Association of Late Deafened Adults. This might be comparable to a sample from the Executive Committee of the British Deaf Association, comprised of individuals with culturally Deaf identities and a sample of the membership of the National Association of Deafened People (NADP) who have quite a different orientation, of being functionally hearing (feeling part of the hearing world), although audiologically deaf. Deriving a Deaf Identity Development Scale

from these two completely different populations and then to suggest they are developmentally related suggests a weakness in this research. The initial pool of 85 items were given to eleven 'judges' to match each item with one of the four stages Glickman proposes. Items were selected for each of the four kinds of identity, determined by interpreter agreement. For example, only items on which more than 8 (73 %) of the judges agreed were included, resulting in the DIDS items. Glickman suggests that this work provides evidence of an operational measure of Deaf people's orientation to, and affiliation with, the Deaf community and culture.

Evidence of weakness in Glickman's study is seen in that only three (27%) of the eleven 'judges' were deaf. Whether this means that they were culturally Deaf people or audilogically deaf is not stated, although it is the only occasion in Glickman's paper that a lower case 'd' for deaf is used, whereas the other references to deaf are typed with a capital 'D' (convention proposed by Woodward, 1972). This could be interpreted to mean that the entire panel of 'judges' were hearing. Although he makes it clear more work is to be done before the DIDS is ready for clinical or research use, there is no indication of a need to revise sample group criteria.

Melis and Stichting (unpublished) presented a paper on some initial aspects of their work at the 1997 Congress of the European Society for Mental Health and Deafness (Manchester U.K.). Based in a psychiatric unit for deaf people in the Netherlands, their work raises the problem of what they see as difficulty in diagnosing and treating depression in deaf people. They have developed an approach comparable to that used in the mainstream (hearing) population, and continue both medical and behavioural

methods. Using cognitive behavioural therapy to challenge what they see as destructive and 'hard-to-deal-with' thoughts, Melis and Stichtine identify several automatic thoughts, such as:

- I will never manage to have good contact with hearing people.
- Hearing people are always better.
- Hearing and deaf people will never be equal.
- As a deaf person I cannot participate in a hearing world.

These thoughts are seen as requiring challenge and replacement, in order to improve and enhance self-confidence and feelings of self-control. The work is as yet incomplete and continues to create discussion. The ATIQ contains several comparable items revealing thoughts that are related to positive scores on the GHQ-12 psychological distress questionnaire. Items No. 7, 'Hearing people often put down deaf people'; No. 12, 'Deaf people can be just as equal to hearing people'; No. 10, 'If I am the only deaf person in a group I feel uncomfortable'; and No. 15, 'People dislike me because I am deaf' indicate similar negative automatic thoughts.

The ATIQ questionnaire is designed to measure indices of Deaf identity and cultural affiliation. The sample is drawn from a population of people who were deaf by the age of three. The questionnaire is intended to be of use in research studies which examine deaf people's attitudes, as there is no existing method to effectively gather this. Some studies look at Deaf populations as homogenous and will conduct studies using a criteria that merely stipulates that respondents know some Sign Language (Brauer, 1993). This gives no indication as to the identity and attitude of the deaf respondent. There have been attempts to develop measures in assessing the self-esteem of deaf people. However, these studies have adapted scales designed for non-

deaf people to assess the self-esteem of deaf individuals. This type of written text modification raises questions concerning the validity of such findings. Widely adopted measures of self-esteem in the mainstream population include the Self Esteem Scale (Rosenberg, 1966) and Self Esteem Inventory (Coopersmith, 1967). Studies on deaf populations using these scales attempt to compare the self-esteem of deaf people to that of hearing people. Studies have focused upon educational settings, using schools and college students drawn mostly from further education as their sample. This probably gives a limited perspective on the development of self-esteem after completing education. The ATIQ contains some comparable items seen in Rosenberg's Self-Esteem Scale. For example, "On the whole, I am satisfied with myself". Results of investigations of non-deaf populations suggest that there is little difference in the way self-esteem develops following the teenage years. However, in a deaf population, changes in self-esteem are likely to continue beyond adolescence considering the traditionally longer period of development of deaf individuals. This is based on the consensus that deaf children who do not access Sign Language but who are expected to learn language using aural-oral methods only, will be likely to access less information from the external environment than those who do. The latter includes deaf children of deaf parentage who use Sign Language as a first language.

A number of external influences and factors such as the possibility that college settings for deaf people provide a relatively secure environment in which the growth and nurturing of deaf identity and esteem can be fostered. The educational environment is likely to be in contrast to other environments the deaf person may have experienced after completion of formal education. A number of these studies

have adopted some measures without established validity for the deaf population in assessing the self-esteem of deaf people. Deaf people are seen to have a lower self-esteem when compared with non-deaf people (Bat-chava, 1993). Deaf people have lower educational and economic status than hearing people (Schien and Delk, 1974). A meta-analytic review of the literature (Bat-chava, 1993) shows that having deaf parents and using Sign Language in the home are associated with higher self-esteem.

### The Development of the Attitude and Identity Questionnaire (ATIQ)

During the preliminary stage of the development of the ATIQ questionnaire a diverse range of commonly used statements made by deaf people about themselves was collected. This led to the development of an initial list of 55 items through ethnographic methods (see Appendix 5). They were collected over a period of twelve months' observation and recording in a range of informal settings where Deaf people were in discussion at various gatherings or events and Deaf Centres for deaf people. These are events the writer was involved in, and which occasionally took a form similar to facilitated group discussion. The dynamics in these provides a way of extracting false or extreme views and providing an inter-rater reliability of its own (Patten, 1987). For each statement (or expression) to be selected it had to have been used, or seen to have been used or expressed at least three times, by different people before being included, and therefore not a view of one individual. The expressions and beliefs were recorded from gatherings across the U.K. The expressions highlight attitudes towards other deaf people, their own deafness and identification with each other in a natural setting. Items also reflect attitudes towards non-deaf people. The

author's own personal and professional experience with the Deaf community provided the conceptual framework for the development of the ATIQ.

This was followed by a process of translation and back translation (Brauer, 1993). The items were gathered in their source language (British Sign Language) and then translated into English. This process was used to ensure adequacy and reliability in cultural and linguistic matching between the two languages. This resulted in 32 items (Appendix 6). Twenty-three items in total were removed throughout the process and these can also be seen in Appendix 6. This was unfortunate since a number of the items that were removed held interesting discussion points. However, because it was difficult to obtain a regular and accurate English translation from the originating language, BSL, and in view of the need for an adequate written form of the translation of the questionnaire into the target language (English) it was decided not to include the items. It is hoped, instead, to further develop this questionnaire in future research in order to produce an accurate and reliable recorded form in English (target language) and video tape in BSL (originating language).

#### Backtranslation and Translation Process

If the questionnaire was never going to be administered or required in written English then it would have been possible to have retained most of the items. Because there is no BSL script that is commonly used, this was not possible. The questionnaire would obviously be administered to people in its written English form as well as in its originating language, BSL. Although the ATIQ is written in the first person, in BSL it is produced in the second person, using 'you' and this is the format used



throughout. The items in the ATIQ are psychologically and culturally congruent with many of the norms, values and beliefs held within the Deaf community. It could be argued that the fact that BSL can only be recorded on videotape in Sign Language, might render the language vulnerable to distortion, for example, through the use of multi-channel concepts in BSL which often have no equivalent in written or spoken English and which might even be a determining factor in unsuitability to be translated into written English, where visual emphasis and other non-verbal information is lost. One of the benefits of development of a questionnaire such as the ATIQ using the back translation process is that it is easily translated from one language into another (BSL/English) in a straightforward and clear manner.

This involved recruiting six individuals. Three were native Deaf Sign Language users who taught BSL and had college qualifications. Three were bilingual (English/BSL) and two were from deaf families. Two of the 6 were functionally bicultural and could communicate with non-deaf people using spoken language and were hearing members of the register of Qualified Sign Language users (CACDP). The 6 were divided into two groups A and B. The original 55 items were presented to three of the group (Group A) in BSL on videotape. They were asked to provide a written English translation of what they saw. The other three (Group B) were given the first group's (Group A) translations and asked to provide a BSL translation of what they read. Two weeks later the two groups were then exchanged and the process was repeated. Twenty-one items showed that some problems in conceptual equivalency had occurred in the process of translation and were removed. Examples of items which raised problems in translation and which were removed are shown in Table 6.1.

**Table 6.1: Example items removed from ATIQ during backtranslation process.**

Item Number	Example Translations
<p><u>Item 6:</u> "I am confident to ask people to write down what they say when I don't understand them".</p>	<p>I have the confidence to interrupt if I cannot understand and to request that things be written down.</p> <p>I often cannot understand hearing people when they converse, but I am OK - I can always ask them to write down things for me.</p> <p>If I don't understand what people are saying, I can ask them to write it down.</p>
<p><u>Item 7:</u> "I feel my deafness is a barrier to the world".</p>	<p>I feel cut off from the interesting things that are happening because I am deaf.</p> <p>If there is something interesting going on, I feel I cannot intervene to find out what it is because I am deaf.</p> <p>I am aware of many different and stimulating things going on around me but I am frustrated because I cannot become involved due to my deafness.</p>
<p><u>Item 10:</u> "Deaf people have advantages hearing people do not have".</p>	<p>The hearing have access to TV, radio, media and speech but deafness has its advantages.</p> <p>Deaf people and hearing people live in a different world. For example, hearing people have TV, radio and music but this does not mean they are superior to deaf people. There are advantages in being deaf.</p> <p>Because hearing people can benefit more from things like radio, TV and music, some people think that they are better provided for but deaf people have different benefits and are equal.</p>
<p><u>Item 37:</u> "Deaf people can be just as equal to hearing people".</p>	<p>The deaf are oppressed by the hearing.</p> <p>Hearing people dominate deaf people.</p> <p>Hearing people always put down deaf people.</p>
<p><u>Item 44:</u> "Hearing people often put down deaf people".</p>	<p>Hearing people are always teasing and getting at deaf people.</p> <p>Hearing people always tease and make fun of deaf people.</p> <p>Deaf people are always being got at by hearing people.</p>

As can be seen, although some of the translations seem reasonably close to the meaning in the originating language, there was a sufficient degree of ambiguity in the translation and therefore a risk of some items being misinterpreted, which indicated

removal. It was felt inappropriate to consider modification of the originating or target language, a method adopted by Glickman (1993), due to the desire to retain as much as possible of the originating presentation. At that stage there were thirty-four items in the questionnaire. The remaining items retained the meaning, morphology and syntax of the source language BSL after the back translation process was conducted. Baker and Battison (1980) note that Sign Language has multidimensional features and has a range of styles and lexical variants, syntax and 'dialects'. Native BSL users are more likely to demonstrate fluency throughout this continuum which might include variants of English word ordering. This is further discussed in Westermeyer (1987). This process of assessing inter-rater reliability was deemed to be a good indicator that the BSL used would be satisfactorily understood by those to be interviewed, due to achieving conceptual equivalency.

### Scoring

One of the issues this questionnaire raises is how the responses are scaled. In order to obtain a score, items need to have a value, so that the total score reflects the degree of identity and attachment towards deaf people and community and attitudes towards their own hearing status and those of others. It is arguable that applying a value to each item is subjective. The questionnaire is used as a way of achieving some knowledge in a structured interview situation, of the individual's impression and response towards deafness. Individual item scores which produce a negative response would not necessarily be conclusive. For example, Question No. 26 'It is ideal for Deaf people to have Deaf partners' - if the respondent agrees with this statement, this can be taken as a sign of acquisition of Deaf values. However, should the respondent

disagree, this would not necessarily indicate rejection of Deaf identity and values, and the response would be considered in the context of the whole questionnaire. Deaf people who orientate towards more culturally hearing values, (preferring oral language and socialising with non-deaf people for example), can be identified from the responses to the questionnaire as a whole, not by focusing on individual items.

Considerable discussion took place with a number of colleagues on what could be considered an appropriate value for each question. This included discussion with those who were involved in the backtranslation and translation process. The discussions took place after the translation was complete. The assigned values are representative of the views of the culturally Deaf people involved in discussion. Each response was allocated a score of zero or one, dependent upon which of the two responses, 'agree' or 'disagree' was given.

Following this a pilot study using the ATIQ was carried out on a group of ten deaf people. Their responses indicated a good level of understanding of the items and appeared to be appropriate to their level of involvement and attachment, or non-attachment, to other deaf people and also provided a good measure of attitudes towards their own deafness. There were two items, however, which when administered, appeared to be confusing and had raised several questions seeking clarification. These two items were; 'I wear my hearing aid so other people will think I am a bit hearing' and 'I feel that people look at me because I am deaf'. Participants in the pilot study felt the item referring to wearing a hearing aid ought to be conveying the point that many deaf people appear to wear hearing aids as an

indicator of the deafness, rather than an indicator of 'hearingness'. This item was removed due to its lack of clarity. In relation to the second item that was removed, the pilot group commented that this created questions in the context of the environment, regarding whether or not people would actually know of the deafness. The process that has been described illustrates the face validity and inter-rater reliability of the questionnaire.

The completed Attitude and Identity Questionnaire (ATIQ) had 32 items. The minimum score is zero and the maximum 32. The scoring key is shown in Table 6.2

**Table 6.2: Values Assigned for Attitude and Identity Questionnaire (ATIQ) - Scoring Key**

Question No.	Agree	Disagree	Question No.	Agree	Disagree
Q1	0	1	Q17	1	0
Q2	1	0	Q18	0	1
Q3	1	0	Q19	1	0
Q4	0	1	Q20	0	1
Q5	0	1	Q21	0	1
Q6	1	0	Q22	0	1
Q7	1	0	Q23	1	0
Q8	0	1	Q24	0	1
Q9	0	1	Q25	1	0
Q10	0	1	Q26	1	0
Q11	0	1	Q27	1	0
Q12	1	0	Q28	0	1
Q13	0	1	Q29	0	1
Q14	1	0	Q30	0	1
Q15	0	1	Q31	0	1
Q16	0	1	Q32	1	0

*[Codes based on original order of items]*

The 32 item ATIQ, produced after the process of translation and back-translation was then subjected to factor analysis, which is based on patterns of correlation between questions. The reason for choosing this analysis was to look at attitudes and values and to see if a factor structure emerged. It would be useful to know if the items fell into groups and if any structure emerged which might then assist in understanding responses. This would also enhance what the values represented in the ATIQ are when grouped and by which features. This process also enables examination of how the scoring can be read and interpreted. For example, a score of 1 or 0 has to reflect a measure of the same thing within the total possible score of a group of items, a factor. The highest and the lowest scores need to reflect the same continuity and not be measurements of different items. The items in each group therefore had to be co-operating with each other closely and had to support each other.

Using this community sample of 97 people, a principal factors analysis was performed by Varimax Rotation to produce the most meaningful interpretation. This was obtained by the extraction of 11 factors which accounted for 71% of the overall variance. The results are presented in Appendix 6.

Four factors could be interpreted meaningfully. Several variables load to at least a moderate degree on more than one factor and this causes some problems in interpretation. The four factors are identified as: 1. Identity and Attachment According to Hearing Status; 2. Self-Esteem and Confidence; 3. Attitude Towards Hearing Status of Others; 4. Perception of Hearing Status. Table 6.3 illustrates the eigenvalue and variance of each of these particular factors.

**Table 6.3 Attitude and Identity Factors**

<b>FACTOR 1: <u>Identity and Attachment According to Hearing Status</u></b>		<b>FACTOR LOADING</b>
<b>Eigenvalue 5.69      Variance 17.8%</b>		
ATIQ 2: My best friends are deaf		0.76
ATIQ 3: I am most relaxed when I am with deaf people		0.76
ATIQ 7: Deaf people understand me best		0.73
ATIQ 21: My close friends are hearing		-0.73
ATIQ 23: I feel uncomfortable if I am the only deaf person in a group		0.35
ATIQ 25: I have a strong feeling of identity as a deaf person		0.76
ATIQ 26: It is ideal for deaf people to marry other deaf people		0.49
ATIQ 27: I really wish I was hearing		-0.35
ATIQ 28: I prefer being with hearing people		-0.72
ATIQ 30: I have a strong sense of belonging to the Deaf community		0.72
ATIQ 32: I am satisfied I am deaf		0.52
<b>FACTOR 2: <u>Self-Esteem and Confidence</u></b>		<b>FACTOR LOADING</b>
<b>Eigenvalue 3.89      Variance 12.2%</b>		
ATIQ 4: I feel I have a hard life because I am deaf		0.47
ATIQ 5: I feel nervous because I am deaf		0.65
ATIQ 8: I blame my deafness for my problems		0.37
ATIQ 9: Sometimes I pretend to understand other people when really I do not		0.49
ATIQ 10: People dislike me because I am deaf		0.63
ATIQ 11: I don't like it when I have to tell other people that I am deaf		0.55
ATIQ 12: I feel quite confident		-0.56
ATIQ 19: I lead a normal life just like anyone else		-0.32
ATIQ 20: I worry when I see people talking because I wonder if they are talking about me		0.57
ATIQ 24: I feel nervous if I miss something and I have to ask people to repeat		0.57
<b>FACTOR 3: <u>Attitude Towards Hearing Status of Others</u></b>		<b>FACTOR LOADING</b>
<b>Eigenvalue 2.13      Variance 6.6%</b>		
ATIQ 1: I would be a better person if I could hear		0.17
ATIQ 16: I feel rejected by the hearing world		0.69
ATIQ 17: Hearing people often put down deaf people		0.86
ATIQ 18: I am angry because I was born deaf		0.76
ATIQ 29: I feel angry towards hearing people		0.47
<b>FACTOR 4: <u>Perception of Hearing Status</u></b>		<b>FACTOR LOADING</b>
<b>Eigenvalue 1.89      Variance 5.9%</b>		
ATIQ 13: Deaf people make more mistakes in life because they are deaf		-0.43
ATIQ 14: Deaf people can be just as equal to hearing people		0.39
ATIQ 15: Being deaf is absolutely terrible		0.49
ATIQ 22: I feel embarrassed signing in public		0.63
ATIQ 31: I do not like mixing with deaf people		0.66

There were some ATIQ items which had low loadings. ATIQ item No. 6 had a loading of -0.20 in factor 1. Another low loading (0.35) is seen in ATIQ item No. 23 which falls in factor 1. There were 12 ATIQ items in factor 1, 10 in factor 2, 5 in factor 3 and 5 in factor 4.

Factor 1 was named Identity and Attachment According to Hearing Status. High scores on this factor would indicate the hearing status orientation of the participant including preferred socialization patterns is towards the deafness rather than rejection of deafness.

Factor 2 was named Self-Esteem and Confidence. High scores would indicate a level of confidence and positive esteem in relation to the deafness. Anxiety concerning deafness would be indicated by low scores on this factor.

Factor 3 was named Attitude Towards Hearing Status (Own and Others). High scores on this indicate acceptance of the deafness and little suggestion of adjustment difficulties or negative beliefs about hearing people.

Factor 4 was named Perception of Hearing Status. Low scores on this indicate negative attitudes and beliefs towards deafness. High scores would, therefore, indicate positive beliefs about being deaf.

The intention of the principal factors analysis is to gain, to some extent, an appreciation of what the ATIQ is measuring. Some of the variables load onto more



than one factor; two variables have low loadings. The ATIQ does not present immediately as a tool with a particularly clear factor structure. However, this explorative analysis provides the reader with an understanding of the interaction of the underlying dimensions running through the ATIQ.

The 32-item ATIQ was administered in face-to-face interviews using British Sign Language to a sample of 102 deaf people drawn from the North West of England. Respondents were asked to give a response of Agree or Disagree to each item. The results are in Chapter Seven, Analysis Part IV.

## **CHAPTER SEVEN**

### **DESCRIPTION OF THE STUDY**

#### **Method**

Twelve Social Service Departments (SSD) throughout the North West of England were approached. These were the ten SSD's of Greater Manchester: Oldham, Wigan, Salford, Manchester, Stockport, Rochdale, Trafford, Tameside, Bury and Bolton, The Chester Society for Deaf People, (contracted by Cheshire Social Service Department), and Lancashire SSD. The reason for selecting this method to obtain a sample population was carefully considered. Most deaf people, regardless of status of hearing loss, will have had some contact with their local SSD, not necessarily for help regarding any particular problem, but more often for access to technical aids to daily living, such as visual alerts for the telephone, doorbell and other technical aids. Each Social Service Department was visited to discuss the possibility of interviewing a random sample of deaf people in their geographical area. (Copies of the correspondence with Local Authority Social Service Department may be found in Appendix 7).

A meeting was arranged with each department's Team Leader or Senior Social Worker with the Deaf, for each of the twelve areas in order to ask for their assistance in compiling a random sample selection of their deaf population. Each social worker was asked to follow clearly specified guidelines and criteria in randomly selecting every tenth person from their population of deaf people. The social workers were required to use a random sampling procedure from a list of names comprising the

deaf population in their area. There were asked to identify all those who met the criteria for the study and then to draw out one from every ten. The names were randomised first so as to avoid any bias that might emerge in chronological order selecting. The interviewer assisted with the administration of this task and oversaw that the random sampling process was followed. The population was to comprise, for audiological purposes, deaf people with experience of deafness of 90 decibels plus, who were either born deaf or had become deaf prior to the age of three. Where the age of onset of deafness was in doubt, for example, if it was not certain deafness was experienced prior to the age of 3, these people were excluded. The age range was restricted to those aged 16-65. This was due to questions relating to work experience and changes in communication with family. The age limit is placed to reduce the influence of dementias.

This population has been drawn from a community sample as opposed to previous studies, many of which gathered populations from clinics or schools for deaf children with special needs (Williams, 1970; Rainer & Altschuler, 1971; Denmark, 1985).

### Interview Questionnaires

The first questionnaire, the Background Interview Questionnaire (BIQ), was designed for this study, (Appendix 8). This contained various questions including changes in familial styles of communication over the years. It might be the case that a family of non-deaf people communicated purely orally with their young deaf child and later had changed to using non-verbal means to communicate or perhaps had learnt some Sign Language. Non-verbal means might include gestures, facial expression or some

written communication. Sign Language refers to British Sign Language, a unique language in its own right (Deuchar, 1972) or Signed Supported or Signed Exact English, both being based on the structure and grammar of the English language. A number of external influences may have been in process during the changes, if any, and it was hypothesised that most families did not change their styles of communication in any significant way. This was on the basis that non-deaf family members were usually accepting advice from the various professionals who become involved with families when a child is seen to have experience of deafness. Many deaf adults report that the insistence on speech and prohibition on using signs during childhood indicated to them that their deafness was not accepted by their families (Bowe, 1986). The acceptance and use of sign may be viewed as acceptance of one's deafness, which would lead to higher self-esteem. Having deaf parents and using Sign Language in the home are associated with higher self-esteem (Bat-chava, 1993). There were also questions on educational experiences and qualifications and questions designed so that individuals could reflect upon their educational backgrounds and learning experiences and also to state how they felt about their jobs and chosen vocations or careers as appropriate. Also, whether they had experienced any unwanted periods of unemployment. It was hypothesised that most deaf people would express some degree of dissatisfaction with their jobs, if in employment at all, and would also report difficulties at work usually linked to communication and misunderstandings. The difficulties which this study anticipates participants reporting relate mainly to communication difficulties and misunderstandings which arise from a lack of awareness on the part of the employer and work colleagues of deafness, misconceptions about deafness or an unwillingness to help facilitate some co-operation

with the deaf employee. Misunderstandings might arise out of a hearing person misinterpreting a deaf person's facial expression as aggressive or hostile for example, especially if it is accompanied by Sign Language (Jones and Pullen, 1988; Padden and Humphries, 1988). In addition, and perhaps secondary to that of the primary problem of ignorance and disinterest on the hearing person's part is the deaf person's probable lack of hearing awareness.

Experiences of abuse, sexual and physical, neglect and emotional abuse were included. A number of studies have indicated that deaf people are at higher risk of abuse. A study completed in England (Kennedy, 1988), reported findings that indicate that in a large number of deaf children, abuse may be suspected by the teacher or social worker working with the child but that no action was taken. This was seen mainly as a result of scarcity of resources or lack of skills, knowledge and training in child abuse issues. Research shows that many survivors in adulthood suffer psychological difficulties and emotional distress and will often require help and support to continue on with their lives (Bannister, 1983). The figures for children who are deaf are known to be higher when compared with their non-deaf peers. This has been ascertained from American research (Kline, 1982; Zirpoli, 1986) and can be seen in this study to be reflected in the U.K. Chapter 8 focuses on deaf people and abuse.

If a reply was still not been received from the area social worker by the following month, October, 1992, another letter was sent and a telephone call made using the

Typetalk exchange if the number given was not a textphone number. Details of the Typetalk relay service are provided in the Glossary (page 488).

All departments visited co-operated fully with what was required. Only one department expressed some reluctance because they felt that deaf people would not be interested in taking part, but on agreeing, wished to be paid for their co-operation and administrative time (Chester Society for the Deaf). In fact this area generated one of the highest response rates (see Table 7.1). Funds had not been allocated for such purposes and money from the travel budget allocated to this research was used to pay the Society. No deaf people were paid to be interviewed nor were any of the Social Services Departments paid for their co-operation. Of interest, was that a large number of the service managers and Social Services Department Directors were enthusiastic and encouraging about this research and wrote letters supporting the research. Each social work officer was given copies of a letter from the interviewer (Appendix 7) which was for the social worker to send to those deaf people in the sample. The letter had a 'tear off' slip at the bottom for the receiver to write in their name and address and was accompanied by a stamped addressed envelope. The letter was brief and clear, offering an appointment for me to visit them at home in order to describe and explain the research. They could then decide whether or not they wished to participate. It was not feasible or appropriate to send them details of the research beforehand so that a decision could be made before a visit. This is because for many of the sample that emerged, British Sign Language (BSL) was the first language and this research was designed to be accessible to deaf BSL users. In addition it is of cultural necessity that the interviewer be available to meet the

participants in the first instance to discuss and seek participants' permission. Letters are not usually a strong feature in deaf-deaf communication hence the high number of people who had filled in the request slip for a visit was of significance. Table 7.1 illustrates the number of letters sent out by geographical location, totalling 199. The figures represent approximately 10% of each local authority area deaf population. Once permission was obtained a consent form was signed (Appendix 7). The consent was in accordance with the Data Protection Act (1988) to use their data and to make the results known. The confidential nature of the research being undertaken was stressed to all participants, and that their name and identity would be kept completely confidential. It was also explained that data would be coded and all completed data sheets from interviews would be identified by number only. The number of responses received was 102 (51.7%).

**Table 7.1: Number of Questionnaires sent out: Returns by area and Gender**

Area	Number Sent Out	Number of Returns	M	F	% Returns
Trafford	15	8	4 (50)	4 (50)	53.3
Stockport	12	6	3 (50)	3 (50)	50
Lancashire	11	6	4 (66.7)	2 (33.3)	54.5
Wigan	18	7	3 (28.6)	5 (71.4)	38.9
Tameside	25	10	4 (40)	6 (60)	40
Bury	9	5	1 (20)	4 (80)	55.5
Manchester	21	12	7 (59.5)	5 (40.5)	57.1
Bolton	12	6	4 (66.7)	2 (33.3)	50
Cheshire	49	27	12 (44.4)	15 (55.6)	55.1
Rochdale	9	4	3 (75)	1 (25)	44.4
Salford	10	6	3 (50)	3 (50)	60
Oldham	8	5	3 (60)	2 (40)	62.5
<b>TOTAL</b>	<b>199</b>	<b>102</b>	<b>50</b>	<b>52</b>	<b>51.78 (Mean)</b>

*Numbers in brackets designate percentage*

Each participant who completed the 'tear off' slip at the bottom of the letter requesting more information was visited. The details of the research was explained and the purpose was outlined. Everyone said they would like to be interviewed. The confidential nature of the research was reassuring for a great many of the participants who were able to disclose abuse. Following agreement to be interviewed each participant was seen twice. The Background Interview Questionnaire (BIQ) (see Appendix 8) took about two hours to complete for each person. The information gathered in this questionnaire included, in addition to the questions highlighted above, personal details such as age, gender, ethnicity, communication with family when they were young compared to the way family communicated now, and if there had been any changes in communication since the deafness was identified. The list of questions that compiled the Background Interview Questionnaire contained in Appendix 8.

The questionnaire also asked if there were any other deaf people in the family as this may have influenced communication and identity development. There were two questions regarding the discovery of the deafness. The first question asks at what age the participant was when the deafness was confirmed. The next question asked at what age the deafness was first noticed prior to confirmation. Education and methods of communication at school, occupational experiences and preferences, social activities and interests are also included. This questionnaire asks direct questions about their social (hearing status) preferences and whether the participant preferred to socialise with deaf or hearing people, and whether their partner (if any) was deaf or hearing. This particular question aims to try and establish the orientation of the partner in terms of deafness or hearingness, not merely whether the partner was deaf



or non-deaf. Whether respondents felt that their vocation had been influenced by their deafness was also discussed.

The final section focused on abusive experiences that interviewees may have suffered. This mainly referred to sexual or physical abuse. Participants were asked, after having established that the definitions were clearly understood. It was explained that support would be provided if the participant so wished and the confidential nature of the research was stressed again. The possibility existed that some participants might suffer distress upon disclosing painful experiences of the past, often not previously discussed. Emerging repressed memories might result in some distress and it is important that these individuals are appropriately provided for by counselling and befriending support. Fortunately, a befriending support group for deaf people had formed in the North-West area and use of their resources was obtained in addition to referring three participants to people who had completed a certificate in counselling skills course which the writer was directing at the University of Manchester. A number of participants from the sample indicated emotional abuse as children. This was in the form of excessive and continuous bullying and teasing. Twenty (19.6%) of the sample reported emotional abuse. The issue of abuse and deaf people's increased vulnerability to abuse is discussed in detail later in Chapter 8 of this study.

Some of the participants required counselling and support for a short period of time following disclosure of abuse. Three people received long term counselling, for one year, following disclosure. The results of the information gathered from the first interview were recorded in written English directly onto the questionnaire. Questions

on abuse were recorded in a separate section at the end of the interview questionnaire. It was this first interview which formed the database on which subsequent information was gathered.

The second visit, which was arranged in advance, either at the time of the first visit or by letter, was used to interview the participants using the General Health Questionnaire (GHQ-12), to detect anxiety and depression. Goldberg (1978) and The Attitude and Identity Questionnaire (ATIQ) which was developed by the writer for this research. The reason for selecting the GHQ-12 questionnaire in preference to the GHQ-30 which has been more frequently used in research is described in Chapter five which discusses the increasing popularity of the GHQ-12. The ATIQ design and analysis is detailed in Chapter 6. The second interview was also used to clarify anything which might have been unclear from the information gathered in the first visit. Each question was asked in British Sign Language. Responses were recorded in writing, after explaining at each stage what the choice of responses could be. The Attitude and Identity (ATIQ) scale responses were coded as either "disagree" or "agree". The Goldberg Questionnaire used a four point scoring scale to measure the degree of agreement for each question asked. This was translated into Sign Language for each participant. The GHQ-12 questionnaire appears in Table 7.2, (page 211).

## Interviews

### First Stage

The information gathered in total from each participant therefore took several hours to collect. This is why each participant had to be interviewed in two sessions. The

sessions took two hours each. Research work with deaf people demands knowledge of, and application of, deaf mores - names and cultural mannerisms which means you do not just walk in the house and start firing away lots of questions (Jones and Pullen, 1988). It is polite to talk about one's geographical origins. It is quite usual for deaf people to ask each other about where are they from before asking what your name is, which is usually asked last, if at all. It is not unusual to ask if there are other deaf people in your family - and if so, then this is a topic of great interest and indeed celebration. It is always a great joy to meet people who are deaf and if one knows or attended the same school as the interviewer's relatives then it is a source of interest and enjoyment. It is not considered appropriate to behave in another fashion for example, withholding information about other people in the family who are deaf. The chances are they know each other. This is one of the reasons the interviews took so long. The interviewer (Sharon Ridgeway) had deaf parents who attended Old Trafford and Margate schools for Deaf children as well as the London School for Jewish Deaf children. With such a variety of schools between them, the likelihood of offspring being known at any one part of the country was quite high.

The beginning of each interview was, therefore, rather like going through a kind of "initiation" ceremony, the end result which earns a level of acceptance and trust. It would probably be quite difficult for a non-deaf person to achieve a similar degree of familiarity and relaxation in such a similar situation. Jones and Pullen (1988) have written on this issue of cultural identification and of how important this beginning process is to any deaf person being interviewed. The details of the questions to be asked did not seem to be the main concern of the deaf interviewees. It was more

about 'where are you from' and 'what are you doing'. For many of the sample of deaf people to be interviewed, it was the first time that a deaf person had made contact on this level.

None of the participants had previously been seen by a deaf professional person. Some had experience of interviews from different people who were hearing. Research has shown that deaf people are more likely to have a negative self-concept when compared to non-deaf people (Brauer, 1988) and this is sometimes reflected in relationships with other deaf people. Some deaf people will tend to "pull down" other deaf people who are working with hearing people in the Deaf world and appear to be somewhat more successful or seem to be getting on very well in their work. This kind of behaviour is almost group-like, where a group of deaf people might 'gang up' on a 'traitor' who is 'doing well'. Parallels could be drawn with a Black person working with White people in a professional or semi-skilled capacity, who may be seen as belonging to **them**. These situations indicate a 'them and us' scenario. Baker-Schenk (1986) has used the illustration of crabs. Crabs, when placed in a bucket tend to 'pull down' other crabs trying to climb out by clinging onto the 'escaping' crab. This illustrates what seems to be characteristic of some groups of oppressed people and minority groups. The oppressed person is self critical and negative and does not usually believe they have the potential to achieve or get on in life. These negative feelings might be hiding a more covert feeling of low self worth and a negative self image which the 'successful' deaf person might threaten. Feelings of betrayal in the context of "we are not supposed to be able to do this" and 'they' (hearing) owe us (because they have better lives than us). Low self esteem will be

experienced as well as often feeling unable to think positively in this respect. Also experienced is basic mistrust of one's self and peer group. Often this is due to the belief that the 'oppressors' are superior and know better. To illustrate this a deaf person sees a newsflash item about an increase in mortgage rates for example, and proceeds to tell a deaf colleague. The second deaf person would actually 'check out' this information with a non-deaf person first before responding, hence seeking 'verification' from a non-deaf person first. This reflects the basic mistrust of both self and their peer group. This can be compared to Black people, members of the Black community who see the White community as superior and achieving a better status in society, with good jobs and therefore might desire to be white to achieve the same. These points are made here to assist the reader in realising the significance of the earlier comment regarding going through an "initiation ceremony", a kind of 'checking out' process prior to 'acceptance'.

There was another issue which arose during the interviews. This was the issue of recording the interviews by video camera. Bringing a video with a camera and tapes meant that interviewing would lose its naturalness and spontaneity. A large number said they would not be happy with this. It was decided not to record all the interviews on video tape and instead information was recorded in written format as we progressed through the interview. Even this was not quite in tune with Deaf cultural values. Recording had to be done by pausing at intervals, and by pausing the interview was effectively stopped. Eye contact was lost when bending down to write notes, which was done as quickly as possible, so as to keep the interviewee in the here and now. Speed was of the essence in case the interviewee's mind wandered

onto another topic altogether, such as activities at the local Deaf Centre. Sometimes during a 'pause', someone might try to wave the writer back into the listening mode, attract the interviewer's attention and regain eye contact, to talk about something directly or indirectly related to the interview questions. Some of the interview questions caused emotional responses such as those relating to school activities and peer group contact. Participants were encouraged to think about areas in their life that they may not have thought about in many years and which may sometimes have been quite painful for them. This was particularly true for those who revealed abusive experiences. It is a task for the interviewer to create a balance as to when it is appropriate to pause. Another way useful and relevant information was stored was by using iconic memory and visual encoding. Doing the recording like this meant that it was necessary, and appropriate, to go through the details recorded with each participant so as to ensure recording was correct. This part of the interviewing was reassuring to the interviewees who were having complete access to their own material, translated into written English and Sign Language interchangeably. For most of the participants, it was the first time that they were fully participating in an interview or discussion with a professional who was making notes. The questions were 'read' back to participants from the written translation into British Sign Language. This was done using the participant's own regional signs variations. Twenty percent of British Sign Language contains regional variations (Herd, 1996). This achieved two objectives: The first was to ensure the writer's interpretation, translation and back translation was correct, and to give participants the opportunity to make changes as they wished. People could look at the writer's notes if they wished but only one person actually took up this offer. This might be due to the low

chronological reading age possessed by the majority of the sample and the considerable effort that would have been required. Reading newspapers, letters, circulars, adverts, announcements and similar forms of written communication are often not meaningfully comprehended. What was happening in the interviews is that because everything was conveyed using the fundamental concepts of British Sign Language, there was apparently little or no anxiety present about misunderstanding the question. Comments from some of the participants reflected this. Participant No. 79 signed "Oh I feel good to have full understanding of what research means - and I can understand everything without feeling worried". Participant No. 5 commented "I had a hearing woman come last year from the university - she didn't sign very well and I was a bit worried about what she meant by the questions".

Misunderstandings can arise through not being able to understand the cultural aspects of the non-deaf interviewer. This raises a number of cross cultural issues which may not be obvious to either the deaf person or the non-deaf interviewer. A non-deaf interviewer, using Sign Language, might mis-perceive the facial expressions of the deaf person sitting in a 'hostile' manner. For example, the interviewee may express an apparent 'disgruntled' expression, but which might relate to how the person felt during the particular time being referred to. The non-deaf person might know some signs but may not be familiar with the cultural and natural overt expression of feelings and thoughts and position in time, direction and placement of signs and therefore misinterpret the deaf person. Other misunderstandings arise through difficulty in lipreading and this applies even in situations where the speech reader may

have a good knowledge of English. Sometimes deaf people might insist on using speechreading alone which renders them at risk of misinterpretation.

Misunderstanding also arises when the interviewer fails to understand what is being said. These misunderstandings are generally derived from lack of awareness, cross cultural conflict and lack of a common language in which to converse. This is deduced from their own comments about previous interviews they may have experienced with non-deaf people. It is not sufficient to acquire a vocabulary of signs. Without awareness of Deaf cultural values, meaningful conversation is minimal. A degree of fluency in British Sign Language and a full appreciation and understanding of cultural issues is essential in a study such as this where the nature of the questions demand a high level of sensitivity. All of the first interviews used this method of recording by 'pausing' at intervals to record. This process can be likened to pressing the 'pause' or 'hold' button whilst watching a video. Each interview was time consuming and at times tedious. It was considered to be an important part of the interview, providing reassurance to participants and provided some with enhanced self-esteem in that what they wanted to say was of value and was being noted. This process of interviewing was used in the first set of interviews but it was not used in the second set of interviews.

### Interviews - Second Stage

The second set of interviews used material which provided multi-choice answers. The General Health Questionnaire, (Goldberg, 1972) was selected (Table 7.2) and the Attitude and Identity Questionnaire (ATIQ), (Table 7.3) designed for this study. Both



of these questionnaires are described. The General Health Questionnaire (GHQ-12) has twelve questions to elicit a score which if above a threshold mark, would indicate psychological distress. The cut off point was 6. The GHQ-12 questions give each participant a choice of four responses which can be seen in Table 7.2.

**Table 7.2: GHQ-12**

<b>Have You Recently</b>				
Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been able to concentrate on whatever you are doing?	Better than usual	Same as usual	Less than usual	Much less than usual
Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less than usual	Much less than usual
Been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
Felt capable of making decisions about things?	More so than usual	Same as usual	Less capable	Much less capable
Felt that you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling reasonably happy all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
Been able to enjoy your day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual

Each choice response was given after translation from English to British Sign Language. Responses were translated into English, and checked for accuracy. Participants frequently had to be reminded that we were not looking at the past but at complaints or difficulties over the last few weeks. As we were going through the questions it was as if there were many things going through their minds like the exercising of self awareness which was the first time for the majority of participants

of the sample. Participants were encouraged to think about how they felt in response to each of the questions in a way that encouraged self-exploration. This applied particularly to the questions in the Attitude and Identity Questionnaire (ATIQ), (Table 7.3).

The GHQ-12 was quite quick to complete - about 20-25 minutes for each participant. The ATIQ took about 50-60 minutes to complete. Responses were recorded on the questionnaires and the response to each question read back to the participant.

Participants were interviewed twice, totalling 199 interviews using the Background Interview Questionnaire (BIQ), the Attitude and Identity Questionnaire (ATIQ), designed for this study and the GHQ-12. One hundred and two people took part in the first stage interview and 97 took part in the second stage. Three of the second stage interviews were abandoned because the participant was unable to fully participate in what was being asked, one person had moved away and could not be traced and one person declined to continue into the second stage. In addition to the interviews, eighteen face-to-face sessions were held with different participants at their request, prior to their agreeing to participate. These sessions explained the details and purpose of the research.

Data collected from the interviews are shown by histograms and barcharts illustrating the distribution of responses. The GHQ-12 scores are correlated with the Background Interview Questionnaire (BIQ) to explore correlations as are the ATIQ scores. The GHQ-12 and ATIQ are correlated and this produces a highly significant relationship as hypothesized. Results of the various statistical analyses are produced throughout.

**Table 7.3: Deaf Attitude and Identity Questionnaire (ATIQ)**

A	D	1	I would be a better person if I could hear.
A	D	2	My best friends are deaf.
A	D	3	I am most relaxed when I am with deaf people.
A	D	4	I feel I have a hard life because I am deaf.
A	D	5	I feel nervous because I am deaf.
A	D	6	My deafness is a problem for other people but it is not a problem for me.
A	D	7	Deaf people understand me best.
A	D	8	I blame my deafness for my problems.
A	D	9	Sometimes I pretend to understand other people when really I don't.
A	D	10	People dislike me because I am deaf.
A	D	11	I don't like it when I have to tell other people I am deaf.
A	D	12	I feel quite confident.
A	D	13	Deaf people make more mistakes in life because they are deaf.
A	D	14	Deaf people can be just as equal as hearing people.
A	D	15	Being deaf is absolutely terrible.
A	D	16	I feel rejected by the hearing world.
A	D	17	Hearing people often put down deaf people.
A	D	18	I am angry because I was born deaf.
A	D	19	I lead a normal life just like anyone else.
A	D	20	I worry when I see people talking because I wonder if they are talking about me.
A	D	21	My close friends are hearing.
A	D	22	I feel embarrassed signing in public.
A	D	23	I feel uncomfortable if I am the only deaf person in a group.
A	D	24	I feel nervous if I miss something said and I have to ask people to repeat.
A	D	25	I have a strong feeling of identity as a deaf person.
A	D	26	It is ideal for deaf people to marry other deaf people.
A	D	27	I really wish I was hearing.
A	D	28	I prefer being with hearing people.
A	D	29	I feel angry towards hearing people.
A	D	30	I have a strong sense of belonging to the Deaf community.
A	D	31	I don't like mixing with deaf people.
A	D	32	I am satisfied that I am deaf.

® Deaf Attitude and Identity Questionnaire created for this study by the writer.  
(Ridgeway, S)

## ANALYSIS

### Part I

#### The Background Interview Questionnaire (BIQ)

Interviewees were asked questions which related to communications with their families, education, further and higher education opportunities, employment and social relationships in terms of hearing status. A number of questions were asked concerning experiences of abuse. Identified factors concerning the abuse of deaf people are described in Chapter Eight.

#### Description of Population

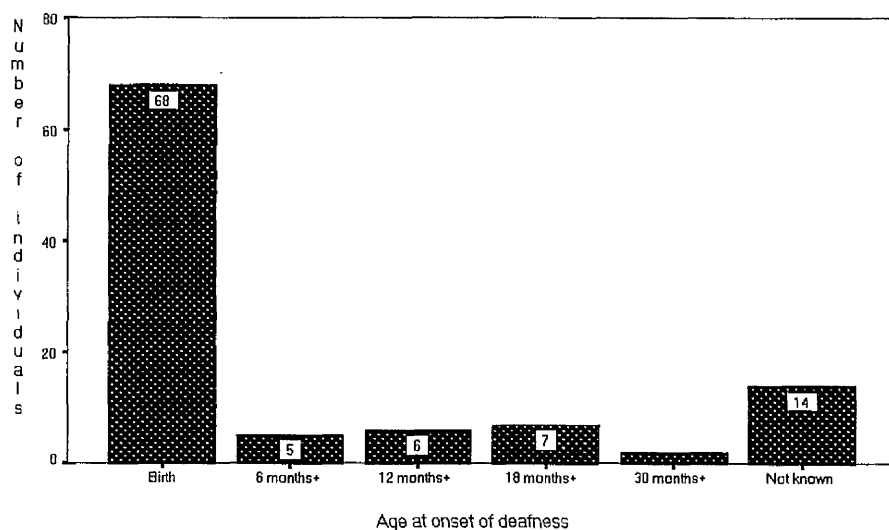
The gender distribution of the population showed that 58 (56.9%) were females and 44 (43.1%) males, replicating most other studies. Females are usually more likely to respond to questionnaires than males, although here the number of male responses was greater than envisaged. Males typically will hide or avoid talking about their difficulties. In this study, however, males were keen to share their worries and talk about sensitive issues without being particularly defensive. The mean age of the population sample (n=102) is 41, range = 17-65, S.D. = 13.06, representing a fairly even distribution. Ninety-five (93.1%) of the sample were of European origin, 3 (2.9%) African, 3 (2.9%) of Asian origin and one person was from the Middle East. Sixty-nine percent of those interviewed were living with a partner. This includes marital relationships. Eighteen (17.6%) were living with their parents and 15 (14.7%) were living alone. Five (4.9%) of the sample had disabilities. One was

an Ushers person and another suffered Multiple Sclerosis and was mobile by wheelchair. Three people had learning difficulties and relied upon their carers to meet their everyday care needs.

### Family

Figure 7.1 shows the distribution of age at onset of deafness.

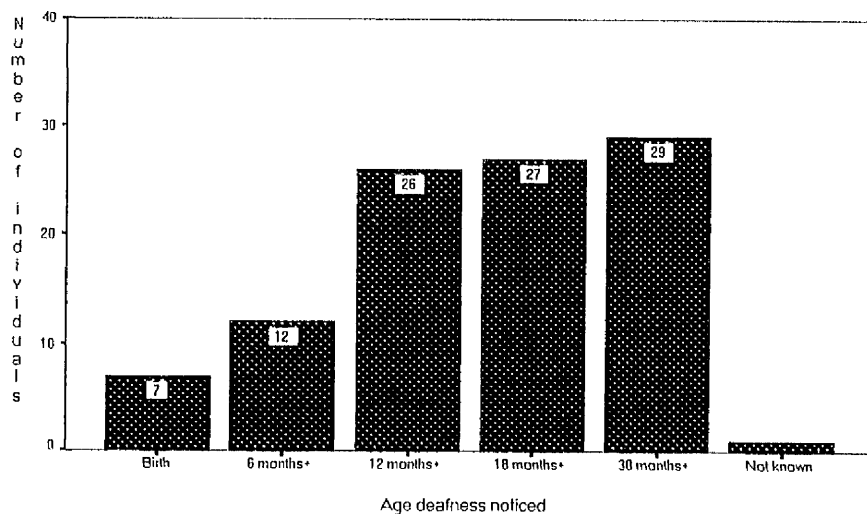
**Figure 7.1** Age at onset of deafness



This shows a high percentage of participants consider themselves deaf from birth. This is almost certainly inaccurate but there does seem to be some difficulty in determining this as this information came from the participants themselves. Some individuals will have received details of their deafness from their families where communication permitted. Several participants believed they were born hearing but became deaf through a fall. Where this is dubious, it is possible that carers found this easier to communicate or was a way of alleviating guilt, particularly where participants asked "why am I deaf?".

The information provided was usually obtained from their families and therefore may not have been reliable, particularly if families were uncomfortable with the deafness, or if communication difficulties meant restricted information was easier. Five (4.9%) of the participants became deaf at the age of 6 months or more and 5 (4.9%) at the age of 12 months or more. A large number reported deafness at 30 months or more - generally due to illnesses, such as meningitis.

**Figure 7.2** Age deafness noticed



Comparing the information in Figure 7.1 with that in Figure 7.2, (age deafness was noticed) we see a pattern emerge whereby 56 (54.9%) of participants reported that their deafness was not identified until they were over 18 months old. Twenty-six (25.5%) of these reported that their families had no idea of the deafness until they were over 2½ years old. In a further breakdown the following emerged; 26 (25.5%) participants reported their deafness was noticed at age 12 months; 18 (17.6%) at 18 months; 15 (14.7%) at 24 months; 14 (13.7%) at 30 months and 14 (13.7%) at 36 months.

**Figure 7.3**    Distribution of causes of interviewee's deafness

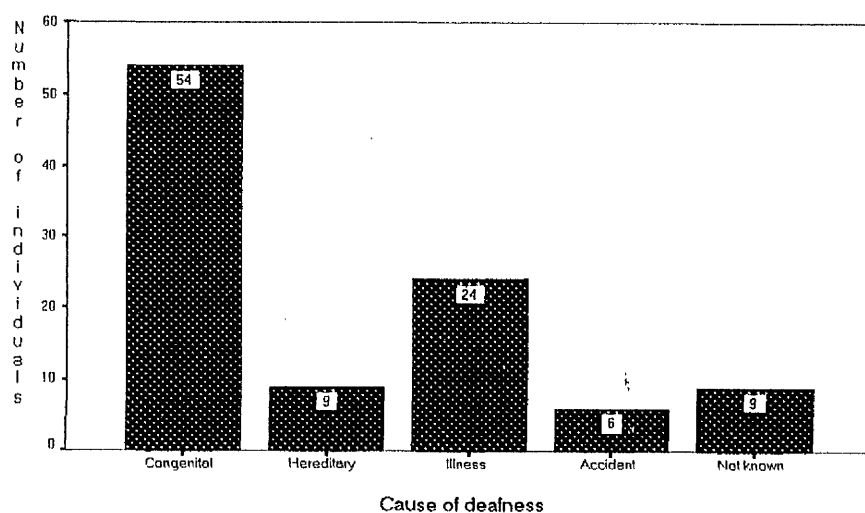


Figure 7.3 indicates that along with other studies (Conrad, 1979), most of the emerging deafness was probably acquired through illness at an early age. The term hereditary here refers to those deaf participants who had deaf parent(s) and "accident" means deafness occurred after birth. Since this information has been taken from participants themselves, it is possible that some of the details may be inaccurate, through either inappropriate conclusions on the part of the participant and the family or perhaps from lack of access to information. There are several acquired causes of deafness in children which might relate to the critical prenatal period (Rubella and congenital syphilis are examples) and the prenatal period (Hypoxia or Kernicterus, for example) and the postnatal period. Meningitis and some ototoxic drugs are examples of causes of deafness at this later stage. Approximately 60% of early childhood deafness in the United States is due to hereditary factors (Paul and Jackson, 1993) and many influenced by different factors at any time, before, during and after birth. Genetic causes of deafness can arise at birth or by a result of a gradual deafness (Rose, Conneally and Nance, 1976).

Deafness can also be caused by hereditary factors such as Usher's or Waardenberg's syndrome. Sometimes the deafness is 'pure'. This refers to a familial hereditary gene without any link to any syndrome or disability. This has been known to be described in the U.S.A. as 'clean' deafness (Malzuchan, 1994). This term has not been adopted in the U.K. possibly to avoid offending those who may be deaf from other causes or to avoid the implication that deafness which has not arisen from familial hereditary factors is 'unclean'. There has been confusion regarding the use of the terms 'acquired' and 'congenital', and confusion over the terms hereditary and genetic. This has been partly due to insufficient understanding about the meaning of the words being used. Congenital deafness could be familial (genetic) or acquired. The terms 'postnatal' and 'acquired' deafness are sometimes seen to be used interchangeably. Some of these terms have different meanings depending upon how one perceives the value of terms such as 'acquired' deafness for example. Many parents and carers were not aware of their child's deafness for years. Different health concerns were often reflected by geographical location and also depended upon the incidence or prevalence of deafness in a given area. It is also the case that a large number of families and professionals attributed childhood deafness to sickness the mother may have incurred in pregnancy. Alexander Graham Bell had originally presupposed that, to a large extent, deafness would be discouraged by the social separation of deaf people from each other. However, it was later realised that it was non-deaf (hearing) people who mainly produce deafness. Ninety-nine percent of deaf children are born to hearing parents (Padden & Humphries, 1988). Hereditary deafness has been a generic label for many conditions. Konigsmark (1969) produced a classification grouping which led to more than 150 kinds of deafness being



identified. Ballantyne and Martin (1993) have provided a detailed section in "Deafness: Causes, Prevention and Treatment" which will be of interest to those who are unable to view deafness as anything other than a shortfall in the human person.

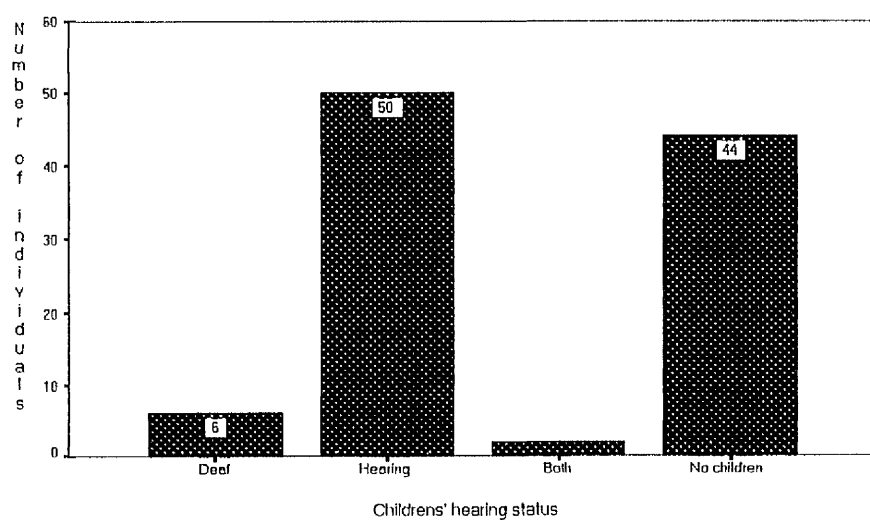
The legend shown in Figure 7.3 groups different types of 'causes'. It does not capture the depth of the medical study of deafness and 'causes' that have been identified by the medical profession as the study essentially takes a cultural and linguistic view of deafness. Over 200 genes linked to deafness have been discovered and a constant quest for 'improvements' in health care to eradicate and eliminate deafness is often seen as a priority thus indicating that deafness is seen as being a form of poor health. Rubella is an example of an environmental factor which a great deal of money has been ploughed into research programmes because of implications for child morbidity.

Of those who had deaf family members, 26 (25.5%) were of deaf parentage. This reflects a fairly typical representation of deaf people from deaf families - most studies indicate a range between 8-12% (Martin, 1979; Padden & Humphries, 1988). The others are comprised mostly of paternal relatives such as an uncle or cousin. Some had a deaf sibling. Many of the population reported that their carers experienced immensely sad feelings upon discovering their child's deafness. One participant (Participant No. 72) recalled her mother as later saying she had been 'devastated'. Others recalled their parents being 'shocked' or 'very upset'. Some interviewees were not aware of what was happening at the time but were conscious something was 'wrong'.

This indicates the needs of hearing parents who experience deaf children, usually in a negative way at first. Such impressions have a lasting and profound impact upon their deaf child's wellbeing, particularly in terms of **accepting** the deafness. Little support is available to non-deaf parents, such as advice and support, counselling, befriending and meeting other non-deaf parents of deaf children. Conversely, when deaf parents have hearing children, professionals such as audiologists, social workers from various field teams tend to become involved quite quickly and for apparently longer periods of time than if the parents were hearing. Similar situations arise when deaf parents have deaf children, as participants in this study have indicated. Several professionals became involved, often without the deaf parents knowledge or understanding of why or what the apparent concerns are.

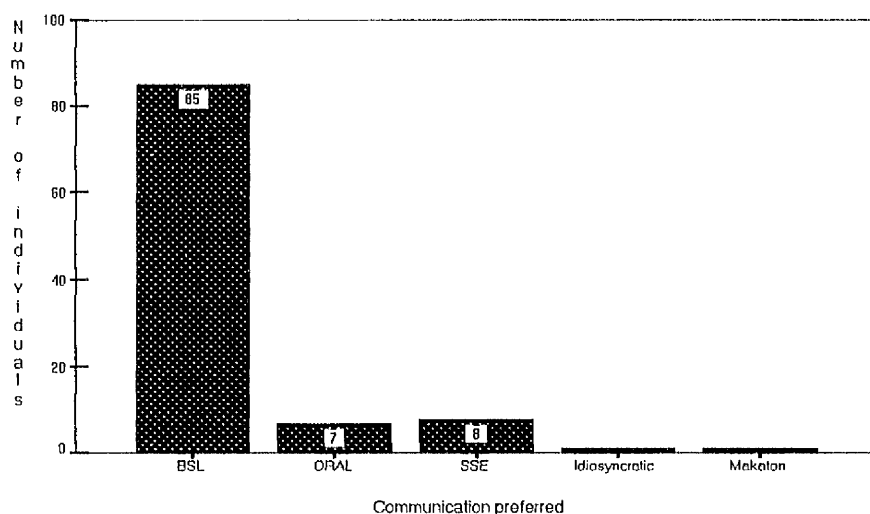
The Background Interview Questionnaire (BIQ) also asked about the hearing status of participants children. Figure 7.4 shows the distribution.

**Figure 7.4** Distribution of hearing status of interviewee's children



Of the 58 (56.9%) who had children, 6 (5.9%) had deaf children only and two had both deaf and hearing children. Previous studies show that an average 10% of deaf children are from deaf families (Padden & Humphries 1988). Fifty (49.0%) participants had hearing children only and 44 (43.1%) had no children. The figure for those not having children seems to be a little higher than the norm for the U.K. population.

**Figure 7.5** Distribution of interviewee's stated preferred method of communication



### Communication Issues

Figure 7.5 gives a breakdown of how participants answered the question 'What communication do you prefer to use?' Eighty-five (83.3%) of participants stated that they preferred to communicate in BSL. Seven (6.8%) said they preferred to speechread whilst 8 (7.8%) preferred Signed English. One person with learning difficulties used idiosyncratic modes to communicate with people he knew. Another person with learning difficulties used Makaton to communicate, although it did seem he could have accessed BSL had this been provided.

**Figure 7.6** Distribution of styles of communication actually used in interview

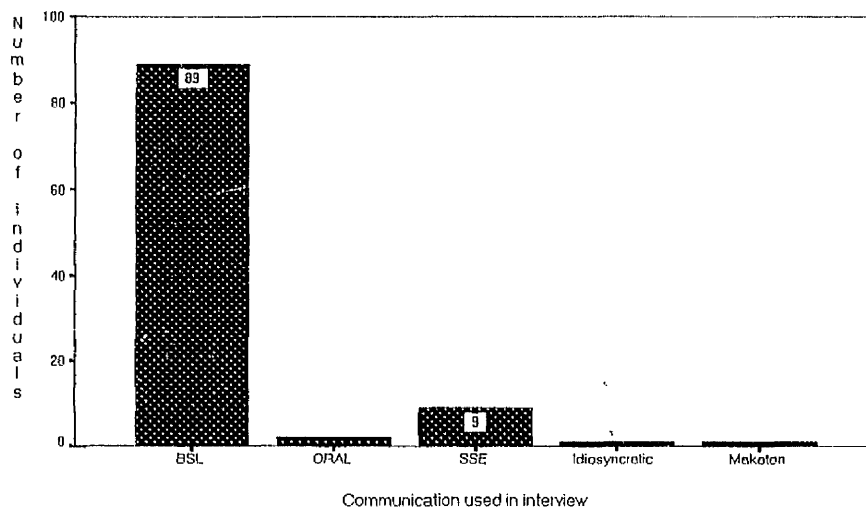
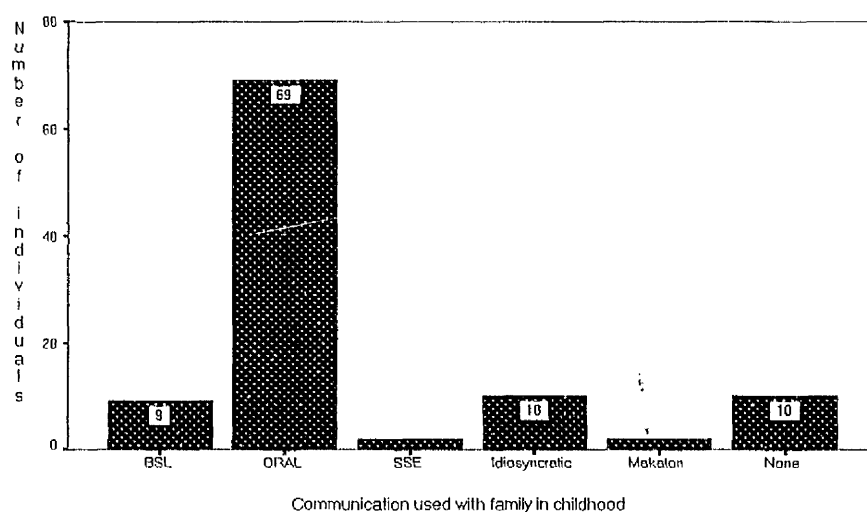


Figure 7.6 provides a further breakdown of the communication used, based on the interviewers own observation during the interview. This graph shows that there were a few but significant changes to the actual perceived communication preferences of the participants shown in Figure 7.5. Figure 7.6 shows that of the five people who previously indicated they preferred speechreading, four were actually using BSL during the interview and one was using signed English. This raises an interesting issue linked to self-esteem and image of the deafness. A negative self-esteem can produce a lack of confidence and this is reflected in a lack of pride in the Deafness and its culture and language. Deaf people with low self esteem might try to hide their deafness and attempt to 'pretend' to function as non-deaf people by using speechreading. Speechreading (using oral methods to communicate), is seen as a 'hearing' persons function. Deaf people who fall into this group might receive comments such as 'Oh you lipread very well', or 'You manage very well' or even 'You speak very well'. Non-deaf people tend to be seen as being of 'better value' and worth than deaf people.

**Figure 7.7**    **Communication Used with Family in Childhood**



Participants were asked about communication used by their families when they were young and growing up with them. This was compared to the results of another question which was 'Are there any differences in the way your family communicate with you now - compared to when you were younger?'. Figure 6.7 shows the distribution of participants' answers to the initial question relating to childhood communication experiences and shows, as expected, that most of the population sampled, 69 (67.6%), communicated using oral/aural methods (speechreading), with the use of aids to hearing, whilst growing up with their families. The 9 (8.8%) using BSL were of deaf parentage. Idiosyncratic communication as previously indicated, refers to a combination of methods excluding sign language, but includes gesture and possibly signs, speechreading and written communication. Ten (9.8%) said no communication took place. By this it is meant that the families did not display any interest in attempting to communicate in any way with the participant, who commented that their families acted as if they were hearing and continued to use non-deaf (profoundly hearing) modes of communication, for example, talking without eye

contact with the deaf person. In discussion with some participants, it seemed probable that more participants would have classified communication with their families as 'none'. Participants tended to say oralism which they rated as the same as no communication. In retrospect, a specific measure containing questions to try and gain an indication of how much was actually understood by participants would have been useful. It was conveyed by participants, however, that implicit in Oralism was difficulty in comprehending information.

Participants were asked about communication now in comparison to when they were younger. A large number reported no changes. Participant No. 67 reported signing when younger then the family moving to oral communication when older. Since this pattern was an unusual one further questioning revealed that what she mistook for signing was natural gesture, such as pointing. Communication was thus quite limited.

Thought is needed as to how to group the communication methods families used. This section focused mainly on communication between the participant and his carers. It seemed sensible to use a five code span, communication was categorised as BSL or English (e.g. SSE, oral, idiosyncratic or Makaton). Some people said that they felt there had been no communication taking place throughout their childhood but it was only much later during their school years that some meaningful communication took place in an oral form. The implication is that it was only when the participants had begun to learn some English (for reading and writing) that they could use speechreading skills they had acquired.

**Figure 7.8** Distribution of changes in communication with family now

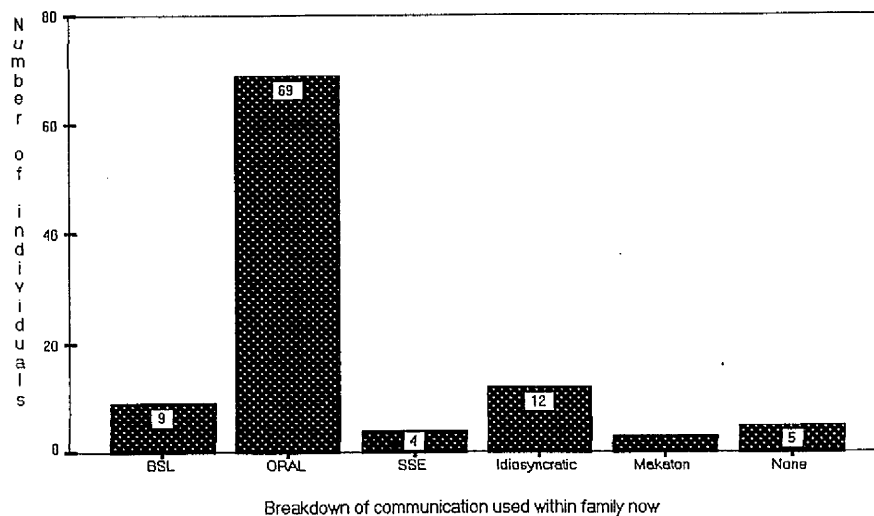
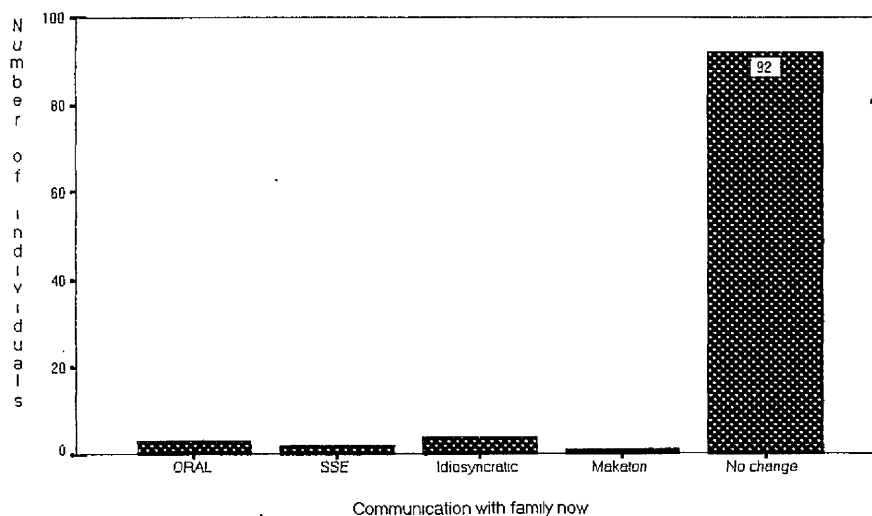


Figure 7.8 gives a breakdown of the communication methods and language being used in families now. The number of British Sign Language users remains the same. No family had learnt BSL to communicate with their deaf children. What these figures indicate, not surprisingly, is that 92 (90.2%) of this population reported no change in communication methods with their families since childhood and that only 8 (7.8%) had shifted their communication style. The breakdown of this can be seen in Figure 7.10. However, recent research (Gregory, 1994) reveals that this trend is changing, particularly in the younger age group.

**Figure 7.9** Method of communication with family now



Of the three families who used oral (speechreading) methods only two families learnt to communicate in Signed Supported English and one family developed idiosyncratic signs. One family who previously used idiosyncratic signs (gestures) turned to Oralism. Of the families who were previously seen as not communicating at all, two began to use speechreading and the other two families from this group of perceived non-communicators developed idiosyncratic signing. Another family learnt Makaton to communicate with their deaf child with learning difficulties. The remaining five therefore continued to use profoundly hearing (Ridgeway's term) methods of communicating. Talking without eye contact is one example of a profoundly hearing method of communication. The trend suggests most families stick to the same way of communicating from the beginning. The group which caused the most frustration to deaf people, were those families who did not 'adapt' at all, (the no communication group) and there was a significant decrease in their numbers by fifty percent by the time the participant had started High School, although communication was still essentially inadequate according to participants.

**Figure 7.10** Communication used by interviewees with their partners

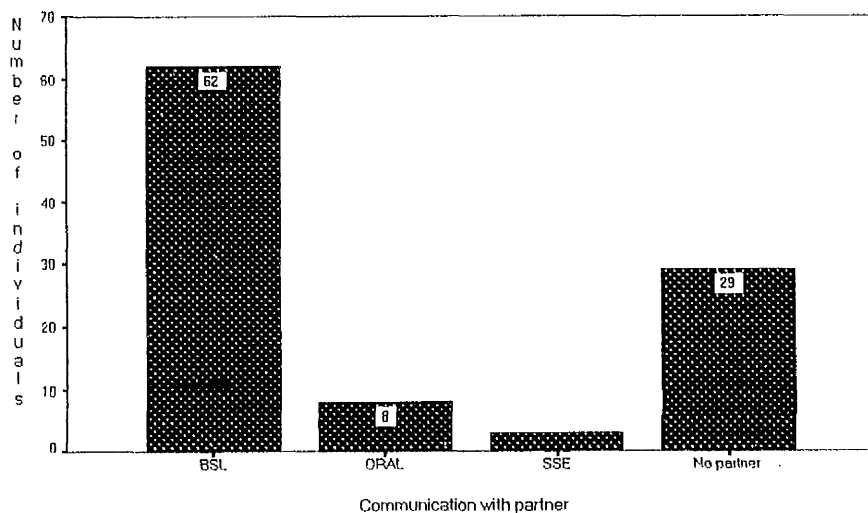




Figure 7.10 illustrates the breakdown of communication with partners. Sixty-two (60.8%) of participants communicated in BSL with their partners whilst eight said they used speechreading. It is likely that some of these participants used either BSL or Signed English in their communication but did not wish to "admit" this due to low esteem of deafness. Of the twelve participants who had non-deaf partners, one couple communicated in BSL and two couples communicated using Signed Supported English. Therefore, nine of the mixed marriages communicated using speechreading.

**Figure 7.11** Distribution of methods of communication used by interviewees with their children

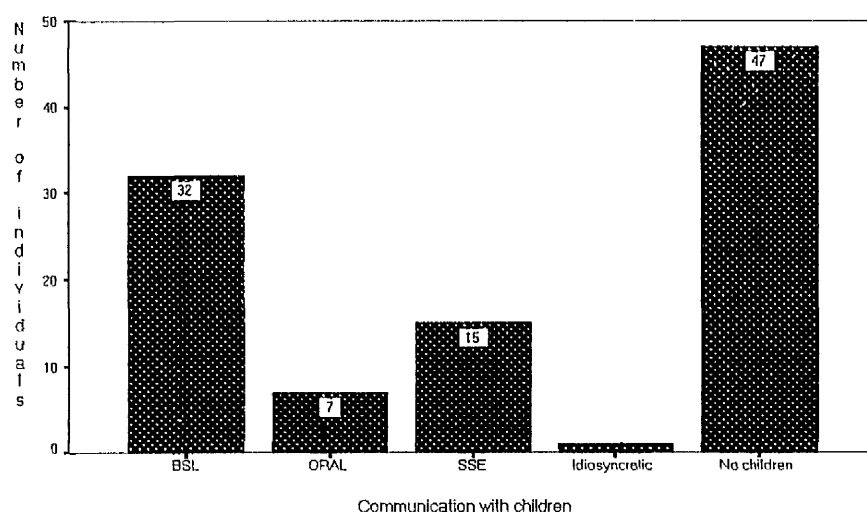


Figure 7.11 illustrates communication styles with offspring. The same observations apply here as to the previous figure sharing the distribution of communication methods participants used with their partners. A large number tend to use sign supported English with their children. One of the reasons is felt to be because many of the hearing children have not acquired positive attitudes and awareness of their parents' deafness, probably internalising some of the negative effects of oppression and discrimination in a hearing society towards deafness. Several research studies report that non-deaf children of deaf parents tend to relate primarily to their non-deaf

grandparents who tend to adopt a protective attitude towards their deaf offspring even into adulthood (Harvey, 1989). This may reinforce negative and patronising attitudes on the part of hearing children towards their deaf parents in this triad (Corker, 1994; Harvey, 1989; Phoenix, 1990).

Participants were asked about communication in schools. Eighty-six (84.3%) interviewees were placed in what may be considered an essentially non-communicating environment (using purely oral/aural methods) and 16 (15.7%) were placed in establishments which used both languages. Signed English and speechreading was used depending upon the skills of the teacher. This pattern was much the same for secondary schooling.

Interviewees were also asked about their experience of meaningful communication with their teachers in school. Meaningful communication here refers to more than simple gesture. Fifty-seven (55.9%) pupils felt that their teachers understood them, most of the time, leaving 45 (44.1%) who felt they were not understood most of the time. To some extent this can only be an approximate measure. It is often presumed or assumed that the other has understood what has been said. However, it would be reasonable to conclude that most pupils did feel understood given the growing familiarity teachers acquire of their deaf pupils communication with them.

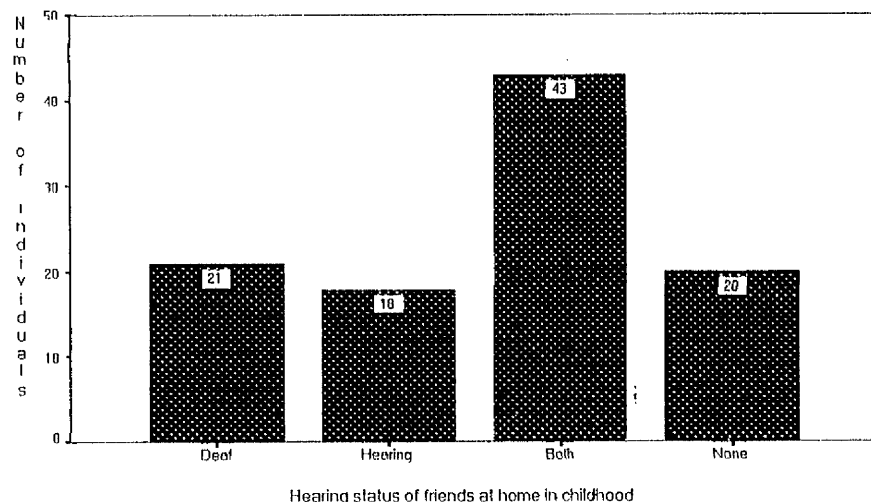
When the question is reversed to assessing pupils' level of comprehension of teachers, most participants 62 (60.8%), reported that they failed to understand what was being said to them whilst at school. Forty (39.2%) felt they understood their teachers most

of the time. It is likely that a greater number of deaf pupils will be understood by their teachers than to be able to understand them, because in order to understand, the deaf pupil has to speechread. Low levels of comprehension in English, for reading and writing provide evidence of difficulty in speechreading. Teachers, on the other hand, tend to get 'used' to their pupils and can understand some of what is described as "unintelligible speech" to those unfamiliar with deafness.

Questions were also asked about how participants communicated with their school friends. Those who attended a non-signing school with other deaf children tended to communicate with each other in Sign Language outside of the classroom. Those who attended a Partially Hearing Unit or mainstream setting tend to do the same if there were other deaf children attending. However, in one particular PHU, the number of deaf pupils of a similar age was low and playtime interaction involved deaf pupils of a wide age range, due to the ease in communication.

Figure 7.12 gives a breakdown of the hearing status of interviewees' peers during their schooldays. Figure 7.13 gives details of the modes of communication interviewees used with their deaf peers at school. Most of the factors influencing this was determined by the setting in which interviewees' education took place. This is the section we move to next.

**Figure 7.12** Hearing status of interviewee's friends at home during childhood



Participants were asked what was the hearing status of their peers at home, regardless of schooling attended. Figure 7.12 shows that participants had a mixture of friends at home. Forty-three (42.1%) knew both deaf and hearing children and 21 (20.6%) had deaf friends only. These were usually those who attended the same school and lived locally accessible. Of those who had hearing friends, only two were still in contact with them. Eighteen (17.6%) had only hearing friends at home, two of these attended hearing school and had no deaf friends outside of school. Comments included "My deaf friends lived too far away so I had to join with hearing". Another commented, "I was always the last one to go home after playing - they (hearing children) all went first". Three of those who were mainstreamed commented that they did not know any other deaf people. Twenty (19.6%) reported having no friends at all at home during childhood. Of the 64 (63.36%) who had deaf friends, 59 (57.8%) communicated in British Sign Language and the rest used a combination of speechreading and signing (BSL and SSE). Fifteen (14.78%) of those who had

hearing 'friends' at home, 61 (59.8%), were able to use some speechreading or signing to communicate. However, 41 (40.2%) participants had no hearing friends.

**Figure 7.13** Distribution of interviewee's methods of communication with school friends who were deaf

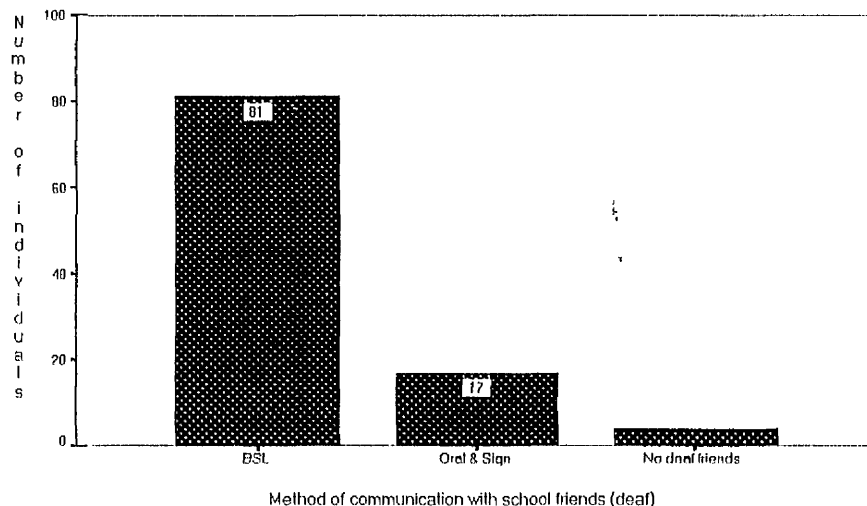


Figure 7.13 illustrates how deaf children who knew other deaf children at school communicated with each other. Not surprisingly, 81 (79.4%) communicated in British Sign Language. Seventeen (16.6%) used both speech and Sign Language and 4 (3.9%) had no deaf friends to use any Sign Language with, as none of their hearing peers or carers signed. When participants were asked about their communication styles with their deaf friends at home, 31 (30.4%) reported having no deaf friends.

### Education

The type of educational setting that interviewees attended was also asked of participants. None of the participants were placed in a signing environment at infancy although of those who attended a residential school for the deaf from an early age 61 (59.8%) felt they began to develop their cultural and linguistic features and

behaviour became more Deaf centred as children picked up BSL naturally amongst each other.

By the time the interviewees entered junior school, the numbers of those attending a school for deaf children went up from 61 (59.8%) to 72 (69.9%), those attending a mainstream setting went down from 12 (11.8%), all of which were orally based, to 6 (5.9%). One participant attended a special school and learnt Makaton. At secondary ages further changes were noticed. The number of those attending a Partially Hearing Unit increased from 1 (1.9%) to 6 (5.9%). Those attending mainstream school reduced to 4 (3.9%) from 6 (5.9%). One of these pupils who had previously attended mainstream school was placed in a special school for handicapped children. This pattern was similar for secondary school level. Twenty-five (24.5%) attended a deaf school as a day pupil and one continued to attend a Partially Hearing Unit. The number of those who were transferred to a deaf school increased from 72 (69.9%) to 75 (73.5%). These figures reflect a trend whereby the placing of deaf children into a deaf school is seen as a 'last resort' with the emphasis being first on aural/oral methods practised in an integrated setting. Although the deaf schools practised aural/oral methods there was some degree of comfort experienced by the children through being together and having access to **some** communication with each other, which stimulates cultural and linguistic attachment. The subsequent histories of most deaf people is that their English is poorly developed - for reading and writing, usually attaining a maximum mental reading age of 8.75 years (Conrad, 1979) and the development of British Sign Language, often initially unsophisticated, comes rather late.

Most participants, 61 (59.8%), despite the difficulties in communication with teachers at school, reported being happy at school but forty-one (40.2%) recalled being miserable and unhappy. During this part of the interview, the comments participants made indicated that being together with other deaf people seemed to help alleviate frustration. One man commented "The teachers were cruel but we (peers) were together".

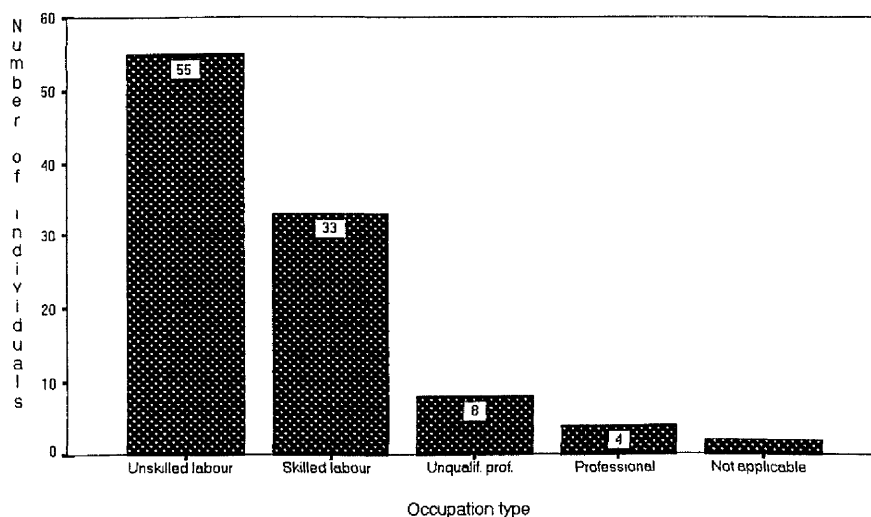
Opportunities in further education were quite limited. Sixty-five (63.7%) of interviewees did not access to Further Education (F.E.), 27 (26.5%) attended a hearing F.E. College, (mainly in practically orientated subjects which required little written academic presentation), 2 (1.9%) attended a deaf F.E. College and 8 (7.8%) experienced both Deaf and hearing F.E. settings. Twenty-six (25.5%) of participants had accessed a vocational training programme. These were usually linked to what contacts the school had with various local training programmes or work experience opportunities. They were usually in manual occupations such as catering, hairdressing, carpentry or car body work. Over fifty percent of this group secured manual work in factories. One person worked as a support teacher, another as an assistant social worker and another as a community development worker. Only two were in professional occupations; Design Engineering and Technical Instructor in Architecture. One person was starting their own business in typesetting. This reflects the difficulties deaf students have in accessing programmes. These figures also show that deaf people have tended to have little choice - mainly what the schools offer - and later have often been surprised at the wide breadth of opportunities that exist for non-deaf people.

Finally, as can be expected, and as previous studies have indicated, there is a low level of academic achievement, 85 (83.3%) having no qualifications at all and 17 (16.6%) had qualifications, such as CSE or City and Guilds. Four people had O'levels, one of whom had A'levels. Three people had obtained a diploma (two in engineering and one in architecture). One person had obtained a B.Tec in computers.

### Employment

A high proportion of deaf people were unemployed, forty-eight (47.1%), when compared to non-deaf people within the population. Two people were unable to seek employment due to severe learning difficulties. Employers who lack awareness of deaf people may tend to discriminate. The Disability Discrimination Bill (December, 1996) is an attempt to address the situation by making possible legal action against employers who discriminate. Legislation only applies to companies employing more than two hundred employees. This indicates that the present position is not likely to alter considerably during the next few years and it is probable that the occupational profiles will remain much the same. Deaf people are under-employed and placed in poorer jobs with fewer responsibilities (Kyle, Thomas & Pullen, 1989).

**Figure 7.14** Distribution of interviewee's occupation type





One percent of the deaf population manage to access higher education. This is a recent increase from 0.1% (1993), (Traynor, 1997). Not surprisingly, when interviewees were asked the question "Are you satisfied with your work experience?", 59 (57.8%) said no and 38 (37.2%) felt they were satisfied. Five did not respond, (three had learning difficulties and two were students). The main reason given for those not satisfied with their work was that the job they were in was not of their choice. They felt no choice had been given and that they were pushed into doing a job that was in essence 'arranged' for them. One person, a middle aged man, commented "I learnt I had a job when I had to get up at 07.00 am one morning". Several participants were employed in rehabilitation units on low pay, or in other establishments such as Remploy, a company employing people who are disabled who might find it difficult to seek integrated employment. A 51 year old woman, commented "I hate my work place - no-one to talk to week after week. I feel I am in a prison but I cannot leave because I must eat". Yet another commented, "I am given the dirty jobs that no-one else wants but I can't argue - I just put up with it. The social worker can't help". A comment from another young man gives us further insight into the isolation felt "I eat alone - I do everything alone - sometimes I go to the toilet to cry. No-one knows".

**Figure 7.15 Deafness seen to affect career choice**

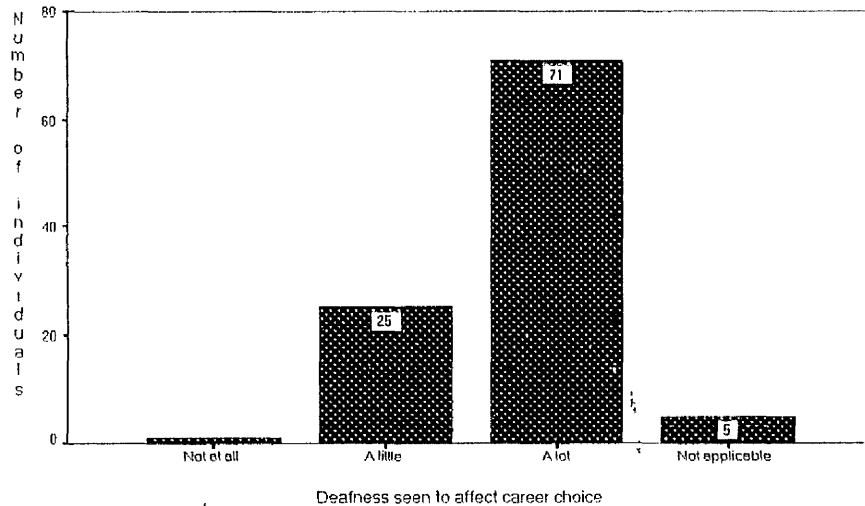


Figure 7.15 shows the breakdown of how much interviewees felt career choices had been influenced by their deafness. This figure reveals that 71 (69.6%) of people interviewed felt, to a large degree, that it was because of their deafness that they were in their present job. They felt if they were hearing, the situation would have been different in terms of choices. Only one person felt that his career choice was "unaffected" by his deafness, and had taken up opportunities that were sought and offered. Twenty-five (24.5%) felt their deafness had partly affected career 'choice'.

**Figure 7.16 Nature of difficulties at place of employment**

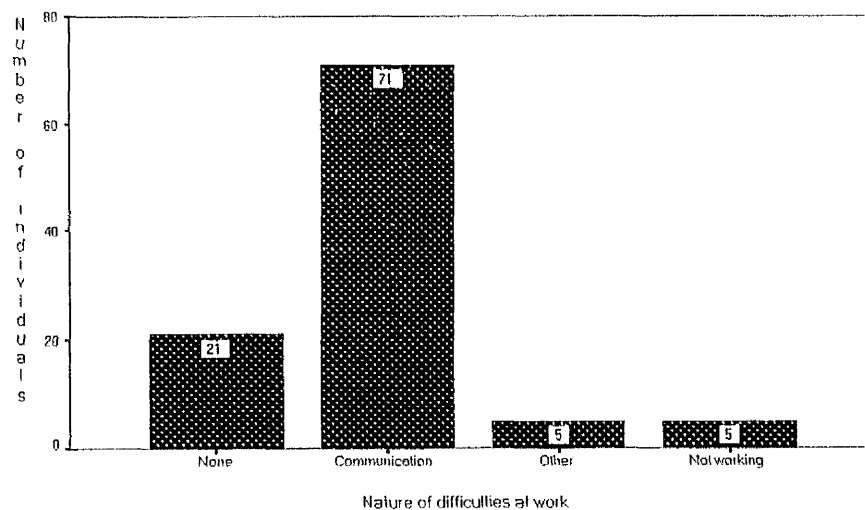


Figure 7.16 shows how interviewees perceived the nature of particular difficulties at work. Seventy-six (74.5%) of those interviewed reported difficulties with work - 71 (69.6%) of which were attributed to difficulties in communication. Participants often described always being alone. Participant No. 69 stated, "Non-one wants to have lunch with me". Participant No. 74 reflected the possible difficulty employers had in explaining new tasks; "I was moved from one position to another, without knowing why or what I was doing". Participant No. 3 commented; "They used to pass all the work to me while they stood there chatting". Participant No. 61 said; "They just gave me all the rubbish work because I could not understand them". Finally, a quote from participant No. 9; "Sometimes I was in trouble because I could not understand them nor could they understand me".

### Abuse

Interviewees were asked about experiences of abuse suffered in childhood. The concept of abuse was explained and described to each person who was interviewed. Sexual, emotional, and physical abuse was described. This ensured participants were well informed about what was being asked.

Interviewees were asked if they had abusive experiences which they did not want or which made them feel confused or hurt. A more direct question was asked relating to sexual abuse "When you were growing up did anyone want you to do something sexual?". Depending upon the responses, participants would be asked further questions as appropriate. Four people were unwilling to respond to this part of the interview. A total of 58 (60.6%) deaf people reported physical and sexual abuse.

Thirty-eight (40%) of the sample reported experiences of rape or attempted rape (sexual assault). (Legal definition confirmed by NSPCC Lawyers Society, 1997), prior to the age of 16. The perpetrators were all hearing except for one, who was deaf. Only 2 (5.26%) of this sample had reported this previously. Chapter Eight contains an examination of the findings.

Twenty (20.6%) of the sample population reported physical abuse. The figure reflects abusive experiences by carers and teachers at school and from parents who appeared to be frustrated at attempts to communicate to their deaf child. Non-deaf parents tended to smack and engage more in physically abusive behaviour with their deaf children than they do with their hearing children. Eleven (10.8%) females reported experiencing both sexual and physical abuse by their partners. None of them felt able to change the situation. Three had been taking anti-depressants on a long-term basis.

### Social Relationships in Terms of Hearing Status

Participants were asked questions about the hearing status of social relations. Figures 7.17 and 7.18 give a breakdown of the findings.

**Figure 7.17** Distribution of interviewee's social affiliation by hearing status

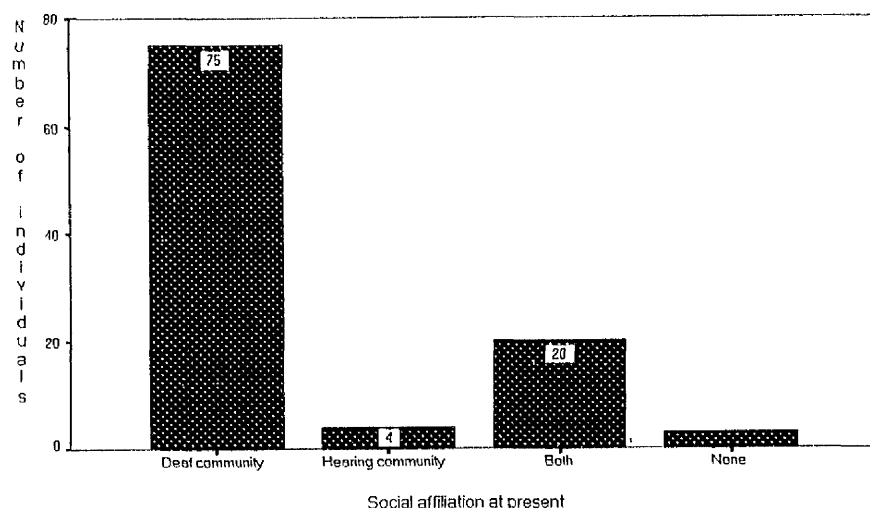
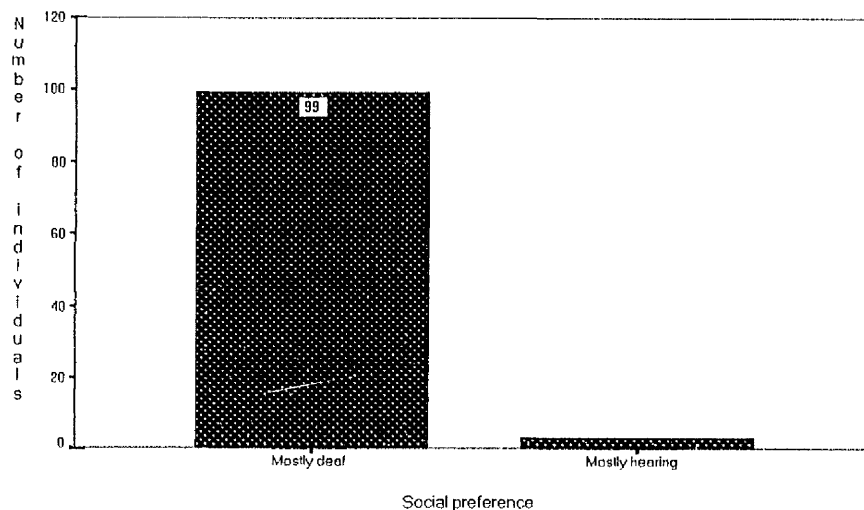


Figure 7.17 describes with whom participants tended to spend their social and leisure time with, in terms of hearing status. Seventy-five (73.5%) identified with members of the Deaf community only. Four (3.9%) identified with non-deaf people only and 20 (19.6%) socialised with both deaf and non-deaf people. Three people (2.9%) said they did not affiliate socially with anyone. Interestingly, these figures are not indicative of their preferred social affiliations which can be seen in Figure 7.18.

**Figure 7.18** Distribution of interviewee's social preference



Ninety-nine (97.1%) participants would prefer to socialise with other deaf people if they felt that they could choose. This is an increase of 14 (13.7%). Figure 7.17 shows actual affiliation which doesn't appear to reflect desired affiliation. Deaf people from a mixed partnership (deaf and non-deaf) said they felt obliged to meet some of their hearing partners leisure and social activities. One man said he had left his wife and that he felt uncomfortable at the local Deaf Centre, where her friends supported her, and had subsequently turned to the local Working Mens club. Three people (2.9%) stated that they preferred to mix with hearing people most of the time because they could talk and didn't "need" to go to the Deaf Centre or join in social activities with other deaf people.

Some deaf people are in mixed relationships where communication might be difficult and where their individual social needs are not met. Some factors are probably influenced or determined by the details that can be seen in Figure 7.12, which gives a breakdown of who their friends were at home during their childhood. Although 18 (17.6%) had only hearing friends during their schoollyears, it appears that in later years this had decreased to 4 (3.9%) who had only hearing friends although the actual preference figure, (seen in Figure 7.17) shows 3 (2.9%) would choose to mix with only hearing people.

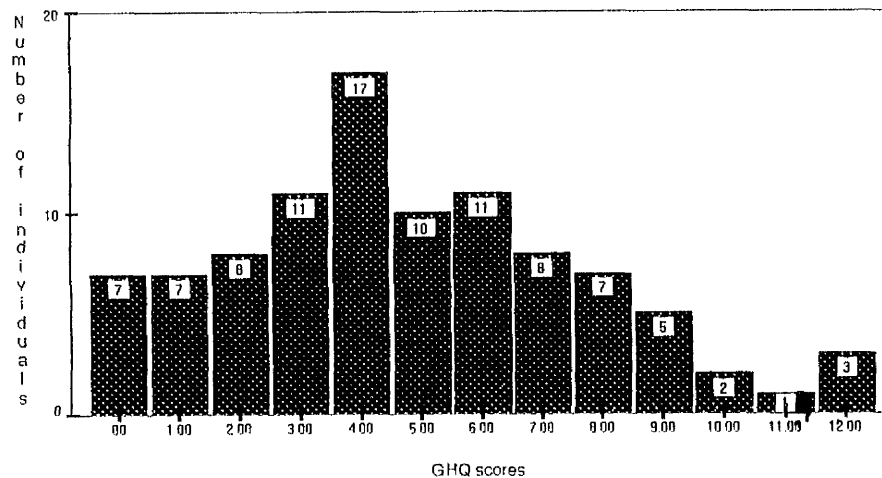
## ANALYSIS

### Part II

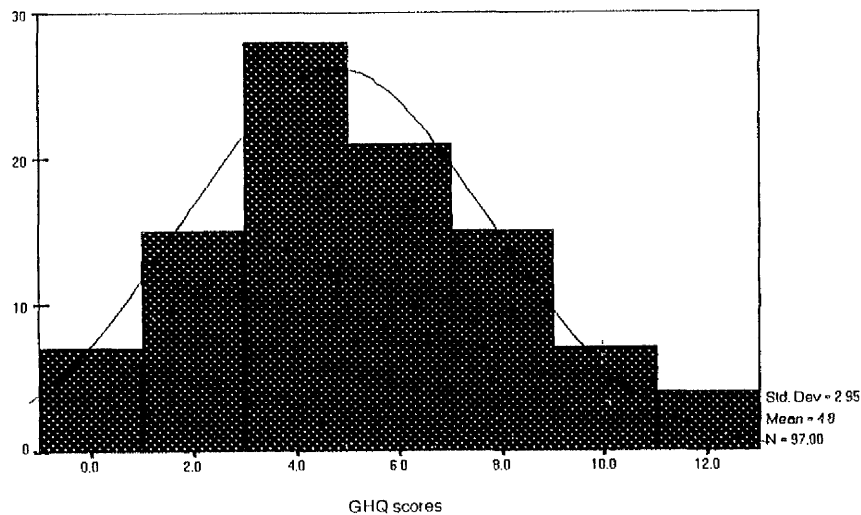
#### Exploration of Relationship Between (GHQ-12) and Background Interview Questionnaire (BIQ)

The distribution of the GHQ-12 scores are shown in Figure 7.19, ( $n=97$ , mean score = 4.8, S.D. = 2.95). Figure 7.20 provides a histogram of the distribution. Ninety-seven of the original sample of 102 were able to complete the GHQ-12 questionnaire. Five were unable to complete, three of whom had moderate-severe learning difficulties and although were supported by their families at interview, it was not possible to be fully confident of appreciation. One participant had moved away and one participant changed their mind about continuing with the second stage of interview. These five were therefore excluded from the sample.

**Figure 7.19** Distribution of General Health Questionnaire (GHQ-12) Scores



**Figure 7.20** Histogram of results of interviews using General Health Questionnaire



The GHQ-12, (Goldberg, 1978) scores and the Background Interview Questionnaire (BIQ) responses were correlated with each other. Some significant relationships emerged.

Details of the scoring method used can be seen in Chapter 5. A simple high and low categorisation of the GHQ scores (0-6 negative, 7-12 positive) is incorporated in analysing results in this study. Another categorisation is also used where scores are divided into three groups, 0-4, 5-7 and 8-12, to further explore results. In some cases a significant correlation exists using one scoring method but not in the other. Table 7.4 lists the variables, some of which have been found to correlate with the scores of the GHQ-12. Included are those variables not found to be significant at the 95% confidence interval but may be suggestively significant.



**Table 7.4: Chi-squared and Value of Total GHQ-12 Score by Background Interview Questionnaire Items**

Variable	2 GROUP SCORING		3 GROUP SCORING	
	Chi-Squared	p value	Chi-squared	p value
Gender	1.62	.202	3.94	.139
Age	.07	.999	6.38	.605
Domestic situation	.96	.620	2.61	.625
Partner's Hearing status	4.77	.092	22.08	.000*
Cause of Deafness	.47	.980	2.00	.981
Onset of Deafness	4.31	.505	14.56	.149
Age Deafness noticed	2.79	.593	14.19	.077
Communication preferred as stated at interview	2.37	.306	2.06	.725
Communication actually used during interview (observed by interviewer)	0.21	.900	3.54	.472
Communication used with partner	0.55	.905	9.86	.131
Communication used with children	1.53	.821	12.34	.137
Deaf others (family)	.31	.576	.662	.718
Communication style in family when young	8.55	.128	12.84	.233
Communication in family now	.40	.939	5.54	.476
Communication used at school	.00	.980	.199	.905
Understanding of teacher whilst at school	2.61	.106	8.26	.016*
Teachers' understanding of participant whilst at school	2.58	.108	5.70	.058
Happiness at school	1.36	.244	1.81	.040*
Friends in home area (by hearing status)	4.73	.193	7.11	.311
Qualifications obtained	0.69	.404	3.15	.207
Vocational training accessed	1.89	.168	7.79	.020*
In employment	.06	.801	.166	.921
Type of occupation	1.20	.752	10.82	.094
Satisfaction at work	3.31	.190	2.24	.691
Choice of career	1.90	.592	3.78	.707
Difficulties encountered at work	2.67	.443	4.78	.572
Social affiliation (by hearing status)	4.61	.203	20.46	.002*
Preferred social affiliation (by hearing status)	2.10	.349	10.73	.030*
Sexual abuse	2.02	.156	6.10	.047*
Physical abuse	4.24	.040*	3.62	.164

\* Significance at 95% confidence interval

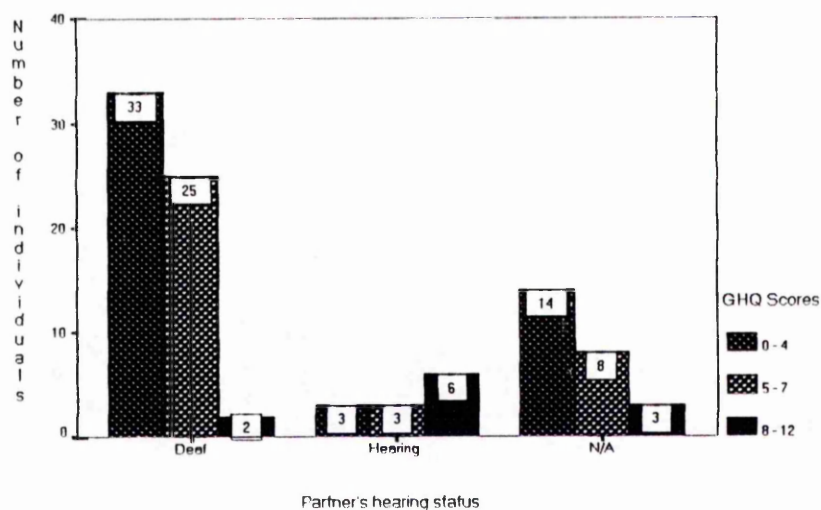
p = < 0.05

### Family Relationships and Domestic Situation

As can be seen in Table 7.5 the GHQ total scores correlated with a number of background variables. Linked to family relations and domestic circumstances, there was one particularly significant relationship ( $p=0.002$ ) between the GHQ and partners hearing status. This is shown in Figure 7.21. Those with hearing partners tend to have higher (positive) GHQ scores compared to those whose partners are deaf ( $p=0.000$ ). There was no significant association found between GHQ scores and domestic situation (whether or not the participant was in a relationship), those living alone were the smallest group yet highly representative in the higher score range of GHQ. This can be seen in Figure 7.22.

The GHQ scores were correlated with the age of onset of deafness and the age deafness was confirmed. The results are shown in Figures 7.23 and 7.24. Although the correlation data are not statistically significant, Figure 7.24 suggests that the sooner the deafness is confirmed, the slightly better the GHQ score obtained. Those who were not able to provide details regarding the date deafness began, appear to have higher scores on the GHQ altogether. As can be seen in Figure 7.23, the later the age the deafness is confirmed the higher the likelihood of the GHQ score being positive, indicating psychological ill-health.

**Figure 7.21 Partners Hearing Status and GHQ**

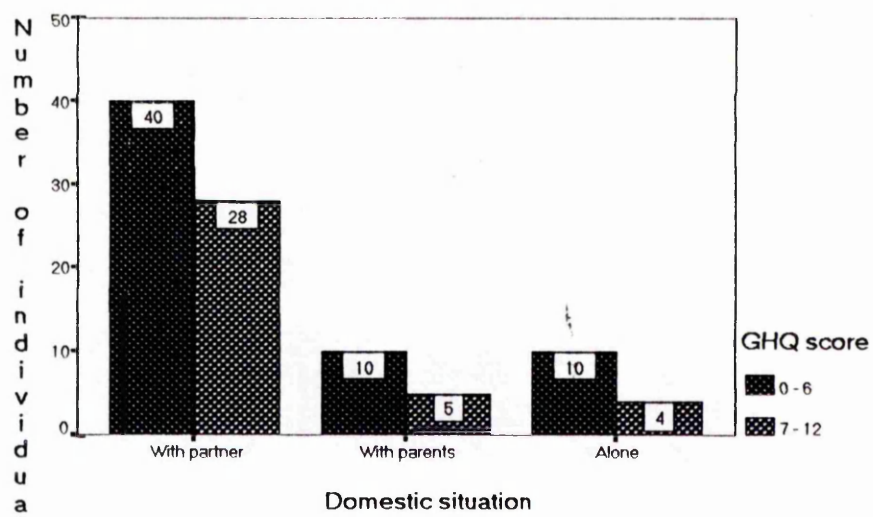


*Chi-square = 22.07; df = 4; p = 0.002*

**Table 7.5: Partner's Hearing Status and GHQ**

Partner's Hearing Status	GHQ SCORES			Total
	0-4	5-7	8-12	
Deaf	33	25	2	60
Hearing	3	3	6	12
No Partner	14	8	3	25
<b>Total</b>	50	36	11	97

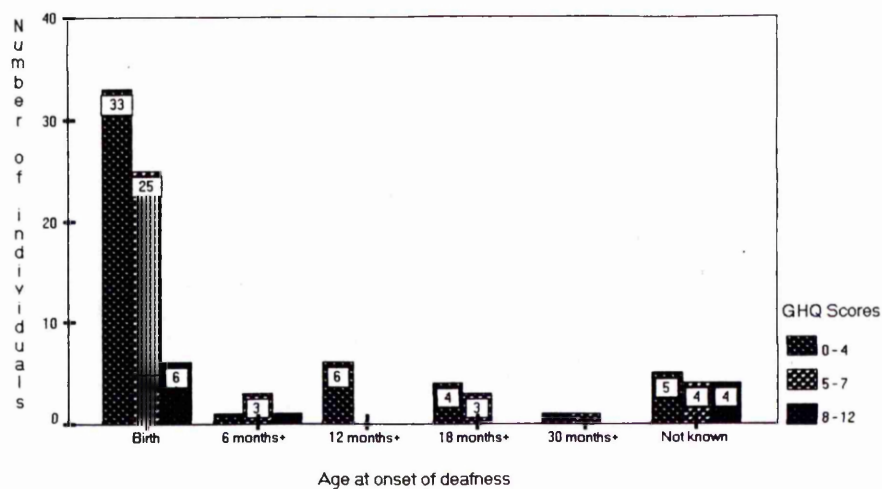
**Figure 7.22 Domestic Situation and GHQ**



**Table 7.6: Domestic Situation and GHQ**

Domestic Situation	GHQ SCORES		Total
	0-6	7-12	
With partner	40	28	68
With parents	10	5	15
Alone	10	4	14
<b>Total</b>	<b>60</b>	<b>37</b>	<b>97</b>

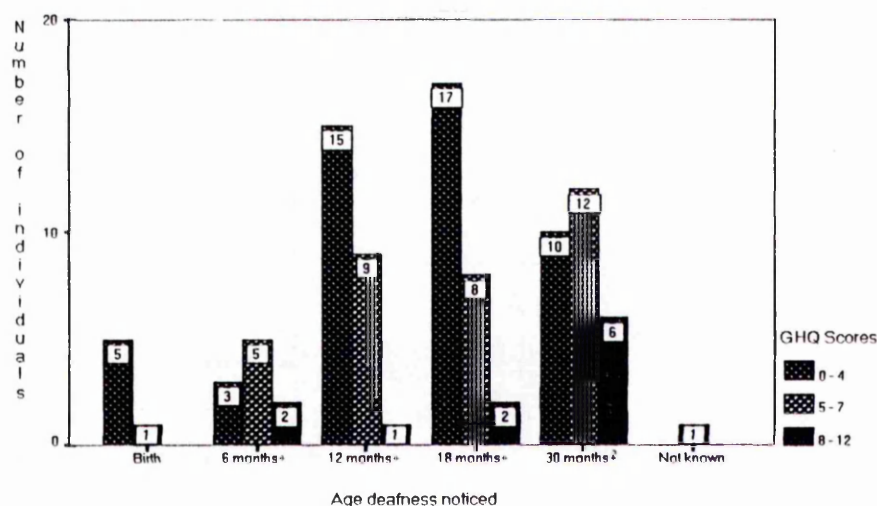
**Figure 7.23 Age at Onset of Deafness and GHQ**



**Table 7.7: Age at Onset of Deafness and GHQ**

Domestic Situation	GHO SCORES			Total
	0-4	5-8	9-12	
Birth	33	25	6	64
6 months +	1	3	1	5
12 months +	6	0	0	6
18 months +	4	3	0	7
30 months +	1	1	0	2
Not known	5	4	4	13
<b>Total</b>	<b>50</b>	<b>36</b>	<b>11</b>	<b>97</b>

**Figure 7.24 Age Deafness Noticed and GHQ**



**Table 7.8: Age Deafness Noticed and GHQ**

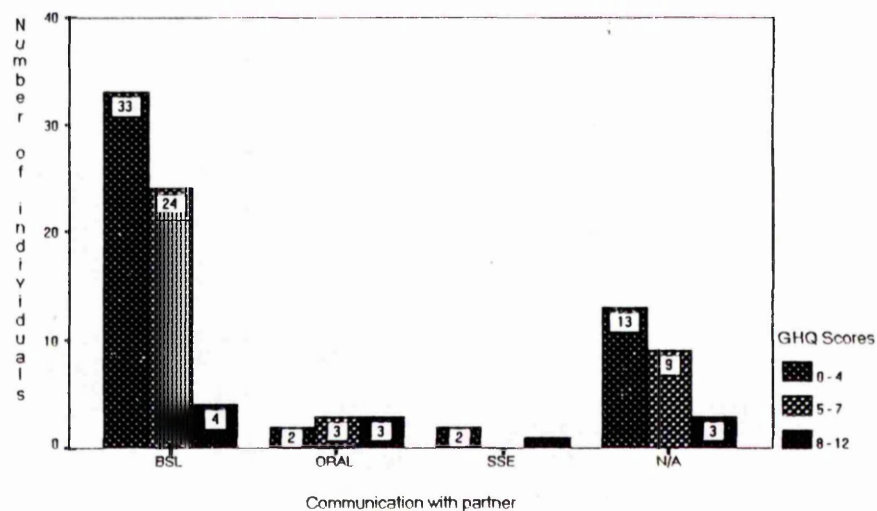
Age Deafness Noticed	GHQ SCORES			Total
	0-4	5-8	9-12	
Birth	5	1	0	6
6 months +	3	5	2	10
12 months +	15	9	1	25
18 months +	17	8	2	27
30 months +	10	12	6	28
Not Known	0	1	0	1
<b>Total</b>	50	36	11	97

### Communication in the Family

Most participants communicated with their partners in British Sign Language (Figure 7.25). (The results were not significant but the oral group which has a low number of participants contains a high number of positive GHQ scores). Significance was not seen when GHQ scores were correlated with communication styles of participants' children. Figures 7.26 and 7.26a show the distribution of GHQ scores when correlated with responses to the question regarding communication methods with the

family. Questions related to participants own identification of communication used with their families when young and communication used with families now. The responses to both questions were then compared and this is shown in Figure 7.27. Positive GHQ scores appear to fall in all categories except for those using Sign Language.

**Figure 7.25** Communication with Partner and GHQ

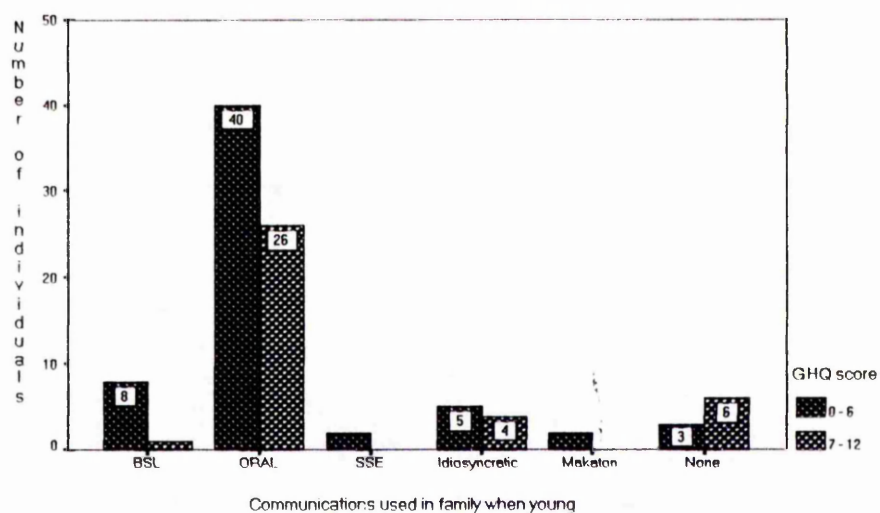


**Table 7.9:** Communication with Partner and GHQ

Communication with Partner	GHO SCORES			Total
	0-4	5-7	8-12	
BSL	33	24	4	61
Oral	2	3	3	8
SSE	2	0	1	3
No Partner	13	9	3	25
<b>Total</b>	50	36	11	97



**Figure 7.26 Communications Used in Family when Young and GHQ**

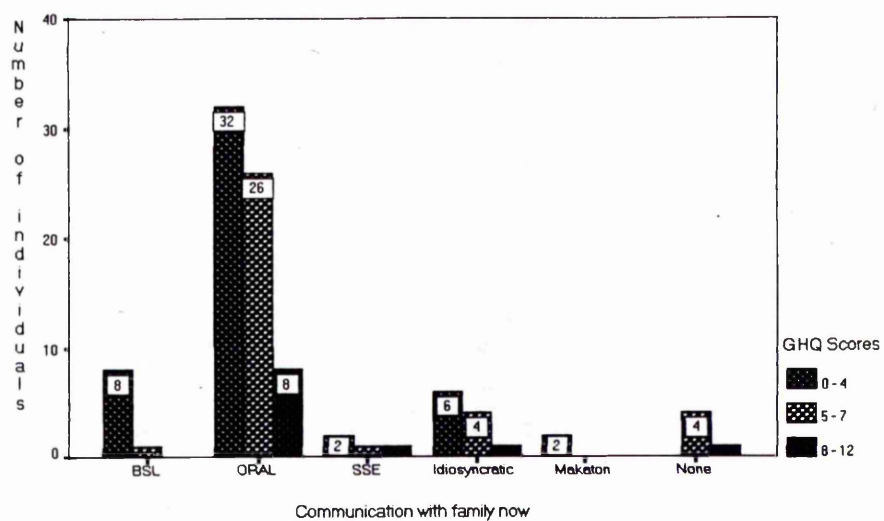


**Table 7.10: Communications Used in Family when Young and GHQ**

Family Communications When Young	GHQ SCORES		Total
	0-6	7-12	
BSL	8	1	9
Oral	40	26	66
SSE	2	0	2
Idiosyncratic	5	4	9
Makaton	2	0	2
None	3	6	9
<b>Total</b>	60	37	97



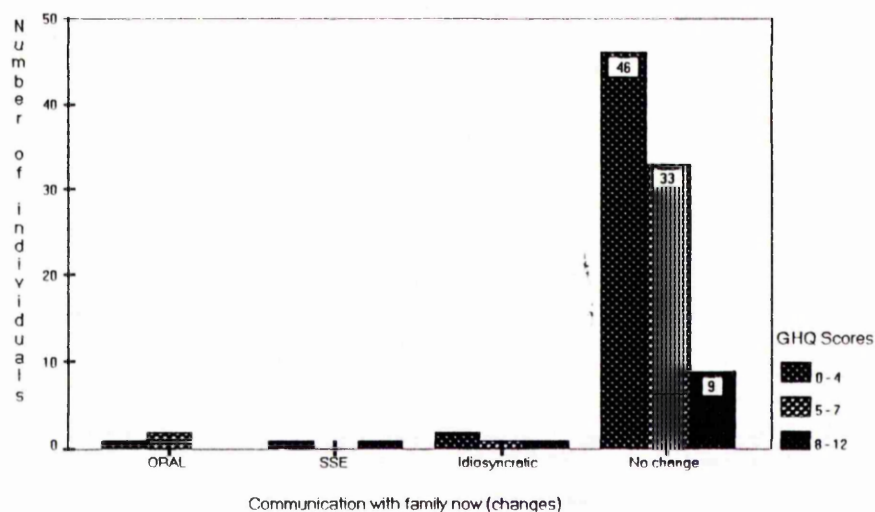
**Figure 7.26a Communications With Family Now and GHQ**



**Table 7.11: Family Communications Now and GHQ**

Family Communications Now	GHQ SCORES			Total
	0-4	5-8	9-12	
BSL	8	1	0	9
Oral	32	26	8	66
SSE	2	1	1	4
Idiosyncratic	6	4	1	11
Makaton	2	0	0	2
None	0	4	1	5
<b>Total</b>	<b>50</b>	<b>36</b>	<b>11</b>	<b>97</b>

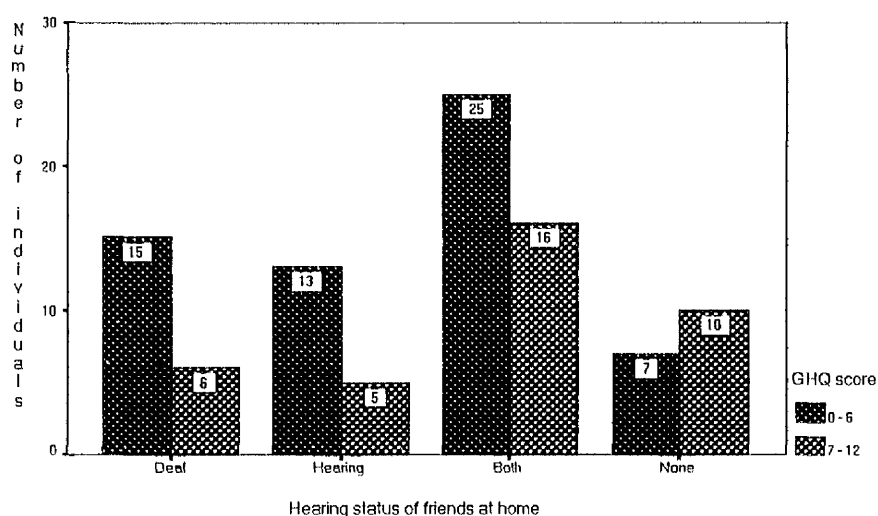
**Figure 7.27 Breakdown of Changes in Communication with Family Now and GHQ**



Interviewees were also asked about the hearing status of their friends at home and how they communicated. This question was asked in order to obtain an idea of how many people had experienced access to a child peer group out of school. As expected, most interviewees socialised with their deaf school friends where possible. Few reported having had access to a deaf peer group out of school. This was found in all school categories.

Figure 7.28 shows the distribution correlated with the GHQ scores. This was not significant. Those with the highest incidence of psychological distress appear to be those who had both hearing and deaf friends. Further questioning revealed that of those who had both this referred to access to deaf friends from school (Partially Hearing Units and Deaf Schools) and access to hearing friends at home.

**Figure 7.28 Hearing Status of Friends at Home and GHQ**



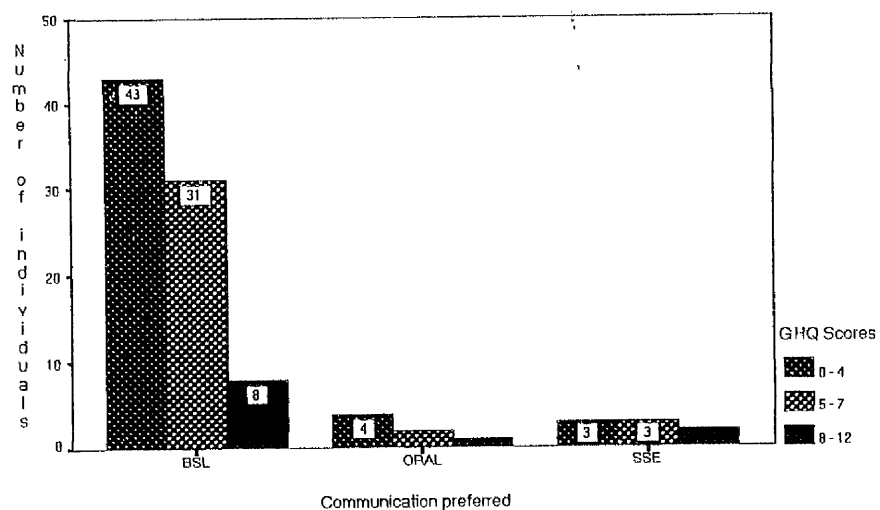
**Table 7.12: Hearing Status of Friends at Home and GHQ**

Friends at Home	GHQ SCORES		Total
	0-6	7-12	
Deaf	15	6	21
Hearing	13	5	18
Both	25	16	41
None	7	10	17
<b>Total</b>	60	37	97

The group reporting no friends appears to be most likely to present with higher GHQ scores. The group of people with both hearing and deaf friends score higher than any other group although the trend decreases in number. This could suggest marginality (i.e. being a 'marginal' member of both communities), hence the likelihood of identity issues emerging.

Participants were asked what their preferred way of communicating is. Those who said Signed English indicated the highest scores on the GHQ (Figure 7.29), using the 3 group scoring method. This trend can also be seen in the 2 group GHQ scoring in Figure 7.30.

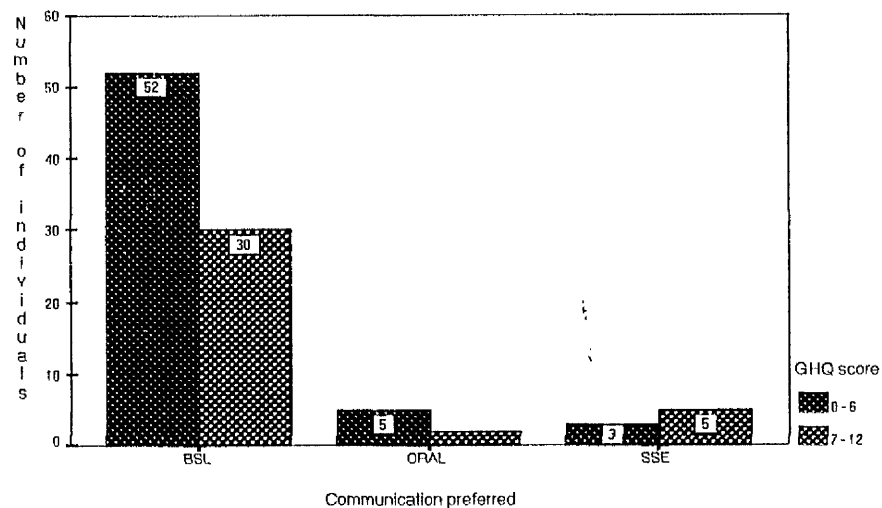
**Figure 7.29 Communication: Stated Preference and GHQ**



**Table 7.13: Stated Preferred Communication and GHQ**

Stated Preferred Communication	GHQ SCORES			Total
	0-4	5-7	8-12	
BSL	43	31	8	82
Oral	4	2	1	7
SSE	3	3	2	8
Total	50	36	11	97

**Figure 7.30 Communication: Stated Preference and GHQ**



**Table 7.14: Communication: Stated Preference and GHQ**

Stated Preferred Communication	GHQ SCORES		Total
	0-6	7-12	
BSL	52	30	82
Oral	5	2	7
SSE	3	5	8
<b>Total</b>	<b>60</b>	<b>37</b>	<b>97</b>

However, the interviewer observed that there were some differences in what participants had responded compared to what was actually used at interview. The changes were not significant.

Eighty-two people said they preferred to use BSL although 86 were seen to use BSL by the interviewer. Seven people said they preferred to use oral/speechreading

methods only but through observation, only 2 people were using this method during interview. Finally, 8 people said they preferred using Signed English but in interview, nine people were using this mode of communication.

These results show that a number of people interviewed who considered themselves oral *only* were using BSL or SSE variations.

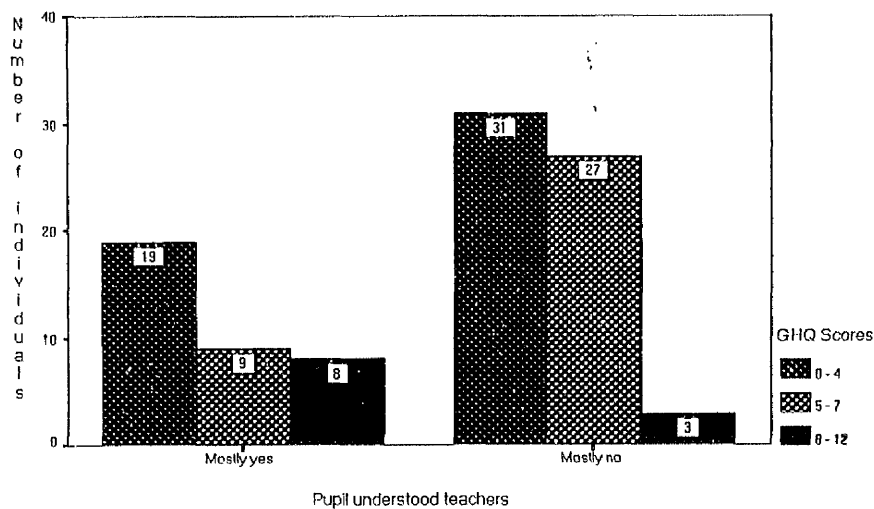
### Educational Experiences

This section examines GHQ threshold scores and the level of significance in relation to participant's feelings about communication at school with their teachers. Most pupils who attended residential school tended to have one teacher for a majority of their lesson interaction. Today deaf children are more likely to meet a number of different teachers and so the possibility of developing communicative familiarity to the extent they used to is less likely.

Figure 7.31 shows that most pupils did not understand their teachers and there are a number of borderline cases. Borderline cases are those who fall in the 5-8 threshold scoring group. Of those who reported not understanding their teacher, there is a high incidence of those reporting psychological distress ( $p = 0.016$ ). Participants were also asked if they felt their teachers had understood them. Fifty-two (50.9%) of participants felt they were understood most of the time and 45 (44.1 %) felt they were not understood most of the time. Both threshold group scores are shown in Figures 7.32a and 7.32b. There is no statistical significance but the figures appear to suggest significance.

Forty (39.2%) of participants described feeling unhappy at school most of the time, with 57 (55.8%) feeling that they were happy most of the time. There was no statistical significance reported. However there does seem to be a trend that the more they felt happy at school, the less likely psychological problems would emerge in later life.

**Figure 7.31 Pupil Understood Teachers and GHQ**



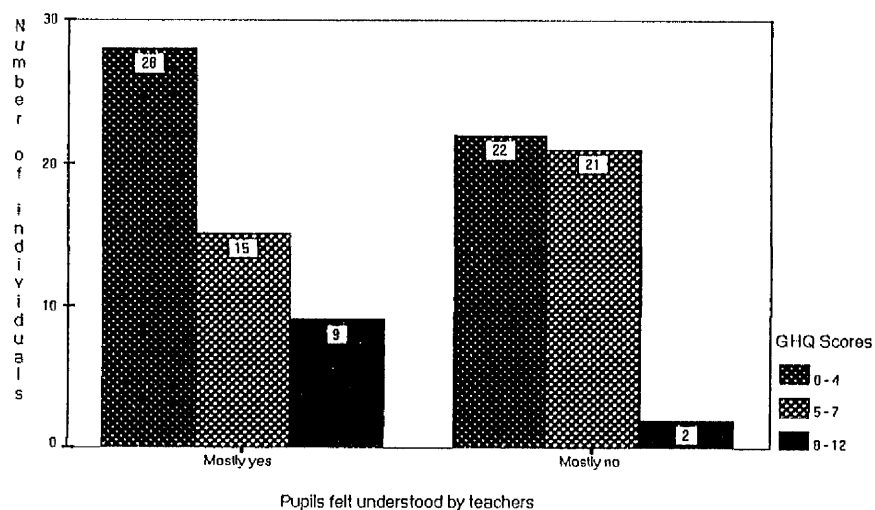
**Chi-square = 8.25; df = 2; p = 0.016**

**Table 7.15: Pupil Understood Teachers and GHQ**

Pupil Understood Teacher	GHQ SCORES			Total
	0-4	5-7	8-12	
Mostly yes	19	9	8	36
Mostly no	31	27	3	61
<b>Total</b>	<b>50</b>	<b>36</b>	<b>11</b>	<b>97</b>

**Figure 7.32(a)**

**Pupils Felt Understood by their Teachers and GHQ**

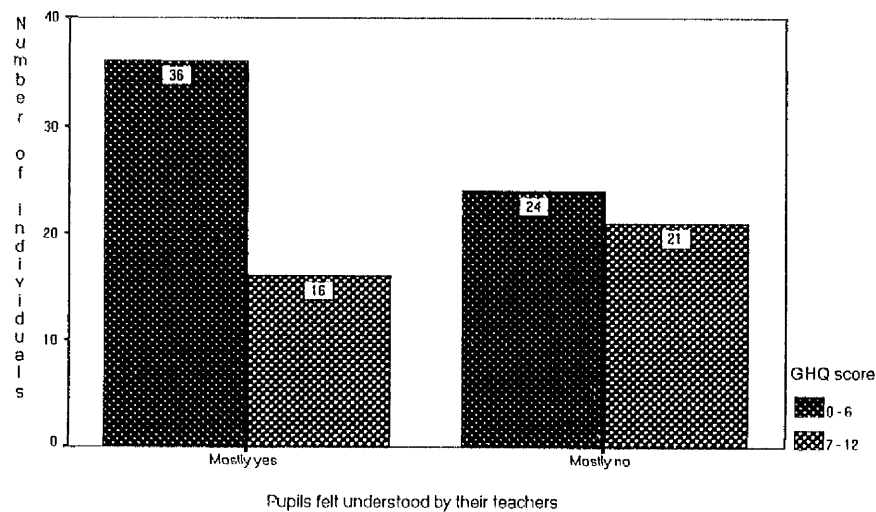


**Table 7.16a: Pupils Felt Understood by their Teachers and GHQ**

Teachers Understood Pupil	GHQ SCORES			Total
	0-4	5-7	8-12	
Mostly yes	28	15	9	52
Mostly no	22	21	2	45
<b>Total</b>	50	36	11	97



**Figure 7.32(b) Pupils Felt Understood by Teachers and GHQ**



**Table 7.16b: Pupils Felt Understood by Teachers and GHQ**

Teachers Understood Pupil	GHQ SCORES		Total
	0-6	7-12	
Mostly yes	36	16	52
Mostly no	24	21	45
<b>Total</b>	<b>60</b>	<b>37</b>	<b>97</b>

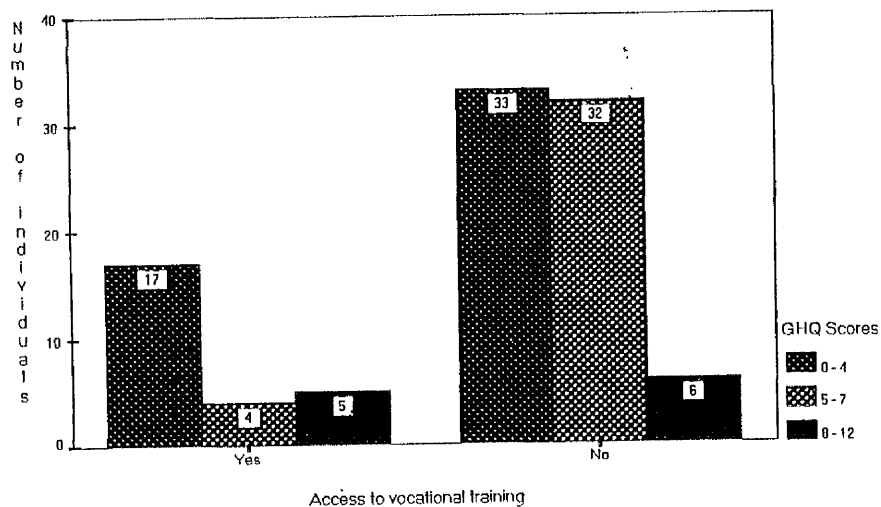
### Employment and Training Experiences

Most participants did not access vocational training. A significance of 0.020 was found when this variable was correlated with the GHQ-12 scores. This is seen in Figure 7.33.

Figure 7.34 shows the various occupations and GHQ-12 scores. The significance is suggestive and there appears to be a trend towards psychological distress in the more professional and skilled occupations.

Many participants reported experiencing difficulties at work. Figure 7.35 shows the different types of problems presented - most of which relate to communication. Forty-one percent of this group, seen in Figure 7.35, also experienced psychological difficulties, although there was no statistical significance.

**Figure 7.33 Access to Vocational Training and GHQ**

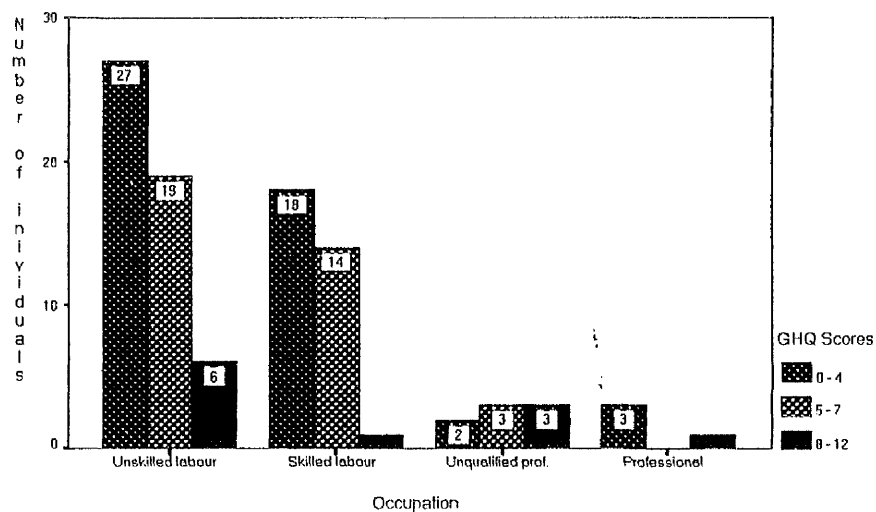


*Chi-square - 7.79; df = 2; p = 0.020*

**Table 7.17: Access to Vocational Training and GHQ**

Vocational Training	GHQ SCORES			Total
	0-4	5-8	9-12	
Yes	17	4	5	26
No	33	32	6	71
Total	50	36	11	97

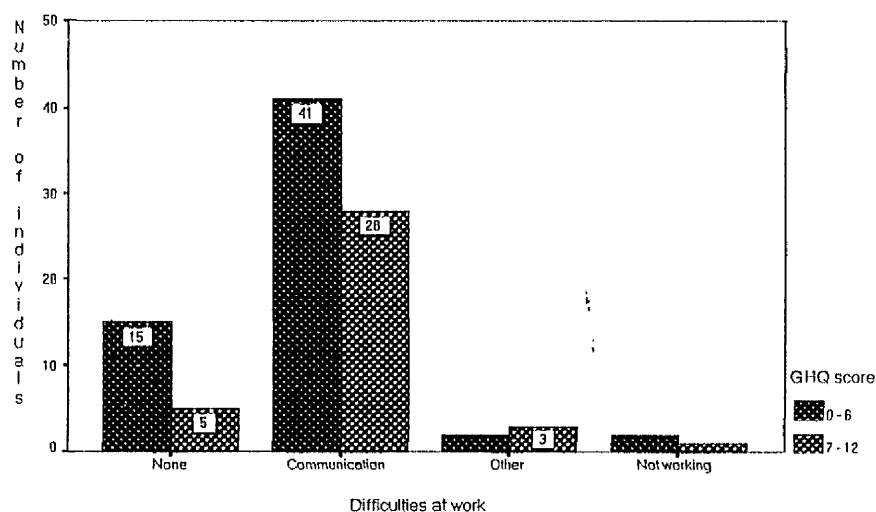
**Figure 7.34 Type of Occupation and GHQ**



**Table 7.18: Type of Occupation and GHQ**

Occupation	GHQ SCORES			Total
	0-4	5-7	8-12	
Unskilled Labour	27	19	6	52
Skilled Labour	18	14	1	33
Unqualified Professional	2	3	3	8
Professional	3	0	1	4
<b>Total</b>	50	36	11	97

**Figure 7.35 Difficulties at Work and GHQ**



**Table 7.19: Difficulties at Work and GHQ**

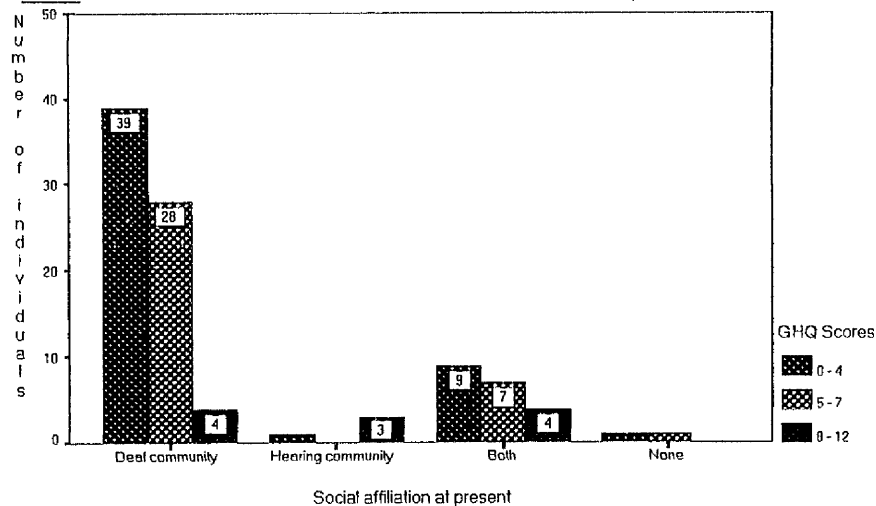
Difficulties at Work	GHQ SCORES		Total
	0-6	7-12	
None	15	5	20
Communication	41	28	69
Other	2	3	5
Not applicable	2	1	3
<b>Total</b>	<b>60</b>	<b>37</b>	<b>97</b>

### Social Relations by Hearing Status

Participants were asked about who they tended to socialise with most of the time. Figure 7.36 shows that those who socialised only with hearing people scored the highest on the GHQ-12 ( $p = 0.02$ ) using the three group scoring method. This

shows that deaf people who affiliated with hearing people had the highest GHQ scores. It also shows that those who affiliated with deaf people only had the lowest GHQ scores. Those who said they socialised with both did not appear to be significant. Some deaf people are married to non-deaf people and do not affiliate with other deaf people despite wishing they could. Some younger deaf people also expressed a desire to mix with deaf people but were discouraged from doing so. Some participants had negative experiences with the Deaf community and were cautious about re-establishing links.

**Figure 7.36 Social Affiliation at Present and GHQ**



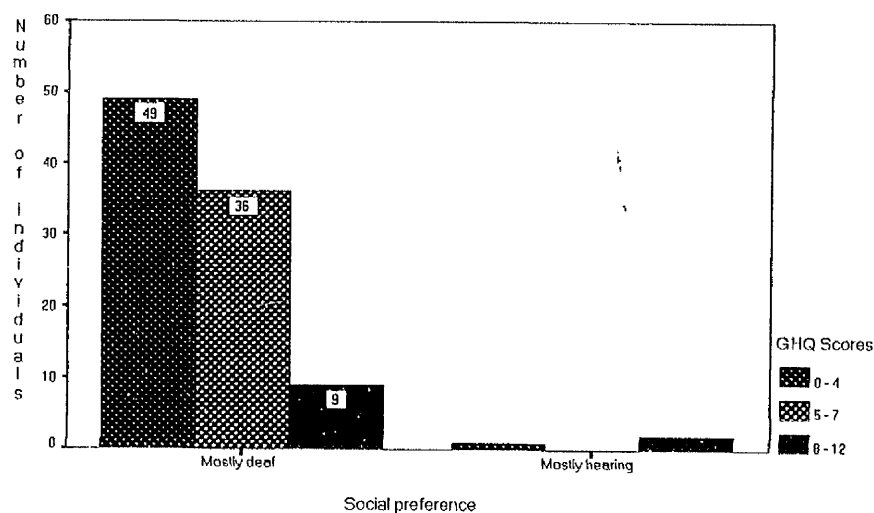
*Chi-square* = 20.46; *df* = 6; *p* = 0.002

**Table 7.20: Social Affiliation at Present and GHQ**

Social Affiliations at Present	GHQ SCORES			Total
	0-4	5-7	8-12	
Deaf community	39	28	4	71
Hearing community	1	0	3	4
Both	9	7	4	20
None	1	1	0	2
<b>Total</b>	50	36	11	97

Participants were then asked about hearing status social preference if any different to present social circumstances. Figure 7.37 shows the majority preferred to affiliate with deaf people.

**Figure 7.37 Social Preference and GHQ**



**Chi-square = 10.72; df = 4; p = 0.030**

**Table 7.21: Social Preference and GHQ**

Social Preference	GHQ SCORES			Total
	0-4	5-7	8-12	
Mostly deaf	49	36	9	94
Mostly hearing	1	0	2	3
<b>Total</b>	50	36	11	97

Deaf people who preferred to mix with hearing people only, scored high on the GHQ ( $p = 0.03$ ). The trend appears to reverse for those who prefer to socialise with other deaf people. This indicates cultural identification may have a role in psychological well-being.

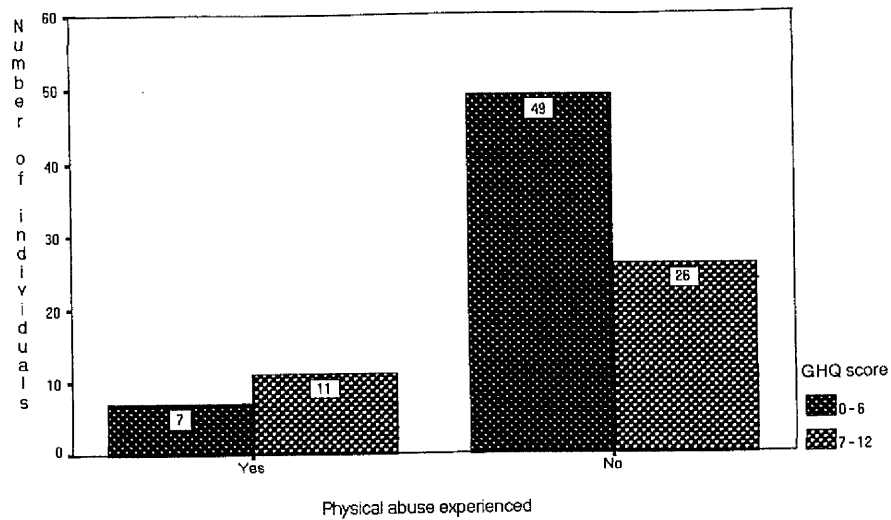
## Adverse Experiences

### **Physical Abuse**

Figure 7.38 shows the incidence of physical abuse as reported by interviewees. The figure shows that 61.1 % of those physically abused have high GHQ scores compared to 34.6% of those not abused, with high GHQ scores. The effect of physical abuse becomes apparent in those with high scores on the GHQ using the 2 group scoring method. Physical abuse associated with GHQ score obtains a Chi-squared value of 4.24, which shows a statistically significant difference ( $p = 0.040$ ) between those physically abused and those not physically abused on the GHQ threshold score.

Figure 7.39 shows GHQ-12 scores correlated with the reported incidence of sexual abuse and this was found to be significant ( $p = 0.04$ ). This indicates that experiencing a sexually abusive experience in childhood will likely lead to psychological difficulties, as evidenced by higher numbers scoring positive GHQ scores. The figure shows that using the 3 group scoring method, 64.9% of those who experienced sexual abuse scored highly on the GHQ-12. This is compared to 39.3% of those not sexually abused who had high GHQ scores. There seems to be two trends. Those not sexually abused have low GHQ-12 scores (0-4) and those who are borderline (5-8), are dominantly those sexually abused. Sexual abuse is discussed in more detail in Chapter Eight.

**Figure 7.38 Physical Abuse Experienced and GHQ**



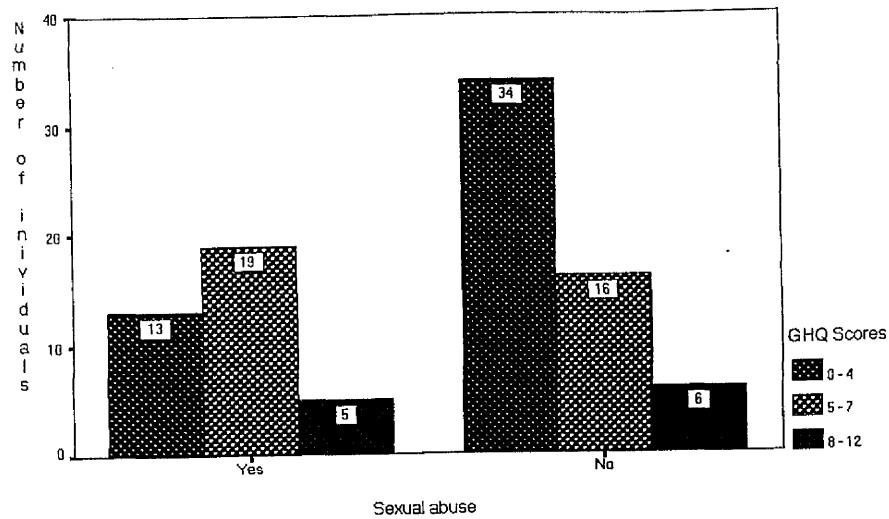
***Chi-square = 4.24; df = 1; p = 0.040***

**Table 7.22: Physical Abuse and GHQ**

Physical Abuse	GHQ SCORES		Total
	0-5	6-12	
Yes	7	11	18
No	49	26	75
<b>Total</b>	56	37	93



**Figure 7.39 Sexual Abuse and GHQ**



*Chi-Square = 6.10; df = 2; p = 0.047*

**Table 7.23: Sexual Abuse and GHQ**

Sexual Abuse	GHQ SCORES			Total
	0-4	5-8	9-12	
Yes	13	19	5	37
No	34	16	6	56
Total	47	35	11	93

## ANALYSIS

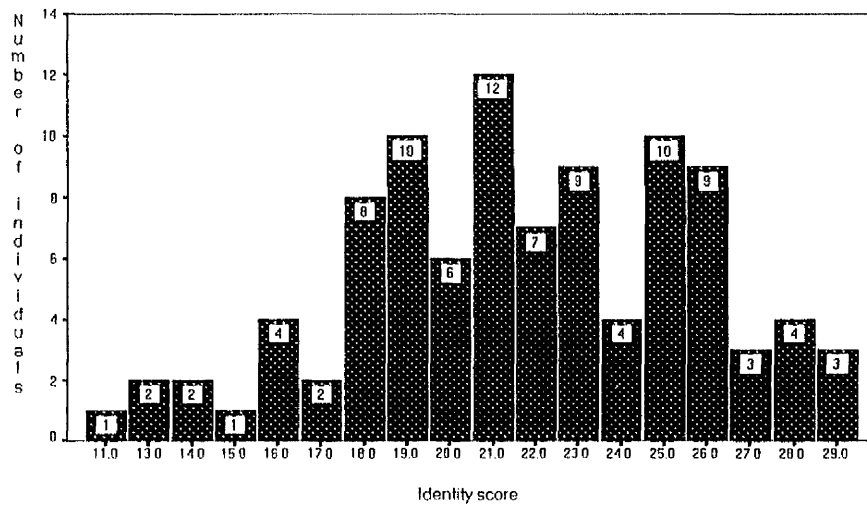
### Part III

#### Attitude and Identity Questionnaire (ATIQ) Scores Correlated with Background Interview Questionnaire Variables - (BIQ)

The Attitude and Identity Questionnaire (ATIQ) is a 32 item questionnaire designed for this study and formed the basis for the final part of the interview stage. This section describes the correlations between the ATIQ and selected background variables.

The distribution of scores (n=97) on the ATIQ are shown in Figure 7.40. Five people in the original sample of 102 were unable to complete this questionnaire. Three had moderate/severe learning difficulties, one person moved away and one person withdrew from the second interview stage. Figure 7.41 shows a mean score distribution of = 21.70, (S.D. = 3.98, range 11-29). The distribution suggests that a high number of the population appear to identify with other deaf people and have Deaf cultural values. The lowest score was 11, indicating low Deaf identity and negative attitudes towards both themselves and to other deaf people. The highest score was 29 which 3 (3.1%) people achieved. The correlation matrix for the ATIQ appears in Appendix 11.

**Figure 7.40** Attitude and Identity Scores of Participants

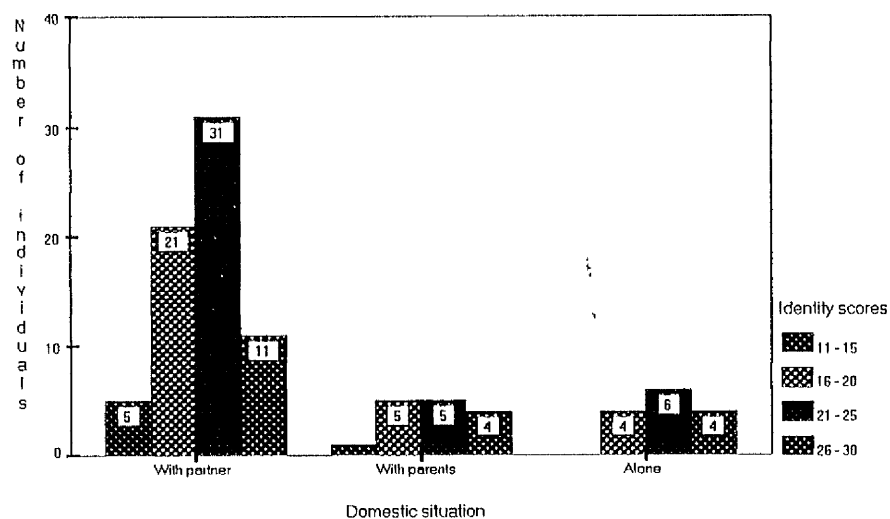


The ATIQ scores have been placed into 4 groups: 11-15, 16-20, 21-25 and 26-32. Some have been distributed into two groups: 11-21 and 22-32. The reason for dividing the scores in this way is because more information can be seen and obtained regarding the possible relationships between ATIQ scores and the background details.

### Family and Relationships

Figure 7.41 shows the ATIQ correlated with domestic circumstances (whether the participant was living with a partner, alone, or with parents). This is not significant but is mentioned because those participants living with parents appear more likely to possess a positive identity. Of those living alone, most participants scored highly on the ATIQ. Figure 7.42, although not statistically significant, seems to indicate that those with hearing partners appear likely to have lower scores on the ATIQ.

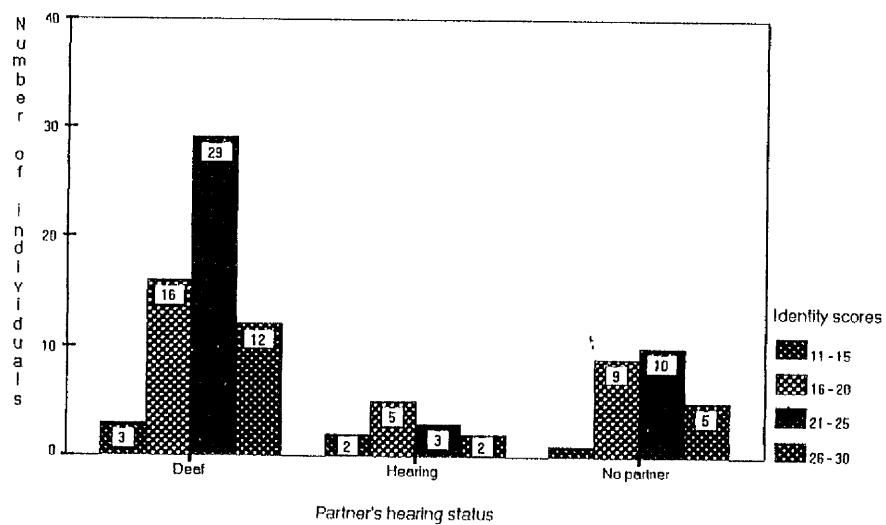
**Figure 7.41 Domestic Circumstances and ATIQ**



**Table 7.24: Domestic Circumstances and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Domestic Situation					Total
With partner	5	21	31	11	68
With parents	1	5	5	4	15
Alone	0	4	6	4	14
Total	6	30	42	19	97

**Figure 7.42 Partner's Hearing Status and ATIQ**

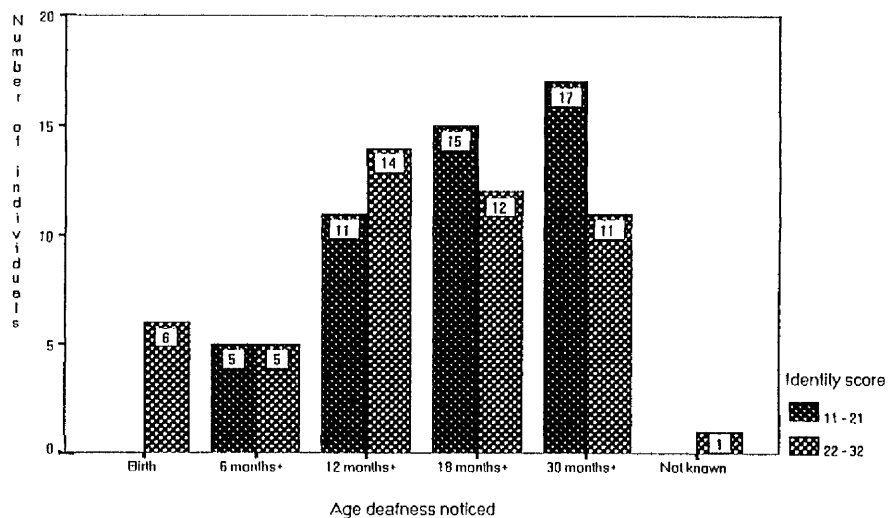


**Table 7.28: Partner's Hearing Status and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Partner's Hearing Status					Total
Deaf	3	16	29	12	60
Hearing	2	5	3	2	12
No Partner	1	9	10	5	25
Total	6	30	42	19	97

There was no significant correlation between the age of onset of deafness and ATIQ score or the age deafness was confirmed and ATIQ although as can be seen in Figure 7.43, the later the deafness is confirmed, the more likely participants indicate negative feelings regarding their deafness.

**Figure 7.43 Age Deafness Noticed and ATIQ**



**Table 7.29: Age Deafness Noticed and ATIQ Score**

Identity Score	11-21	22-32	
Age Deafness Noticed			Total
Birth	0	6	6
6 months +	5	5	10
12 months +	11	14	25
18 months +	15	12	27
30 months +	17	11	28
<b>Total</b>	<b>48</b>	<b>49</b>	<b>97</b>

The ATIQ scores were correlated with the hearing status of participants' friends at home. Although not statistically significant, it was noticed that those who had both deaf and hearing friends seemed to have lower ATIQ scores. This is illustrated in Figure 7.44. Those who had no friends at home were as likely to develop negative attitudes towards their deafness as positive attitudes. In other words, there seems to

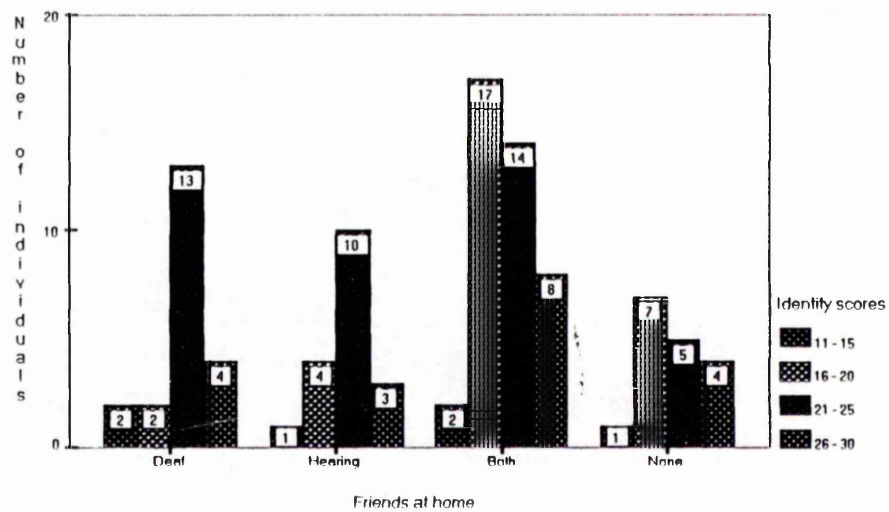
be an equal chance of developing a negative attitude as there was to developing a more positive attitude towards their deafness and those of others.

### Communication Issues

When the ATIQ scores were correlated with the interviewees self-perception of their communication method (Figure 7.45), there was no statistical significance, although those who said they communicated in Signed English or who said they used speechreading methods appeared to score poorly on the ATIQ. When participants modes of communication were observed and recorded some differences emerged. This was significant ( $p = 0.001$ ) and is seen in Figure 7.46. There are differences in participants self-perception perhaps due to the higher value placed upon oralism and the desire to communicate in a hearing orientated way.

A statistically significant association was found relating to the ATIQ score and the communication styles used by participants families when young and in the present day. These are seen in figures 7.47 and 7.48.

**Figure 7.44 Friends at Home and ATIQ**

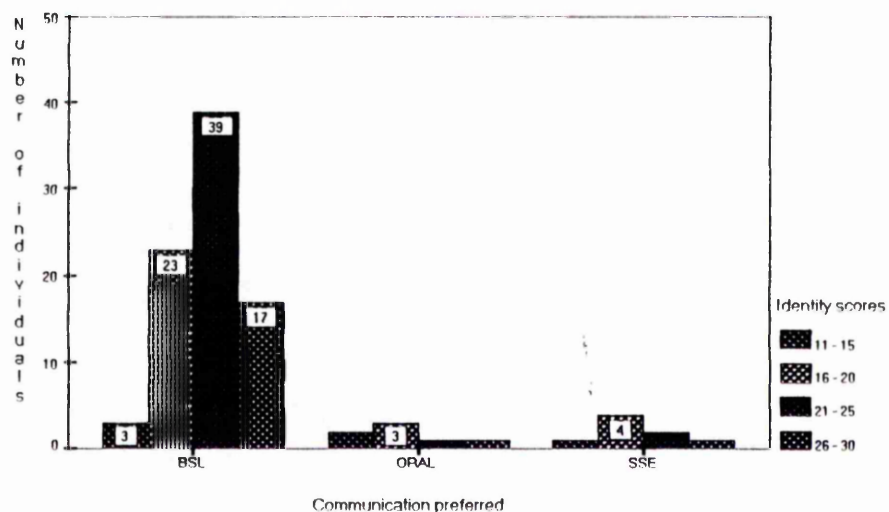


**Table 7.30: Hearing Status of Friends at Home and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Hearing Status of Friends at Home					Total
Deaf	2	2	13	4	21
Hearing	1	4	10	3	18
Both	2	17	14	8	41
None	1	7	5	4	17
Total	6	30	42	19	97



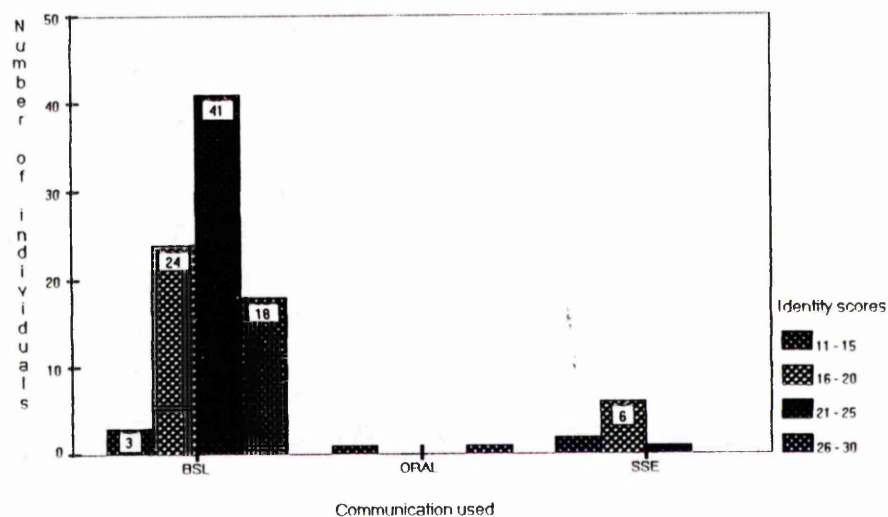
**Figure 7.45 Preferred Communication and ATIQ**



**Table 7.31: Preferred Communication and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Participant's Stated Preferred Communication					Total
BSL	3	23	39	17	82
Oral	2	3	1	1	7
SSE	1	4	2	1	8
Total	6	30	42	19	97

**Figure 7.46** Communication Used at Interview and ATIQ

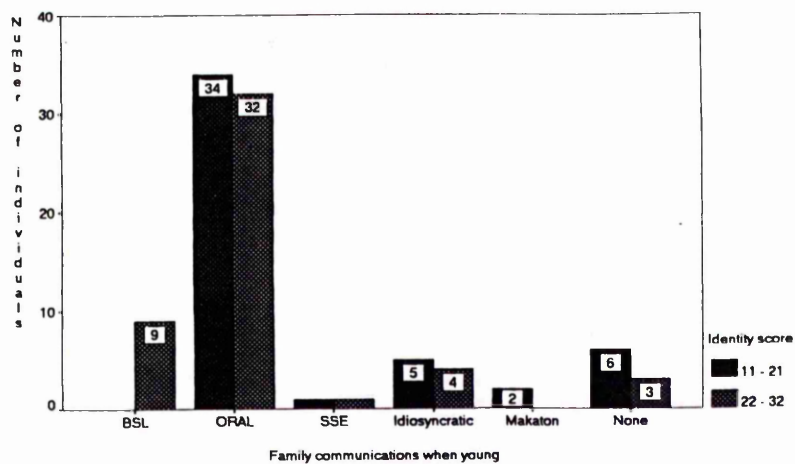


**Chi-Square = 21.73; df = 6; p = 0.001**

**Table 7.32:** Communication Used by Participant at Interview and ATIQ Score

Identity Score	11-15	16-20	21-25	26-30	Total
Communication Actually Used by Participant at Interview					
BSL	3	24	41	18	86
Oral	1	0	0	1	2
SSE	2	6	1	0	9
<b>Total</b>	6	30	42	19	97

**Figure 7.47 Family Communications when Young**

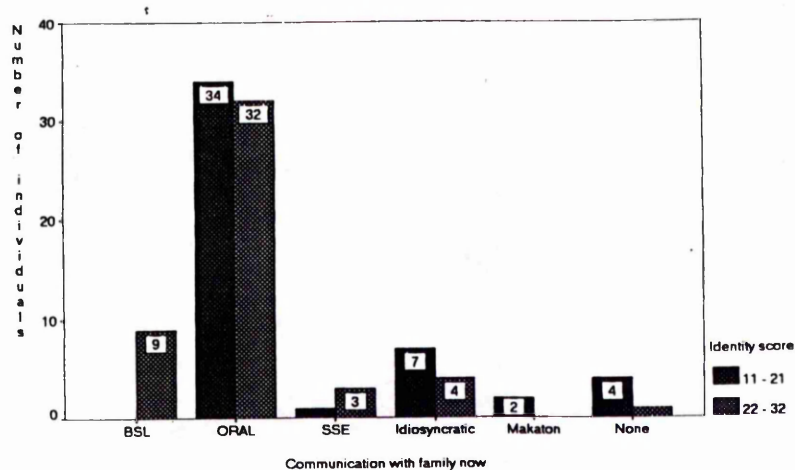


**Chi-square = 12.16; df = 5; p = 0.033**

**Table 7.33: Family Communications When Young**

Identity Score	11-21	22-32	Total
BSL	0	9	9
Oral	34	32	66
SSE	1	1	2
Idiosyncratic	5	4	9
Makaton	2	0	2
None	6	3	9
<b>Total</b>	<b>48</b>	<b>49</b>	<b>97</b>

**Figure 7.48** Communication with Family Now



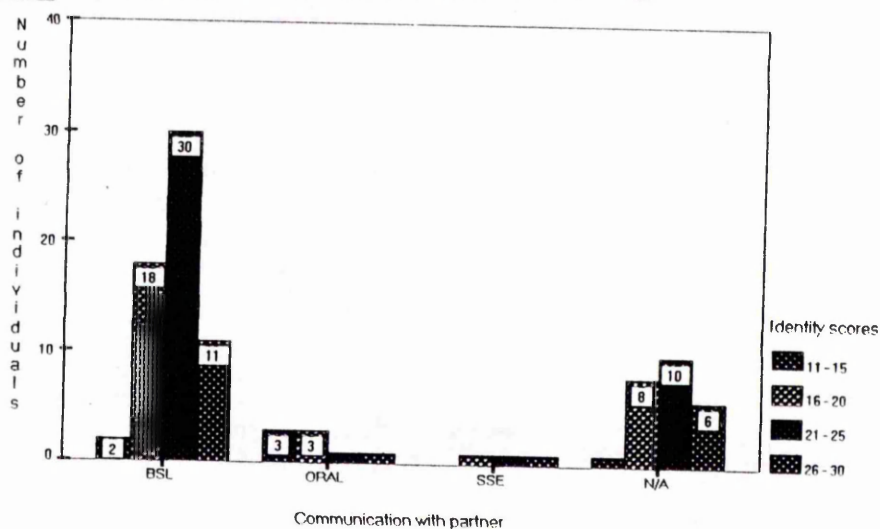
**Chi-square = 14.67; df = 5; p = 0.012**

**Table 7.34:** Communication with Family Now

Identity Score	11-21	22-32	Total
BSL	0	9	9
Oral	34	32	66
SSE	1	3	4
Idiosyncratic	7	4	11
Makaton	2	0	2
None	4	1	5
<b>Total</b>	<b>48</b>	<b>49</b>	<b>97</b>

The ATIQ and communication style with partner ( $p = 0.04$ ) is seen in Figure 7.49. Those who communicated using Oral methods or Signed Supported English scored poorly on the Identity Questionnaire. There was no significance found when the ATIQ was correlated with experience of communication with their family in childhood or now. It was anticipated that there might have been some relationship found between those interviewees whose families used Sign Language when in their childhood, compared to those who did not. However, it may be that the size of this sample is too small for possible significant correlations to show.

**Figure 7.49** Communication with Partner and ATIQ



**Chi-square = 17.25; df = 9;  $p = 0.044$**

**Table 7.35:** Communication Used with Partner and ATIQ Score

Identity Score	11-15	16-20	21-25	26-30	
Communication Used with Partner					Total
BSL	2	18	30	11	61
Oral	3	3	1	1	8
SSE	0	1	1	1	3
No partner	1	8	10	6	25
<b>Total</b>	6	30	42	19	97

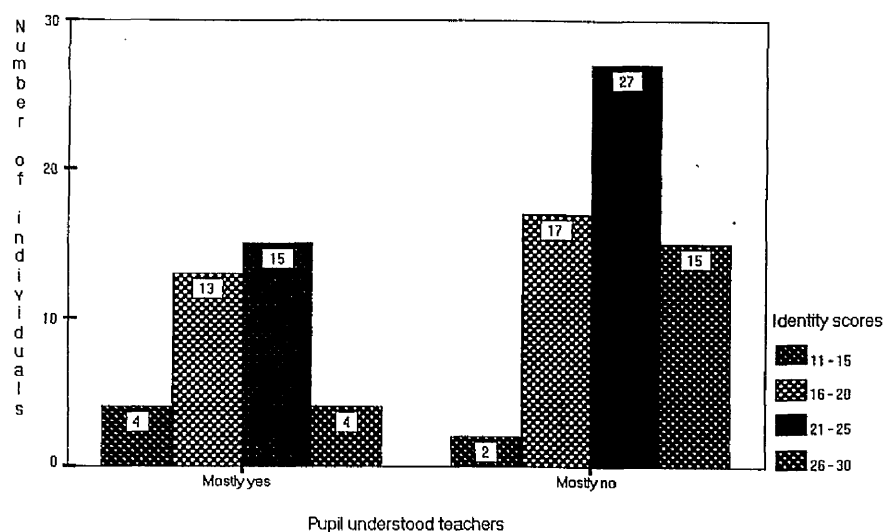
### Education Experiences

There did not seem to be any difference reported by those who felt understood by their teachers and those who did not feel understood by their teachers on the ATIQ. Figure 7.50, although not statistically significant, shows that a suggestive relationship exists between interviewees understanding of teachers and the ATIQ.

The type of infant education received by interviewees (Figure 7.51), appeared to have some relationship with ATIQ scores. Those who attended mainstream nurseries or Partially Hearing Unit nurseries appeared to do the worst on the ATIQ, although were not significantly associated ( $p = 0.09$ ). This suggests early experiences in terms of communication adopted can have a lifetime effect upon image and attitude and identity attachment.

Participants who felt mostly unhappy at school appeared to do better on the ATIQ than those who felt happy. This is seen in Figure 7.52 ( $p = 0.047$ ). This might suggest deaf children who interact with each other provide mutual support and thus a protective factor emerges for psychological health.

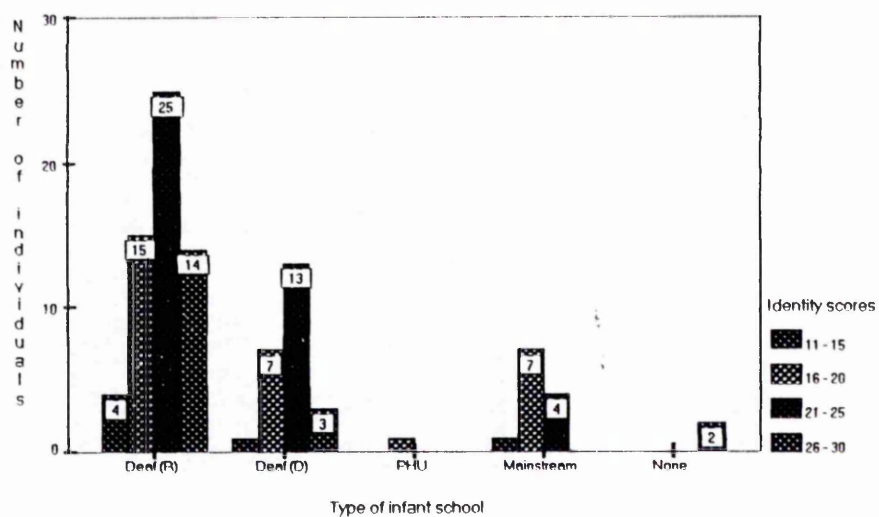
**Figure 7.50 Pupil's Understanding of Teachers**



**Table 7.36: Pupil's Understanding of Teachers and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Pupil's Understanding of Teachers					Total
Mostly yes	4	13	15	4	36
Mostly no	2	17	27	15	61
Total	6	30	42	19	97

**Figure 7.51 Type of Infant Education and ATIQ**

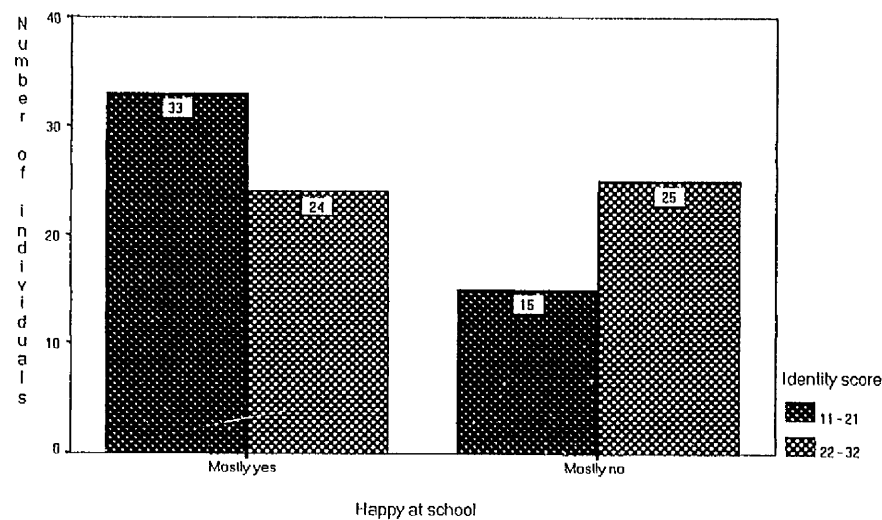


**Table 7.37: Educational Placement in Infancy and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Educational Placement in Infancy					Total
Deaf (R)	4	15	25	14	58
Deaf (D)	1	7	13	3	24
PHU	0	1	0	0	1
Mainstream	1	7	4	0	12
None	0	0	0	2	2
<b>Total</b>	<b>6</b>	<b>30</b>	<b>42</b>	<b>19</b>	<b>97</b>



**Figure 7.52 Happy at School and ATIQ**



*Chi-square = 3.91; df = 1; p = 0.047*

**Table 7.38: Happy at School and ATIQ Score**

Identity Score	11-21	22-32	
Happy at School			Total
Mostly yes	33	24	57
Mostly no	15	25	40
Total	48	49	97

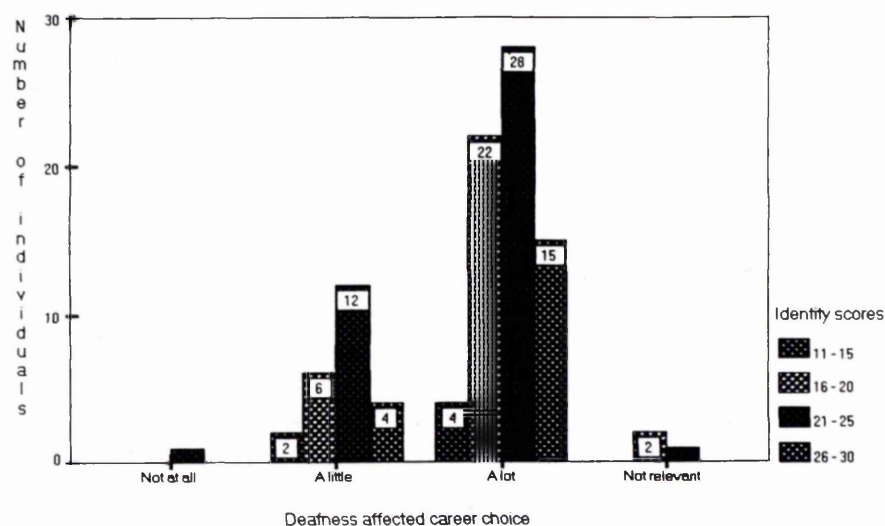
### Employment and Training Experiences

Little could be found to relate specific career and vocational training with the ATIQ.

An implication gained from the data was that those who felt their deafness affected their career choice scored the highest on the ATIQ. This is shown in Figure 7.53.

There was no relationship between employment status (whether or not they were in employment) and ATIQ, although there was a significant relationship ( $p = 0.04$ ) between vocational status and the ATIQ. Figure 7.54 shows that those participants who were in professional occupations tended to score poorly on the ATIQ whereas those who were in manual type occupations tended to do well on the ATIQ. No significant relationship was found between work satisfaction and ATIQ scoring.

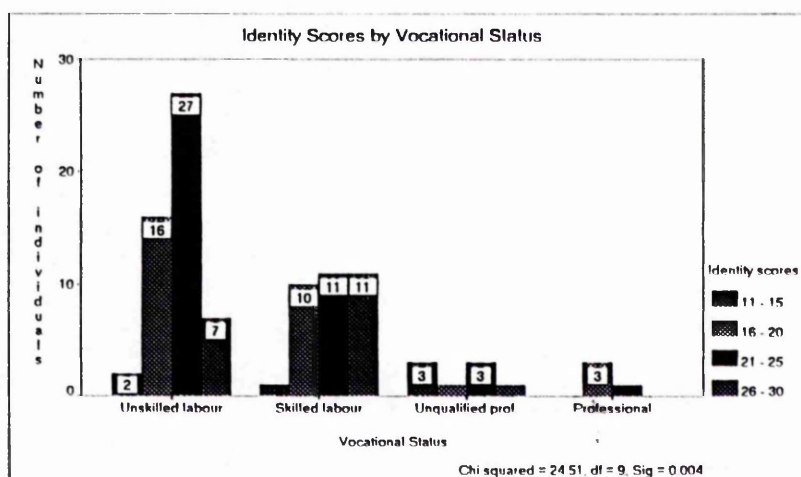
**Figure 7.53 Deafness Affected Career Choice**



**Table 7.39: Deafness Affected Vocational Career Choice and Identity Score**

Identity Score	11-15	16-20	21-25	26-30	
Deafness Affected Vocational Choice					Total
Not at all	0	0	1	0	1
A little	2	6	12	4	24
A lot	4	22	28	15	69
Not Applicable	0	2	1	0	3
<b>Total</b>	6	30	42	19	97

**Figure 7.54 Vocational Status and ATIQ**



**Table 7.40: Vocational Status and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Vocational Status					Total
Unskilled labour	2	16	27	7	52
Skilled labour	1	10	11	11	33
Unskilled professional	3	1	3	1	8
Professional		3	1		4
<b>Total</b>	6	30	42	19	97

### **Social Relationships by Hearing Status**

Those participants who tended to socialise mainly with deaf people scored the highest on the ATIQ. This can be seen in Figure 7.55. Those who socialised only with hearing people appeared to do poorly on the ATIQ. ( $p = 0.003$ ).

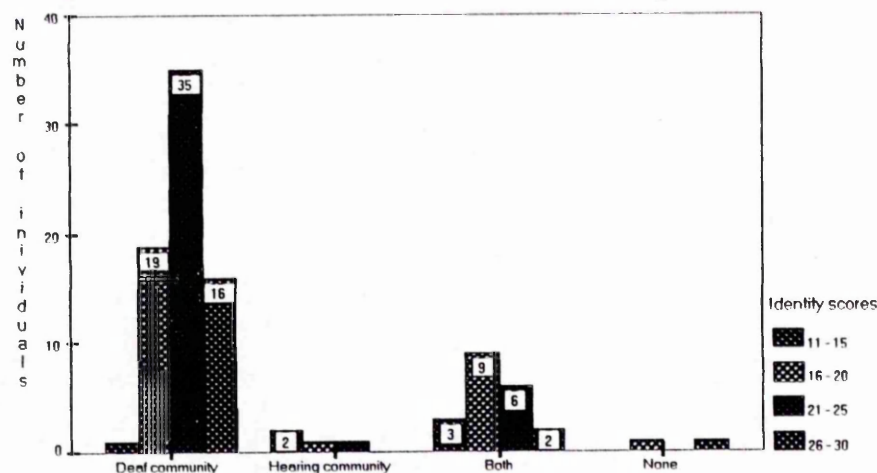
When asked who the participant would *rather* socialise with, if any different to present socialisation pattern, a highly significant relationship was found. An

examination of the ATIQ scores of those who would prefer to socialise with deaf people and those who prefer to spend social time with only hearing people showed that those who preferred to socialise with deaf people generated higher scores. The trend was reversed with those preferring to socialise with hearing people and is seen in Figure 7.55 ( $p = 0.000$ ).

### Abuse

No relationships were found at a statistical level of significance between experience of abuse and ATIQ score.

**Figure 7.55** Social Affiliation at Present and ATIQ

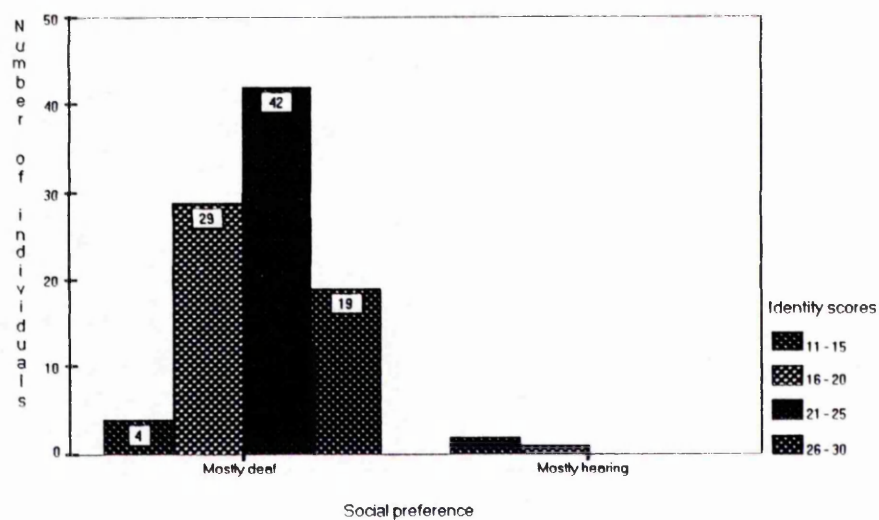


**Chi-square = 25.19;  $df = 9$ ;  $p = 0.003$**

**Table 7.41:** Actual Social Affiliation Group and ATIQ Score

Identity Score	11-15	16-20	21-25	26-30	
Actual Social Affiliation Group					Total
Deaf Community	1	19	35	16	71
Hearing Community	2	1	1	0	4
Both	3	9	6	2	20
None	0	1	0	1	2
<b>Total</b>	<b>6</b>	<b>30</b>	<b>42</b>	<b>19</b>	<b>97</b>

**Figure 7.56 Social Preference and ATIQ**



**Chi-square = 20.25; df = 3; p = 0.000**

**Table 7.42: Preferred Social Group and ATIQ Score**

Identity Score	11-15	16-20	21-25	26-30	
Preferred Social Group					Total
Mostly Deaf	4	29	42	19	94
Mostly Hearing	2	1	0	0	3
Total	6	30	42	19	97

## ANALYSIS

### Part IV

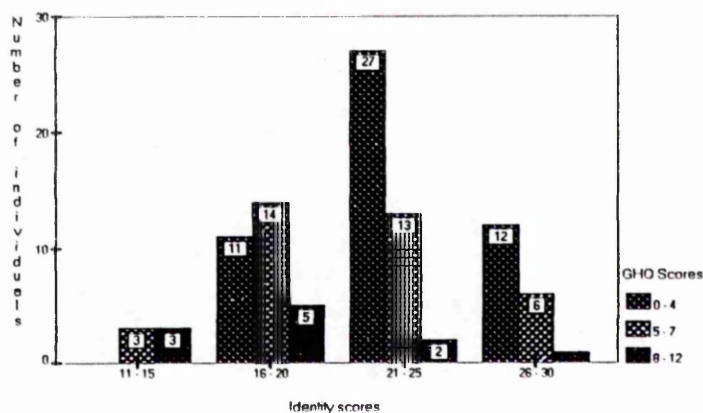
#### Attitude and Identity Questionnaire (ATIQ) and General Health Questionnaire (GHQ-12)

##### Use of the ATIQ in the Present Study

This chapter will examine the hypothesized relationship between the ATIQ and the GHQ-12. The design and purpose of the GHQ questionnaire is described in Chapter Five and the design and purpose of the ATIQ is described in Chapter Six. The description of the population study and background details are described in Chapter Seven.

Figures 7.57 and 7.58 show a highly significant relationship between the two questionnaires. In Figure 7.57 the GHQ-12 scores are divided into three groups: 0-4, 5-8 and 9-12.

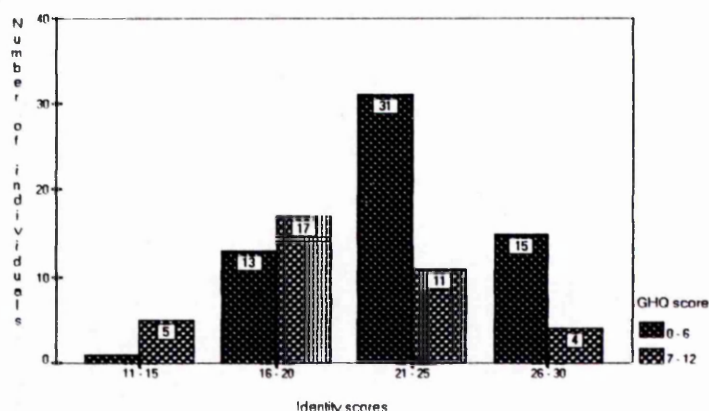
**Figure 7.57** General Health Questionnaire Scores by Attitude and Identity Scores



$$X^2 = 18.67, df = 6, p = 0.005$$



**Figure 7.58** General Health Questionnaire by Attitude and Identity Scores



$$\chi^2 = 14.45; df = 3; p = 0.002$$

The relationship was significant (Chi square 18.67;  $df = 6$ ;  $p = 0.005$ ). Figure 7.58 shows the GHQ-12 scores divided into two groups: 0-5 and 6-12. The threshold for psychological disturbance is six or above. Again, this is highly significant (Chi square = 14.45;  $df = 3$ ;  $p = 0.002$ ).

What these statistics suggest is that there is a significant relationship showing that the higher the ATIQ score, (indicating a positive Deaf attitude towards hearing status and Deaf community values), the lower the GHQ-12 score, (indicating lower levels of psychological distress). Both Figures 7.57 and 7.58 show that higher GHQ scores are accompanied by lower ATIQ scores and that the two variables produce a relationship with a negative correlation, in opposite directions.

The reader will remember that the ATIQ is designed to gain an appreciation of the individual's affiliation or ambiguity towards their own and others hearing status. An assumption cannot be formed on the basis of one response but needs to be incorporated into the context of responses to the questionnaire as a whole. The results of T-tests are seen in Tables 7.43 and 7.44. Some of the Items are negatively related and some are positively related. As can be seen, ATIQ items 1, 12, 15, 18, 19, 24, 27, 28, 29 and 32 have significant relationships with scores on the GHQ-12. The ATIQ items referred to here appear to relate mainly to self-image and rejection of deafness. Items 1,15,18 and 19 relate to image and perception of hearing status. Items 27 and 28 reflect the degree of identity and attachment to members of the Deaf community. Items 29 and 32 reflect attitudes towards hearing status. What these figures suggest is that those factors identified in this analysis of the ATIQ are strongly related to psychological health.



**Table 7.43: T-Tests between mean total scores of ATIQ and GHQ items**

GENERAL HEALTH QUESTIONNAIRE ITEMS  Have you recently ...	ATIQ DISAGREE		ATIQ AGREE		Significance level
	Mean ATIQ Score	(SD)	Mean ATIQ Score	(SD)	
GHQ 1: ...lost much sleep over worry?	22.71	(3.63)	21.05	(4.09)	0.045 *
GHQ 2: ... felt constantly under strain?	23.05	(3.19)	21.37	(4.11)	0.099
GHQ 3: ... been able to concentrate on whatever you are doing?	19.00	(3.62)	22.01	(3.92)	0.023 *
GHQ 4: ... felt that you are playing a useful part in things?	19.18	(4.89)	22.02	(3.77)	0.025 *
GHQ 5: ... been able to face up to your problems?	20.06	(4.29)	22.05	(3.85)	0.061
GHQ 6: ... felt capable of making decisions about things?	19.53	(4.26)	22.10	(3.83)	0.021 *
GHQ 8: ... been feeling reasonably happy, all things considered?	18.47	(4.23)	22.49	(3.52)	0.000 **
GHQ 9: ... been able to enjoy your day to day activities?	18.59	(3.52)	22.36	(3.78)	0.000 **
GHQ 10: ... been feeling unhappy and depressed?	23.24	(3.03)	20.75	(4.22)	0.001 *
GHQ 11: ... been losing confidence in yourself?	23.23	(3.33)	20.84	(4.09)	0.004 *
GHQ 12: ... been thinking of yourself as a worthless person?	22.56	(3.21)	20.86	(4.49)	0.034 *

The last column shows the significance in the difference between the two 'groups' of scores.

\* = 0.05

\*\* = 0.001

**Table 7.44: T-Tests between mean total scores of GHQ and ATIQ items**

QUESTION	GHQ DISAGREE		GHQ AGREE		Significance level
	Mean GHQ Score	(SD)	Mean GHQ Score	(SD)	
ATIQ 5: I feel nervous because I am deaf.	4.43	(2.90)	5.62	(2.93)	0.068
ATIQ 9: Sometimes I pretend to understand other people when I really don't.	3.17	(2.41)	5.15	(2.95)	0.009 *
ATIQ 11: I don't like it when I have to tell other people I am deaf.	4.54	(2.94)	5.94	(2.77)	0.074
ATIQ 12: I feel quite confident.	6.41	(3.32)	4.44	(2.76)	0.011 *
ATIQ 15: Being deaf is absolutely terrible.	4.31	(2.87)	7.19	(2.07)	0.000 **
ATIQ 18: I am angry because I was born deaf.	3.91	(2.48)	5.27	(3.09)	0.028 *
ATIQ 19: I lead a normal life just like anyone else.	8.30	(2.54)	4.38	(2.72)	0.000 **
ATIQ 24: I feel nervous if I miss something said and I have to ask people to repeat.	4.05	(2.93)	5.37	(2.85)	0.027 *
ATIQ 27: I really wish I was hearing.	4.17	(2.77)	5.97	(2.96)	0.004 *
ATIQ 29: I feel angry towards hearing people.	3.79	(2.63)	5.57	(2.70)	0.003 *
ATIQ 32: I am satisfied I am deaf.	6.42	(3.48)	4.55	(2.81)	0.040 *

The last column shows the significance in the difference between the two 'groups' of scores.

\* = 0.05

\*\* = 0.001

## CHAPTER 8

### CHILDHOOD ABUSE AND DEAFNESS

#### PART A

##### Prevalence of Sexual Abuse in a Community Sample of a Deaf Population

The process of selecting the random sample drawn for this thesis is described in Chapter seven. In addition to a series of questions focusing on educational, family, communication, vocational and social experiences, participants were asked a series of questions related to sexual and physical abuse. Prior to presenting the questions, the meaning of abuse was outlined and questions encouraged to enable clarification for each interviewee. This was followed by an explanation of the terms and the particular definition(s) being used in the study.

The definition of sexual abuse used in this study includes rape and attempted rape, both serious forms of sexual abuse. The terms are confirmed by the Law Society, London, with whom the National Society for the Prevention of Cruelty to Children work. In addition, the abuse was required to have taken place prior to the age of 16. A number of participants volunteered information about other forms of sexual abuse but because participants were not specifically questioned on sexual abuse other than the two criteria items, these are not included in the analysis. This is a narrow and exact definition of sexual abuse compared to those used by other studies.

Schechter and Roberge (1976) provide a definition intended to cover a broad spectrum of sexual abuse:

**"The sexual exploitation of children refers to the involvement of dependent developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to and that violates the social taboos of family roles" (p.129)**

This definition is useful but probably somewhat restrictive. The important point is that sexual relationships between adults and children constitute child abuse because sexual relationships are meant to be of free will and of the full informed consent of both partners. Because the concept of rape or attempted rape implicitly indicates an act of sexual violence, the following feminist definition offered by Kelly (1984) is of relevance:

**"... any sexual act that is experienced by the woman or girl, at the time or later, as a threat, invasion or assault, that has the effect of hurting her or degrading her and/or takes away her ability to control intimate contact". (p.41)**

The range of reported prevalence rates of different studies therefore rely upon the definitions of sexual abuse used, which are usually significantly much broader than that used in the present study. Of the participants in the sample, 58 females and 44 males reported sexual abuse. Sixty-five percent are female and 35% male. These figures are high compared to mainstream (non-deaf population) studies. A range of figures for comparison are given in the following section. The most frequently cited figures are those of a British study conducted by Baker and Duncan (1985), which suggested twelve percent for girls and eight percent for boys. This is based on a definition of sexual abuse which includes kissing, fondling, masturbation, cunnilingus and vaginal and anal penetration. Russell (1983) studied the incidence of sexual abuse amongst females in San Francisco U.S.A. and found thirty-eight percent had suffered sexual abuse at least once prior to the age of 18. Russell (1984) (U.S.A)

also found in a door to door random sample, that twenty-eight percent of females reported sexual abuse under the age of 14. This figure is formed on a 'normative' and not a mental health definition, which means the sample is drawn from the community. The National Society for the Prevention of Cruelty to Children reports that on average more boys are being registered for child sexual abuse, particularly among 5-9 year olds (N.S.P.C.C., 1990). Ninety-seven percent of abusers are male (Finklehor, 1984; Kelly, 1989). The N.S.P.C.C. (1990) suggest that only 2 percent of females sexually abuse children although some researchers are suggesting the figures are higher for female perpetrators than was previously thought.

Each participant in this study was asked if they had experienced sexual abuse. If an adverse sexual experience was reported, further questions focused on the experience of whether they knew the perpetrator; how long the abuse took place over time; and the frequency of the abuse. A further question was asked to establish whether they had ever told anyone previously.

The figure, 38.1 %, found in this community sample far exceeds figures given for any other study examining incidence of childhood sexual abuse within a deaf population. It is highly likely that the figure would have reflected a much higher incidence of sexual abuse in deaf children if a broader definition of sexual abuse had been used in the study. The Local Authority Social Service Departments were involved in two of the total of 40 who experienced sexual abuse. In one case, the offender served a prison sentence and in the other, the victim was afraid and changed her mind.

## **Analysis**

The population of those who reported sexual abuse according to the definition used in this study were separated from those who did not report sexual abuse. Those who were sexually abused were then grouped together and the results correlated with each questionnaire. Items from the first questionnaire which gathers the background details, such as family communication, educational and vocational experiences and social interaction were correlated with those who reported sexual abuse. Significant relationships were found and these are shown in Table 8.1.

**Table 8.1: Co-Dependence of Sexual Abuse and Background Variables**

Variable and Values	Sexually Abused	Sexually Abused (Percentage)	Not Sexually Abused	Not Sexually Abused (Percentage)	Significance Level
<b><i>Happy at School?</i></b>					0.042 (5%)
Yes	8	(21.1)	24	(42.1)	
Mostly Yes	12	(31.6)	11	(19.3)	
Mostly No	4	(10.5)	11	(19.3)	
No	14	(36.8)	11	(19.3)	
<b><i>Physically Abused</i></b>					0.010 (5%)
Yes	12	(31.6)	6	(10.5)	
No	26	(68.4)	51	(89.5)	
<b><i>Felt Understood by Teachers</i></b>					0.043 (5%)
Mostly Yes	16	(42.1)	36	(63.2)	
Mostly No	22	(57.9)	21	(36.8)	
<b><i>Accessed Vocational Training</i></b>					0.083 (10%)
Yes	6	(15.8)	18	(31.6)	
No	32	(84.2)	39	(68.4)	
<b><i>Occupation</i></b>					0.019 (5%)
Unskilled labour	24	(63.2)	28	(49.1)	
Skilled labour	8	(21.1)	24	(42.1)	
Unqualified professional	6	(15.8)	2	(3.5)	
Professional	0	(0.0)	3	(5.3)	

## PART B

### A Sample of Clients Referred to the Writer's Clinical Practice

This section examines a sample of twenty-two clients referred to the writer's clinical practice at the National Centre for Mental Health and Deafness. The sample has been selected in order to represent a broad range of clientele who also came from a wide geographical area and who have suffered sexual abuse. The sample is probably representative of the population who have suffered sexual abuse.

The history of sexual abuse is not always presented by the client initially. Various factors influence the initial presentation which include access to information, knowledge of the concept of abuse, being able to disclose, and whether or not communicating with someone about the abuse in the victims own language has been possible. The reason the clients in this sample were referred is also discussed as are selected background details such as age, gender, educational background, communication with family and communication in educational setting. Knowledge and understanding of clients following assessment by the writer is also discussed as is hearing status and gender of the perpetrator. The outcome of therapy offered is discussed.

This is a relatively new field in Deaf issues. The main contributions to the literature are American, with only one small attempt to quantitatively research the prevalence of abuse in the U.K. (Kennedy, 1988), although specific criteria was not used in her study. This is discussed further in the next section. The next section considers the paucity of literature in this field and the lack of information regarding the experiences

of deaf victims. A number of risk factors are identified (Ridgeway, 1993) and formulated by the writer and will be seen as specific to deaf children but may also be shared with other children, for example, children with speech disorders or children with learning difficulties and disabilities.

## Discussion

An analysis of twenty-two clients referred to the National Centre for Mental Health and Deafness to the writers clinical practice are discussed. The clients names are disguised and any other possible identifying or recognisable features are also amended or omitted, without distorting the intention of presentation to the reader. The mean age of the clinical sample (n=22) was 31.3 (range 15-46). There were fifteen females and seven males. Most of the sample communicate using British Sign Language as their preferred language. Four people considered themselves bilingual and bicultural. For the purposes of this discussion, bilingual and bicultural is taken here to mean the ability to functionally interact with non-deaf people, and communicate in, both British Sign Language and English, either in spoken or written form. Awareness of ability to functionally use English to communicate was taken from both the client and referrer (a medical professional) or background social report which is usually provided by the social worker involved. Table 8.2 illustrates details of cases gathered which are also now described individually.



Table 8.2: Clients Reporting Sexual Abuse in Childhood : Sample taken from clinical practice

Client No.	Initial	Sex	Age at Referral	Childhood Communication	Cultural Identity (Self Perception)	Type of School *	Perpetrator			Age when Abused
							Hearing Status	Gender	Relationship to Victim	
1	A	M	34	None	Deaf	PHU	H	M	Older pupil	7-10
2	B	F	25	None	Deaf	PHU	H	M	Father	12-15
3	C	M	29	None	Deaf	R and D	H	M	Family friend	7-9
4	D	F	36	None	Deaf	PHU Special (D)	H	M	Uncle	9-15
5	E	M	33	Spoke Orally	Hearing	M	H	M	Father	7
6	F	F	17	None	Deaf	D	H	M	Uncle	9-16
7	G	F	15	None	Deaf	R	H	F	Family friend	12-15
8	H	M	26	Spoke Orally	Bi-cultural	R	D	M	Older pupil	9-12
9	I	F	16	Spoke Orally	Bi-cultural	R/D	H	M	Mother's partner	7
10	J	M	39	None	Deaf	R	H	M	Staff at school	9-10
11	K	F	26	None	Deaf	M	H	M	Uncle	7-15
12	L	M	46	None	Deaf	D (Deaf)	H	M	School staff	8-11
13	M	F	31	None	Deaf	PHU	H	M	Taxi escort	9-12
14	N	F	36	None	Deaf	Special School(D)	H	M	Male carer at school	8-10
15	O	F	45	None	Deaf	R	H	M	Relative	8-10
16	P	F	29	None	Deaf	R	H	M	Father	15-24
17	Q	F	44	Gesture	Deaf	R	H	M	Family friend	8-10
18	R	F	31	Gesture	Bi-Cultural	Special School(D)	H	M	Grandfather	8-14
19	S	F	32	Very little	Deaf	Special School(D)	H	M	Older pupil and later partner	11
20	T	F	40	None	Deaf	Special School(R)	H	M	Uncle	7-11
21	U	M	19	Speechreading	Deaf	D and R	H	M	Unknown	16
22	V	F	32	Speechreading/ oral	Bi-Cultural	R and PHU	H	F	Older pupil	13-15

\* R = Residential School for Deaf Children      Special (R) = Mainstream Special School - Residential  
D = Day School for Deaf Children      Special (D) = Mainstream Special - Day  
PHU = Partially Hearing Unit      M = Mainstream

### Case 1

A, male, 34, culturally Deaf Sign Language user, living alone, depressed low mood, recent suicide attempt. Issues linked to sexuality and identity. Communication with parents through pointing, no siblings, attended Partially Hearing Unit, offered a period of Deaf Centred therapy. Revealed history of sexual abuse between age 7-10 by older hearing pupil at school, feels this is why he is now gay, feels a lot of anger towards the perpetrator, abuse was systematic, penetrative and violent and involved tying T.M. with ropes. T.M. benefitted from therapy, redirected expression of anger.

### Case 2

B, female, 25, culturally Deaf BSL user, low mood and at times aggressive behaviour. No communication with family, albeit for simplest of gestures, attended residential school for deaf children until aged 12, then transferred to a day school PHU setting. Living alone, unemployed, history of difficulty forming relationships. An attempt to disclose to mother the sexual abuse by stepfather was rejected, history of attempted suicide, aggressive behaviour, described as 'moody and bad tempered' at school. Sexual abuse included penal penetration of vagina. This took place from age 12-15. Perpetrator was stepfather (hearing). R.B. received weekly Deaf Centred psychotherapy for a period of six months making the effort to travel a considerable geographical distance. Enhanced self-image and esteem resulted and R.B. disclosed abuse to family. Although family rejected R.B., she continued to gain benefit from Deaf Centred therapeutic intervention.

### Case 3

C, male, 29, culturally Deaf, Sign Language user, unemployed, living at home with adoptive parents, request for assessment relating to allegations of sexual abuse towards two younger males 15 and 16. M.F. separated from wife, access to siblings denied. Minimal communication with family using mainly gesture. Later a younger brother developed some Sign Language skills. Residential School for Deaf Children. M.F. resistance to remain as boarder, family agreed to move and M.F. became day pupil at another school for deaf children 8-15 years. Sexually abused by hearing male taxi driver friend of the family, from age of 7-9 years at irregular infrequent intervals. M.F. benefitted from a brief Deaf Centred therapeutic approach as a long distance outpatient, which facilitated exploration of own sexuality, acknowledgement of allegations and was able to explore related issues.

#### Case 4

D, female, 36, culturally Deaf British Sign Language user, mild cerebral palsy, depressed mood and eating difficulties, withdrawn, weight loss from 17 to 11 stone. History of 2 physically abusive (unconsummated) marriages. Minimal communication skills in family, using mainly gesture and speechreading. Attended Partially Hearing Unit then Centre for Spastics. Admitted for three months assessment. Deaf Centred Therapy provided weekly. Disclosed systematic sexual abuse (non-penetrative) by hearing paternal Uncle weekly, 9-15 years. D.P., fearful of males, borderline anorexic, eating nothing most days and frequently vomiting, suicidal ideation. Benefitted from therapy - able to confront fears and distorted self-esteem, sleeping and eating pattern improved and level of insight developed. Continued improvement not possible as discharged from residential facilities - moved back home (200 miles). Continued input offered on monthly basis for short period. There are no local facilities to meet D.P.'s needs.

#### Case 5

E, male, 33, severely progressively deaf speechreader, some signing skills, communicates with family using speechreading, eating difficulties (phobia of choking), obsessional thoughts, anxiety about deafness. Disclosed experience of sexual abuse at age 7; Perpetrator father (hearing). Does not recall sexual abuse after this age. Brief period of counselling enabled exploration of subjective concerns, and development of coping skills.

#### Case 6

F, female, 17, culturally Deaf BSL user, withdrawn, moody and irritable. Extremely limited communication with family members, although mother had recently begun to learn BSL at time of referral to writer. C.A. attended a day school for deaf children. C.A. was systematically abused over a seven year period, from the age of 9 to 16 years. The perpetrator was a hearing man, a member of the extended family. Disclosure initially was rejected. A further attempt to disclose a year later resulted in the conviction and imprisonment of perpetrator. C.A. felt guilty and anxious. The family were split by those who accused her of lying. C.A. developed symptoms of anxiety and became dependent upon her mother. C.A. was anxious of going out alone and had poor social and relationship skills. C.A. was offered therapy but due to geographical distance, was unable to meet more frequently than once monthly. This was offered long term and accepted.

### Case 7

G, female, 15 years, referred due to behaviour problems; mainly attention seeking and disruptive behaviour. No communication with family throughout childhood. Mother has since acquired some sign vocabulary. K.C.'s preferred language is BSL. Attended Residential School for Deaf Children until abuse occurred from age 12-15 by a female hearing friend. An earlier attempt at disclosure was rejected. K.C. was initially diagnosed with mixed conduct and emotional disorder. Anger was expressed towards the perpetrator by whom K.C. felt betrayed and humiliated. K.C. was rejecting support from non-deaf people and was acting out suicidal threats and displaced anger. Brief centred psychotherapy offered as a resident over a short period due to geographical distance. The outcome was a little improvement in coping strategies and a better level of insight, although therapy was too brief to have benefitted K.C. more significantly.

### Case 8

H, male, 26, deaf Sign Language user, unemployed, living independently, history of sexual offences against young boys since aged 14, some communication with mother in childhood, father unknown, Residential School for Deaf Children, history of non-penetrative (dry intercourse) sexual abuse by an older deaf pupil at the school aged 9-12, suffers from recurring flashbacks, becomes extremely upset, usually precedes a similar non-penetrative sexual assault upon another young boy. Blames nightmares for the subsequent attacks. Therapy provided to enable exploration of issues. B.S. reluctant to accept responsibility for his actions against young boys, therapy enabled only partial acceptance of responsibility through exploration of own experiences when young.

### Case 9

I, female, 16, severely deaf, limited signing skills, referred due to behavioural problems at schools, epileptic. Limited communication with family, mother has schizophrenia. Preferred language signing with emphasis towards English. Attended Oral School for Deaf Children as residential and day pupil, sexually abused by an older male pupil at the school. History of sexual assault by stepsister on one occasion and an incident of rape by her mother's previous partner, parents had separated when B.C. was 7 and later reconciled. With the exception of the older pupil at school, perpetrators were hearing. B.C. received Deaf Centred

therapy which resulted in improvement in coping strategies. Diagnosis of epilepsy, suspected to be based on pseudo-seizures, was questioned. Seizures decreased rapidly following therapy acknowledging abuse suffered.

#### Case 10

J, male, 39, culturally Deaf Sign Language user, married, three children, unemployed, presented as anxious and unhappy. No communication in family in childhood, Residential School for Deaf Children, sexually abused at school by adult member of staff from age 9-10. Perpetrator was known hearing male. Therapy offered, P.K. not keen, felt forced to attend NCMHD at suggestion of Social Worker who referred P.K. following concerns expressed by family, including wife and children, attended four sessions then terminated therapy, due to teasing from members of the local Deaf Club about his attendance at the Mental Health Centre. Another service user had seen him and told his friends.

#### Case 11

K, female, 26, Asian, culturally severely Deaf, using BSL as preferred language, low mood, aggressive outbursts. Did not give reason to GP for requesting referral. No meaningful communication with family throughout life. Mainstream Oral School. Presently unemployed living with her young child and partner (Deaf). In therapy, B.L. revealed a history of sexual abuse by maternal uncle from the age of 7 until 15. Abuse included being exploited to Uncle's friends, who also had sexual intercourse with B.L., taking it in turns and observing. B.L. revealed involvement in prostitution which began in early twenties. During therapy, B.L. presented as angry and was subject to angry outbursts where she would break furniture and physically abuse her male partner. B.L. was also at risk of self harm and she expressed a wish to die. Gradually gained insight into her behavioural pattern and developed ways to deal with displaced anger. Therapy ended at client's request, after missed appointments.

#### Case 12

L, male, 46, culturally Deaf Sign Language user, married, three children, factory shopfloor worker, obsessive thinking and fearful of being out of house except to go to work, poor communication with parents in childhood, no siblings. Day pupil at School for Deaf Children. Offered initially cognitive therapy, continuing psychotherapy revealed history of

sexual and emotional abuse at school by an unknown adult (hearing) six or seven times during age 8-11, involved anal and oral penetration. C.C. remained in therapy long term and was able to explore feelings of anger (acting-in) and began to address anxieties. Later work included family and marital therapy.

### Case 13

M, female, 31. A culturally Deaf BSL user, depressed and anxious mood of increasing intensity over several months. Has two children aged 13 and 9. S.L. was reluctant to let the younger child attend school due to suspicion of sexual abuse from her previous partner. Limited communication with her large and extended family during childhood. Limited contact with siblings - six brothers and sisters. S.L. was separated from her mother when aged 6, for one year when she lived with her father. Parents divorced at this time. S.L. attended oral day school for Deaf children from 4-15 years. Sexual abuse occurred between the age of 9-12. The perpetrator was a hearing male taxi driver who escorted deaf children to and from the school. Abuse was systemic and regular every week, and involved forced oral contact with the perpetrator's genitalia and digital penetration. S.L. disclosed at time of referral that she was preventing her son aged 9, from attending school and insisted he had been sexually abused by an ex-partner. Munchausens Syndrome by proxy or projection is considered. S.L. reported she had been involved in truancy, attempts at self-mutilation and sexual intercourse whilst at school. Counselling was offered but S.L. declined further appointments after a few sessions. A number of psychosomatic symptoms emerged at this time and S.L. felt unable to continue with psychotherapy.

### Case 14

N, female, 36, culturally Deaf, concerns around ability to provide care and protection for young son, 7, who had been sexually abused by one of S.T.'s friends. Negative self-esteem and poor self concept. One of a family of nine siblings, communication within family was by pointing, classified as subnormal and attended Special School, limited language development (both English and Sign), living alone, son in temporary foster care. S.T. suffered sexual abuse at school between age 8-10, perpetrator hearing male carer, no understanding of concept of abuse until incidences involving her son initiated Social Services Department involvement. This enabled S.T. to develop appropriate abuse awareness and parental care skills. Poor self-esteem and negative self-concept improved. Therapy enabled S.T. to explore feelings about abusive experiences at school and to protect both herself and her son from further abuse.

#### Case 15

O, female, 45, culturally Deaf Sign Language user, married to physically abusive non-deaf man. Two children, works as Home Care cleaner, depressed mood, sterilized at husband's request. Communication with mother was through pointing, now no contact, Residential School for Deaf children, sexually abused by a hearing relative (did not wish to reveal identity) at intervals between 8-10 years of age, offered Deaf Centred Therapy - attended one session, felt unable to continue because of domestic situation.

#### Case 16

P, female, 29, Culturally Deaf Sign Language user, below average intellect, single, living with family at home, unemployed, low mood, attempted suicide, delusionary and paranoid experiences. Communication with family through pointing. Residential School for Deaf Children, history of sexual intercourse with non-deaf father from age 15-24. An attempt at disclosure at age 28 was rejected. Suffers sleep and eating disturbances. Symptoms of temporal lobe epilepsy of two year onset, possibly related to experience of sexual abuse. Support and counselling offered, M.P. failed to attend appointments regularly. Father subsequently died, therapy recommended and M.P. benefitted from development of confidence and assertion skills.

#### Case 17

Q, female, 44, culturally Deaf Sign Language user, married, two children, unemployed cleaner, history of low mood and depression, suicidal ideation, some limited communication with family when young, residential pupil at School for Deaf Children, offered a period of Deaf Centred therapy, disclosed history of sexual abuse by a known hearing adult family friend when aged 8-10, involved oral and digital penetration. Therapy enabled acknowledgement of abuse and expression of anger. P.D. became more self-aware and confident, went onto attend assertion skills course.

#### Case 18

R, female, 31, severely deaf Sign Language user, language disorder (dysphasia), low mood, threats of self harm and history of fire raising. Little communication with parents both when young and now. Prefers to communicate using speechreading skills and signed English.

Residential School for children with dysphasia (a central language disorder). Lives alone in a flat in a special secure unit. Disclosed in therapy history of sexual abuse at intervals throughout childhood by non-deaf grandfather. Deaf-centred therapy offered weekly enabled N.T. to explore feelings about sexual abuse. Could begin expressing anger constructively. Relationships with inmates and family improved as a result.

#### Case 19

S, female, 32, culturally Deaf BSL user. Problems with caring for her young baby within an aggressive relationship with her husband. Her first child, whom her present partner also fathered, was placed into care due to serious physical abuse and injury sustained by the baby's father. Limited communication with family when young. No contact with mother since the birth of her first child, ten years ago and had not seen her sister or father for several years. L.T. attended several different 'special' schools; unemployed and living with husband and young baby. During therapy, L.T. revealed sexual and physical abuse by an older boy whilst at school aged 11 and then by a partner when she was 18. Her husband had 'rescued' her from this sexually abusive and violent relationship. L.T. revealed present partner regularly physically and sexually abuses her. She was concerned for the care and safety of new born baby. Outcome of therapy increased self-awareness and confidence building skills, level of self-esteem improved as did development of assertion skills. Joint therapeutic work with husband in anger management encouraged development of parenting skills.

#### Case 20

T, female, 40, culturally Deaf Sign Language user, history of behaviour problems, epileptic, mild cerebral palsy, subnormal intellect. Communication with family by use of gesture and speechreading, Residential School for Deaf children during infant and junior years, then transferred to a Special School and attached workshops until 20 years old. Has since lived at home with parents. Admission for multidisciplinary assessments. Began Deaf Centred Therapy and revealed sexual abuse by maternal Uncle (hearing) from the age of 7-11. A previous disclosure attempt failed. Outcome of therapy was a greater level of independency and confidence. However, due to geographical distance, therapy could not continue to be offered, although was regularly reviewed by writer at Belfast satellite clinic.



#### Case 21

U, 19, male, biculturally Deaf Sign Language user, initially presented with symptoms of anxiety, eating and sleeping difficulties since a violent attack resulting in rape. Lives with aunt, some communication with family - parents separated when he was 6, when he then lived with an aunt. Attended mainstream school until age 9 years, transferred to Residential School for Deaf Children. Raped at age 16 by unknown non-deaf male adult. Rape was violent and involved full anal penetration, disclosed this incident two years later to a local clinic doctor. Period of therapy offered, O.G. attended only three sessions saying he felt much better. Was re-referred to writer's clinic several months later presenting with issues linked to sexuality and identity problems. Therapy recommended, progress slow and interrupted by missed appointments.

#### Case 22

V, 32, female, biculturally Deaf Sign Language user, presented with depression and attempted suicide. Reported eating and sleeping disturbance and flashbacks. Lives alone. Some communication experienced with family in childhood. Mother died when V was 11 years old. Attended residential school for deaf children until age 7, transferred to PHU. Sexually abused by a hearing female at school at regular intervals from age 15-17 years. Period of Deaf Centred therapy offered and accepted which V benefitted from. However, therapy was limited and incomplete due to geographical distance. Reviewed at writer's Belfast clinic.

Most of the original presentations were seen as behavioural or affective in origin. Behavioural problems presented ranged from difficulty complying with school environment, poor internal controls, (emotional difficulties) and aggressive temper outbursts. Distressed affective states refer to disturbance of mood, mainly persistent low mood or one of the depressed states that meet diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 1994).

Males were more likely to present as anxious when compared with females. Most females presented with a depressive affective disorder. This means disorders related to changes in mood. For example, mania, depression and bipolar disorder. The level

of distress according to negative response to attempted disclosure was considered. The experience of disclosure of childhood sexual abuse could be related to presentation of psychopathology. This means the perceived response to disclosure may have clinical implications.

In the present study there had been a prior attempt to disclose in six cases, all females, which was seen by the client as being rejected. Case 20 had disclosed to an older sister who advised the client never to mention the issue again. Cases 2 and 16 had attempted to tell the mother but were dismissed. Case 6 had received no response from one parent and negative responses from other members of the family. Cases 7 and 2 had tried to tell a teacher at the school although the abuse was not happening there. Both attempts failed. Each of the clients who had previously attempted to disclose received negative responses, and was known to be aggressive and disruptive throughout school. Table 8.3 provides details of the duration, frequency and nature of sexual abuse suffered. Eighteen of the 22 cases experienced penetrative sexual abuse. Of the remaining 4, 2 were male and 2 female and all experienced long term sexual abuse at intervals, except one male who experienced short term duration when he was 7 years old.

**Table 8.3: Nature of Sexual Abuse: sample taken from clinical practice**

Case No	Gender	Duration of Abuse by Age	Frequency of Abuse	Nature of Abuse
1	M	7-10	Regular intervals	Violent and penetrative (anal)
2	F	12-15	Regular intervals	Violent and penetrative (vaginal)
3	M	7-9	Frequent intervals	Penetrative (anal)
4	F	9-15	Long term regular intervals	Penetrative (vaginal)
5	M	7	Short term infrequent	Orally penetrative
6	F	9-16	Long term regular intervals	Violent, penetrative - vaginal and digital
7	F	12-15	Irregular intervals	Penetrative (digital)
8	M	9-12	Irregular intervals	Non-penetrative
9	F	7	Once	Rape (vaginal) violent non-penetrative
10	M	9-10	Infrequent	Penetrative (anal)
11	F	7-15	Frequent + regular intervals	Penetrative and violent rape
12	M	8-11	Irregular intervals	Penetrative - oral and anal
13	F	9-12	Regular weekly	Digital and oral penetration
14	F	8-10	Irregular	Non-penetrative
15	F	8-10	Regular intervals	Digitally penetrative
16	F	15-24	Regular weekly	Penetrative (vaginal)
17	F	8-10	Irregular intervals	Oral and digital penetration
18	F	8-13	Regular intervals	Non-penetrative
19	F	11	Several times	Penetrative (vaginal) - rape
20	F	7-11	Irregular intervals	Digital penetration
21	M	16	Once	Penetration (anal) and violent rape
22	F	15-17	Regular	Penetrative (digital)

### Concluding Discussion

There are findings linked to the differences in presentation of psychological difficulties between deaf males and females who have been sexually abused. Men tend to present as anxious and females present with low mood or behavioural difficulties, particularly at school or college.

Although many of the clinical sample did not disclose sexual abuse until interviewed or when a therapeutic alliance was established, of those who had attempted to disclose previously, all received what was seen to be a negative response. The symptomatology in these cases were not perceived by the writer to be more severe as appears to be seen in the mainstream population.

The literature, mainly American, that has been produced concerning the statistical incidence of deaf children and childhood sexual abuse, suggests that a higher incidence of sexual abuse amongst deaf children is directly linked to those attending a residential school. Sullivan, Vernon and Scanlan (1987) found a 54% and 50% incidence of sexual abuse of males and females respectively within a Residential School for Deaf Children. This is compared with 10% of hearing boys and 25% of girls (Sullivan et al., 1987). Two different residential schools were in the survey and similar figures were found. The high figures give an indication of how sexual abuse can become almost encultured into a residential setting such as a school, where teachers and care staff are able to exercise a patriarchal rule and where pupils are depersonalized. This would be particularly so with deaf children who would likely

be unable to report the abuse, either through deprivation of language, poor communication or through lack of access to information and awareness concerning the concept of abuse. Within the same setting, older male pupils will sexually abuse younger pupils (Sullivan et al., 1987). However, most of the clinical sample did not attend a residential school. Two of the sample were sexually abused by males 17 years of age, one was abused by a male aged 18. All the other perpetrators were older male adults.

Many of the child victims felt powerless to do anything about the sexual abuse suffered, even if they were able to convey what was happening, because of the fear that perpetrators instilled within them. Eight of the victims in the clinical sample complied with demands for the sexual gratification of the perpetrator under threats of violence made which implied a very serious thing would happen if they tried to tell. Five were female and three were male. In four cases, victims were threatened with the death of a parent or with serious harm to themselves, (three females and one male).

Clearly the abuser feels 'safer' knowing that there is very likely to be difficulties in communicating the experience of sexual abuse, should the deaf child attempt to 'tell'. This is influenced by lack of language development, lack of access to, or understanding or information, and the 'resignation' to what is often considered to be an extension of being deaf, poor self-esteem and self-worth. Many deaf children think the experience becomes part of life. Most clients benefitted from being able to

express anger and grief, in a constructive way. Many chose to express their anger via drawing or by 'bringing' the perpetrator into the room and telling them how they feel, letting the abuser know how angry and hurt they feel. The writer's work with deaf clients who have suffered childhood sexual abuse has frequently included discharging emotions towards the perpetrator and it seems to be an effective method, possibly more so than for non-deaf people, probably due to the *visualised* nature of such work. The Sign Language of Deaf people is a visual and spatial language and a powerful emotion that is expressed visually will lend itself to exploration in therapy, using the most visuo-spatial modes.

### Outcomes

Of the twenty two case examples, six did not sufficiently benefit from therapy. Four declined to accept therapeutic intervention. Of these, two were pre-occupied with domestic problems and one was inadvertently seen attending an outpatients appointment by fellow members of the Deaf community, and suffered teasing at the local Deaf club as a result. The centre has deaf clients from all over the U.K. and the likelihood of bumping into someone known in the deaf world is quite high. Two were unable to attend due to geographical distance which makes travel for outpatient therapy extremely difficult and tedious. Three clients who had begun therapy as residents were unable to continue to benefit, again, due to geographical distance.

This is one of the disadvantages of centralised services. Planned satellite counselling services is something which does need to be considered, whereby counselling services could be offered at outreach locations away from the centre. Locally based services would have a great deal to offer deaf people who present with a range of signs of psychological distress and emotional needs.

## PART C

### Deaf Children Growing up with Abuse

Child abuse, as a public issue, has only a short history, in particular amongst the carers and professionals concerned with child care issues today. In the past it was not unknown for adults to presume that these accounts of suffering given by children and young people were either invented or used as a means of manipulating a situation they did not like or wanted to create. Research sometimes seemed biased in favour of the perpetrator, who was sometimes seen as the victim. Historically reports of incest or attempted sexual activity between members of the same family were sometimes seen in Freudian terms, as displaced or repressed sexual activity and fantasy or denial of acknowledging sexual pleasure. Regarding incest, Henderson (1983) stated "The daughters collude in the incestuous liaison and play an active and even initiating role in establishing the pattern". The premise, taken from Freud, was basically that reports of child sexual abuse by adult women represented Oedipal fantasies. Some theorists felt that children were traumatised by their experiences but that they should have run away or called for help or resisted. The issue of physical coercion was not considered, neither was the psychological power and manipulation of the abusers.

Other writers shared this perspective and there was a consensus of psychological theorists and psychiatric opinion. Later studies appear to create a dichotomy between those children who were abused on one occasion, those whose abuse was termed



'accidental', and those who were repeatedly abused. Some victims of repeated abuse by relatives or acquaintances were seen as participants with typical personalities rather than victims. Some researchers have drawn quite strong conclusions which produce sympathy for the abuser. For example, Revitch and Weiss (1952) suggested that the majority of paedophiles are harmless individuals and that their victims are usually known to be aggressive and seductive children, often encouraging the adult offender to commit the offense.

There has also been a large amount of literature on the subject of the family dynamics and about what is seen as the mother's responsibility in cases of male carer's aggression against children. The views expressed are that the mother actively encourages incest, where the mother is directly responsible, the mother fails to set the limits to prevent incest or is aware of incest but does not or will not acknowledge this. There have been several attempts towards a definition of incest and child sexual abuse. Legally, incest depends upon the blood relationship of the abusing individual to the child and the nature of the sexual act which must include sexual intercourse. Sexual abuse often takes place within the family structure but not necessarily by blood relations. For example, the mother's new boyfriend, stepfathers, or close friends of the family may abuse. The child in these situations has the same emotional dependency as children abused by their fathers, grandfathers and brothers for example. Finklehor (1984) suggests one third of reported cases of child sexual abuse are incestuous, the other two thirds are committed by other powerful and important figures in the child's life.

Some authors have suggested that incest is a symptom of family dysfunction. Bentovim, (1992) and Taylor (1984) suggest that incest is a collective psychopathology of all the family members. The view of the family as being the cause of child sexual abuse remains quite prominent in the literature on sexual abuse (Minuchin, 1974; Kroth, 1979; Russell, 1983; Alexander, 1985; Heap, 1985; Furniss, 1991). Disabled children who were abused in the past were believed or protected even less simply because it was not an acceptable idea that people would target disabled children to become victims.

Child abuse and neglect is one of the most common causes of death of young children in Britain today and up to four children die at the hands of their parents and relatives every week (BASPCAN 1st National Congress, Leicester, 1991). The short and long term effects of abuse on a child can include physical and emotional problems and can include a range of intensities and difficulties. The nature of the problem depends on the individual child and the type and frequency of abuse as well as whom the perpetrator is and how he forces himself upon the child. Abused children tend to have lower self-esteem (Oates, Forest and Peacock, 1985) and are often less ambitious than children who are not abused (Kempe and Kempe, 1984). Physical and developmental delays can often be the result of abuse. Abused children will often do less well in school and may even have developmental delays in language and learning. Poor motor co-ordination has been reported in child sexual abuse victims (Kempe and Kempe, 1984). Often, abused children are aggressive, withdrawn and anti-social, self-destructive and may also be emotionally disturbed (Krent, Schulman

and Brenner, 1988). The affects of abuse can lead to isolation, rejection, poor self-esteem, powerlessness, guilt, anxiety and fatigue as well as stress, stigmatization and sexual behaviour (Baker and King, 1990). Self blame, anger, hatred and frustration are further possible responses to abuse. Anxiety, guilt, anger and experiencing grief processes can be manifested in a variety of ways (Baker and King, 1990)

Gradually, the number of abuse cases that emerged which parallel increasing awareness in the general population became a cause for alarm and a pool of resources was placed into this field. Training courses for professionals, therapeutic techniques for helping victims and statutory child care procedures have all been implemented where none existed, or were improved but they still require further development (Glaser and Froth, 1988). In addition to this, the deepening interest of topics of sex and sexuality and the Womens' Movement and equal rights campaigns, and more recently, focus on children' rights, have all been essential in creating a climate where these topics are more openly discussed and assumptions challenged. The feminist movement has done a lot to enhance awareness of issues of oppression and dominance and this has highlighted some core concerning conditions of worth in which this society has been built and which are now opening for challenge. One of the basic issues confronted by professionals in the field of child sexual abuse is whether or not abuse is a product of dysfunction in the family or a product of a patriarchialism that surrounds a tradition of oppression of women and children and violence in expression? The same questions can be raised in the area of physical abuse, emotional abuse and neglect as well as psychological abuse although they are not

exactly comparable and none produce the shame, guilt, and secrecy that experiencing childhood sexual abuse does.

### Defining Sexual Abuse

Returning to the definition of sexual abuse, since not all children have an understanding of what might be harmful or even that some activities are harmful, or perhaps do not share the same perception of what is exploitative nor share the same view of what might be construed as sexual, this means that children may be abused without being aware of it too. In the case of children who are deaf this risk is higher. Definitions therefore require the examination of the intentions of the abuser as a main criterion. This is not always possible, and there are many factors which need to be taken into consideration. The best available definition however is probably that of Baker and Duncan's (1985) which is based on interviewing 2019 women and men aged 15 or over in a random representative British population. The definition of sexual abuse that each person was presented with involved the idea of someone sexually mature involving them in an activity which the other person expected to lead to their (the perpetrator's) own sexual arousal (Baker and Duncan, 1985). This is the definition which best fits the school of thought which attempts to include the intentions of the abuser. This definition includes activities which may include intercourse, touching, exposure of sexual organs, showing visual pornographic material or talking about sexual things in an erotic way. This is thus a quite broad range of activities. Ten percent of interviewees reported such experiences prior to the age of 16; Seventy-seven percent reported no sexual abuse and 13% did not

answer. Ten percent implies over 4 million people in the U.K. who have been sexually abused as children. However, these figures are lower than some other studies. Hall's (1985) study of 1236 women, found that 21 % reported being sexually abused as children. A study of college students in the U.S.A. by Finklehor (1979) revealed sexual abuse experienced by women were 19% and 9% for men. Baker and Duncan (1985) obtained rates of 12 % for girls and 8 % for boys. These figures show a much higher incidence of abuse towards females than males. All studies have indicated this. Research has shown generally that between 96-99% of abusers are male (Russell, 1983; Kelly, 1991).

Research provides evidence that an increased number of deaf children compared to their non-deaf peers suffer from sexual abuse (Sullivan et al., 1987; Kennedy, 1988; Ridgeway, for this study). The degree of intensity of feelings of oppression and dominance, of violence and cruelty become for a large number of deaf youngsters, a part of everyday life and an internalised negative self concept develops and creates the foundation on which all other experiences of abuse are perceived. Drawing attention to the fact there does not appear to be a universally agreed set of definitions which constitutes the meaning of sexual abuse, it would be useful to discuss this prior to continuing to explore the situation for deaf children. Finklehor, (1984) defines sexual victimisation as sexual encounters of children under age thirteen with persons at least five years older than themselves and encounters of children 13 to 16 with persons at least ten years older. There are many different definitions and a helpful effective definition would be one that is clear about what is meant by the term sexual.

Possible definitions would include intercourse, anal-genital contact, fondling, or an encounter with an exhibitionist. Baker and Duncan, (1985), for example, use the following definition:

**"A child (under sixteen) is sexually abused when another person, who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal". (Pg. 458)**

Schechter and Roberge, (1976) define sexual abuse as:

**"The involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles". (Pg. 60)**

### Deaf Children and Sexual Abuse

Of importance is the term "informed consent". Deaf children have historically not been informed although today are more likely to be, but not necessarily in a language or mode of communication which they can understand. What seems to be emerging is that in the past a large amount of information was withheld from deaf children either because of the belief that it would be better for them not to know and because it would be too difficult and confusing to explain. These views are understandable in the absence of effective and meaningful communication, for example, in schools that use an aural-oral approach. Deaf children of deaf parentage frequently passed information onto their deaf peers rather like a form of sex education. Later, as schools became more obliged to ensure (deaf) children received some form of sex education, information was provided in somewhat covert form - for example, in

written English, rather than by visually explicit material which would be more helpful to deaf children. In the present climate **some** schools provide deaf children with sex education and provide some limited supporting information. Most deaf children, however, might be caught between the hidden aversion towards the teaching of the topic between teachers and the carers of the children. Often, one discipline hopes that the 'other' will do it. It is quite likely that the deaf child will not have internalised the written information if any was provided, and thus will not have built sufficient awareness or worse, could perceive incorrect or misleading facts or information from the written information. The low self-esteem and poor self-concept of a number of deaf children and adults (Brauer, 1988; Carver, 1992) raises this issue because it highlights the "informed consent" aspect of which many deaf children do not have access to the concept in the first place. Since most of what happens in a deaf child's life is not informed, the deaf child tends to learn to just go along with whatever is happening and to accept this. Going out on a shopping trip, going to visit a seaside resort, visiting grandma, having a birthday party, going to the movies are all things that just "happen" to the deaf child growing up since oftentimes the deaf child will not know where he/she is going until he/she arrives.

### Abuse and the Disabled Child

Brief mention will be made here of children with disabilities who are abused. Some of the underlying issues are similar to those raised where deaf children are sexually abused, in terms of the 'rationale' of the perpetrator, who considers it 'safer' to abuse a disabled child, who may be less able to disclose or who will often be disbelieved.

This has been particularly the case for deaf children. People with learning disabilities have been, and remain, extremely vulnerable to sexual abuse.

In a study conducted by Brusadin (1991) in a paper presented at the Ninth International Congress for the Prevention of Child Abuse and Neglect, Chicago, out of a population of 700,000 (total children = 112,535) in the Veneto region in Italy (1989-1990), it was found that 599 children had severe mental or physical handicaps. In this population of 362 males and 237 females the prevalence of a disabling condition was 14% with a mean age of 8.7 years. It was found that 83 children were neglected and 2 suffered from physical violence which brought the prevalence of abuse in the group of handicapped children to be 14.2%. Of the entire population there were 575 sexually and physically abused and neglected children and the general prevalence was 0.5%. The authors have suggested that the strong association that they found between disability and abuse might be due to the effects of the disability itself increasing the risk of abuse or that social conditions within the family might be a risk to increase both disability and abuse. Brusadin concluded, however, that the association between disability and abuse was indirect due to the effects of other social factors, related either to the disability or neglect on the part of carers in the child's life. There has been a huge increase in the number of reports of child abuse across the United States (Krent, Schulman and Brenner, 1988). In 1984 an incidence of 27.3 children per 1,000 cases were reported (Soukup, Wickner and Corbett, 1984). Most cases are not reported. Soukup et al., (1984) have estimated in their American research studies over ten years that for every child sexual abuse victim whose



situation is discovered, there remain 24 undiscovered. Information on the numbers of children who are sexually abused but who do not report it are taken from questionnaires which are completed confidentially by research samples. From the figures given for the 1984 American survey, (Soukup et al., 1984) 43% of the children involved in abuse were under 5 years of age, 33% were 6-11 years of age and 24% were 12-17 years of age. In addition, it was also found that in 49% of the reported cases, the abuse was perpetrated by professionals involved with the care of disabled children. These professionals included social workers, school staff and child care officers. Non-professionals, that is neighbours and friends and relatives, tended to report 54% of the suspected abuse cases reported in this study. The American Office of Human Development Services (1988) carried out a survey in 1988 which ascertained the prevalence of sexual abuse in females to be four times the rate for males.

There have been some studies designed to find the relationship between the incidence of abuse and child disability. It is a generally held belief that children with disabilities are at a higher risk of being targeted by abusers than non disabled children (Kline, 1982; Zirpoli, 1986; Morgan, 1987). There are a number of identified reasons for this: disappointment on the part of the parents; embarrassment, (Morgan, 1987); social and economical pressures; strain in family relationship; budgeting problems and tension and health problems. Families with high levels of stress are found to have higher levels of abuse in their homes (Strauss, 1980). This includes sexual, physical and emotional abuse and neglect. If the disability will be

"handicapping", the "initial impact of the diagnosis is just the beginning of chronic relentless stress" (Murphy, 1982). A child with a disability will thus be a source of stress within the family. Zirpoli (1986) has identified that these children are more likely to be abused for a longer period of time than children who are not disabled and this is in addition to the higher risk for abuse that they suffer. Here is a list of conclusions from my own observations:

Offenders may think it is safer to victimise a child with a disability.

Disabled children often do not receive the same information about sexual abuse as their non-disabled peers and are less likely to understand the appropriateness or otherwise of an abusive or potentially abusive situation.

Disabled children often depend on those who provide services and care for their disability.

A high number of the carers or providers of services are in many cases the perpetrators of the abuse.

Disabled children often receive less affection from the people in their lives in general in comparison to other members of the family and there is also less social interaction with both peer group and friends and others.

These issues indicate that children with disabilities may therefore be more vulnerable to accepting a sexually abusive relationship where they are in need of affection and might accept this as a form of attention or befriending. The child may also be unable to disclose the abuse even if they wanted to and some disabled children have known something has been inappropriate but have been unable to report the abuse either because of their disability or because no-one has been able to try to understand them.

In a study of children with mental and physical disabilities in New Zealand, (Sobsey, 1992), it was found that children with disabilities were more likely to be abused sexually than children without disabilities. The children and adolescents who were sexually abused had a variety of mental physical and sensory disabilities and the abuse was typically severe, repeated and chronic, in particular for children with severe disability (Sobsey, 1992). Teuns (1992) identified a number of children who might be considered as being high risk and vulnerable children in his Amsterdam study. These children included those with congenital abnormalities, handicapped cognitive equipment (learning difficulties), neurological delays, blindness or deafness. Teuns suggests that there may be a variety of poorly understood ego disturbances within the child being abused which might result in difficulty coping with aggression, inadequate stimulus or hyperactive response to stimuli. The environment may become negative in terms of its response to the disabled child, this creates an at risk situation for the child in addition to his initial vulnerability. For example, a congenitally handicapped child is more often exposed to rejecting attitudes than a child without such features or characteristics. According to his definition deaf children are already high risk children and are becoming increasingly vulnerable in terms of society's rejecting attitudes.

Knutson and Sullivan (1993) conducted a review on the incidence of abuse where the child has a communicative disorder. Communicative disorders, in their definition, include hearing impairment, speech or language impairment - cleft lip or palate (United States Department of Education, 1989). With increased recognition of the

role of language in successful psycho-social interaction and development (Rice, Wilcox and Hadley, 1992), communicative 'competency' is increasingly seen as a risk factor for abuse. However, there is some debate over whether it is the disability causing stress that results in abuse, mainly physical abuse or neglect (Jaudes and Diamond, 1985) or if the disability is a consequence of the abuse. A number of developmental difficulties have been associated with abuse (Augoustinos, 1987). Disabilities can not only be a form of chronic stress or for carers of disabled children but can be instrumental in the process of attachment and belonging. Bowlby has written extensively on the subject of attachment development.

#### Studies in the U.S.A.

Whereas 8% of hearing boys and 12% of hearing girls report sexual abuse (Baker and Duncan, 1985), the rates from the American studies of deaf children indicate 54 and 50% for boys and girls respectively. This, apart from being much higher, is unusual as in this particular case the figure is higher for boys than for girls. In a study of 150 children attending a residential school for deaf children, interviewees revealed 75 of the 150 children (50%) reported they had been sexually abused. Twenty of them were victims of incest at home (Sullivan, Vernon and Scanlan, 1987). In yet another study involving 100 deaf children from several different parts of the U.S.A. (18 States) who were from a mixture of mainstream and residential educational services a high incidence of sexual abuse was reported. Interviews of the 64 children who attended residential schools revealed 40 who had been sexually abused at school, 10 sexually abused at home and 15 sexually abused both at school and home. The 35

children who came from mainstream placements reported similarly high findings. Twenty-one reported sexual abuse at home, 9 reported sexual abuse at school and 5 reported sexual abuse both at home and school (Sullivan and Scanlan, 1987). The deaf population reporting sexual abuse said that the abuse often occurred in transit from home to school or school to home, or in their in bathrooms or in bed. The residential children were more likely to have been abused at school and about 20-25 % of the deaf young people interviewed were sexually abused both at school and at home (Sullivan, Vernon and Scanlan, 1987). It appears then that the often long bus rides or taxi journeys that many residential school deaf children have to make became a high risk situation for sexual abuse particularly since a large number of these trips were unsupervised, although to a lesser extent today because of more stringent procedures in recruitment of care workers generally. More recently the Paedophile Supervision Registers Act in the U.K. has come into force as of September 1st 1997. This goes some way to providing protection for the public.

Professionals appear to play a greater role in the lives of deaf children and thus will be more likely to identify or suspect an abusive or potentially abusive situation concerning a deaf child than a non-professional due to their inability to sign and a lack of understanding of the communication issues and the fact that over 81 % of deaf children are unable to communicate with their hearing parents (Phoenix, 1988). This means that the professionals, who do have some communication skills or understanding of deafness will be more likely to have some understanding of the deaf child and what he or she is trying to communicate than the parents will.

The studies from the U.S.A. show high numbers of the incidence of sexual abuse reported. There are a number of issues involved in the subject of child sexual abuse and issues arise in the definitions used, in the criteria of age, in the level of psychological development of the child, in the comparative emotional damage suffered and in the perception of the activity. This thesis does not address these issues nor does it enter into a debate on the criteria which should or should not be used but is simply highlighting the concerns which need to be borne in mind when reading any material related to this field.

#### Studies in the U.K.

Studies in the U.S.A. (Money, Annecillo and Kelly, 1983; Gabarino, 1987; Gabarino, Brookhouser and Authier, 1987; Taitz and King, 1988; Ammerman, Van Hasselt, Hersen, McGonigle and Lebetesky, 1989; Flaherty and Weiss, 1990 and Hill, Hayden, Lakin, Meke and Arnado, 1990), which examined the incidence of abuse in children with disabilities led to studies involving children with sensory disabilities and the observation that deaf children were at higher risk from all forms of abuse.

Margaret Kennedy conducted a study in Britain of the incidence of sexual and physical abuse of deaf children in 1988 involving a survey of teachers and social workers with deaf people. Questions asked if they were involved in deaf child care cases, and if abuse was suspected. Three hundred questionnaires were sent out to the teachers and social workers and 156 responses were received. The questions asked for the number of cases where there was a suspicion of abuse (e.g. a recent complaint

or concern being investigated). The questionnaire also asked how many confirmed (following enquiries and established procedures resulting in confirmation of abuse) cases of sexual, physical and emotional abuse had there been during the year of the survey. The returned results showed physical and emotional abuse, 192 suspected, 86 confirmed; sexual abuse, 70 suspected, 50 confirmed. Kennedy's research has a number of weaknesses. No definitions are given for sexual or physical abuse. The questionnaires in the sample were sent out to known social workers and teachers working with deaf children and adults which excludes the majority of child protection workers who are not specialists in work with deaf people. Furthermore the social worker with deaf people is not always involved in cases of sexual abuse of deaf children; neither are teachers. The research is therefore highly biased and probably not a statistically valid piece of research. However, the figures do suggest a serious problem and provide an indication of the incidence of abuse in deaf children, supporting American research which has shown a higher incidence of sexual abuse of deaf children than hearing children (Sullivan, Scanlan and La Barre, 1986; Swan, 1987).

#### Present Study: Misperceptions of the Meaning of Abuse

In the present community sample study in a population of 102 deaf adults from the North West of England, the criteria used to define sexual abuse was explicit and precise and the definition covered the terms rape or attempted rape. For this study the terms mean attempted or actual vaginal or anal penetration by an adult with a person under 16 years of age. In all the reported cases, the adult was over 19 years

of age. Interviewees were encouraged to express what they feel may have been an adverse experience whether or not they realised it was abusive. In Sign Language it is easier to convey the question with an openness which encourages the interviewee to understand that their experience of abuse, no matter how they see it, can be recognised. It has materialised in several interviews that the interviewees had thought that their own experience did not count and had therefore attempted to minimise them. This did not seem to be a product of psychological defence mechanism but rather more of a reflection of a belief that these experiences were a part of normal everyday life and happened to everybody. A number of women in the sample initially said they had not been abused sexually but clarification of their concept of abuse revealed they had inappropriate, misinformed or incorrect beliefs about sexual abuse.

**Case Example:** One young woman, Mary (28), was made to perform fellatio when she was seven years old, on a regular basis, for a non-deaf male school escort twice weekly over a period of three years, whilst a day pupil at a Partially Hearing Unit. Initially Mary had said she had not experienced abuse. When the definitions were discussed, Mary then revealed she had thought that sexual abuse was limited to penal vaginal penetration.

Of particular interest here is the understanding of the term rape. A number of deaf women reported that they had never experienced rape but when they described the abuse they had suffered, we have discovered that what they experienced was in fact rape.

**Case Example:** One woman, Rachel, was raped by her landlord whilst a student at college for Deaf people. She was seventeen at the time. The perpetrator said if she did not agree to sexual intercourse with him, he would tell her parents she was a bad girl. Rachel 'agreed' to sexual intercourse and believed that because she had 'agreed' it could not be



called rape and therefore what was happening was her own fault and her responsibility.

**Case Example:** Another rape victim, 56 year old "Molly", said she was raped when she was thirteen. When told to comply by her violent father Molly thought that because it was her father it could not be considered rape.

**Case Example:** Richard (22), was raped whilst walking past a bus station and pushed into an alleyway by a motorcyclist who threatened him. Richard was sixteen at the time and was going home from visiting friends for the weekend. Richard who attended a residential school for deaf children, thought only women could be raped and hid his experience until he was twenty-two, when he began to develop symptoms of anxiety and obsessional features. He was referred to the writer for psychotherapeutic assessment.

Some of these misperceptions may be attributed to the fact that rape when presented in movies is usually violent and sometimes sadistic. This may be a reflection of the lack of access to information in their first language, British Sign Language. The implication is that information is processed, based upon what is seen and "not heard". For example, we know that rape does not have to be overtly violent. In fact, contrary to what is often seen on T.V. and other media, there is often no struggle and a victim can be physically compliant in an act of rape. In these cases, what defines an act of rape is the lack of consent to penetration and which, because it can appear passive, may "persuade" the onlooker into thinking this is not an act of rape simply because it does not involve violence. Many of the participants who were interviewed who reported sexual abuse were reporting the abuse for the first time and some were learning new concepts about the issue of abuse also for the first time. This will be discussed in more detail later. Also of interest is that in this study ten women

reported both sexual and physical abuse by their partners. This is over 10 % of the study population.

### Deaf Children and Abuse - Risk Factors

Deaf children seeking to report sexual abuse may also have problems in finding someone who they can confide in - finding someone who can understand them may be a terrible strain, especially if the deaf child is having to try and use speech that may be unintelligible even to those who know the child well. The child may not have developed Sign Language, because the environment has predominantly presented with verbal oral/aural communication or may have suppressed the development of Sign. As previously reported 81 % of deaf children are not able to communicate with their hearing parents and are thus probably not fully integrated members of the family. Teachers at the school or other professionals involved with the child may or may not know Sign Language, hence the additional difficulty in reporting abuse or attempted abuse. Sometimes, even if the adult the child is trying to tell knows Sign Language, difficulties may persist where the vocabulary may not be known to the adult or maybe the child is using an ideosyncratic sign vocabulary of their own and which the professional may not recognise or understand. This might lead to the information being dismissed, misused or misunderstood. The effect this may have on the deaf child can have long lasting implications for trust and esteem.

Generally, in about 80% of cases where a child has been sexually abused, the perpetrator is someone the child knows (Peters, 1976; NSPCC, 1987). Ninety-four

to ninety-seven percent of perpetrators are male (Russell, 1983; Kelly, 1991) and 80% of boys are sexually abused by men (Finklehor, 1986). This means that perpetrators who are attracted to young children will often try to gain employment in school establishments where there is already a tendency of pupils to comply with authority. This places the deaf child in a high risk group and the research figures shown earlier, of surveys in the U.S.A. demonstrate this. Deaf children are already vulnerable simply by the fact that they become almost totally dependent upon those who are in charge of their care. Deaf children cannot know what is not seen and thus depend upon others for their access to any information, access to love, care and their physical and emotional needs as well as social needs. In addition, as pointed out by Sullivan, Vernon and Scanlan (1987) and Kennedy (1988), deaf children tend, as all children are, to be quite curious, although in the case of deaf children this characteristic might be more pronounced in their search for information through inadvertent lack of stimulation compared to non-deaf children who receive stimulation 24 hours a day in the auditory, as well as visual, channel. This positive stimulation enhances mental and physical social well-being. Deaf children receive limited stimulation if linguistically deprived.

Another factor which has a significant influence on the lives of sexually abused deaf children is that a feeling of depersonalization seems to be present in the way they describe their responses. Depersonalization is a change in self-awareness whereby the person experiences feeling unreal. Those who experience this do feel this is difficult to describe, and feel 'detached' from their own experience - to the point

where it can be like the 'cutting off' of emotions. Depersonalization can occur in a broad context, in schools as well as in the home environment. One of the participants interviewed in this survey reported how every morning the pupils were forced to queue in a line to go to the toilet to empty their bowels. This was during the years 1970-1980. The pupils at that time, and possibly even later than this, were made to sit on the toilet until the act was completed and would be hit on the back of the head with a bunch of keys if nothing was produced (Personal Communication, 1995). The fact of being unable to access activities on an equal basis - for example, witnessing an argument and being unable to take sides, join in, play referee or form an opinion, creates the situation where the deaf child becomes more ingrained into his inferior role and thus accepts what is offered. The attitudes of those around the deaf child is the main concern where depersonalization takes place, reinforcing the intangible feeling of 'you're not the same quality as us so you have to just make do with and accept your situation in life' creates the feeling of depersonalization and thus acceptance - a passivity which can become pervasive.

Deaf children probably have very little or no information about sexual issues, sexual behaviours and the usual behaviours and expectations and norms in sexual encounters. Some professionals go on to suggest that deaf children are also more likely to be abused because they may like or welcome intimate contact more than non-deaf children as this will be viewed as a form of love and being cared for. Obviously this view cannot be dismissed as it is highly likely that a deaf child without appropriate access to his first language, without access to information and an appropriate

environment stimulation (mental and physical) may interpret the intentions of a perpetrator as the intentions of someone who loves and cares about them and the child may not want to reject them. These factors probably contribute to why even fewer deaf children than non-deaf children report abuse when it happens. Less than 5% of the non-deaf population report abuse to formal authorities. In this study only 2 participants had reported the sexual abuse experienced to an authority, for example, the local social worker or a teacher. The percentage is much less, since deaf children will usually not understand abuse issues nor be aware of systems for reporting and quite often will not be aware it is wrong. In addition, children do not discuss sexual abuse unless they are specifically asked (Sgroi, 1982). This is partly due to limited understanding and knowledge of what is happening and is probably more so for deaf children which is why in the sample population interviewed, specific and concrete detailed questions were asked relating to possible experiences of abuse. Because of the deprivation of early language development many deaf children experience, this means deaf children are more likely to be concrete in responses to questions - including in child sexual abuse cases. Researchers suggest that deaf children will respond if examples are provided but this could be 'leading' or 'feeding' and which could be potentially misleading. Responses from deaf children therefore tend to be to closed questions (Yes and No questions), with difficulty in responding more abstractedly to open questions.

Psychologically, children, deaf or hearing, may fear rejection, punishment, loss of love from parents or blame for sexual incidents. Children can also harbour for years

feelings of revenge, illness, disease, being pregnant, being taken away or removed into care or an institution. Perpetrators usually make the children afraid and create an atmosphere of fear in the child (Finklehor, 1986). Deaf children will respond with fear to threats from perpetrators who warn them about the results of their "telling". Fear is fostered into the deaf children who then live in fear of telling and this has quite far reaching implications and consequences on their behaviour. They may fear that they will not be believed, that their parents will divorce or the parent *or* the offender will go to prison (Sullivan, Vernon and Scanlan, 1987).

There are a number of risk factors which have been identified in various studies using a non-deaf sample population. Finklehor (1980) has produced a "Sexual Abuse Risk Factor Checklist". This consists of factors such as having a stepfather, low income, not being close to mother which are seen as increasing the risks of sexual victimization for girls by 10-20%. Kempe and Kempe (1978) also identified a number of risk factors such as parent being beaten as a child, low self-esteem, social isolation, and unrealistic expectations of the child or the child's behaviour. These risk factors have been used to predict risk quite accurately (Bedford, NSPCC, 1987). Unhappy parental childhood and bonding problems are a further two examples, the latter are probably the most likely factors to be taken into consideration where deaf children are concerned. This is because quite often there is little bonding with the family in terms of issues linked to communication. Eighty-eight percent of deaf children are born to, or placed with, non-deaf carers and of this, 81% (Pheonix,

1988) will not have experienced effortless communication with either of their parents during the first few years of their life.

### Environmental Risk Factors

Bolton et al., (1989) have described an 'Abuse of Sexuality Model' (Table 8.4)

**Table 8.4: Abuse of Sexuality Model**

1	<b>Ideal Environment:</b> Supportive, nurturing of sexuality, sexual information given on request at appropriate level for child.
2	<b>Predominantly Nurturing Environment:</b> Much as described above, but inhibited communications.
3	<b>Evasive Environment:</b> Little information about sexuality given; information may be intentionally or unintentionally misleading; confusion results.
4	<b>Environmental Vacuum:</b> No information; little affectionate interchange; feelings ignored or not discussed.
5	<b>Permissive Environment:</b> No restrictions about sexuality; accurate information given but with such frequency and at such a level that it cannot be digested; child may be exposed to adult behaviours and nudity which are over stimulating.
6	<b>Negative Environment:</b> Misinformation, negative attitudes, sex is bad, harmful, abnormal, sign of moral weakness.
7	<b>Seductive Environment:</b> Gives message that child is interesting to adults in sexual ways; sexual contact not usually present; information presented to titillate the child.
8	<b>Overtly Sexual Environment:</b> Sexual contact between adult and child; attempted or successful vaginal/anal intercourse; cunnilingus; anilingus; fellatio; genital fondling; digital penetration.

The model (Table 8.4) lists eight different types of environments most children growing up experience. In relation to the experience of deaf children growing up, it is unlikely that access to environment Type 1, the ideal environment, would be experienced. This is given the language deprivation most born deaf or early deafened children experience. Environment type 2 is also unlikely to be available, particularly in terms of nurturing and 'moral' considerations. Religious considerations can create fear and confusion where access is often limited to what is actually seen - hence, descriptions heaven and hell may be taken quite literally. Many of the residential schools that the deaf adults attended as children practised a form of religion, often quite rigidly. Several of the sample reported abuse by religious representatives within the school such as nuns or priests. It was extremely difficult to question or protest in such circumstances.

Environment Type 3 and 4 were often experienced by deaf participants in the sample. Parents generally avoided situations where explanations had to be given and would often provide short or gestured responses to questions. Many participants felt unattached to their non-deaf families as a result. The other environments listed in the context of deaf children, would relate to the increased likelihood of a deaf child becoming vulnerable to the experience of sexual abuse. Visual information gathered in environments 6 and 7 can lead to misconceptions, often unintentional. A deaf child will easily pick up messages about sexual activities, based on what is seen. An



environment might unintentionally present as 'seductive' to a child who may access sexual material and think it is okay or 'normal' - and fail to pick up the educational cues adults give.

A number of particular factors can therefore be seen to emerge in families where there are deaf children. Warning signs of possible risk of abuse in studies of non-deaf children (e.g. Finklehor, 1980), include not being close to mother, low income having a stepfather, parent being beaten as a child, low self-esteem, social isolation and unrealistic expectations of the child. Table 8.5 shows a list of risk factors which are considered additional to those previously mentioned. These predictors of abuse may be of relevance for all deaf children in terms of their psychological and social well-being.

**Table 8.5: Abuse Predictors for Deaf Children**

a	<p><b>Early Language Development</b></p> <p>Most deaf children will have minimal language skills in English and particularly in Sign Language, at least during the early years of life. In addition, the discovery of deafness is often not made at onset of deafness. This can delay appropriate language development.</p>
b	<p><b>Exposure to Deaf Peers</b></p> <p>Deaf children often lack access to their peers in childhood. This is particularly so until access to school, dependent upon school environment. In the present educational climate of integration, some deaf children may experience isolation from their peers until perhaps their teenage years. This has implications for psycho-social development of deaf children and the self-concept.</p>
c	<p><b>The Perception of Deafness within the Family</b></p> <p>If the family views the deafness as negative, which in most cases it will initially be, the child will pick this up and will likely internalise it. Such feelings can go on for years with carers often not accessing appropriate information until much later in the deaf child's life. Some of the participants reported bitterness towards professionals who had not provided their families with help or access to signed communication. Some parents had begun learning Sign Language much later in the deaf adult's life. Low self-worth gradually develops and attachment may be sought from others. This puts the deaf child in a position of vulnerability to abuse. Poor or inappropriate parental involvement in the deaf child's life are additional factors to predisposition to abuse. Unrealistic expectations might be held of the deaf child in addition to low expectations which may be perceived because of the deafness. The deaf child may internalise a low level of self aspiration.</p>
d	<p><b>Self-Image and Self-Worth</b></p> <p>A negative self-image and poor level of self-esteem often develops as a consequence of the difficulties in growing up in a 'non-communicating' non-deaf family. Access to information is restricted and negative feelings towards the deafness are internalised. This indicates vulnerability to abuse by adults who may express 'acceptance' and willingness to provide appreciation and affection to the deaf child. Low feelings of self-worth may be reinforced by adverse abusive experiences which 'confirm' the internalised negative perception of the self.</p>
e	<p><b>Social and Educational Isolation</b></p> <p>Deafness is well known for its potentially isolating experience and this is particularly so for deaf children and young people, although not usually for deaf children from deaf families. Educational experiences may be potentially isolating, depending on placement and this creates increasing vulnerability to abusive experiences. Perpetrators of abuse are attracted to children who appear isolated as this makes it safer for the abuser.</p>
f	<p><b>Deaf Consciousness Development</b></p> <p>What this means is the development and awareness of being deaf, knowledge of deaf issues, attachment to cultural aspects of Deafness and of a shared sense of belonging and togetherness with likeminded others. Without this awareness, deaf children will often be behind in terms of skills such as confidence building, assertion and ability to distinguish and express emotions.</p>
g	<p><b>Deaf Identity Development</b></p> <p>Learning about deaf people and the community, Deaf culture and the way of life of Deaf people are all part of Deafhood (Term coined by Ladd, 1997). Deaf humour, arts, theatre and Deaf centred events, are all part of being culturally Deaf. Knowledge of Deaf history and achievements by Deaf people are also part of understanding and being deaf. Deprivation of access to such knowledge can cause feelings of rejection which in turn often results in inferiority feelings, thus creating further disposing factors to vulnerability to abusive experiences.</p>

### Deaf Parents' Views on Child Abuse

In one of the first studies of abuse and deaf children, Schlesinger and Meadows (1972) found their figures suggested carers of deaf children were more likely to use physical restraint and punishment than if the children were hearing. Whether this materialises in the reverse (deaf parents of hearing children) does not appear to have been discussed in the literature although the writer held a number of informal conversations with a range of deaf adults in North London in 1990. What these conversations revealed were that deaf parents tended to minimise the effects of abuse generally. The deaf population involved in this group suggested that children, both deaf and hearing, because they were young, would not suffer problems later as a result of physical abuse because they get over these things and it was a normal part of life to experience problems, including abuse. However, when questioned about their views on how they thought children would respond to being sexually abused, nearly all the deaf parents said that, although they knew it was wrong, the children would get over it and 'forget'. They associated lack of **visual** suffering with a very much minimising attitude towards the effects of sexual abuse even when information on psychological implications was conveyed to the deaf parents by the writer.

### Psychological Consequences of Childhood Sexual Abuse

Sexual abuse seems to be a major mental health issue at all ages (Frude, Peake, Sambrooks, Stratton and Cullen, 1990). Cole and Putnam (1992) in their research suggest a strong similarity between childhood and adult responses to child sexual abuse, for example, distortions in body image as a child may lead later on to eating

disorders as an adult. Female survivors of child sexual abuse may experience 'revictimisation' (Wyatt, Guthrie and Notgrass, 1992) from other abusers. Male survivors are seen to suffer more likely from disturbed sexual functioning (Beitchman, Zucker, Hood, da Costa, Akman and Cassavia, 1992). Smith and Bentovim (1994) conducted a review of what they consider to be observed psychological impact of childhood sexual abuse and identified sexualizing, anxiety and emotional effects, depressed mood and behavioural effects of childhood sexual abuse.

A U.K. survey (Ussher and Dewberry, 1995) found that out of 775 women who had survived sexual abuse in childhood, 68% felt angry, 66% experienced shame, 60% guilt, 5% anxiety, 31% were afraid of sex and 27% afraid of males. Two percent reported no effect.

The main predictor of long term psychological problems within the mainstream (hearing) population appears to be based on whether the sexual abuse occurred in the context of actual or potential violence, verbal threats or blaming the child. Vernon (1997) in his analysis of 20 deaf male paedophiles, suggests a link between the violent sexual abuse many of them experienced themselves as children and the behavioural and emotional difficulties experienced in later life. Here we can see similarities to the experiences of the clinical sample who are the focus of this section. Another predictor identified was the duration or frequency of the abuse. Severe long term sequelae have consistently been associated with penetrative abuse and abuse of longer term duration (Jehu, 1988; Mannarino, Cohen, Smith and Moore-Motily, 1992).

This does not seem to be reflected in the participants of the writer's clinical sample, nor seen in the community sample. Ramsey (1990) suggests a clinical syndrome of Post-traumatic Stress Disorder (PTSD) (DSM-IV, American Psychiatric Association, 1994), which is an identified group of symptoms seen as a consequence of a distressing event which is not usually experienced. Symptoms include recurring and intrusive thoughts, (sometimes referred to as 'flashbacks'), reliving the 'event', sleeplessness and hyper vigilance (Ramsey, 1990). These are similar to the anxiety effects identified by Smith and Bentovim (1994)

Not all children or adults will experience such symptoms of PTSD. Nine (cases 1,2,4,6,8,13,16,21 and 22) of the clinical sample of Deaf people presented with some symptoms of PTSD. Of these nine, one did not experience penetrative sexual abuse. However, 'early maladaptive schemata' (deeply held dysfunctional beliefs which influence the response to the event through its interpretation) is seen to account for this (Young, 1987). Deaf children who suffer sexual abuse tend to interpret the sexually abusive activities in a way which provides a 'rationale' for what happened, as seen from the responses of interviewees in the community sample. Beliefs are internalised which 'explain' what happened to them as children, and as such, are interpreted from a psychoanalytic perspective. Survivors with disorders have been found to have more intense self-derogatory and self-denigratory beliefs and 'abuse related information-processing bias'. For example, hyper vigilance to abuse related cues which often involve intrusive thoughts. From a cognitive-behavioural perspective, (Foa, Steketee and Rothbaum, 1989) the symptoms of PTSD might link

to phobias and aphobic avoidance. Only two of the clinical sample (cases 5 and 12) could be seen to display phobic symptomatic behaviour.

The developmental psychopathology model of Cole and Putnam (1992) (Table 8.6) suggests three areas of self-development where external stressors (such as child sexual abuse) cause difficulties:

**Table 8.6      The Developmental Psychopathology Model (Cole and Putnam, 1992)**

1.	<i>Self-Integrity</i>	Identity confusion and dissociation
2.	<i>Self-regulation</i>	Poor affect and impulse control (includes being self-destructive and self-critical)
3.	<i>Social problem</i>	Insecurity, distrust, suspiciousness, isolation and lack of intimacy

Many deaf children will experience disruptions in these areas in their childhood and in growing up, and need to develop coping skills in respect of the deafness. The experience of child sexual abuse in deaf children could reinforce the need for the existence of the ability to deal with problems in the external environment (disruptions). These disruptions in self-development can be explained in relation to the role of different coping strategies adopted during different developmental stages (Cole and Putnam, 1992). What this means is, for example, in early childhood, denial or dissociation may be adopted as a primary coping strategy. Later, these defence mechanisms may become rationalization, or in blaming others. The deaf victims of childhood sexual abuse in the clinical sample (n=22) tend to experience

some dissociation and later tend to blame others or provide a rationale for the experience. Several complained of low mood.

### Therapeutic Intervention and Deaf Children

Psychotherapeutic intervention work with abused deaf children and adults has had little mention in the literature. This has been an issue in integrated settings - where intervention programmes have been seen as inadequate (Franken and Vanstolk, 1990). The best known work using a psycho-therapeutic programme, comes from the Boys Town National Research Hospital, Omaha, U.S.A. by Sullivan, Scanlon, Brookhouser and Schulte (1992). Their sample of 72 children, (all of whom were sexually abused at a residential school for deaf children) was compared with a control group which emerged naturally as a result of parental refusal of consent for psychotherapy. Psychotherapy was offered for two hours weekly for thirty-six weeks. Apparently the longer than usual therapy session was offered because of what the authors perceived to be necessary because of communication problems. It is not clear quite *why* this was decided as necessary but nevertheless the psychotherapy had a positive effect, as seen by pre- and post-intervention scores on the Child Behaviour Checklist (CBC) (Achenbach and Edelbrock, 1983). Those providing the psychotherapy were all fluent in Sign Language (which contradicts the rationale for longer sessions being needed) and all were trained with expertise in what they term the psychology of deafness. Unfortunately, the psychology of deafness is not explained and the psychotherapy programme looks more like an educational programme to create self-awareness and assertion skills, which was based on

programmes for disabled children (Sullivan and Scanlon, 1987). A programme was implemented in seven schools in the U.K., the results of which have been positive. Seventeen (17.6%) percent of those in Knutson and Sullivan's (1993) study of children with communication disorders (hearing impairment and language difficulties) had been referred after one single sexually abusive incidence. Thirty-six percent had been abused several times over a period of less than 12 months. Twenty-five percent were suffering sexual abuse for over 1 year and less than 3 and 21.6% suffered sexual abuse for more than 3 years. Table 8.3, Nature of Sexual Abuse (clinical sample)', illustrates the duration of sexual abuse over time that individual cases suffered, its nature and frequency. Seventy-three percent suffered sexual abuse for more than three years, 9.1% of which were non-penetrative experiences. Nine percent endured abuse for less than three years and 9% reported sexual abuse (rape) on one occasion. One person (case 19) reported being raped several times.

There are implications for the training and awareness of professionals involved in the care of deaf children and their families. Many child protection workers lack knowledge and awareness of deafness issues and will often depend upon their social work colleagues who work with deaf people. Assessment and services are far from adequate and the potential for deaf children to suffer abuse and to be 'missed' is probably greater than previously, due to increased use of integration and mainstreaming practice in education and the decreased contact deaf children are likely to experience with their peers. Furthermore, increased use of invasive surgery to prevent deafness or to promote use of 'hearing' mechanisms is likely to mean that



access to deaf orientated information at an early age is increasingly less likely. It is often assumed that people are definitely going to be, or are, psychologically damaged as a result of the experience of child sexual abuse. It is important to keep a differentiation here, of human rights and mental health issues otherwise it would lead to a common assumption that sexual abuse was only so if the child was disturbed, or distressed, as a result. All children will, however, probably experience some confusion, at least, by the experience (Baker, 1983).

There is a need for a variety of self-assertiveness and confidence building programmes to be adopted at schools where there are deaf children. A project run by the National Deaf Childrens Society (U.K.) is looking at the use of employing a 'PATHS' (Greenberg, Kusche, Cook and Quamma, 1995) programme in schools for deaf children. PATHS is an American social and emotional programme being piloted in seven schools in the U.K. and is based on Promoting Alternative Thinking Strategies (PATHS). Teachers are trained in the intervention model and then provide PATHS lessons. Such 'intervention' strategies help promote vocabulary and skills in identifying emotional experiences and beliefs linked to the way emotions are experienced, perceived and managed.

### Deaf Abusers

It is not known how many deaf abusers may have suffered abuse themselves although research seems to suggest it is common for child sex abusers to have suffered sexual abuse in their childhood. There is no reason to suppose this is any different for deaf

people. In an informal count of deaf sex offenders referred to the National Centre for Mental Health and Deafness during 1994-95, out of a figure of 11 deaf males, 6 said they had suffered sexual abuse in childhood. Most exhibited similar personality traits of rigidity and resistance to accepting responsibility for their actions. According to Vernon (1997), there are some factors that differentiate between deaf and non-deaf paedophiles. Vernon identifies these as Primitive Personality Disorder; brain damage; and rubella embryology. All of his study of twenty male paedophiles have psychiatric and psychological diagnoses other than the paedophilia. Vernon uses the term Primitive Personality, also known as Surdophrenia, the validity of which is questionable. He also discusses at length, the speech intelligibility of his sample and uses the word illiterate without explaining what he means. Speech Intelligibility is irrelevant as is the level of English competency in relation to committing sexual offences against children, which Vernon discusses several times. The ability to plead in court and to be involved in the construction of one's own defence is obviously a vital part in ascertaining competency in standing trial but does not depend upon speech or literacy as Vernon seems to indicate.

The mean performance IQ of the sample was 102.8 although this does not seem to be reflective of the high rate of cases with brain damage which he suggests is one of the risk factors in his sample of paedophiles. Several of the sample had brain damage. Vernon does not provide a definition but by U.K. standards this will probably refer to learning difficulties. Poor internal and impulse controls are not

necessarily a result of brain damage as such but probably more likely a result of deprivation of early mental stimulation and deprivation of natural language mode of signing. There does seem to be a tentative link between the degree of violence experienced during their own childhood sexual abuse and the form of paedophilia practised later. Becker (1994) suggests that 58-80% of adult paedophiles began their abusive behaviour while they are adolescents. Vernon's study is a pathologization of paedophilia and as such is probably debateable in terms of the model and rationale used.

This chapter has presented a clinical profile of presentations at the writer's practice who have suffered sexual abuse and has identified some psychological sequelae resulting from the abuse. This chapter also presented a study of the prevalence of sexual abuse in the Deaf community and has raised a number of issues as a result.

## CHAPTER NINE

### PSYCHOTHERAPY AND DEAF PEOPLE

#### Review of the Literature

**"If you had a child, who was experiencing emotional difficulties, help would be easily accessible - you could go and get counselling anywhere - but if your child was deaf - you might have to search for days to find somebody".**

*Personal Correspondence (1995)*

The above quote from a non-deaf mother of a fifteen year old boy is representative of the views of many carers who seek help for deaf young people and adults who want or need access to counselling and who often find that to gain access then requires a great deal of commitment. Clients will often have to travel for counselling and the lack of knowledge of deaf issues many professionals display is daunting.

Counselling is a fairly new concept in the Deaf community and it is only recently that some deaf people themselves have come forward and asked for better access to counselling and who wish to see an increase in the numbers of counsellors who can work with deaf people. Prior to this, non-deaf people, social workers, care workers and other professionals working with deaf people, would recommend counselling for deaf people but conclude that counsellors were not available because there was hardly anyone with the appropriate skills, including fluency in Sign Language. Because Sign Language is a minority group language, this has meant there are difficulties in assuring that deaf people can acquire appropriate access to information in the care of both their physical and mental health needs. Programmes of Health Promotion do not

usually include targeting deaf people and in this respect, deaf people are at risk. The World Health Organisation (1986) states that Health Promotion is to enable a healthy environment, provision of health information and to reduce ill-health. It also stresses that people should have personal choice and responsibility in health. The World Congress of the World Federation of Mental Health (1997) addressed a large range of issues related to wellness; a healthy body and mind, culture, social structures and environment but there has been no attempt to include deaf people in congress nor any appropriate language support provided for deaf people to access proceedings.

Access to counselling is an important facilitator in the mental health and well-being of many individuals who might experience mental ill-health. Articles are published in medical and related journals providing evidence of the success of various therapeutic approaches in resolving different types of mental health difficulties. Research has also shown significant effects for a wide variety of psychotherapy methods and these issues have been widely debated (McGrath and Howson, 1987) despite claims that psychotherapy has no significant treatment effect (Shepherd, 1984). The Mental Health Digest (bulletin) has an increasing number of short reports concerning counselling, which appear to dominate its pages, particularly during 1996 and 1997. It is increasingly recognised that psychotherapy can help not only what are now described as emotionally based disorders, such as obsessions, phobias and some affective mood disorders, and research evidence suggests long term psychotherapy, of the use of cognitive therapy can benefit some individuals who suffer from a psychotic disorder. There has been a large profile given to the integration of therapies in recent years which are still referred to individually as under four main

categories: cognitive; behavioural; analytical; and systematic. Sometimes, they might all be grouped into two: cognitive-behavioural and dynamic-interpersonal. Furthermore, many reports show alternatives to inpatient hospital care, such as counselling and group work, are not only more effective, but decrease the likelihood of relapse and some researchers argue it is more cost effective (Sledge, Tebes, Wolff and Helminaik, 1996).

### Deaf People and Counselling

Only recently has an interest been shown in the topic of counselling and deaf people. Traditional and individualistic approaches to theory on human development have often been what might be termed as 'sound blind'. This section will discuss areas in counselling and psychotherapy that require particular consideration and awareness when working with deaf people.

During the last few years there has been a shift in attitudes towards deaf people being able to benefit from counselling. As previously mentioned, the prevailing attitude was that deaf people could not benefit from psychotherapy. There does not appear to have been any literature published prior to 1971 (Sussman, 1988). Eventually the field adopted the view that some deaf people benefit from counselling but suggested that only intelligent deaf people could benefit (Levine, 1981). If a deaf person was seen to have fluency in English and able to lipread English, then they were considered more likely to be able to make themselves understood to non-deaf "signers", who inevitably signed using English syntax. It appears likely therefore, that prior to BSL being seen as a language in its own right, Deaf people who used BSL with non-deaf

signers would have been judged to be of low intellect. It was hardly likely that non-deaf professionals would have recognised their own short comings in this respect given the then lack of awareness of Deaf culture and linguistic issues. Reasons put forward as to the lack of facilities and resources for deaf people and their counselling needs, according to Levine (1981), were due to difficulty in defining deaf people and furthermore, he asserts there are few characteristics of deaf people, as a group, that distinguish them from the general population. Most non-deaf counselling professionals have never encountered a deaf person socially nor worked with a deaf person in therapy (Roach, 1979). Therapists will experience frustration which arise from not being able to communicate easily and perhaps experience a sense of inadequacy. Non-deaf therapists need to concentrate upon language and communication and appropriate expression, more than would be encountered in work with non-deaf clients. Hoyt, Siegelman and Schlesinger (1981) consider this to be emotionally and physically draining. The view that deaf clients would grow to be overly dependent upon the therapist, and become passive was commonly assumed and many non-deaf therapists experience rescue fantasies in their guilt feelings about being hearing (Hoyt et al., 1981). It has been suggested (Hoyt et al., 1981) that Deaf clients may typically fail to keep appointments or arrive 20-30 minutes late, a phenomenon, they suggest, is partially due to the relationship of language deficits to the ordering of temporal experience.

The field of psychotherapy and deaf people has moved forward during the last few years. A number of publications address counselling and psychotherapeutic approaches in work with deaf people (Anderson and Roster, 1985; Haley and Dowd,

1988; Harvey, 1989; Ridgeway, 1995a/1995b,1996; Corker, 1996; Avraham, 1995; Roe and Roe, 1991; Wilson, 1994; Austen, 1996). The field lacks research although a study by Wilson (1994) begins to address this issue. Increasingly, mental health practitioners and researchers have begun to turn their attention to the development of culture-specific techniques in counselling and therapy. This interest has developed through the knowledge that minority racial groups did not appear to use mainstream services as much as other people in the population, mainly, white Westernised people (Sue, 1990; Beliappa, 1991; Fernando, 1995). Services were either underused by minority groups or that the use of mental health facilities was terminated prematurely, by the user, often after only one session (Sue, 1977). The view that services were 'culturally encapsulated' was suggested (Pedersen, Draguns, Lonner and Trimble, 1981; Sue, 1990). Services have been accused of failing to provide training opportunities and experiences which could be relevant to minorities by professionals involved in counselling and mental health (Carney and Kahn, 1984; Sue and Sue, 1977a). A number of conferences, seminars and workshops have since been funded in order to try and redress the balance - and to provide a better service to minority group clients. Recommendations by the Division of Counselling Psychology of the British Psychological Society suggest that culturally sensitive and relevant counselling strategies should be applied to suit the various sociopolitical realities, lifestyles and cultural values of minority group individuals (Atkinson, Morten and Sue, 1989; Sue, 1990). In none of these studies have the needs of culturally Deaf people been mentioned.



A major theme of the literature on cross-cultural counselling is cultural and racial development theory (Sue and Sue, 1990; Helms, 1990). Issues in transcultural and multi-racial counselling have been addressed (Cayleff, 1986; d'Ardenne and Mahtani, 1989; Lago and Thompson, 1989; Sue and Sue, 1990; Van der Veer, 1992), none of whom refer to deaf people, although there are parallels to be drawn with particularly regarding cultural and linguistic issues. In essence, little has been done to address Deaf issues in therapy, apart from "The Deaf Alliance", (Ridgeway, 1994), which addresses these issues more directly.

### Training Issues - The Background

Rarely are deaf people, as a cultural minority group, addressed in any of the mainstream training programmes, including courses aimed at providing awareness of cultural issues. This is the case for many disciplines and especially so in the health professions and related various therapeutic disciplines. Such a large gap in service provision, poor recognition and lack of knowledge of Deaf people, their culture and community leaves Deaf people unsafe and at risk (Ridgeway, 1994). Kennedy (1992) makes the same point relating to the ongoing vulnerability of deaf people to abuse. The failure to include in professional training programmes information and research details about deafness, culture and community, in order to challenge and eliminate old myths and stereotypes is an expression of the medical and psychological professions "Hearist" and Deaf phobic attitudes which continue to be maintained by their own criteria.



An increasing number of deaf people who express a need for counselling and therapy, will either be offered counselling from a non-deaf counsellor with an interpreter, (there are often practical problems in relation to regular bookings with the same interpreter or in meeting interpreter fees), or a non-deaf counsellor with only beginner's level British Sign Language (Ridgeway, 1994). A number of issues are raised concerning the use of therapy and the 'third' person (the interpreter) which include distortion or interference with transference and countertransference (Harvey, 1989) and core conditions (empathy, unconditional positive regard and congruency) from a Rogerian perspective (Rogers, 1951). Transference refers to the unconscious levels of thinking and feeling towards other which are transferred onto the therapist. Counter Transference is the therapist's response to the dynamics of the transference. The therapist needs to be aware of these feelings and behaviour coming from the client and use them in the counselling relationship to promote growth and movement. These concepts originate from the psychotherapeutic practice of Freud and are now used in many different counselling approaches. Transference could not develop should the client speak one language and the counsellor another. It would be similar to offering counselling to a mono-lingual French speaking client by a counsellor who had only completed an evening introductory course in French. Yet it often happens where deaf people present with mental health difficulties and require psychotherapy.

Deaf people's counselling needs are mostly met by non-deaf people. This is likely to continue for the next few years or so, until, in Jungian terms, the deaf collective unconscious begins to rise and deaf people start to readily accept counselling from other deaf people. Low levels of self-image and esteem contribute to the rejection

and suspicion of other deaf people who are qualified professionals and their tendency to identify with the 'aggressor', (the non-deaf person), a defence mechanism often used by oppressed members of a minority group who prefer to attach themselves to the larger majority group (Roe and Roe, 1991). This refers mainly to deaf people who have negative feelings of self worth, and a poorly developed self concept, in relation to their deafness, that they use their frame of reference for all deaf people, projecting their own values and self worth onto other deaf people. In this way, 'hearing' values and culture are seen as being better - hence the 'identification with the aggressor'. Introjection occurs where the values and attitudes of non-deaf people are internalised by the deaf person. This might also be interpreted as 'positive' transference in Freud's position, whereby the therapist, if non-deaf, is idealised and becomes all important to the client.

More deaf people however are becoming interested in learning about counselling and becoming trained in counselling. At the time of writing, there are only two culturally Deaf qualified counsellors in the U.K. in addition to two deafened qualified counsellors who use Sign Language. Four centres offer counselling training at various levels for deaf people. These are Willmorton College, Derby, which runs certificate courses in counselling skills and theory; the Westminster Pastoral Foundation (WPF), London, offers a certificate course in Counselling Skills and Attitudes for Deaf people and more recently, a Diploma in Counselling Skills. The WPF also provides access to deaf students on their mainstream Advanced Diploma in Psychodynamic Therapy. A third centre called COMPASS, based in Liverpool, provides access for deaf people on their introductory courses in counselling which are

a 'primer' for those who might then wish to study at certificate level elsewhere. The University of Manchester's Faculty of Education previously offered introductory and certificate levels in counselling skills for deaf people. City College, Manchester, now offers an Advanced Diploma course in Therapeutic Counselling for deaf students with course tuition directly in Sign Language. The latter is seen as a major development in the field of counselling for deaf people who seek training leading to a professional qualification in counselling and not just at certificate level. All of the courses mentioned are led by hearing people, except for those at the University of Manchester, which were led by Ridgeway (1992-1996). The City College courses are run by both deaf and non-deaf tutors. Some deaf people might prefer to access mainstream courses. This might be for a variety of reasons - geographical, or lack of desire to train with other deaf people. This is not to say that training for deaf people is different to training for non-deaf people. There are however, a number of key areas that separate issues in training deaf people and non-deaf people. These are now described.

### Deaf Centred Therapy

Deaf Centred Therapy is an area worthy of the attention of counsellors and therapists as well as for discussing some common clinical issues. A model of deaf therapy is provided here built on the writer's clinical practice and experience. The importance of incorporating Deaf issues into counsellor training stems from a "hearist" bias inherent in many traditional counselling theories and theories of personality development. Training programmes need to include sufficient background and knowledge about Deaf issues so that Deaf clients do not have to educate counsellors

about their deafness. Trainers need to be aware of and include information on the development of a Deaf identity and the process of this identity across the entire life span of the Deaf individual.

Counsellors need to be able to discriminate when the client's hearing orientation needs to be the focus of counselling and when it does not. For example, if a deaf client wishes to discuss the relationship she has with her deaf children, the hearing status may not be the focus. For example, many deaf parents of **hearing** children have described being visited by various professionals (Personal Correspondence, Davies, 1993) on the birth of a child to check that language development is normal and developmental milestones are reached, suggesting strategies to assist the non-deaf child cope with their deaf parents. In these situations hearing status becomes an issue both for the professionals and the deaf parents, who wish to explore hearing status in therapy. A skilled therapist needs to look at the significance of events in connection with the past and present in relation to the deafness by exploring traditional values within the culture and the roles of different members of the family.

Many other issues need to be included in training programmes, including issues of mixed hearing status relationships and differences between degrees of deafness. Issues in working with families of deaf people and with young deaf people should also be included in programmes aimed at counsellors in training.

## The Principles of Deaf Centered Therapy

There are many historical issues which affect the way deafness is seen by those in the caring and psychotherapy disciplines and 're-training' is often required if clients of all hearing status' are to be provided with equal respect. It is not enough to just offer Roger's (1951) Core Conditions of Unconditional Self Regard, Congruence and

Empathy, and it is not enough to understand other approaches incorporating Psychodynamic principles or Behavioural principles such as Cognitive Behaviour Therapy.

Core conditions of Deaf Centred Therapy includes respect - for whatever orientation the client indicates in terms of his or her hearing status. This means any therapist will need to think about, explore and work through their own attitudes to hearing status. Deaf people have faced discrimination and oppression, and have probably encountered well meaning hearing people who have intervened but unintentionally caused further distress. As a result of these collective historical experiences, trust and the acquisition of trust, towards the therapist, is hard earned. The issue of trust is a major one for the deaf client in therapy (Stansfield, 1987). Respect towards Deaf culture and Deaf ways is also required. The ethics would become questionable if this could not be maintained by the discipline involved in helping the deaf person. The British Association of Counsellors (1995) has produced a series of information leaflets and a Code of Practice for those using counselling skills as well as a Code of Practice outlining ethical and professional responsibilities of counsellors. If the therapist is of a different culture, for example, is non-deaf and has only experienced hearing

culture, then the therapist has a responsibility to acquire as much knowledge as possible about Deaf issues and culture, and also about the many different sub-cultural groups within it - such as ethnic groups, gay and lesbian groups, religious groups, national groups and DEX, (a support group for deaf people who attended mainstream education and who raise identity issues, many of whom consider themselves members, or who wish to become, members of the Deaf community). It is the responsibility of the therapist to be aware of these groups and how they meet the sub-cultural needs of Deaf people.

Maylon (1982) describes his concept of "Gay Affirmative Therapy" as being a therapy which is not actually a separate system of psychotherapy but contains a range of psychological knowledge needed to work with gay and lesbian clients, from a non-traditional perspective (Maylon, 1982). This is comparable to the idea of Deaf Centred Therapy (Ridgeway, 1995a). Deaf Centred Therapy is not an independent system of psychotherapy but represents psychological knowledge which in turn challenges traditional views of deafness. It challenges the view that deafness is a pathological variable.

Isay (1989) believes it is important for the therapist to be uncritical, accepting and to express thoughtfulness, caring and regard for clients. A model for Deaf Centred Therapy will underly behavioural, psychodynamic and humanistic branches of therapy, taking into consideration the skills and conceptual understanding required, using them in an appropriate manner, in a Deaf centred approaches.

### Non-Deaf Therapists Working With Deaf People

It has often been the case that the deaf client has had to provide information on Deaf issues to their counsellors or supervisors themselves (Ridgeway, 1995a and b). In the writer's experience of having non-deaf supervisors whilst on work placements, many hours were spent explaining various aspects of Deaf culture, the aims and values of the Deaf community in relation to identification with other deaf people. One particular supervisor was unable to shift her thinking from the view that deaf people must want to be with hearing people and hence feel more 'mainstreamed' instead of specialised, as she saw it. She used wheelchair users as an example to illustrate that individual wheelchair users did not want to spend a lot of time only with other wheelchair users. This highlights the fact that non-deaf people tend to have a hearing orientated frame of reference. Clients in therapy with a non-deaf therapist may see the therapist as representing society's hopes to help them become hearing. For example, research into cochlear implants, the **titles** of national organisations such as 'Hearing Concern' and 'Defeating Deafness' which serve to remind deaf people that there is hope and effort to eliminate the Deaf community. More recently, genetic screening has been highlighted and how this affects the Deaf community (The End of Deafness? University of Central Lancashire, Conference, 1996).

The need for deaf clients to educate their therapists may decrease with deaf aware therapists, both deaf and non-deaf. The following case illustrates an example of difficulties that arise.



**Case Example:** Mary, (29), a culturally Deaf person, sought help for depression following a termination of pregnancy. She was first seen by her GP, who referred her to the district clinical psychology department. There, she was seen by a clinical psychologist for two sessions before the psychologist decided Mary would be best helped by a colleague whose parents were apparently deaf. Agreement was obtained and Mary was seen by a second psychologist. Although the psychologists parents were deaf, she had no understanding of Sign Language, but good speech reading skills and was completely reliant on Mary's ability to oralise visually, English words. Mary suggested using an interpreter as she felt she could develop a rapport with this therapist. However at this point she was discharged and referred on to a mental health centre for deaf people instead. Mary was seen by the writer by which time a number of other issues and frustrations had emerged.

The example shows how the first psychologist had made the assumption that because her colleague knew other deaf people, then they must be able to work with deaf people, indicating a belief that deaf people are a homogeneous population. The second helper had made the assumption that because she could understand her parents and they could understand her, that she would have no trouble working with other deaf people, thus revealing a false belief that she was apparently aware and knowledgeable about Deaf issues, culture and language.

In another example, we can see how the client's cultural and linguistic needs had been almost completely overlooked.

**Case Example:** Rachel (52), a happily married woman with two sons saw her GP and complained of feeling depressed. He prescribed her a course of anti-depressants. She communicated in British Sign Language but they communicated by writing in English, although her English level matched that of a child of nine years of age. After three months she returned still complaining of depression. Her GP prescribed a further course of anti-depressants which again produced no benefit. She had a number of side effects from the medication but which at the time she thought was because she felt so low and unhappy. After another three months her GP referred her to the local mental health team who sent a community psychiatric nurse to see her. The nurse wrote to the GP saying Rachel appeared well and as communication was a problem, she did not think it would benefit Rachel for her to visit again. After a further three

months, Rachel was referred to the local mental health community day centre. Rachel attended once a week. There was no communication. An interpreter was never provided and the local social worker who had beginners level Sign Language was at a loss as to how to assist Rachel who by then was quite withdrawn. The local psychiatrist saw her and based on lipread conversation, diagnosed a receptive language disorder, using DSM-III-R criteria. Rachel stopped attending the day centre. Apparently she used to sit down in a corner all day and only got up when staff would wave her over for tea. Rachel took an overdose, and was seen by the Consultant Psychiatrist who suggested she attend the day centre again to see a counsellor there in an effort to engage her in some activities. Rachel went once more and again following this, took another overdose. The Community Psychiatric Nurse suggested that Rachel be referred to the National Centre for Mental Health and Deafness. There Rachel was offered counselling and within weeks showed a marked improvement.

Rachel had become depressed because her remaining son had left home. She felt very upset when this had happened. Both of her children were hearing and her husband is deaf. There were issues linked to loss and bereavement to be worked through to try and help create some independency for herself, which included learning how to use Typetalk if she wanted to telephone anyone. Previously, her son had made all the telephone calls for her. Gradually, through therapy, Rachel was encouraged to develop a Deaf consciousness and go along to the Deaf centre occasionally although she never attended regularly. Rachel went on to do voluntary work helping other deaf people and has trained to be a 'befriender'. A similar sequence of events occurred in the following example:

**Case Example:** A deaf therapist (personal communication 1995) received a referral to see a young deaf man, Mike, for counselling for sexuality issues and concerns he wished to express. The deaf therapist, who was not culturally Deaf, found it difficult to establish an alliance with Mike and attributed this to what he saw as Mike's poor language skills. The deaf therapist could not effectively communicate using British Sign Language, which Mike was using, with very little oral English, and this led the therapist to make the assumption that Mike, who was from another county in the U.K., was using only regional signs and thus could not be understood except by those from the same school or local area. This expression of an incorrect presumption on the part of the therapist

**led Mike to develop further problems with his self image. It also conveys inappropriate beliefs about Sign Language. The therapist used good Sign Supported English and considered this was sufficient to communicate with any signing Deaf person. Unfortunately, the therapist held misconceptions about sign vocabulary and did not appreciate only 20% of British Sign Language in conversation are regionalised.**

Where possible, service users, could be encouraged to "interview" the therapist in advance, to check mainly for attitudes and perceptions of the therapist towards the deafness. This does not mean the therapist is meant to have firsthand knowledge and awareness of Deaf issues, culture and community, but more to explore at the attitudes and the ability to get on together. If the therapist thinks deafness is unnatural, or inferior to being hearing, or that deaf parents cannot provide care and safety for their usually non-deaf children, in the same way that hearing people can, then it would be difficult to work with that person. These beliefs would be conveyed on an unconscious level as would ambivalence.

Therapists do need to have a comfortable and appreciative orientation to all degrees of hearing status before working with deaf people. The non-deaf therapist who says they have never experienced mixed feelings or felt guilty about being hearing are deceiving themselves. Acknowledging these emotions ('blind' spots would be another way of putting it) would be useful to any non-deaf therapist, who has an interest in working with any deaf person. This can be compared to white people who say they do not have any racist feelings nor prejudices. White people who deny differences, saying we are all the same, are being 'racist'. Racism and prejudice are exhibited by everyone (Greene, 1985). The denial of differences between ethnic groups for

example is considered a form of racism as it denies the importance of recognising cultural differences (Katz, 1978).

### The Deaf Experience

All deaf people have experienced some form of oppression related to their being deaf. The subjective feelings in terms of these experiences require exploration. For some clients these feelings will be already on the surface waiting for such an opportunity but for others, there may be some expressed denial of such experiences. The hearing orientation of the client may influence this. Constructive controlled anger released within boundaries is helpful. Identification and expression of anger can also help expand the range and depth of awareness of different feelings. If oppression is internalised, this can lead to self abuse (Bannister, 1985; Figley, 1985; Bagley and King, 1990). Partner abuse (Farley, 1992) or domestic violence, is another way of acting out repressed anger (Clark and Midanik, 1982). Anger at the self for being different and other feelings are sometimes affected in generalising and then perhaps not given attention or there is less awareness (Clark, 1987).

The study conducted for this research shows that depression and anxiety are major issues for deaf people. Often, this comes from anger, denial of self and feeling emotionally weak - Clark reported that:

**"You feel decreasing self-esteem in the uphill fight against subtle everyday messages that tend to invalidate you, and turn your anger inward on yourself. It is an unfortunate downward spiral that does not permit corrective evidence from experience".**

*Clark, 1997*

In some ways, Deaf Centred Therapy challenges the ethics and professionalism of the counselling therapy profession in terms of challenging the 'rules'. 'Touching' (using hands) is an example of contact in its physical form. Touching is a Deaf 'norm'. The therapist needs to be encouraged to make a point of physical contact - visually, it says "you and I, we are equal". Saying this, or signing this, does not convey the message as effectively. Place of contact point requires a degree of sensitivity and not be a patronising 'pat' on the back. It needs to be done whilst eye contact is maintained and to a level that expresses a "peer" type of relationship conveying that the client is not inferior or second class. Some clients reported feeling 'second class', not only with non-deaf people but also with deaf professionals.

**Case Example:** Peter (31), whom I saw for short-term counselling, repeatedly expressed the view he thought I was ever so clever like some other deaf people and that he would never be clever. He said in one of our early sessions that he felt stupid and uneducated. We explored these negative feelings together, in the context of his earlier experiences of him bullying other children when he was at school.

*(Example from writer's clinical practice)*

### Defence Mechanisms

The example illustrates that deaf and non-deaf people need to be aware of these issues and display sensitivity. Furthermore, it is quite common for a deaf person to believe that a non-deaf person is more 'clever' and able, and so attribute what they perceive to their own 'shortcomings' to "oh, well it's because they're hearing". This might be seen as a defence mechanism (rationalisation). However, a high percentage of deaf people have been found to have a poor self concept (Brauer, 1991) and negative self esteem which cannot be over emphasised. For some deaf people, internalisation of a degree of oppression results in using other defence mechanisms such as

rationalization and reaction formation. By this the deaf person may present as so outward as to appear to practise a form of discrimination reversed. Such culturally Deaf people might refuse to interact with non-deaf people, may avoid eye contact and might feel hostility towards non-deaf people.

**Case Example:** Edward, a 44 year old culturally Deaf man, who lives with his Deaf wife and her Deaf parents, displays an almost exaggerated image of his pride at being Deaf that he considers himself to be actually better than non-Deaf people altogether. This may be interpreted as a defence (rationalization) for what might be perceived as a more difficult life. (Ridgeway)

**Case Example:** Martin and Jane, a Deaf couple, who have lived together for seven years, use Sign Language with each other, do not socialise or mix in the Deaf community. They have a few non-deaf friends with whom communication is through speechreading. They appear to have no contact or interest in Deaf activities or other Deaf individuals and do not see the point of what they call 'making differences'. (Ridgeway)

It is possible that the defence mechanisms of rationalization and denial are being used here. It is as if the couple feel they do not want to show their deafness and are saying indirectly that they are the same as their non-deaf friends yet the couple share many cultural features with members of the Deaf community.

### Transference

Transference is a vital part of therapy (Freud, 1905/1971) which is about the client displacing feelings and attitudes, which belong to other people, onto the therapist. When the therapist is deaf, it is useful to observe and explore, the clients view and perception of the therapist's deafness which could be seen as troublesome, burdensome or a hindrance to the therapeutic process (Melgoza, 1972). Melgoza (1980) discusses in detail about some of the reactions of clients to therapists with disabilities such as blindness or paraplegia and suggest some clients, who already feel

weak or damaged, might feel even worse if allocated a therapist with a physical disability, feeling perhaps more 'cheated' by circumstances in their lives (Melgoza, 1980). This can happen in cases where a deaf client is disappointed to be allocated a deaf therapist and feels that the therapist cannot assist on the assumption that if the therapist is deaf then he or she also has a range of difficulties and problems. This could be compared to a culturally hearing expression of, "the blind leading the blind". The deaf client may feel he or she is placed in a similar position. A client with problems expressing hostility directly may use the therapist's own disability as a way to express hostility towards the therapist indirectly (Melgoza, 1980). Examples might include envy of the way the deaf therapist appears to manage (especially if the therapist is perceived to be more disabled - for example, if the client can orally communicate with hearing people whilst the therapist does not.

### Identification

Another aspect of Deaf Centred Therapy is to help the Deaf client become more Deaf, more representative of their Deaf state of being and aware of themselves and congruent with the Deaf self. Aspects of self-enhancement by other social minority communities and groups such as black communities are a good example of growing awareness and esteem developing. A new Black awareness has developed over the past several years, 'Black is beautiful' creates a positive image for black people's self esteem from what they originally felt ashamed of. Asserting being Black minimises the importance given to the white world (Walker, 1995). More 'whole' could be another way of describing this.

The deaf therapist may also at times go into the role of the good parent during the client's therapy. This is an important aspect of Deaf Centred Therapy, helping to facilitate and enlighten through increased awareness and insight. This could be argued to be in some ways an 'educative' role for the therapist to take on with the client. In some ways it is appropriate for the therapist to take on this role. Eighty-one percent of deaf people cannot communicate with their non-deaf parents (Phoenix 1988). A large percentage of deaf people will not have formed appropriate attachment or bonding with their immediate family. Therapy with African-Caribbean clients is more effective if the therapist is also Black, (Green, 1985; Ridley, 1988), although to some extent, depending upon the awareness, knowledge and acceptance of the white therapist, a mixed alliance can be useful and can bring benefits. Identification with the therapist can play a role in therapy (Greene, 1985). Here is another example from the writer's clinical practice:

**Case Example:** Through a process of identification with the therapist Sandra, a nineteen year old girl who presented with anxiety and panic attacks when out travelling, was able to learn to look into herself and develop awareness of her deafness. She was able to identify with the therapist some of her previously hidden Deaf ways (Deaf traits) and begin to assert herself as a capable individual. She recognised her negative feelings had come from the non-deaf world and it was not very long once this was achieved, that the frequency of her panic attacks reduced considerably.

Melnick (1972) and Blanck and Blanck (1974) have described in more detail how identification can be used in the therapeutic alliance. The client may also use identification in transference by taking on some part of the 'personality' or 'way' of the deaf therapist such as some signs that the therapist uses or the way the therapist



uses a sign. This may provide comfort to the client whilst going through a particular stage in the therapy.

### Transcultural Counselling

Apart from class distinctions within a culture, cross-cultural differences in language use can be extremely different from one culture to another. An example here involves the use of language. In some African languages, the same word might mean both angry and sad. This doesn't mean that such cultures experience fewer feeling states. This means that specific emotions are not particularly separable in the spoken vocabulary (Leff, 1973). However, some people have concluded that because of this 'restriction' in the feeling vocabulary, that depression does not arise much in Africans (Carothers, 1953). The criteria by which someone is considered to be an expert and as trustworthy are not the same in all cultures. The same goes for specific therapeutic techniques. Some methods or approaches may be considered useful in one culture and perhaps inappropriate or even ridiculous in another culture. Therapists need to develop cultural empathy and can do this through awareness of cultural differences (Dahl, 1989). Deaf people, apart from presenting as a cultural group can also be members of various other cultural minority groups - such as African Caribbean, or religious and cultural groups such as Judaism. This implies that professionals would need good bicultural awareness.

Counsellors establishing themselves in work with deaf people are advised to set aside a specific period of time to introduce themselves and explain their role and function. The idea of counselling as an approach to problem solving is in itself culture-bound

(d'Ardenne and Mahtani, 1989). Clients who come from different cultures need to internalise these ideas and may need to ask questions of the counsellors. Counselling clients who share the same culture sometimes raises confidentiality issues and the counsellor needs to know how to approach these challenges in an appropriate manner. For example, clarifying the very separate role of counselling and mixing socially within the Deaf social scene. Sue (1990) discusses this as being comprised of two parts, expertness (ability) and trustworthiness (motivation). Evidence of formal qualifications may not be enough for some clients, regardless of the hearing orientation of the therapist, who might need to 'prove' their expertise and understanding in practice.

### Culturebound Concepts

Psychotherapy has evolved primarily in Europe and America which are quite different to cultures in other parts of the world and include concepts as orientation, individualism, status and expertise (Katz, 1985).

Psychotherapy borne of the non-Deaf cultural norms of Europe, nurtures self-centredness, self-exploration, self-disclosure and self-determination (d'Ardenne and Mahtani, 1989). Aspects of counselling in transcultural settings may find these concepts obstructive and difficult to comprehend. The transcultural counsellor, rather like the non-deaf therapist in therapy with a deaf client, needs to appreciate their theoretical approach may not be seen to be the most appropriate. The non-deaf white European therapist might find working with deaf people rather like working with a member of an ethnic minority group - in terms of the morals, values and beliefs

which present as different to those of European (Westernised) norms. The implication is that as different cultures have different ways of coping with distress, so deaf people have different ways of coping compared to non-deaf people. The counsellor's knowledge and value of the client's culture is thus appreciated. Clients from Asian backgrounds usually require solutions to practical problems without reference to internal change. Yet the therapeutic goal of western counselling may entail developing insight and self awareness (d'Ardenne, 1988). This is very much the situation in therapy with deaf clients. Deaf clients might feel the counsellor is wasting time focusing on past events (Katz, 1985) and may find it difficult to respond to a non-directive approach (Atkinson, Maruyama and Matsui, 1978). The counsellor may be seen as 'unskilled', if direct comments are not given (d'Ardenne, 1988). This is something frequently seen in the writer's clinical practice. The appropriately skilled counsellor will be able to accept the deaf clients internal and external worlds, within the often hostile low-level deaf aware environment in which deaf people usually live.

#### White is not Black and Hearing is not Deaf

In a transcultural alliance, for example, involving a Black client and a White therapist, there may be feelings of inferiority held by the client. White therapists have been brought up with the confidence of their superior position, and may feel that any deviation from being white is inferior (Eleftheriadou, 1994). Equally, a black client who may have encountered racism in the past may come to expect or assume that anyone who is white will exhibit racist attitudes. The effect of this on the therapists own frame of reference and upon the counselling relationship obviously

needs to be explored. Thomas and Sillen (1972) present a range of attitudes which white therapists may hold about their black clients. Clients can be seen to bear "the mark of oppression" (d'Ardenne and Mahtani, 1989), where the behaviour of black people is seen as pathological. In this model, black people become the disabled victims or, as Thomas and Sillen (1972) have suggested, handicapped by racism.

This is so powerful that when the white therapist is sympathetic, the black client may feel dehumanized. At the other end of the range of attitudes proposed by Thomas and Sillen (1972), is that some white therapists may treat their black clients as white people in black skin. This is sometimes described as 'colour blindness' (Katz, 1978). The implications of this for those counsellors who use humanistic approaches is the need for flexibility in approach in work with deaf people, whose cultural background may compare with those of black and asian people. Deaf people from families who use a language other than English or British Sign Language as the primary mode of communication present a unique trilingual (or multicultural) challenge. This population is growing in the U.K. in areas such as London, Bradford and Leicester. The premise to this, as is to the entire study, is that all deaf people are members of a larger Deaf culture and that some Deaf people combine two or more cultures which create an experience which is different to the usual single culture experience.

There are undoubtedly comparisons to be made here between these observations of attitudes towards black people and attitudes towards deaf people. At one end of a continuum being sympathetic is a form of patronism in which an alliance would not

be equal (Thomas and Sillen, 1972), and at the other end, the non-deaf therapist may display what could be termed as "sound blindness". It is not only therapists who might display such attitudes but any one of the 'helping' professions also.

### Attitudes and Expectations in Mixed Culture Alliances

#### **Practical Issues**

A number of practical issues are raised by d'Ardenne and Mahtani, (1989) in relation to attitudes and expectations in transcultural counselling appear in Appendix 9.

When this model is applied to a mixed hearing status alliance with a deaf client a range of questions emerged as are seen in Table 9.1.

**Table 9.1      Mixed Cultural Issues - Considerations of the Non-deaf Therapist**

1	How the non-deaf therapist's training and learning approach to deafness affects your attitude to your client
2	Whether or not the non-deaf therapist sees the client's hearing status as a cause of the present problem
3	Whether or not the non-deaf therapist sees the client's Deaf culture as part of the solution to the present problem
4	Whether or not the non-deaf therapist can accept, acknowledge and understand the culture of the Deaf client
5	Whether or not the non-deaf therapist's expectations and assumptions about the clients Deaf culture affects the counselling outcome
6	Whether or not the non-deaf therapist's hearing status prejudice has an effect on the counselling relationship

Rachel (52), who was presented earlier is an example of a deaf person whose difficulties were seen as originating from her deafness by the various professionals who had been responsible for her psychotherapeutic needs. Reference had not been made towards her cultural needs. The GP and psychiatrist were in effect "sound blind". Rachel suffered what Thomas and Sillen (1972) describe as a "mark of oppression".

### Issues in Oppression

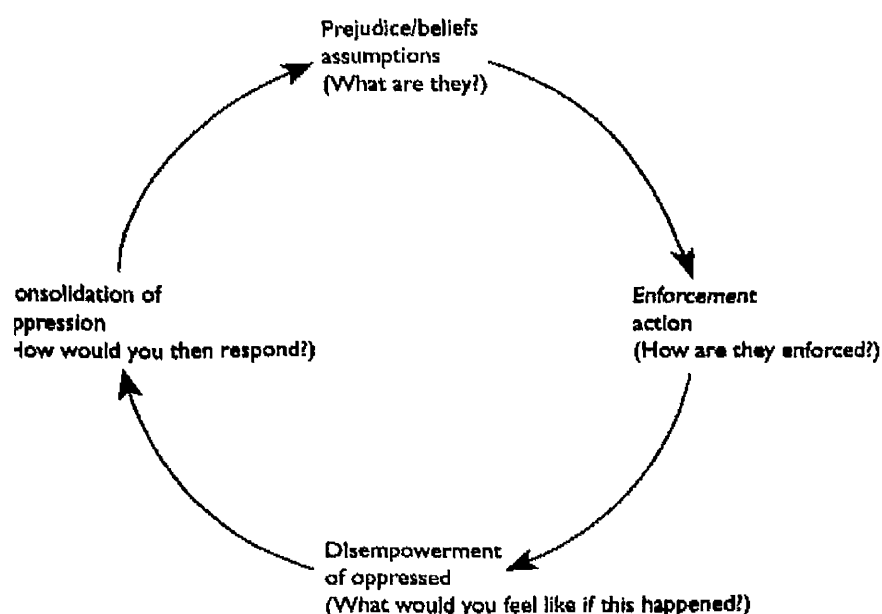
Herek (1984) provides a portrait of people who hold negative attitudes towards homosexuality, some of which can be compared with views of some non-deaf people involved in the lives of deaf people. He lists nine points:

1. Less likely to have had personal contact with identified lesbians and gay men.
2. Less likely to report having engaged in homosexual behaviours or to identify themselves as lesbian or gay.
3. More likely to perceive their peers as manifesting negative attitudes, especially if the respondents are males.
4. More likely to have resided in areas where negative attitudes are the norm, especially during adolescence.
5. Likely to be older and less well educated.
6. More likely to be religious, attend church frequently, and subscribe to a conservative religious ideology.
7. More likely to express traditional, restrictive attitudes about gender roles.
8. Less permissive sexually or manifesting more guilt or negativity about sexuality.
9. More likely to manifest high levels of authoritarianism and related personality characteristics.

Not all these points apply to deaf people but some points are worth considering in the context of non-deaf people who are working in the field of deafness.

Fran Walsh, a mainstream non-deaf lecturer and workshop tutor uses the illustration in Figure 9.1 to describe the cycle of oppression operating.

**Figure 9.1: Cycle of Oppression**



Source: ® Fran Walsh, February 1992

Oppression can emerge in a number of areas as a result of discrimination. Figure 9.1 illustrates a cycle which is begun at any one of the four key areas which involve myths and beliefs about deaf people, how beliefs turn into everyday inappropriate practices based on recommendations or findings in work with deaf people, feelings of 'disempowerment' as others are making decisions involving deaf people's needs, and the build up and gradual consolidation of the oppression. This figure summarises

the difficulties that deaf people face in society, as a part of their everyday life. How oppression is internalised and ways to interrupt the cycle is given in Appendix 10.

**Case Example:** Adrian, (34), works for a large clothing company. He has some deaf friends who he sees at irregular intervals. He enjoys attending the occasional national rally for deaf people but he does not like to be seen associating with a deaf colleague at his place of work. Adrian explained that he does not want his hearing colleagues at work to think he is one of those deaf people who have to sign and prefers to use his voice, use pen and paper or speechread wherever possible. Adrian confided that he did feel quite left out and occasionally made a mockery of, and was teased, about his deafness but that he tolerated this because he felt he humoured them so he wasn't totally forgotten about like the other deaf person was. It appeared that Adrian felt that tolerating his work colleagues' abuse and teasing was a way for them to like him. In this manner, Adrian appears to identify with his aggressor.

There are, as previously discussed, several defence mechanisms (Kovel, 1976; Brown and Pedder, 1979; Patterson, 1986) and one frequently seen amongst minority group individuals is the tendency to identify with the aggressor. In Adrian's case, the aggressors are the non-deaf people who discriminate against him. Adrian was referred to me after seeing his GP complaining of feelings of anxiety.

Leigh (1991) writes about a similar client for whom it was important to be "just like everyone else" and who struggled to look "normal". This client refused to be seen by a deaf therapist (Leigh) whom the client perceived as having a "speech impediment". Leigh points out however, that it was not until her third session with him that she revealed her deafness and that up until then there had been no difficulties in understanding each other. Leigh felt her client's beliefs were so ingrained that he was "successfully" transferred to a non-deaf therapist. For Leigh (1991) the **Deafness** is not automatically presented. Leigh sees the deafness as a hidden factor that emerges through the process of communication. She sees the way the client



presents as providing diagnostic information. It could be argued however, that this is misleading and dishonest. The first focus for Leigh seems to be communication as opposed to the writer's emphasis upon cultural features. Communication grows from this.

### Alliance Preparation - Issues for Deaf Therapists

Communication matching is therefore only a part of the alliance development and refers to the process of developing a mutual language. The counsellor needs to be able to use their core skills in a way that matches the clients frame of reference. This means to display the ability to comprehend concepts presented in sign that matches their own level of sophistication in Sign Language use. Leigh (1991) sees deaf people as using different communication **methods**. Communication methods refers to the various communication systems including varieties of Sign (not Sign Language) which are based on English. Leigh goes on to say that 'many deaf people use the sign language of their country of origin which grammatically is very different from the *native* (writer's emphasis) language in the country of origin" (p.5) It looks as though Leigh is saying Sign Language is not a native language of any country. Research has shown every country has its own indigenous Sign Language (World Federation of the Deaf Resolution, July, 1995).

A cultural match, or at least sufficient understanding and knowledge of culture, is likely to be the vital factor in establishing an alliance. A higher level of empathy and genuineness has been attributed to deaf therapists by deaf clients, (Brauer 1979; Ridgeway, 1995a and b). This is likely to be due to the cultural factor of

commonality of experience. When a black therapist works with a black client feelings of counter transference can be very powerful (Eleftheriadou, 1994). Strong feelings can be evoked by black clients with a strong dislike of themselves which can result in counter-transference, resulting in the therapist re-discovering their own pain. Eleftheriadou suggests it is the therapist's role to raise these issues in therapy. However, this depends upon the theoretical orientation of the therapist. Another issue which therapists, in particular, need to be aware of, is the possibility of experiencing wanting to become the carer for the client - unwittingly projecting their own needs onto the client. The experience of the therapist's own deafness obviously needs to be explored and it is how this is dealt with that will affect therapy in the alliance on issues linked to communication. Some deaf clients, after having first met their counsellor, have preferred to converse using Signed Supported English (SSE). Then later in the alliance, gradually use more British Sign Language concepts. This was initially thought by the writer to be because deaf clients were used to working only with non-deaf professionals hence the adjustment from BSL to SSE for the therapy sessions. However, it was noticed that this appeared to serve another purpose - on an unconscious level. The preference to initially conversing in SSE enabled a 'distance' for exploration. Although clients knew the writer was Deaf, a shared cultural understanding was gradually achieved in this way. This is an important issue for Deaf therapists as some clients may not want to work solely within their culture, and want to look at the possible aspects of discovery in a 'new culture'. Another issue highlighted is the risk of the deaf therapist being so insular as to appear defensive in presentation to deaf clients who might not feel the same way. Cultural incongruities (meaning differences between cultures in behaviour or language) will

arise and not this does not all culturally deaf people may wish to be matched with a culturally Deaf counsellor.

**Case Example:** David, (27) a client from a deaf family was partially deaf and fluently bilingual and apparently, bicultural. He came to counselling because he was feeling that he was losing control of himself and felt he was being troubled by "outside" pressures. As he was born into a deaf family he quite considered himself as a fully integrated culturally Deaf member of his Deaf family and had incorporated Deaf cultural values, norms and beliefs. He attended first a Deaf school and later attended a partially hearing unit. He felt he had not learnt much about non-deaf culture and values until he went to the PHU. In some ways David felt the therapist represented the "traditional culture" (the culturally Deaf culture) - whilst he wanted to develop the hearing part of his identity. It was as if wanting to be in the hearing world was a trend - a fashion. David could obviously, because of his dual functioning, enter either world as he wished. The two cultures were in conflict and there was tension within his own relationship with his partner Morgan, who was a non-deaf gay activist. David frequently projected his angry feelings onto Morgan, and the emerging theme was that he identified with him, as his partner, who was also part of a minority group facing oppression from anti-gay attitudes in the wider society. Gradually as counselling progressed, David discovered how in his social world he had been extremely close to his family, who appeared to be dependent on him to meet some of their communication needs. This resulted in David later wanting to break away, in irritation with what he now perceived as having too many demands placed upon him during his teenage years. David felt he had not considered his own needs and was in one way rebelling against what he saw as the family 'morals', values and beliefs by, for example, being hearing and having a non-deaf partner. Once this anger had been addressed David could see how his attempts to integrate into another culture had led him to believe he had actually adopted many of the non-Deaf cultural values and norms, although it was on a superficial level, hence feelings of external conflict arose as a result of internal conflict over values he had tried to reject. He had 'decided' which culture he wanted to adopt but found he could not "shake off" his Deaf culture as he then wished to. Gaining insight in therapy helped him to move forwards and begin to look at bicultural issues as a way of dealing with identity and crosscultural conflicts he had been experiencing within the split. (*Example from author's clinical practice*)

Therapists need to be particularly careful, irrespective of theoretical orientation when considering effects of experiences of discrimination and oppression. How one deaf person experiences anxiety during an oppressive situation will be different to another

deaf person's experience of the same kind of situation, sometimes extremely different. More information is conveyed between both the therapist and the client within a Deaf alliance than is usually 'picked up' within a non-deaf alliance. This relates to exposure of non-verbal communication. Confusion and anxiety may be overtly visible to the deaf therapist, who needs to exercise caution when using material gathered from "non-verbal" bodily communication which has not been expressed through Sign Language. How a **non-deaf** therapist would deal with this also needs extra consideration, as the therapist might find it hard to distinguish between language communication the client intends to give and non-verbal communication which the client does not intend to give. Recognising and being able to make a distinction is vital to how the therapist responds in the process of the alliance as misinterpretation can set therapy back several sessions.

### Conclusions

Working in a counselling alliance with deaf people, whether the counsellor is Deaf or non-deaf, means thinking about the relationship, the process and outcomes, in different ways to therapeutic work with non-deaf people.

The following suggestions in Table 9.2 might form the basis of such alliances:

**Table 9.2      The Therapeutic Alliance with Deaf Persons**

A	Exploration of deaf clients expectations, what they think counselling is and how they feel about counselling
B	Discussion on the limits and boundaries of confidentiality. What information will be shared with other people, for example, supervisors, referring agency and line managers
C	A non-deaf therapist can encourage exploration of how the client feels about working with a non-deaf counsellor. How does the client feel about working with someone from a different cultural group?
D	Information on the resources available to the client and their family needs to be gathered as does knowledge of support networks. Knowledge of what the client expects as an outcome of counselling can be gathered
E	Knowledge of the hearing status and cultural orientation of the client's family - perhaps both extended and immediate - whether there is any communication or any other deaf members helps both counsellor and client gain an appreciation of the client's world
F	External factors often relate to problems experienced and it is useful to explore factors such as the impact of discrimination and concerns about educational experiences, employment, experiences linked to health matters and whether there are any agencies or organisations the client is linked to which cause anxieties for example
G	A skilled counsellor, regardless of hearing orientation, will be able to encourage discussion on identity - the client's identity feelings and any difficulties and conflicts experienced in connection with this. However, non-deaf counsellors will probably be unable to achieve significant depth in empathy
H	The smallness of the Deaf community and the possibility of meeting outside the alliance at a social function is one of the problems that a counsellor who works with deaf people will face, if they are in any way linked to Deaf community activities and events, educational, social or leisure. Discussing the possibility of accidentally meeting and clarifying how one wishes to be acknowledged, if at all, is particularly helpful towards establishing trust in the therapeutic relationship. This encourages exploration and clarification of boundaries. Examples are described in ' <i>The Deaf Alliance</i> ', (Ridgeway, 1994)

The first sessions are crucial in determining whether or not the client returns (Sue, 1990) and because of discriminatory and oppressive experiences and low self concept, the issue of trust becomes particularly important.

The therapist's role in working with deaf clients is broader than working for non-deaf clients. It would not be inappropriate to take on a more directive role, and assist the deaf client within an educational parameter. There are many differences between individuals within the heterogenous deaf population. These preparatory steps are guidelines which all counsellors working with deaf people need to be aware of, regardless of hearing orientation and before therapy can begin.

The examples that have been described here illustrate a range of clinical manifestations of internalised oppression, and defence mechanisms such as denial, rationalization, and identification with the aggressor. The task of the therapist, whether deaf or non-deaf, is thus to assist in de-tangling the client's internal conflicts for the benefit of the better functioning of the ego, regardless of reason for presentation and regardless of theoretical orientation.

Deaf youth of today face many anxiety provoking situations. Increased use of mainstreaming and partially hearing units in school which do not monitor psychological effects can mean an unsafe environment in terms of well being and an emerging Deaf identity will be a key factor to positive psychological health. Young deaf people will come across verbal and emotional abuse at home, school or in the work place. Over 70% of participants in the study, who are employed, reported unhappiness at work related to communication issues. Thirty-eight percent of deaf people interviewed for this study reported suffering from severe sexual abuse under the age of 16 years. This figure is more than the mainstream norm, which holds a much wider definition than that used in this study, of around 12% (Baker and

Duncan, 1985). An incidence of between 40-50% of behavioural and emotional difficulties is reported in deaf children and young people (Health Advisory Service, Department of Health, 1997). This has significant implications for the mental health and well being of deaf people. Poor self-esteem, isolation, bullying, lack of appropriate support and learning opportunities contribute towards the vulnerability of young deaf people today.

## CHAPTER TEN

### DISCUSSION

The effect of attitudes and identity upon the psychological health and well-being of deaf people in the community and its relationship to the acquisition of Deaf cultural identity has been examined.

The incidence of psychological distress using the General Health Questionnaire (1972) in this sample ( $n = 102$ ) was found to be much higher than for the hearing (non-deaf) population. The Attitude and Identity Questionnaire (ATIQ) designed for this study was used to gather information on self-esteem and image and attitudes towards participants' own and other's deafness. Background details were gathered as was information in relation to experiences of abuse.

The present study is also an attempt to measure psychiatric disturbance of deaf individuals, that does not rely on the various diagnostic standards of individual clinical workers. The aim is to obtain an estimate of the degree of psychiatric distress within a Deaf orientated and Deaf centered framework.

The data was collected using British Sign Language in face-to-face interviews. The translation into English and back translation of the instruments were described. A high number of Deaf people reported psychological ill health (38.1%) and a highly significant relationship ( $p = 0.002$ ) with the ATIQ was found.



A particularly high incidence of the experience of severe sexual abuse was reported (40%). Sixty-five percent of those sexually abused scored highly on the GHQ-12. A statistically significant difference was found (Chi-squared = 6.10;  $p = 0.047$ ) between those sexually abused and those not sexually abused. Twenty percent of the population reported physical abuse which took place at home and/or at school, perpetrated by both deaf and non deaf adults and older peers. Sixty-one percent of those physically abused had high GHQ scores, obtaining a Chi-square value of 4.24;  $p = 0.04$ . The relationship between psychological ill health and the Attitude and Identity Questionnaire (ATIQ) was found to be highly correlated; ( $p = 0.002$ ). This is a negative correlation which means the poorer the identity measure the greater the psychiatric distress experienced.

The study has considered deafness in the context of a transcultural model and also draws on aspects of the social disability model. These models seem to be relevant to members of the Deaf community, including deaf people who do not see themselves as members. The social model enables recognition of the requirements of deaf people and their cultural and linguistic needs whilst the disability model enables recognition of the barriers to access to information and interaction within society. The transcultural model provides a way of combining the two models in a cross-cultural context, so incorporating the cultural and linguistic status of Deaf people and also recognising the way disability is imposed by society's dominant hearing orientated needs.

A perspective is given concerning the background and history of the mistreatment and potential diagnostic errors in the field of mental health and deafness. There are a number of identified concerns regarding the use of psychological tests and clinical interview questionnaires upon deaf people which have been standardized on non-deaf populations. A particular range of skills and a level of awareness on the part of hearing clinicians which appertain to deaf people are required.

There has been increased interest in the presentation of mental health problems in Deaf communities which has reversed the previous trend of assuming that deaf people rarely indicated depressive illness, but often presented with behavioural problems. Only recently has deafness itself begun to be eliminated as a cause of pathological behavioural deviations. This study has shown that Deaf people present with a spectrum of mental health problems, as wide as that seen in non-deaf people, and to a greater extent.

The developmental history and other background information has rarely been collected from deaf clients themselves. Usually other involved professionals provide the necessary details in order to assist the clinician in formulating a diagnostic appraisal. This still happens to a large extent, particularly when interviewing culturally Deaf people and where the clinician does not have sufficient bilingual skills. Being responsible for translating into another language what an individual is saying is not just a simple matter and depends on the situation or context. Assessment of the mental state and well-being of a culturally Deaf person by a non-fluent signer is therefore inappropriate and should be regarded as unprofessional practice.

Deaf people are far more likely than hearing people to receive a label related to a mental disorder and as a result are more likely to receive treatment, to be prescribed medication and kept longer in hospital (Dunn and Fahey, 1990). There are doubts as to the feasibility of non-deaf administered interviews with deaf clients. One schedule used, The Present State Examination (PSE) has been extensively criticized for its symptomatology and for missing subtle differences between groups in notions of the self and emotional expression (Marsella and White, 1982; Littlewood, 1986; Fernando, 1988).

Furthermore, clients will often shift from their primary language in order to accommodate the clinician, who may have Sign Language skills, but does not demonstrate sufficient fluency to instil confidence in the client of being fully understood. The study of deaf children's character and personality 'traits' and how awareness of emotions develop led by default to attempts to identify a Deaf personality. Recent studies of the hearing parents of deaf children (Gregory, 1995) show that negative terms are applied by non-deaf parents to their deaf children as if they were features of deafness, rather than from a failure to recognize the difficulties that deaf children face in their environment. Studies of deaf children of deaf parentage have provided evidence that deprivation of access to communication and language tends to lead to poorly developed cognitive skills (Meadow, 1980; Meadow-Orlans, 1987; Vestberg, 1989). Parental influences upon deaf children probably contribute to a greater extent in terms of behaviour (Marshark, 1993) which is observed and learnt (internalised) than with non-deaf children, which means that these families have a greater role in the shaping of psycho-social development of deaf

children, simply due to reliance upon environmental visual clues which are inevitably dominant.

Communication skills appear to be of greater importance when examining issues relating to deaf children born into non-deaf families, with attachment probably being of less significance in these families than has previously been assumed. Bowlby's studies (1973) of the importance of parental attachment may be somewhat different for deaf young children and probably babies too, who depend upon communication through a common language, in the same way as non-deaf children, in order to receive communication or express themselves. This does not imply a level of modification needs to be made in these families when considering attachment theories but rather, this suggests that the process of attachment is not happening *because* of the lack of communication taking place. This study shows that this means an approach which focuses on oral-aural means is inappropriate. The process of attachment is a natural feature of a common bond which develops through communication. Bowlby (1973) called this monotrophy (special attachment to the mother). If communication is restricted, then this will likely affect the attachment process. This can be seen in psycho-therapeutic relationships, where if there is no common language, transference and counter-transference will not be able to occur as a necessary part of the process. In the same way as attachment to a carer(s) is considered a particularly necessary part of childhood development, this process of attachment is considerably stunted where there is no common language. A number of participants in this study, when asked about communication with families used in childhood and communication used with their families now, have indicated lack of

attachment formation to their hearing families. Many respondents felt estranged or rejected by their families and some did not know where their siblings were now living. Comments were made such as that by Participant 15; "I have no contact with any of my family - I am not bothered" and Participant 43; "I don't see them (my family). It is difficult to communicate, I don't understand" and Participant 78; "Why should I bother? They never did (anything) for me". These comments were seen to reflect the feelings of 60% of those interviewed.

Another issue implicitly linked with communication is identity. The fifth stage in Erikson's theory (1968) of development is relevant to the deaf adolescent. This is the stage where conflict in role and identity develop. The deaf child will have experienced a number of different social groups and this includes possible interaction with non-deaf as well as deaf people. An integrated sense of self-identity is crucial for positive mental health and well-being. The deaf people of this study, up until secondary school age, were still in conflict with society's expectation of how they should behave, as hearing people, as best as they could, or to develop a Deaf identity together with their peers. Those participants in the study who attended a Partially Hearing Unit or a mainstream school tended to have fragile identities and had anxious personalities. This provides evidence of the need for extra support in these environments, in both human and technological forms, rather than suggesting PHUs or mainstreaming is not successful. Essentially, peer group support accessibility has been identified by those respondents attending PHUs and mainstream settings as vital. Coherence of self, self-esteem and a positive self-concept has been identified as weak (Bat-chava, 1993; Brauer, 1979) in many deaf young people due to the deaf and non-

deaf conflict role confusion experienced and expectations imposed. This study has shown that when a measure of identity pertaining to Deaf culture is obtained, a significant relationship emerges with a measure of psychological well-being.

Issues relating to the effects of translating written material into British Sign Language and then the backtranslation have often been problematic and have not been seen as bilingual instruments. The use of instruments designed in written text originally standardized on a non-deaf population continue to be used with deaf people and translation processes often simplify, which results in them being seen as patronising and tends to incorporate non-deaf norms. These tools were not designed to incorporate the norms of non-deaf populations. This study incorporated a reliable process which consisted of Deaf and non-deaf native Sign Language users and bilinguals (English and BSL) who translated the text version of the ATIQ whilst another group translated the BSL version into English. The groups performed the back translation process for the other group and items with poor linguistic equivalency were removed from the ATIQ. This proved to be highly reliable through using a combination of both deaf and non-deaf bilinguals in the translation process. Bearing in mind that the Attitude and Identity Questionnaire (ATIQ) was originally developed in BSL and the translation and backtranslation process has been given an important role in the final design of the questionnaire, the ATIQ can be considered a functionally bilingual tool to measure identity attitude and self-esteem in relation to deafness.

The 'interviewer' effect discussed in two studies (Hindley et al., 1993; Brauer, 1992) has examined non-verbal messages which may be inadvertently given out by the BSL-using interpreter or interviewer. Neither of the studies were conclusive and one (Hindley et al., 1993) was poorly designed. The likelihood of a Sign Language 'interviewer' effect will probably be comparable to that of non-deaf populations who may inadvertently receive non-verbal messages from the way questions are audibly verbalised, written or presented.

The ATIQ was designed for this study in its originating language, BSL. It is a questionnaire designed to gain an impression of an individual's attitude towards his or her own and other people's deafness; of identity and attachment to other Deaf people and anxiety and self-esteem in relation to hearing status. No other study has, as far as the writer is aware, produced an instrument with similar parameters and so no psychological instrument exists that could be used to gather this information. The ATIQ, readers are reminded, was originally created in BSL. As such there is no other questionnaire which has been designed in the same way.

The Background Interview Questionnaire (BIQ) revealed a number of significant findings. There were a high number of male respondents who were willing to discuss personal issues and to fully participate in the study. Fifty-five percent reported that their deafness was not identified until 18 months of age and 26% reported discovery at 2½ years of age. The delay in time between discovery and confirmation of deafness is probably now, hopefully, decreasing as audiological and technological advances continue.

Many of the respondents seemed to be aware of, and remembered, their parents' sadness and grief at having a deaf child. Over 90% of families did not change their communication style with their deaf child throughout their lives. These families continued to use mainly hearing orientated methods to communicate. Only two families were reported as having learnt some Signed English. Although the situation may have improved recently, given the age range of the population interviewed (17-65 years), this reinforces the need for appropriate intervention as early as possible. Such intervention needs to consider the cultural and linguistic needs of deaf children from an early age, as soon as the deafness is discovered. This means provision of access to Sign Language and learning about Deaf people, Deaf issues and knowledge of Deaf history needs to be made widely available to parents and involved professionals. It may not be unreasonable to suppose that gaps in these services be identified at primary care level health services. Primary care services are usually the first point of contact for concerned parents. Provision of counselling and support for families of newly discovered deaf children is another vital tool for parents to be better able to adapt to their deaf childrens' needs which are going to be very different to those of other hearing siblings. Deaf parents who usually communicate in BSL with each other often prefer to use English with their non-deaf children. This may reflect the low value and status given of the language, BSL that they choose to use with peers and also reflects poor self-esteem and self-esteem in relation to the deafness experience.

A large number of respondents reported being unhappy at various kinds of schools and even more reported a lack of understanding of teachers and vice versa. This



appears to have occurred in all educational settings when the participants were at school. Where pupils were understood and were able to understand what was being communicated, school would not have been such a negative experience. Happiness at school may then be determined largely by the ability to communicate freely and without the linguistic restrictions often placed upon deaf children. The percentage of participants who attended deaf schools increased as they got older, which suggests that pupils, once they were seen as 'failing' within mainstream settings or PHU's, were transferred to a deaf school as a last resort. This suggests that mainstream and PHU's at that time were not meeting the deaf child's language and cultural needs hence the 'transfer' to a residential deaf school. Although most deaf children prefer to be with their peers and use Sign Language to communicate, this can be effectively facilitated in integrative settings locally. The major problem with this, as most participants pointed out, is that they would have limited social contact out of school hours if there were no deaf friends to play with nearby. Interestingly, of all the respondents, only two remained in contact with their 'non-deaf' peers from childhood.

The area of vocational training and employment has been relatively inaccessible to the Deaf community who are usually given what is considered a suitable vocation or an available position, usually unskilled manual. Over 75% of participants experienced problems at work where they were often in isolation and communicative silence all day. Many felt their deafness was seen as creating a number of barriers. These negative experiences reported in the BIQ were correlated with the two questionnaires, the GHQ and the ATIQ and several statistically significant relationships were found. The following variables were found to have an effect upon an individual's

psychological health and well-being, indicated by their GHQ score; partner's hearing status (those with non-deaf partners manifested poorer psychological health (Chi-squared value = 4.24;  $p = 0.000$ ); lack of understanding of teachers (Chi-squared value = 8.25;  $p = 0.016$ ); experiencing difficulty in being understood at school, (which is a tentative statistical significant (Chi-squared value = 5.69;  $p = 0.058$ ); and being socially attached to the non-deaf community (Chi-squared value = 20.46;  $p = 0.002$ ). A significant relationship was also found between those who did not access vocational training and GHQ scores (Chi-squared value = 7.79;  $p = 0.020$ ).

The ATIQ has provided evidence of the way attachment and feelings of belonging to the Deaf community can be affected by life experiences. Significant correlations were found between low ATIQ scores and the following: observed modes of communication used with interviewer as opposed to participants' self-stated mode ( $p = 0.001$ ); communication style with partner using oralism ( $p = 0.04$ ); communication with family when young ( $p = 0.033$ ); and now ( $p = 0.012$ ); occupying a professional vocation ( $p = 0.020$ ); those who said they socialised only with non-deaf people ( $p = 0.003$ ); and those who would rather socialise only with deaf people ( $p = 0.000$ ). Unhappy school experiences correlated significantly with positive scores on the ATIQ ( $p = 0.047$ ). This seems to suggest a possible protective effect from the way deaf peers supported each other, thus creating an environment which offers a sense of belonging.

The GHQ-12 and the ATIQ demonstrate a strong correlation (Chi-square = 4.45;  $p = 0.002$ ). The factor emerging in the psychological health and well-being of deaf

people relates to poor deaf identity and attitude. Having a positive Deaf identity means less anxiety in situations that may trigger stress, such as contact with unfamiliar non-deaf people and is linked with enhanced self-esteem, positive self-concept and a higher level of confidence.

This study has illustrated a number of issues linked to the experience and effects of serious sexual abuse. Over 40% of the sample participants reported sexual abuse. Previous studies have shown that populations of disabled children suffer similar targeting from perpetrators but the figures the present study identifies far exceed any other study. A number of risk factors are identified which can be shown in Table 8.4 (page 322) in addition to those identified in the mainstream population. There appears to be little difference in symptomatology of psychological disturbance between deaf and non-deaf people. Deaf sexually abused males reported anxiety more often than deaf females. Of the male victims, none had attempted to report the abuse. In only 2 cases of the total sample of those interviewed, did the information reach statutory services. The reader is reminded that the term sexual abuse discussed here refers to the experience of rape or attempted rape prior to the age of 16 and are, in legal terms, serious forms of sexual abuse. There were a large number of other participants in this study, both male and female, who experienced non-penetrative sexual abuse and this figure appears to be in excess of 30%. There were also a number of participants who reported rape over the age of 16. Eleven females reported chronic sexual and physical abuse from their partners, nine of whom were non-deaf. Severe long term psychological sequelae has been found to be associated with penetrative or long term abuse (Jehu, 1988; Mannanno et al., 1992) although

this does not seem to be the case in the present deaf sample population, both clinical and community samples. However, described symptoms of Post Traumatic Stress Disorder seem to be linked to penetrative sexual abuse within the clinical sample.

Many of the victims from both the community and clinical samples reported thinking that such acts were normal; were meant to happen; or were the result of them being naughty. Rationalisation or dysfunctional beliefs are forms of defence mechanisms used which have the effect of enabling deaf children to survive these experiences. The strength of these convictions seemed to come from the fact that the abusers were usually non-deaf and thus were seen as being right in what they were doing. This is accepted by the usually already poorly formed ego (Sinkkonen, 1994) and sense of self, and self-image in relation to the deafness.

Interestingly no significant relationship existed between ATIQ scores and reported sexually abusive experience. Sexual abuse might be perceived as one of a number of oppressive experiences imposed by non-deaf people and could have the effect of Deaf community membership being seen as a source of support and a place in which to belong.

What this seems to point to is the need for ongoing contact with the families of deaf children. Although it could be argued that parents of deaf children do not need to be supervised any more than parents of non-deaf children, evidence does suggest that there is at least a three-fold increase in the incidence of sexual abuse and the reader is reminded that this refers to rape and attempted rape. Table 8.3 (page 294)

provides an outline of abuse predictors and could be incorporated as guidelines when parental capacity is assessed. A thorough assessment of parental capacities (or parental responsibility as termed in the Children's Act, 1981) could be a basis on which to gauge the level of safety a deaf child will experience in the home circumstances and the degree of interaction that will arise. Such an assessment would obviously need to consider the emotional, psycho-social and physical needs of the child. This would provide information on how willing or motivated parents are to learn about their deaf child and specific cultural and linguistic needs, going as far as, where appropriate, incorporating a new and probably dominant perspective on life.

The numbers of deaf children who experience sexual abuse at residential school, for example, is likely to continue to decrease as the numbers of deaf children who are placed in integrative settings increase. However, there is a pressing need to incorporate special programmes in all settings, which will provide deaf children with the awareness and knowledge needed to protect themselves. The PATHS programme (Greenberg, Kusche, Cook and Quamma, 1995) described earlier, organised by the National Deaf Children's Society, in Britain, provides children with skills to express a range of emotions and to understand the concept of choice.

Many of the presentations of psychological distress would benefit from psychotherapy. The past few years have seen little change occur in the continuation of restricted services deaf people receive and lack of opportunities for training although more recently, a climate is emerging where culturally Deaf people are now training to become counsellors. Not only is access to counsellor training becoming

available, but counselling is now increasingly being requested by Deaf people themselves.

Similarities between psychotherapeutic work with deaf people and transcultural models of counselling are emphasized as are particular issues in the Deaf alliance (the relationship between client and counsellor using a Deaf centered focus) which differ from traditional approaches. The focus of this section has been upon the cultural encapsulation of services. This refers to the almost exclusive use of Western theoretical models of therapy based upon use with non-deaf people. The development of transcultural models has enabled some recognition of the cultural and linguistic needs of deaf people to take place which include special issues linked to transference and counter-transference, conscious and unconscious processes, and the positive and negative use of defence mechanisms. Table 9.1, (page 360) illustrates some of the issues that might arise in a mixed hearing status alliance for example and Table 9.2, (page 367) shows a range of practical and other issues such as culture and identity which need to be considered by the therapist. The present position in Europe is that there are very few professionally trained counsellors who are deaf and who use Sign as a preferred language. There are no qualified nurses who are Deaf and there are no qualified doctors who are Deaf although there are two practising deaf medical doctors in Germany and one deafened medical officer in the Netherlands.

The introduction to this thesis raised the question of who is Deaf from two different perspectives, those of the disability model and the cultural model. The writer suggests that both models are of value in understanding the position of Deaf people

in society. That is, as a cultural minority and as a group who suffer widespread discrimination. The high correlation between deaf people's identity and psychological health has far reaching implications for the healthy development of cognitive schemata in their personal and interpersonal lives. A natural extension of the link found between deaf identity and psychological health lies in an examination of the field of parenting deaf children, interaction deaf children have with their peers and adults in society, and in educational and vocational experiences.

Evidently there is a need to focus on empowering and informing Deaf people and involved professionals. This has both social and educational implications which can be seen as involving the recognition of the Deaf community and culture as having a positive influence in the lives of Deaf individuals. From an educational perspective this entails the recognition and use of BSL because of its inextricable and embedded connection with Deaf culture and the norms and values of that culture.

Deaf people are likely to be socio-economically disadvantaged. The correlation between social class and mental illness (Marsella, 1995) is well established, and the negative consequences of urbanization on the mental health of poorer populations (social isolation, disorganization, disintegration and stress) are also acknowledged (Blue, Ducci, Jaswal, Ludermer and Harpham, 1995). What can be drawn from these studies is that Deaf people are at risk from economic, and other social factors. Deaf people are thus, for most of their lives, disabled and those deaf people who suffer mental distress are doubly disadvantaged.

Deaf people do not have equality of opportunity with hearing people in terms of preventative and therapeutic mental health services and are at risk on 'disability' grounds, by being members of a linguistic minority and through experiencing mental health problems in a non-communicating environment. Furthermore, the clinician who is unfamiliar with Deaf issues will nearly always face a diagnostic dilemma in dealing with the psychologically disordered deaf client. This is complicated by linguistic and sociocultural barriers in addition to the intrapsychic condition of the deaf client.

This is noted by Littlewood and Lipsedge (1982):

**"Psychological abnormality is always recognised against a background of particular beliefs about normality which are themselves cultural. Within given biological constraints there is considerable variation in both the presence and the type of psychological expression. This variation is socially determined".**

(in Beliappa, 1991, page 45)

There may also be differences in the way deaf people present with various types of psychological distress which are as yet unrecognized or uncatered for in any definitions of the DSM-IV or ICD-10.

The present study has shown the self-esteem of deaf individuals is affected by group identification. This means those deaf people who identify more strongly with the Deaf community will tend to have a higher self-esteem. According to Social Identity Theory (Tajfel, 1981), this does not by itself mean that the strength of identification with deaf people is associated with self-esteem but rather that it is dependent on the deaf person feeling that the group offers something positive to their social identity.



This study has shown the higher the deafness orientation of the family during childhood the higher the level of identification with other Deaf people and that this process of identification will take place earlier.

Alternatives are needed as a consequence of inequalities deaf people face within the mental health system with respect to patterns of admission to mental hospitals, diagnosis (and misdiagnosis), treatment (drugs-based and less psychotherapy) accommodation and after-care services. In addition, poor referrals, a low take-up of services and lack of information about services influence the present climate of inadequacy. The NHS Mental Health Task Force (1994) has identified that African Carribeans are continuing to be over represented in psychiatric institutions at all levels. The consensus of opinion is that psychiatric treatment does not seem to take account of the impact and effects of racism and that this means little acceptance of the importance of using and practising culturally diverse methods. Although the report does not refer to Deaf people the issues are practically identical and the term racism can be easily substituted with the terms discrimination and oppression.

As previously suggested, the statistically strong correlation between the ATIQ and the GHQ scores have far reaching implications in almost every sphere of life that a deaf person may encounter. The way provision is made for deaf children and their families, beginning with the early months, can be influenced positively by these findings. All services and agencies catering for the needs of deaf people ultimately can benefit from these findings.

Models of provision for mental health services for deaf people would benefit from the support and encouragement of involvement of deaf people at healthcare planning; consultation with deaf clients and deaf professionals; the setting up of support groups for deaf people in the community; training and awareness about deafness in medical schools and other disciplines; and most significantly, the development of mechanisms for involvement of deaf mental health service users in community care facilities. The latter development, in line with the increased integration of deaf people in mainstream society will enable deaf people's needs to be more widely noticed resulting in less alienation being felt by deaf people.

Whilst this thesis is by no means suggesting that integration into the wider society is the sole ultimate aim for Deaf people, it does suggest that regardless of the model used, in whatever setting, that Deaf people who have access to their deaf peers and who communicate freely and without boundaries in the mode of expression, are more likely to have much better psychological health and a sense of Deaf well-being than those whose experiences in society have resulted in negative feelings regarding their own deafness and the deafness of others.

From the results of the use of the GHQ on a deaf population in this study, it can be seen that deaf people suffer more than non-deaf people in terms of mental distress. It seems likely that the conventional routes to mental health care are not being accessed or being made use of due to inaccessibility of services. Contact with the GP is usually made when marked physical symptoms appear rather than distress symptoms. There are important questions to be asked regarding the sphere of

'normality' in deaf people and why such a high percentage of deaf people living in the community are presenting with psychiatric distress. The formulations of various health and social care professionals who are inadvertently involved in deaf people's lives contribute to the lower rate of reported psychiatric distress in the Deaf community. In addition, the smallness of the Deaf community and shared resources renders Deaf people susceptible to lack of privacy and therefore issues of confidentiality and trust become of greater importance. This might suggest emotional difficulties are recognized only for some Deaf people and not seen as particularly significant either through the way the Deaf person conceptualises the state of his or her mental health or because professionals have become so familiar with the lack of appropriate care services for Deaf people that there might be an attitude of resignation or acceptance.

Deaf people in employment such as manual labour were more likely to experience discriminatory and/or oppressive experiences. These deaf people are probably less likely to challenge or confront and unlikely to use political avenues to obtain services presently not being provided. Deaf people coping with cultural and language barriers are likely to have been through stressful experiences. The association between life event stresses and increased risk of psychological distress is generally now widely accepted (Murphy, 1977; Littlewood and Lipsedge, 1982). Such linguistic and cultural barriers can, and do, lead to cultural and linguistic isolation which means that the possibility of suffering emotional disturbance is increased.

The conclusion drawn from this study is borne out of the discovery that psychological and psychiatric distress among members of the Deaf community is clearly linked to attitude towards, and identification with, the self and other Deaf people. The onset of a healthy attitude and identity towards their deafness can be overtly given to deaf children from an early age. This will enable a reduction in the high numbers of those deaf people suffering psychiatric distress. In the context of deaf education, the literature does little to prepare deaf pupils for entering into, or learning about, the culture and community of Deaf people. Engaging such an approach would facilitate greater awareness and acceptance of mainstream and Deaf society.

Deaf people who have access to their deaf peers and adults from an early age, and who can practice communication with significant others, freely and without boundaries or limitations in their language are more likely to have better psychological health and a sense of Deaf well-being. This study indicates that the future does not bode well for those whose early experiences in society have resulted in negative feelings regarding their own deafness and the deafness of others.

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## Appendix 1

### **Beck Depression Inventory (1967)**

#### **A**      MOOD

- 0      I do not feel sad.
- 1      I feel blue or sad.
- 2a     I am blue or sad all the time and I can't snap out of it.
- 2b     I am so sad or unhappy that it is very painful.
- 3      I am so sad or unhappy that I can't stand it.

#### **B**      PESSIMISM

- 0      I am not particularly pessimistic or discouraged about the future.
- 1a     I feel discouraged about the future.
- 2a     I feel I have nothing to look forward to.
- 2b     I feel that I won't ever get over my troubles.
- 3      I feel that the future is hopeless and that things cannot improve.

#### **C**      SENSE OF FAILURE

- 0      I do not feel like a failure.
- 1      I feel I have failed more than the average person.
- 2a     I feel I have accomplished very little that is worthwhile or that means anything.
- 2b     As I look back on my life all I can see is a lot of failures.
- 3      I feel I am a complete failure as a person (parent, husband, wife).

#### **D**      LACK OF SATISFACTION

- 0      I am not particularly dissatisfied.
- 1a     I feel bored most of the time.
- 1b     I don't enjoy things the way I used to.
- 2      I don't get satisfaction out of anything any more.
- 3      I am dissatisfied with everything.

#### **E**      GUILTY FEELING

- 0      I don't feel particularly guilty.
- 1      I feel bad or unworthy a good part of the time.
- 2a     I feel quite guilty.
- 2b     I feel bad or unworthy practically all the time now.
- 3      I feel as though I am very bad or worthless.

#### **F**      SENSE OF PUNISHMENT

- 0      I don't feel I am being punished.
- 1      I have a feeling that something bad may happen to me.
- 2      I feel I deserve to be punished.
- 3b     I want to be punished.

#### **G**      SELF HATE

- 0      I don't feel disappointed in myself.

- 1a I am disappointed in myself.
- 1b I don't like myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

H SELF ACCUSATIONS

- 0 I don't feel I am any worse than anybody else.
- 1 I am very critical of myself for my weaknesses or mistakes.
- 2a I blame myself for everything that goes wrong.
- 2b I feel I have many bad faults.

I SELF-PUNITIVE WISHES

- 0 I don't have any thoughts of harming myself.
- 1 I have thoughts of harming myself but I would not carry them out.
- 2a I feel I would be better off dead.
- 2b I have definite plans about committing suicide.
- 3 I would kill myself if I could.

J CRYING SPELLS

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now. I can't stop it.
- 3 I used to be able to cry but now I can't cry at all even though I want to.

K IRRITABILITY

- 0 I am no more irritated now than I ever am.
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time.
- 3 I don't get irritated at all at the things that used to irritate me.

L SOCIAL WITHDRAWAL

- 0 I have not lost interest in other people.
- 1 I am less interested in other people now than I used to be.
- 2 I have lost most of my interest in other people and have little feeling for them.
- 3 I have lost all my interest in other people and don't care about them at all.

M INDECISIVENESS

- 0 I make decisions about as well as ever.
- 1 I am less sure of myself now and try to put off making decisions.
- 2 I can't make decisions any more without help.
- 3 I can't make any decisions at all any more.

N BODY IMAGE

- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel that there are permanent changes in my appearance and they make me look unattractive.
- 3 I feel that I am ugly or repulsive looking.

O     WORK INHIBITION

- 0     I can work about as well as before.
- 1a    It takes extra effort to get started at doing something.
- 1b    I don't work as well as I used to.
- 2     I have to push myself very hard to do anything.
- 3     I can't do any work at all.

P     SLEEP DISTURBANCE

- 0     I can sleep as well as usual.
- 1     I wake up more tired in the morning than I used to.
- 2     I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3     I wake up early every day and can't get more than 5 hours sleep.

Q     FATIGABILITY

- 0     I don't get any more tired than usual.
- 1     I get tired more easily than I used to.
- 2     I get tired from doing anything.
- 3     I get too tired to do anything.

R     LOSS OF APPETITE

- 0     My appetite is no worse than usual.
- 1     My appetite is not as good as it used to be.
- 2     My appetite is much worse now.
- 3     I have no appetite at all any more.

S     WEIGHT LOSS

- 0     I haven't lost much weight, if any, lately.
- 1     I have lost more than 5 pounds.
- 2     I have lost more than 10 pounds.
- 3     I have lost more than 15 pounds.

T     SOMATIC PREOCCUPATION

- 0     I am no more concerned about my health than usual.
- 1     I am concerned about aches and pains *or* upset stomach *or* constipation *or* other unpleasant feelings in my body.
- 2     I am so concerned with how I feel or what I feel that it's hard to think of much else.
- 3     I am completely absorbed in what I feel.

U     LOSS OF LIBIDO

- 0     I have not noticed any recent change in my interest in sex.
- 1     I am less interested in sex now.
- 2     I am much less interested in sex now.
- 3     I have lost interest in sex completely.

**Source: Leigh, I.W., Robbins, C.J. and Wilkowitz, J., *Journal of Clinical Psychology*, 1988, Vol 44., No. 5.**

## Revised Beck Depression Inventory (1988)

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you were feeling all this past week up to today. Circle the number next to the sentence closest to your feelings. If you have a hard time choosing and cannot decide, circle each one that you think is close to your feelings. Be sure to read all the statements in each group before making your choice.

1.     0     I do not feel sad.  
       1     I fee sad.  
       2     I am sad all the time and I can't stop it.  
       3     I am so sad or unhappy that I go crazy.
2.     0     I am *not* depressed when I think about the future.  
       1     I am depressed when I think about the future.  
       2     I feel there is no future for me.  
       3     I feel the future is hopeless and things will not get better.
3.     0     I do not feel like a failure.  
       1     I feel I have failed more than other people.  
       2     I see a lot of failures in my past.  
       3     I feel I am a total failure.
4.     0     I enjoy things now about the same as I did in the past.  
       1     I enjoyed things in the past, I don't enjoy things now.  
       2     I don't enjoy anything anymore.  
       3     I am bored or not satisfied with everything.
5.     0     I don't feel guilty.  
       1     I feel guilty part of the time.  
       2     I feel guilty most of the time.  
       3     I feel guilty all the time.
6.     0     I don't feel I am being punished.  
       1     I feel I may be punished.  
       2     I expect to be punished.  
       3     I feel I am being punished.
7.     0     I don't feel disappointed in myself.  
       1     I am disappointed in myself.  
       2     I am disgusted with myself.  
       3     I hate myself.
8.     0     I feel I am *not* worse than other people.  
       1     My mistakes or weaknesses bother me.  
       2     I blame myself all the time for my mistakes or weaknesses.  
       3     I blame myself for everything bad that happens.
9.     0     I don't have any thoughts of killing myself.  
       1     I have thoughts of killing myself, but I would *not* do it.  
       2     I would like to kill myself.  
       3     I would kill myself if I had the chance.

10. 0 I cry now about the same as I did in the past.  
 1 I cry more now than I did in the past.  
 2 I cry all the time now.  
 3 I was able to cry in the past, but now I can't even cry though I want to cry.
11. 0 The way I feel bothered *now* is the same as in the past.  
 1 I felt *less* bothered in the past. I am *more easily* bothered now.  
 2 I feel bothered all the time now.  
 3 Things bothered me in the past but not now anymore.
12. 0 I have *not* lost interest in other people.  
 1 I was interested in other people *more* in the past. Now I am *less* interested in other people.  
 2 I have lost most of my interest in other people.  
 3 I have lost all of my interest in other people.
13. 0 The way I make decisions has not changed.  
 1 Now I postpone making decisions *more* than I did before.  
 2 I have greater difficulty in making decisions than I did before.  
 3 I can't make decisions at all anymore.
14. 0 The way I look is *not* worse than before.  
 1 I am worried that I am looking old or unattractive.  
 2 I feel my appearance has changed. I look unattractive now.  
 3 I believe that I look ugly.
15. 0 The way I work has not changed.  
 1 I have to force myself to get started (to begin) at doing something.  
 2 I have to force myself very hard to do anything.  
 3 I can't do any work at all.
16. 0 The way I sleep has *not* changed.  
 1 I slept better in the past. I don't sleep as well now.  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 3 I wake up several hours earlier than usual and cannot get back to sleep.
17. 0 I get tired the same now as in the past.  
 1 Now I get tired more easily than before.  
 2 When I do almost anything, I get tired.  
 3 I don't do anything because I am too tired.
18. 0 My appetite is the same as usual.  
 1 Now my appetite is not as good as before.  
 2 My appetite is much worse now than before.  
 3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.  
 1 I have lost more than 5 pounds.  
 2 I have lost more than 10 pounds.  
 3 I have lost more than 15 pounds.

I am on a diet Yes ..... No .....

20. 0 I worry about my health now the same as in the past.  
1 I am worried about physical problems such as aches and pains: or upset stomach: or having a hard time making a bowel movement.  
2 I am very worried about physical problems. It is hard to think about other things.  
3 I am so worried about my physical problems I cannot think about anything else.
21. 0 My interest in sex is the same now as before.  
1 I am less interested in sex now than before.  
2 I am much less interested in sex now.  
3 I have lost interest in sex completely.

**Source:** Leigh, I.W., Robbins, C.J. and Wilkowitz, J., *Journal of Clinical Psychology*, 1988, Vol. 44, No. 5. pp.730-732.

## **APPENDIX 2**

### **General Health Questionnaire (GHQ-30)**

Please read this carefully:

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

#### **HAVE YOU RECENTLY**

- |     |   |                      |                     |                        |                      |
|-----|---|----------------------|---------------------|------------------------|----------------------|
| 1.  | Been able to concentrate on whatever you're doing?            | Better than usual    | Same as usual       | Less than usual        | Much less than usual |
| 2.  | Lost much sleep over worry?                                   | Not at all           | No more than usual  | Rather more than usual | Much more than usual |
| 3.  | Been having restless, disturbed nights?                       | Not at all           | No more than usual  | Rather more than usual | Much more than usual |
| 4.  | Been managing to keep yourself busy and occupied?             | More so than usual   | Same as usual       | Rather less than usual | Much less than usual |
| 5.  | Been getting out of the house as much as usual?               | More so than usual   | Same as usual       | Less than usual        | Much less than usual |
| 6.  | Been managing as well as most people would in your shoes?     | Better than usual    | About the same      | Rather less well       | Much less well       |
| 7.  | Felt on the whole you were doing things well?                 | Better than usual    | About the same      | Less well than usual   | Much less well       |
| 8.  | Been satisfied with the way you've carried out your task?     | More satisfied       | About same as usual | Less well than usual   | Much less satisfied  |
| 9.  | Been able to feel warmth and affection for those near to you? | Better than usual    | About same as usual | Less well than usual   | Much less well       |
| 10. | Been finding it easy to get on with other people?             | Better than usual.   | About same as usual | Less well than usual   | Much less well       |
| 11. | Spent much time chatting with people?                         | More time than usual | About same as usual | Less time than usual   | Much less than usual |



12.	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less so than usual	Much less useful
13.	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
14.	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
15.	Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
16.	Been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
17.	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much more than usual
18.	Been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19.	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20.	Been able to face up to problems?	More so than usual	Same as usual	Less able than usual	Much less able
21.	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22.	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23.	Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24.	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25.	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26.	Been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less than usual
27.	Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
28.	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

29.	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30.	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

*Published by The NFER-NELSON Publishing Company, Permission of Author obtained. (Goldberg, 1978)*

### **Modification of GHQ-30 (Checinski, 1989)**

#### **The last few weeks**

1.	Can you concentrate on (think hard about) what you do?	Better	Same As Before	Sometimes	Can't
2.	Do you worry and can't sleep?	No	Same As Before	Worse	Much worse
3.	Is your sleep restless (hard)?	No	Same As Before	Worse	Much worse
4.	Can you fill your time (busy)?	Yes	Same As Before	Sometimes	No
5.	Do you go out of the house?	Yes	Same As Before	Sometimes	Can't
6.	Are you coping well (same as other people people like you)?	Better	Same As Before	Worse	Much worse
7.	Do you feel you do things OK?	Better	Same As Before	Worse	Much worse
8.	Do you cope with your work?	Better	Same As Before	Sometimes	No
9.	Can you feel love and warmth to family and friends (HEARING)?	More	Same As Before	A little	No

10a.	Is it easy to talk to people you know (DEAF)?	More easy	Same As Before	Difficult	Very difficult
10b.	Is it easy to talk to people you know (HEARING)?	More easy	Same As Before	Difficult	Very difficult
11a.	Do you spend a lot of time talking to people (DEAF)?	More	Same As Before	Less	Much less
11b.	Do you spend a lot of time talking to people (HEARING)?	More	Same As Before	Less	Much less
12.	Are you a useful person at home/work?	More	Same As Before	Less	Much less
13.	Can you make decisions (know what to do) at home/work?	More easy	Same As Before	Difficult	Very difficult
14.	Do you feel worried all the time?	No	Same As Before	Worse	Much worse
15.	Are your problems hard?	No	Same As	Worse	Much worse
16.	Is your life difficult (hard) every day?	Easy	Same As Before	Hard	Very hard
17.	Can you enjoy yourself at home/work	Yes	Same As Before	Sometimes	No
18.	Do problems upset you a lot?	No	Same As Before	More	Much more
19.	Do you feel frightened a lot?	No	Same As Before	More	Much more
20.	Can you try to cope with problems?	Easy	Same As Before	Sometimes	Can't
21.	Do you feel your problems are too much for you?	No	Same As Before	Sometimes	Yes
22.	Do you feel unhappy and depressed (feel low)?	No	Same As Before	Worse	Much worse
23.	Have you lost your confidence (can't cope)?	No	Same As Before	Worse	Much worse

24.	Do you feel you are no good?	No	Same As Before	Sometimes	Yes
25.	Do you feel your life is no good?	No	Same As Before	Sometimes	Yes
26.	Do you feel your future is good?	Better	Same As Before	Worse	Much worse
27.	Do you feel happy with your life?	Yes	Same As Before	Sometimes	No
28.	Do you feel nervous all the time?	No	Same As Before	Sometimes	Yes
29.	Do you feel you would be better off dead?	No	Same As Before	Sometimes	Yes
30.	Are you too nervous and can't go out sometimes?	No	Same As Before	Sometimes	Yes

### **APPENDIX 3**

#### **Bronfenbrenner's Hearing Scale (1940)**

- |     |  |       |          |
|-----|--|-------|----------|
| 1.  | Being hard of hearing keeps me from doing many of the things I like to do.                               | Agree | Disagree |
| 2.  | Since I became hard of hearing, things don't interest me as much as they used to.                        | Agree | Disagree |
| 3.  | Other people may become annoyed at being asked to repeat.  | Agree | Disagree |
| 4.  | The strain of trying to hear makes me sweat.   | Agree | Disagree |
| 5.  | The only time I would be willing to wear a hearing aid would be when I am among people who know me well. | Agree | Disagree |
| 6.  | Being hard of hearing would stop me from taking a job where I have to be the boss.                       | Agree | Disagree |
| 7.  | Because of my hearing, people have been unfair to me.  | Agree | Disagree |
| 8.  | When I meet other people I do all the talking so I don't have to listen.                                 | Agree | Disagree |
| 9.  | Even though I am hard of hearing, I can go to a party and have a good time.                              | Agree | Disagree |
| 10. | Only people who are hard of hearing can help me with my problem.   | Agree | Disagree |
| 11. | Being hard of hearing is worse than any other handicap.  | Agree | Disagree |
| 12. | Being hard of hearing gives me the blues.  | Agree | Disagree |
| 13. | Because I'm hard of hearing some employers may not want to hire me.                                      | Agree | Disagree |
| 14. | Because I am hard of hearing I'm always worried.   | Agree | Disagree |
| 15. | I don't think I can learn to read lips.  | Agree | Disagree |
| 16. | Because I am hard of hearing, the only kind of work I can do is common labour.                           | Agree | Disagree |
| 17. | Because I'm hard of hearing, people turn against me.   | Agree | Disagree |

18.	I would rather not know what is going on than admit that I am hard of hearing.	Agree	Disagree
19.	Being hard of hearing keeps me from going out in public.	Agree	Disagree
20.	Because of my hearing I have trouble remembering things.	Agree	Disagree
21.	I let my hearing trouble get the best of me.	Agree	Disagree
22.	Because I am hard of hearing I'm no good to anybody.	Agree	Disagree
23.	Being hard of hearing never embarrasses me.	Agree	Disagree
24.	Being hard of hearing makes me jumpy.	Agree	Disagree
25.	I cannot get along without a hearing aid.	Agree	Disagree
26.	If the boss finds out I am hard of hearing I won't be able to hold my job.	Agree	Disagree
27.	Because I'm hard of hearing people stare at me all the time.	Agree	Disagree
28.	When I apply for a job, I shall try to hide the fact that I am hard of hearing.	Agree	Disagree
29.	Being hard of hearing makes me stay away from my friends.	Agree	Disagree
30.	Because I'm hard of hearing, I have a right to feel sorry for myself.	Agree	Disagree
31.	Being hard of hearing won't stop me from having a happy family life.	Agree	Disagree
32.	If my hearing stays that way life won't be worth living.	Agree	Disagree
33.	A hearing loss is no problem to me.	Agree	Disagree
34.	Being hard of hearing makes me nervous.	Agree	Disagree
35.	I want to learn lip reading.	Agree	Disagree
36.	Because I am hard of hearing I always get into trouble.	Agree	Disagree
37.	Because I am hard of hearing, it will be very hard for me to get any kind of job.	Agree	Disagree
38.	It is hard for me to tell others about my hearing trouble.	Agree	Disagree

39.	As long as I'm hard of hearing, I can't be popular with people.	Agree	Disagree
40.	Nobody has any business telling me how to handle my hearing problem.	Agree	Disagree
41.	If my hearing gets worse I won't be able to take it.	Agree	Disagree
42.	I drink to forget I am hard of hearing.	Agree	Disagree
43.	I think a hard of hearing person is bound to make mistakes once in a while.	Agree	Disagree
44.	Being hard of hearing is driving me crazy.	Agree	Disagree
45.	Wearing a hearing aid in public would bother me.	Agree	Disagree
46.	Because I am hard of hearing, I can never get a job that pays good money.	Agree	Disagree
47.	I can't stand having people ask me questions about my hearing.	Agree	Disagree
48.	When people ask me if I am hard of hearing I'd rather not answer.	Agree	Disagree
49.	Because I'm hard of hearing, I stay off by my myself.	Agree	Disagree
50.	My hearing gets worse when I am worried.	Agree	Disagree
51.	Being hard of hearing doesn't stop me from living a pretty normal life.	Agree	Disagree
52.	Being hard of hearing makes me feel like crying.	Agree	Disagree
53.	There are some kinds of jobs that a person with good hearing can do better than I can.	Agree	Disagree
54.	Being hard of hearing gets me all tired out.	Agree	Disagree
55.	I don't need anything this hospital can give me.	Agree	Disagree
56.	I may be able to hold my job, but my hearing will keep me from getting ahead.	Agree	Disagree
57.	Being hard of hearing makes me bashful.	Agree	Disagree
58.	I don't think it is fair to have my hearing tested when I apply for a job.	Agree	Disagree
59.	Because I'm hard of hearing I don't go to parties.	Agree	Disagree
60.	My hearing changes from day to day.	Agree	Disagree

61.	I am hard of hearing, but I still have confidence in myself.	Agree	Disagree
62.	Because I am hard of hearing, I don't have any pep.	Agree	Disagree
63.	Because other people don't know how loud to talk to me, I may embarrass them once in a while.	Agree	Disagree
64.	Because I am hard of hearing, I can't keep my mind on what I'm doing.	Agree	Disagree
65.	I won't wear a hearing aid under any conditions.	Agree	Disagree
66.	Even though I'm hard of hearing, there is still some kind of work I can do.	Agree	Disagree
67.	I can't stand having people kid me about my hearing.	Agree	Disagree
68.	When I don't hear what a person is saying I just let it go.	Agree	Disagree
69.	Because I'm hard of hearing, I never speak to strangers.	Agree	Disagree
70.	Because of my hearing trouble, I don't like people.	Agree	Disagree
71.	I have learned how to get along with my hearing trouble.	Agree	Disagree
72.	As long as my hearing stays this way I can't be happy.	Agree	Disagree
73.	Because I don't always hear what people say, they may lose patience with me once in a while.	Agree	Disagree
74.	Being hard of hearing, I won't be able to make a living.	Agree	Disagree
75.	I don't want to go to any hearing classes.	Agree	Disagree
76.	Because I am hard of hearing, I won't be able to make a living.	Agree	Disagree
77.	Because I'm hard of hearing, I am ashamed to go home to my family.	Agree	Disagree
78.	I sometimes make out that my hearing is better than it really is.	Agree	Disagree
79.	Because I'm hard of hearing, I don't like to meet new people.	Agree	Disagree
80.	I don't care if my hearing does get worse.	Agree	Disagree
81.	Being hard of hearing has made a completely different person out of me.	Agree	Disagree
82.	Being hard of hearing makes me feel sad most of the time.	Agree	Disagree



83.	In applying for most jobs, a person with good hearing has a better chance than I have.	Agree	Disagree
84.	Because I'm hard of hearing, people get on my nerves.	Agree	Disagree
85.	If I need a hearing aid, I'll wear it.	Agree	Disagree
86.	Because I'm hard of hearing, my family will have to support me.	Agree	Disagree
87.	Everybody makes fun of me because of my hearing.	Agree	Disagree
88.	When I don't hear what a person has said, I often ask him to say it again.	Agree	Disagree
89.	Because I'm hard of hearing, I sometimes avoid talking with people.	Agree	Disagree
90.	I'm glad I'm hard of hearing.	Agree	Disagree
91.	Being hard of hearing is like having two strikes against you.	Agree	Disagree
92.	Being hard of hearing makes me feel like giving up sometimes.	Agree	Disagree
93.	As far as I am concerned none of these questions are worth bothering about.	Agree	Disagree
94.	I like awake nights worrying about my hearing trouble.	Agree	Disagree
95.	I can't stand having doctors look at my ears.	Agree	Disagree
96.	The only job I can take is one where I can work alone.	Agree	Disagree
97.	Because of my hearing, nobody wants me around.	Agree	Disagree
98.	Only my friends should be told that I'm hard of hearing.	Agree	Disagree
99.	Because I'm hard of hearing, I want to live off by myself.	Agree	Disagree
100.	I hope my hearing gets better.	Agree	Disagree

**Source: E.S. Levine, 1981, 'Ecology of Early Deafness', New York, Columbia.**

## **APPENDIX 4**

### **Glickman and Carey's (1993) Deaf Identity Development Scale (DIDS)**

#### **Hearing Scale**

- 4. Deafness is a terrible disability.
- 7. I feel sorry for deaf people who depend on sign language.
- 12. I don't like it when deaf people use sign language.
- 18. Deaf people should **not** marry other deaf people.
- 25. I don't understand why deaf people have their own culture.
- 29. The focus of deaf education should be teaching deaf children to speak and lipread.
- 38. It is best for deaf people to communicate with speech and lipreading.
- 39. Hearing people express themselves better than deaf people.
- 42. I only socialize with hearing people.
- 46. I would like to have an operation that would give me full hearing.
- 48. Hearing counsellors, teachers, and doctors who specialize in treating deaf people can give me the best advice.
- 53. Sign language should be based on English.
- 54. I call myself "hearing-impaired".
- 59. It is important to find a cure for deafness.

#### **Marginal Scale**

- 2. I don't know how I feel about deaf people.
- 8. It's hard for me to make friends.
- 13. I don't know whether to respect or resent deaf people.
- 15. I don't know whether to call myself "hearing-impaired" or "deaf".
- 20. When I see deaf people use sign language, I walk away.
- 22. Neither deaf nor hearing people accept me.
- 24. I am always alone.
- 32. The best way to communicate is to speak and sign at the same time.
- 36. I don't know whether to think of my deafness as something good or something bad.
- 45. Sometimes I enjoy other deaf people but sometimes they embarrass me.
- 56. I am confused about communication.
- 58. I do not fit in with either hearing or deaf people.

#### **Immersion Scale**

- 3. Deaf people should use ASL.
- 6. Deaf people do not need hearing aids.
- 10. There is no place for hearing people in the deaf world.

- 16. Only deaf people should teach deaf children.
- 19. Hearing people don't help deaf children.
- 23. Deaf people are satisfied with what the deaf world has to offer.
- 27. Hearing people do not understand nor support deaf people.
- 30. I feel angry with hearing people.
- 40. Teaching deaf children to speak is a waste of time.
- 43. It is wrong to speak while signing.
- 50. Only deaf people should run deaf schools.
- 52. I can't trust hearing people.
- 55. Learning to lipread is a waste of time.
- 57. Deaf people should only socialize with other deaf people.

### **Bicultural Scale**

- 1. I enjoy both deaf and hearing cultures.
- 5. I support deaf culture without insulting hearing people.
- 9. American Sign Language and English are different languages of equal value.
- 11. I call myself "Deaf".
- 14. I want to help hearing people understand and respect Deaf culture.
- 21. I can change between ASL and Sign Language.
- 26. I have both deaf and hearing friends.
- 28. When I am with hearing people, I remember my pride as a deaf person.
- 37. I feel comfortable with my child being either deaf or hearing.
- 44. I have thought a lot about what it means to be a proud, strong, deaf person.
- 47. Some hearing people genuinely support Deaf culture and Deaf ways.
- 49. I feel comfortable with deaf and hearing people.
- 51. I feel good about being deaf, but I involve myself with hearing people.
- 60. My hearing friends will fight for Deaf rights.

**Source:** Glickman N. and Carey J., (1993), 'Measuring Deaf Cultural Identities: A preliminary investigation', *Rehabilitation Psychology*, Vol. 38, No. 4, pp.275-283.

## **APPENDIX 5**

### **Initial 55 Item ATIQ Questionnaire**

1. I worry when I see people talking because I wonder if they are talking about me.
2. I feel quite confident.
3. I would be a better person if I could hear.
4. My best friends are deaf.
- † 5. I wear a hearing aid so people will think I am a bit hearing.
- \* 6. I am confident to ask people to write down what they say.
- \* 7. I feel my deafness is a barrier to the world.
8. I am most relaxed when I am with deaf people.
9. I feel I have a hard life because I am deaf.
- \* 10. Deaf people have advantages hearing people do not have.
11. I feel nervous because I am deaf.
12. My deafness is a problem for other people. It is not a problem for me.
- † 13. I feel that people look at me because I am deaf.
14. Deaf people understand me best.
15. I blame my deafness for my problems.
- \* 16. I am confident to approach hearing people to try and communicate.
17. Sometimes I pretend to understand other people when really I do not.
18. People dislike me because I am deaf.
- \* 19. I am useless because I am deaf.
- \* 20. I feel more confident when I am with other deaf people.
21. I do not like it when I have to tell other people I am deaf.
22. Deaf people make more mistakes in life because they are deaf.
23. I feel uncomfortable if I am the only deaf person in a group.
- \* 24. I feel no one understands my feelings.
- \* 25. I like to be with other deaf people.
26. Being Deaf is absolutely terrible.
- \* 27. I always tell people I am deaf.
- \* 28. I think I make problems for other people because I am deaf.
- \* 29. Deaf people are better than hearing people.
30. I feel rejected by hearing people.
31. My close friends are hearing.
- \* 32. I think I am a failure because I am deaf.
- \* 33. I only like to be with hearing people.
- \* 34. I am embarrassed because I am deaf.
- \* 35. I am happiest with hearing people.
- \* 36. I feel sad a lot because I am deaf.
37. Deaf people can be just as equal to hearing people.
38. I am angry because I was born deaf.
39. I lead a normal life just like anyone else.
- \* 40. I try to avoid people because I am deaf.
41. I do not like mixing with deaf people.

- \* 42. I feel embarrassed if I am seen with other deaf people.
- 43. I am satisfied I am deaf.
- 44. Hearing people often put down deaf people.
- \* 45. I feel self conscious with hearing people.
- 46. I prefer being with hearing people.
- 47. I feel nervous if I miss something and I have to ask people to repeat.
- 48. I have a strong feeling of identity as a deaf person.
- 49. I have a strong sense of belonging to the Deaf community.
- 50. It is ideal for deaf people to have deaf partners.
- 51. I really wish I was hearing.
- \* 52. Hearing people think deaf people are stupid.
- \* 53. I feel happier with other deaf people.
- 54. I feel embarrassed signing in public.
- 55. I feel angry towards hearing people.

\* *Indicates item removed after translation and back translation process*

† *Item was subsequently removed after the pilot study.*

## **APPENDIX 6**

### **32 Item ATIQ (Ridgeway, 1994)**

1. I worry when I see people talking because I wonder if they are talking about me.
2. I feel quite confident.
3. I would be a better person if I could hear.
4. My best friends are deaf.
8. I am most relaxed when I am with deaf people.
9. I feel I have a hard life because I am deaf.
11. I feel nervous because I am deaf.
12. My deafness is a problem for other people. It is not a problem for me.
14. Deaf people understand me best.
15. I blame my deafness for my problems.
17. Sometimes I pretend to understand other people when really I do not.
18. People dislike me because I am deaf.
21. I do not like it when I have to tell other people that I am deaf.
22. Deaf people make more mistakes in life because they are deaf.
23. I feel uncomfortable if I am the only deaf person in a group.
26. Being deaf is absolutely terrible.
30. I feel rejected by hearing people.
31. My close friends are hearing.
37. Deaf people can be just as equal to hearing people.
38. I am angry because I was born deaf.
39. I lead a normal life just like anyone else.
41. I do not like mixing with deaf people.
43. I am satisfied I am deaf.
44. Hearing people often put down deaf people.
46. I prefer being with hearing people.
47. I feel nervous if I miss something and I have to ask people to repeat what they say.
48. I have a strong feeling of identity as a deaf person.
49. I have a strong sense of belonging to the Deaf community.
50. It is ideal for deaf people to have deaf partners.
51. I really wish I was hearing.
54. I feel embarrassed signing in public.
55. I feel angry towards hearing people.

*Numerical order is taken from the original list of 55 items. This format is not kept but is reproduced here so that the reader can see the items at a glance more easily in relation to the original item list.*

## The 23 Items Removed from the ATIQ

- † 5. I wear a hearing aid so people will think I am a bit hearing.
- \* 6. I am confident to ask people to write down what they say.
- \* 7. I feel my deafness is a barrier to the world.
- \* 10. Deaf people have advantages hearing people do not have.
- † 13. I feel that people look at me because I am deaf.
- \* 16. I am confident to approach hearing people to try and communicate.
- \* 19. I am useless because I am deaf.
- \* 20. I feel more confident when I am with other deaf people.
- \* 24. I feel no one understands my feelings.
- \* 25. I like to be with other deaf people.
- \* 27. I always tell people I am deaf.
- \* 28. I think I make problems for other people because I am deaf.
- \* 29. Deaf people are better than hearing people.
- \* 32. I think I am a failure because I am deaf.
- \* 33. I only like to be with hearing people.
- \* 34. I am embarrassed because I am deaf.
- \* 35. I am happiest with hearing people.
- \* 36. I feel sad a lot because I am deaf.
- \* 40. I try to avoid people because I am deaf.
- \* 42. I feel embarrassed if I am seen with other deaf people.
- \* 45. I feel self conscious with hearing people.
- \* 52. Hearing people think deaf people are stupid.
- \* 53. I feel happier with other deaf people.

\* *Indicates item removed after translation and back translation process*

† *Item was subsequently removed after the pilot study.*

## **APPENDIX 7**

### **Copy of correspondence with Local Authority Social Services Departments and Interviewees**

#### **LETTER 1**

Date:

Dear

I am sending you a letter from Sharon Ridgeway. She is a Deaf Psychologist working to improve mental health services for deaf people. Sharon is doing some research in ..... (geographical location, e.g. Manchester, Cheshire).

The ..... (County Council, Borough ... ) is supporting Ms Ridgeway's work. Please read her letter for you. Fill in the tear off slip and send it to her if you are interested. She will write to you to make an appointment to come and see you.

**ALL PERSONAL INFORMATION WILL BE KEPT STRICTLY  
CONFIDENTIAL**

Thank you very much for your help in taking part in this important research for deaf people.

Yours sincerely

*This is a sample copy of a letter which the social worker or Team Leader providing services to deaf people sent to the sample gathered from the geographical location they were representing. This letter was sent together with a letter from myself asking for agreement to being interviewed and contained a stamped addressed envelope with which to reply.*



**LETTER 2**

Date:

Dear

I am a Research Psychologist working for Preston Health Authority. I am doing some research into the health care needs of Deaf People and would like to ask you a few questions for this research.

The interview will be for one hour and I can come to see you at your house if this is convenient for you. If you prefer, you can come to see me at my office and I can pay your travel expenses.

This research is very important because we want to try to help to provide better mental health care services for Deaf People.

Please fill in the slip and send it for me (in envelope) then I will make an appointment to see you. If you like you can telephone me for more information or I can explain more what I am doing when I see you.

**EVERYTHING WILL BE STRICTLY CONFIDENTIAL**

My minicom telephone number is 0772 861069 daytime or 0161 248 6907 evenings.

Thank you very much for your help. This is much appreciated.

Yours sincerely

S M Ridgeway (Ms)  
Research Psychologist

-----  
**Yes. I will be pleased to see you.**

**Name:** .....

**Address:** .....

**Telephone: (Please state Voice phone or text phone)** .....

### **LETTER 3**

Date:

Dear

You may remember that I wrote to you about two months ago about research interviews I am doing with deaf people. You filled in a form that you agreed to be interviewed.

I would like to come to see you on .....

If you do not reply then I will know it is alright and I will come to see you. If it is not alright please let me know. You can write to me to tell me what suits you or you can telephone me on 0772 861069 (minicom and voice) or 0161 248 6907 (minicom).

I want to say thank you very much for agreeing to be interviewed in this research about General Mental Health and Deaf people.

I look forward to seeing you.

Yours sincerely

Sharon Ridgeway  
Research Psychologist

**CONSENT FORM**

**MENTAL HEALTH SERVICES TO DEAF PEOPLE**

**CONSENT TO TAKING PART IN RESEARCH INTERVIEWS WITH  
SHARON RIDGEWAY**

I agree to taking part in this research

My name is .....

My address is .....

.....

.....

Signature .....

Date .....

**Sharon Ridgeway, Research Psychologist**  
Department of Psychiatry for Deaf People  
Whittingham Hospital  
Whittingham  
Preston  
PR3 2JH

## **LETTER 4**

Dept Psychiatry for Deaf People  
Whittingham Hospital  
Whittingham  
Preston  
Lancashire

Date:

Dear

### **Mental Health Research - Second Interview**

You may remember that I saw you a few months ago about some mental health research that is being done with deaf people.

I would like to arrange a date to see you again for the last part of the interview. This interview will be for about 1½ hours. I hope it will be alright for me to visit you on .....

If you do not reply (use the enclosed stamped envelope) then I will know it is alright and I will look forward to see you on that date.

If this date is no good, please let me know. Either telephone me on 0161 248 6907 (minicom) or 0772 861069 (both minicom or voice) or write to me (use the enclosed stamped envelope) to tell me what dates suit you.

I want to say thank you very much for your help in this interview. I look forward to see you again.

With best wishes

Sharon Ridgeway  
Research Psychologist

## **LETTER 5**

### **Thank you for giving interviews**

**to: Sharon Ridgeway  
Research Psychologist**

Working on behalf of Mental Health Services to Deaf People

Preston Health Authority  
Whittingham Hospital  
Department of Psychiatry for Deaf People

### **Thank you**

Thank you for taking the time for the interviews. The National Centre for Mental Health and Deaf People wants to try and improve services. We can only do this by finding out what are your needs and how we can help prevent some of the difficulties deaf people have experienced.

All the people who have been interviewed are from Cheshire, Lancashire and Greater Manchester. There were over 102 people interviewed in this study and 225 interviews were held altogether.

### **Why Interviews?**

The reason for interviews is to find out what deaf people want and what is needed. Deaf people seem to stay in mental health care longer than hearing people. Deaf people often receive the wrong treatment or maybe no-one understands what they need. Sometimes this is because of mental health professionals who have no understanding or awareness of deafness and deaf issues, culture and Sign Language. Sometimes this is due to other reasons. This research will help find out what are the main problems deaf people have and try to help improve access to proper services for deaf people.

### **Why you?**

Every local Authority Social Services in Greater Manchester Lancashire and Cheshire was involved in this research. That is how you received a letter from your social worker. A letter and stamped addressed envelope was sent to each person in the sample to ask if it is alright to be interviewed.

### **The way in which you were interviewed**

All the interviews were conducted in Sign Language or as you preferred. The questionnaires used were carefully made and tested. The interviewer (Sharon Ridgeway) followed the questions exactly because it is important that you are not influenced.

Thank you very much for your time and your help. This research is important to find out what deaf people need and will be published. No-one's name or address will be given - this will be kept strictly confidential.

Thank you.

## **APPENDIX 8**

### **Background Information Questionnaire (Ridgeway, 1994)**

<b>Number</b>	<b>Question</b>	<b>Details</b>
1	Participant number	01-102
2	Gender	Male Female
3	Age	5 groups: 16-25 26-35 36-45 46-55 56-65
4	Birth date	
5	Ethnic origin	European African Afro-caribbean Asian
6	Domestic situation	Living with parents Partner Alone
7	Hearing status of partner	Deaf Hearing Not Applicable
8	Hearing status of children	Deaf Hearing Both Not Applicable
9	Cause of deafness (aetiology)	Congenital Natural (hereditary) Illness Accident Not known
10	When was the onset of deafness	Birth 6 months + 12 months + 18 months + 24 months + 36 months +

11	When was the deafness noticed	As above
12	Do you have any disabilities	Yes No
13	Communication preferred	BSL Oral SSE (Signed Supported English) Idiosyncratic Makaton Deaf-blind manual
14	Communication actually used in interview	As above
15	Communication used with partner	As above plus a seventh: Not applicable
16	Communication used with child	As above
17	Any incidence of deafness in the family	Yes No
18	Communication used with immediate family/carers when young	As for No. 15 No. 7: No communication
19	Communication used with immediate family/carers now	As above No. 7: No change
20	Education - type of school: Infants	Deaf School (residential) Deaf School (day) Partially Hearing Unit Mainstream Special School Not applicable
21	Education - type of school: Junior	As above
22	Education - type of school: Secondary	As above
23	Education - Further Education	None Hearing College Deaf College



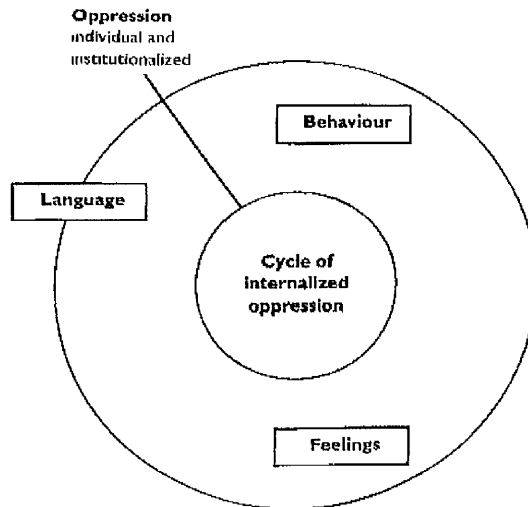
24	Frequency of visits home	Daily Weekly Fortnightly Termly Other
25	Communication used by teachers	Oral Sign + oral BSL
26	Felt understood by teachers	Mostly yes Mostly no
27	Did you understand your teachers	As above
28	Were you happy at school	As above
29	Who were your school friends	Deaf Hearing Both
30	Communication used with deaf school friends	BSL Oral + Sign Oral Not applicable
31	Communication used with hearing friends	As above
32	Communication used with friends at home - deaf or hearing	As above
33	Communication used with deaf friends at home	As above
34	Communication used with hearing friends at home	As above
35	Qualifications obtained	Yes No
36	Vocational training accessed	Yes No

## **APPENDIX 9**

**A number of practical issues raised by d'Ardenne & Mahtani, (1989) in relation to attitudes and expectations in transcultural counselling:**

- How your cultural or racial background affects your attitude to your client
- Whether or not you see the client's culture or race as a cause of the present problem
- Whether or not you see the client's culture as part of the solution to the present problem
- Whether or not you can accept, acknowledge and understand your client's culture
- Whether or not your expectations about the client's culture affects the counselling outcome
- Whether or not your cultural prejudice has a bearing on the counselling relationship
- Whether or not any cultural prejudice or racism experienced by you effects the counselling relationship.

## **APPENDIX 10 'Interrupting the Cycle of Internalised Oppression' (Hillin, 1993)**



The role of allies (professionals, friends, family) challenge the oppression and misinformation by:

- . correcting misinformation
- . express your own views
- . pointing to the consequences of the oppression, e.g. injustice or individual welfare (people may assume that you agree or condone if you don't challenge)
- . showing how and why it is in everyone's interests to end oppression
- . personal example, e.g. behaving in anti-discriminatory ways
- . ensuring that positive role models are accessible, e.g.
  - diverse and representative staff
  - posters
  - TV, video, film, radio
  - books
- . supporting and assisting the individual's own actions
- . interrupting self-abusive behaviour in self and others
- . counselling
- . positive role models
- . taking action to challenge the oppression
- . developing self-affirming and health promoting behaviours
- . building close relationships/friendships
- . estimating isolation
- . emotional expression
  - recognition and validation of feelings
  - counselling, therapy
  - peer support group
  - creative expression, music, dance, drama
- . taking action to challenge the oppression
  - discussion

*Source:* © Anthony Hillin, Training and Consultancy, 69 Pretoria Avenue, London E17 6JZ

This figure illustrates different ways the cycle may be challenged. This model can be applied to almost all minority groups who may experience oppression in various ways. For Deaf communities the creative part of emotional expressions would include signed songs, humour and theatre. Deaf people would be referred to in role models and peer support groups. Positive role models might be unrealistically conveyed by radio so this part would more practically involve theatre and posters.

This figure provides some insight into the amount of often unseen or hidden oppression in society.

# APPENDIX 11 ATIQ CORRELATION MATRIX

	q1	q2	q3	q4	q5	q6	q7	q8	q9	q10	q11	q12	q13	q14	q15	q16	q17	q18	q19	q20	q21	q22	q23	q24	q25	q26	q27	q28	q29	q30	q31	q32	
q1	1																																
q2	.15	1																															
q3	.11	.76*	1																														
q4	.20	.14	.39**	1																													
q5	.02	.15**	.11*	.27	1																												
q6	-.10**	.04	-.19*	.03	.14**	1																											
q7	.59**	.46**	.54	.12**	.07	.20*	1																										
q8	.05	.21	.08**	.12**	.18	.01	.16**	1																									
q9	.09	.01	-.35**	.14	.25**	.05**	-.11	.21*	1																								
q10	.15**	.12	.13	.26	.17*	.10**	.01	.21	.35**	1																							
q11	-.12**	.02*	.04	.21*	.41**	.08**	-.26	.07	.22**	.31**	1																						
q12	.12*	.01	.06	.10	.23**	.34**	.06	-.22	.23	.32**	.14**	1																					
q13	.06	.19	.05**	.25	.15**	.05*	.03	.25	.02**	.27	.01**	.07	1																				
q14	.13*	-.10	.37	.04	-.09	.39	.09**	.02	.14	.10**	-.09	.15	-.20**	1																			
q15	.07*	-.12	.37	.08**	.13	-.01*	-.15*	.15	.07*	.01	.09	-.19	.04	-.04	1																		
q16	.08	.21	.31**	.12**	.12	.11	.33	.21**	.10**	.23	.18**	.01	.19**	-.02	.33	1																	
q17	.09	.25	.24**	.09**	.19	.07**	.19	.25	.07**	.14	.18*	.09	.29**	-.09	.17**	.55**	1																
q18	.13	.17	.09**	.12	.31	.15**	.24*	.25	.12**	.20**	.31**	.01**	.33**	.06	.10	.39**	.46**	1															
q19	.07**	.11	.02	-.11	-.15	.11*	.27	.01*	-.07	.09	.29	.20**	.05	.13*	.12	-.07	.13	.25**	1														
q20	-.00	.21	.20**	.23**	.34	.03	.23	.15**	.20	.21	.25	.25	.06	-.08	.06*	.13**	.10**	.10	.41*	1													
q21	-.03	-.03	-.05	.01	-.03	.11	-.05	-.11	.06**	.12	.01	.01	.01**	-.07	.13**	.21	.17	.00*	.14	.17	1												
q22	-.04	.00	.34**	.01**	.07*	.07*	.04	.21**	.04**	.00	.11	-.05	.21*	.07	.41	.07**	.11**	.15**	.09	.21**	.04	1											
q23	-.02*	.26	.23**	.17**	.15	.08**	.49	.25*	.19**	.16**	.07**	-.02*	.16*	.04	.06	.18**	.23**	.28**	.08	.12	.15**	.05**	1										
q24	.08	.31	.26**	.13**	.21	.08	.54*	.34**	.27	.43*	.24	.14	.16*	-.02	.05**	.20	.21	.24	.04	.39**	.08	.23**	.19**	1									
q25	.01	.26	.64**	.09**	.08**	.15	.48	.03**	.13*	.11	.02	.03	.16	.05	-.41**	.10	.10	.04	.04*	.07**	.42	.06**	.29**	.31**	1								
q26	.11	.35	.13**	.03**	.03	.15	.33*	.21**	.09**	.03	.06	.11	.13**	.01	.19**	.23**	.23**	.06	.31**	.19**	.12	.06	.06**	.31**	.1								
q27	.14	-.11*	.11	.03	.24	.12**	.23	.09**	.01	.10	.13	.07	-.05	.01	.22**	.01	.13	.00	.19**	.04**	.23	.05**	.14	.02**	.22**	.14*	1						
q28	.12	-.56	-.54**	.06**	.07	.01	.38	.10**	.12	.01**	.14	.08*	-.03	.09	.23**	.11	.24**	.02	.26**	.06**	.51	.03	.11*	.14**	.48**	.46**	.26**	1					
q29	.03	.13	.19**	.31**	.04**	.08	.20	.26**	.16**	.14*	.03*	.03	-.09	.09	.12	.33**	.35**	.31**	.10	.08	.13	.12**	.19**	.25	.07**	.15*	.03	.14*	1				
q30	.03	.51	.46*	.17	-.05	.03	.43	.16	.05**	.04	.04**	.04	.09**	.02	.17**	.06	.07	.01*	.14	.29	.37**	.05	.23**	.34**	.44**	.31*	.18	.43	.19*	1			
q31	.13**	.14	.16**	.07**	.01*	.04**	.10**	.17**	.07	.17**	.08	.08**	.21	.09**	.24**	.03	.11	.13	.06**	.17**	.05	.21	.06	.20**	.41**	.13	.09**	.10*	.16*	.16**	1		
q32	.04**	.20	.34**	.16**	.30**	.23**	.22	.05	.18**	.08**	.24**	.24**	.06	.13	.25	.03*	.03	.09	.28	.18**	.37**	.13	.05**	.04	.20**	.11**	.32	.40	.15	.23	.29**	1	

\* p < 0.05 Bold prints indicate the data supports the relationship between the two questions

**APPENDIX 12 (a):**      **Factor Analysis of Attitude and Identity Questionnaire (ATIQ)**

**FACTOR ANALYSIS**

Extraction      1 for analysis 1,      Principal Components Analysis (PC)  
Initial Statistics

Variable	Communality	*	Factor	Eigenvalue	Pct of Var	Cum Pct
IDQ1	1.00000	*	1	5.69260	17.8	17.8
IDQ2	1.00000	*	2	3.89112	12.2	29.9
IDQ3	1.00000	*	3	2.12623	6.6	36.6
IDQ4	1.00000	*	4	1.88786	5.9	42.5
IDQ5	1.00000	*	5	1.67147	5.2	47.7
IDQ6	1.00000	*	6	1.52447	4.8	52.5
IDQ7	1.00000	*	7	1.39178	4.3	56.8
IDQ8	1.00000	*	8	1.30384	4.1	60.9
IDQ9	1.00000	*	9	1.18311	3.7	64.6
IDQ10	1.00000	*	10	1.04197	3.3	67.9
IDQ11	1.00000	*	11	1.00096	3.1	71.0
IDQ12	1.00000	*	12	.92554	2.9	73.9
IDQ13	1.00000	*	13	.85688	2.7	76.6
IDQ14	1.00000	*	14	.80771	2.5	79.1
IDQ15	1.00000	*	15	.69047	2.2	81.2
IDQ16	1.00000	*	16	.66433	2.1	83.3
IDQ17	1.00000	*	17	.61934	1.9	85.2
IDQ18	1.00000	*	18	.56677	1.8	87.0
IDQ19	1.00000	*	19	.54455	1.7	88.7
IDQ20	1.00000	*	20	.49003	1.5	90.3
IDQ21	1.00000	*	21	.45661	1.4	91.7
IDQ22	1.00000	*	22	.36880	1.2	92.8
IDQ23	1.00000	*	23	.36684	1.1	94.0
IDQ24	1.00000	*	24	.30628	1.0	94.9
IDQ25	1.00000	*	25	.28912	.9	95.8
IDQ26	1.00000	*	26	.27420	.9	96.7
IDQ27	1.00000	*	27	.23863	.7	97.4
IDQ28	1.00000	*	28	.22691	.7	98.2
IDQ29	1.00000	*	29	.18889	.6	98.7
IDQ30	1.00000	*	30	.16943	.5	99.3
IDQ31	1.00000	*	31	.12332	.4	99.7
IDQ32	1.00000	*	32	.10995	.3	100.0

Hi-Res Chart      #: Factor scree plot

PC extracted 11 factors

## Factor Matrix

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	
IDQ1	.12402			-.12466	.48157	
IDQ2	.79822					
IDQ3	.78156	-.11899	-.11125			
IDQ4	.23926	.42575	-.13545			
IDQ5	.10660	.62178	-.23881			
IDQ6	-.20782		-.27224		-.65639	
IDQ7	.68225	-.19057		.22645		
IDQ8	.33018	.45481	.24224	.14718	.14160	
IDQ9		.50623			.13665	
IDQ10	.26688	.53790	-.32471		.22295	
IDQ11		.49628	-.24775			
IDQ12		-.39657	.42384	-.19375	.22093	
IDQ13	.24149	.21756	-.21696	-.42624	-.12862	
IDQ14		-.15496	.35709	.26062	.42570	
IDQ15	-.30061	.39303	.20597	.35129		
IDQ16	.41386	.31013	.31680	-.37964		
IDQ17	.43014	.34366	.39371	-.55085	-.12305	
IDQ18	.25176	.52057	.38320	-.38516		
IDQ19	.15738	-.40523	.13001	.19037		
IDQ20	.30435	.41692	-.14720	.38138	-.14203	
IDQ21	-.70445	.18487		-.15275	.10885	
IDQ22		.27411	.22387	.59564	.15833	
IDQ23	.45787	.17202				
IDQ24	.45540	.41132	-.17114	.14002	.24996	
IDQ25	.72218	-.28711	-.32728		.14688	
IDQ26	.51343		.22334		-.31593	
IDQ27	-.29871	.30432			.38516	
IDQ28	-.67181	.31750			.12607	
IDQ29	.31546	.33869	.43359			
IDQ30	.65658	-.10972	-.17382	.20194		
IDQ31	-.20462	.14942	.63274	.26148	-.38646	
IDQ32	.40097	-.56649		-.12805	.24915	
	Factor 6	Factor 7	Factor 8	Factor 9	Factor 10	Factor 11
IDQ1	.12958	.58627			-.26199	-.15856
IDQ2	-.12164	.22081	.11265	.11781		
IDQ3	-.27020		.15698			
IDQ4	.23268	.38350	-.16878	-.23349	-.40471	.31601
IDQ5			.28753	-.15233		
IDQ6		.16842	-.24161		-.20890	-.22262
IDQ7	-.14276		-.10422	-.39318	.10292	
IDQ8	.41293	.15091	-.26038			.10063
IDQ9	.36549	-.46139				-.16935
IDQ10	.20783		.13191			-.21820
IDQ11	-.21237	-.27118	.28560	-.15189		.43524
IDQ12					-.10954	.45600
IDQ13	.38191	.31345			.39967	.21066
IDQ14	.29311	-.18385		-.31325	-.20909	
IDQ15		.41420			.35711	

IDQ16		.12414		.10943	-.21787
IDQ17	-.10099		.14589		
IDQ18	-.16556	-.13634	.21808	.11518	
IDQ19	.57654	.25445		.12530	
IDQ20		.23531	.13179		
IDQ21	.17644	-.14393	.31277	-.14930	.25313
IDQ22	-.20479	-.22185	.31159	.24938	.14376
IDQ23	-.13619	-.42441	-.47002	.20870	
IDQ24	.20602	-.20382	-.17188	.39804	-.10714
IDQ25	-.18183		-.15504	.13429	.16406
IDQ26	.26822	-.12812	.44165		.18415
IDQ27	-.23740	.27005	.37002		
IDQ28		-.10247	-.10295	-.17922	.12524
IDQ29	-.11928		-.17243	-.35101	-.14426
IDQ30		-.11536	.18020	-.16514	.15967
IDQ31		.17816			
IDQ32	.14850	-.12896	.10629	.22902	

### Final Statistics

Variable	Communality	*	Factor	Eigenvalue	Pct of Var	Cum Pct
IDQ1	.73358	*	1	5.69260	17.8	17.8
IDQ2	.75362	*	2	3.89112	12.2	29.9
IDQ3	.76035	*	3	2.12623	6.6	36.6
IDQ4	.80811	*	4	1.88786	5.9	42.5
IDQ5	.57860	*	5	1.67147	5.2	47.7
IDQ6	.74455	*	6	1.52447	4.8	52.5
IDQ7	.76559	*	7	1.39178	4.3	56.8
IDQ8	.69062	*	8	1.30384	4.1	60.9
IDQ9	.67919	*	9	1.18311	3.7	64.6
IDQ10	.64212	*	10	1.04197	3.3	67.9
IDQ11	.72953	*	11	1.00096	3.1	71.0
IDQ12	.65700	*				
IDQ13	.80183	*				
IDQ14	.66664	*				
IDQ15	.72843	*				
IDQ16	.60012	*				
IDQ17	.82043	*				
IDQ18	.75759	*				
IDQ19	.67475	*				
IDQ20	.54033	*				
IDQ21	.80682	*				
IDQ22	.77898	*				
IDQ23	.71371	*				
IDQ24	.77140	*				
IDQ25	.84287	*				
IDQ26	.74396	*				
IDQ27	.61003	*				
IDQ28	.65641	*				
IDQ29	.61012	*				
IDQ30	.65990	*				
IDQ31	.71889	*				
IDQ32	.66937	*				

VARIMAX rotation 1 for extraction 1 in analysis 1 - Kaiser Normalization

VARIMAX converged in 16 iterations

### Rotated Factor Matrix

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
IDQ1	.13348			-.17661	
IDQ2	.77806	.18581			
IDQ3	.80617	.15996		.12509	
IDQ4	.10107			.26054	
IDQ5		.12189	.26505	.60850	
IDQ6					
IDQ7	.53895				
IDQ8		.25712	.28799		.27624
IDQ9	-.19663	.10200	.73413	.16157	
IDQ10		.15074	.64957	.27724	
IDQ11			.14036	.80212	
IDQ12		.13310	-.49389	-.14251	
IDQ13		.19089	.10839		
IDQ14	-.12187	-.13935	.16658	-.21111	
IDQ15	-.32432				.70341
IDQ16		.66684	.14796		-.11126
IDQ17	.13636	.87449			-.14549
IDQ18		.80837			.19754
IDQ19	.13252	-.25002		-.35533	
IDQ20	.27781		.31152	.44473	.26662
IDQ21	-.56211				
IDQ22					.84711
IDQ23	.17115	.21268			
IDQ24	.38674	.20411	.68343		.23305
IDQ25	.82859				-.13866
IDQ26	.33380	.16863		.15803	-.11314
IDQ27	-.23399			.36186	.18405
IDQ28	-.69251	-.10398		.21071	.10431
IDQ29	.15209	.51231	.14412		.13403
IDQ30	.75067				
IDQ31	-.30264	.23260	-.27158		.34248
IDQ32	.43516			-.46282	-.14780

### Factor Analysis

	Factor 6	Factor 7	Factor 8	Factor 9	Factor 10	Factor 11
IDQ1		.15603		.24785		.76170
IDQ2	.16939	-.10399	.19348			.15198
IDQ3			.18943			.12470
IDQ4				.81991		.16585
IDQ5		-.21398		.13660		.20721
IDQ6		-.79934	-.10180	.17437		-.15423
IDQ7	.10392	.11673	.65627			



IDQ8	.24730		.18481	.59174	.10518	
IDQ9				.12280	-.12499	-.14228
IDQ10					.20985	.24002
IDQ11	-.11437	.15758				-.14086
IDQ12		.56410	-.16970			
IDQ13				.25032	.81792	
IDQ14	.14414	.53549	.20486	.16417	-.41577	
IDQ15						.30430
IDQ16	.12652		.26185			.13188
IDQ17						
IDQ18	-.14109					
IDQ19	.63952	.18192			.10235	
IDQ20	.24633	-.13918			.11891	
IDQ21	-.26118		-.61387	.15549		
IDQ22					-.15801	
IDQ23	-.20466		.69487	.23486		-.18553
IDQ24			-.17338	.12532		
IDQ25	-.22879	.16883			.15726	-.15409
IDQ26	.70817	.12415				-.19129
IDQ27	-.12234			-.18275		.57457
IDQ28	-.31766					
IDQ29				.25595	-.46370	
IDQ30				.22427		-.14793
IDQ31	.47672	-.14533			-.34932	
IDQ32		.36233		-.19200	.23833	

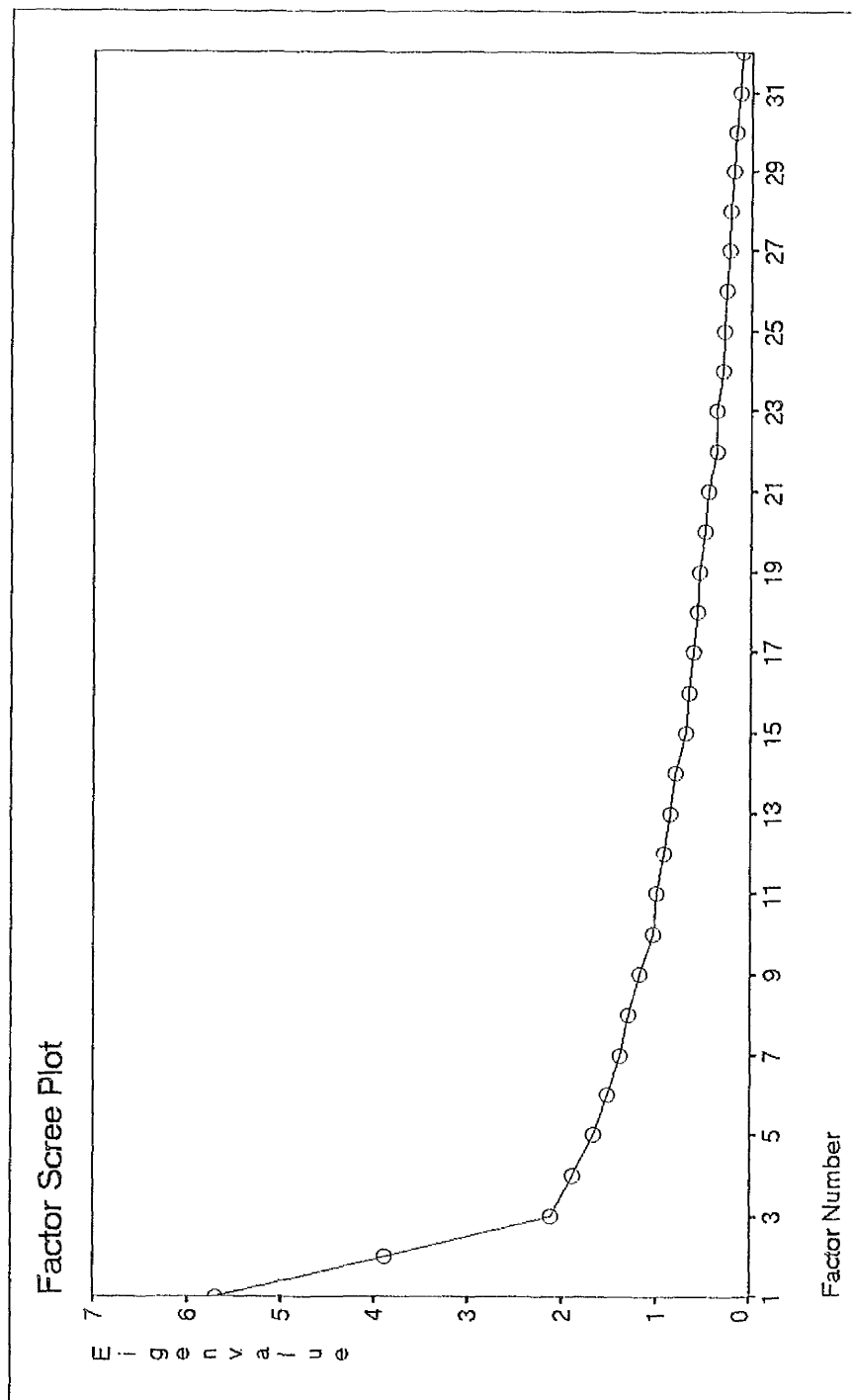
### Factor Transformation Matrix

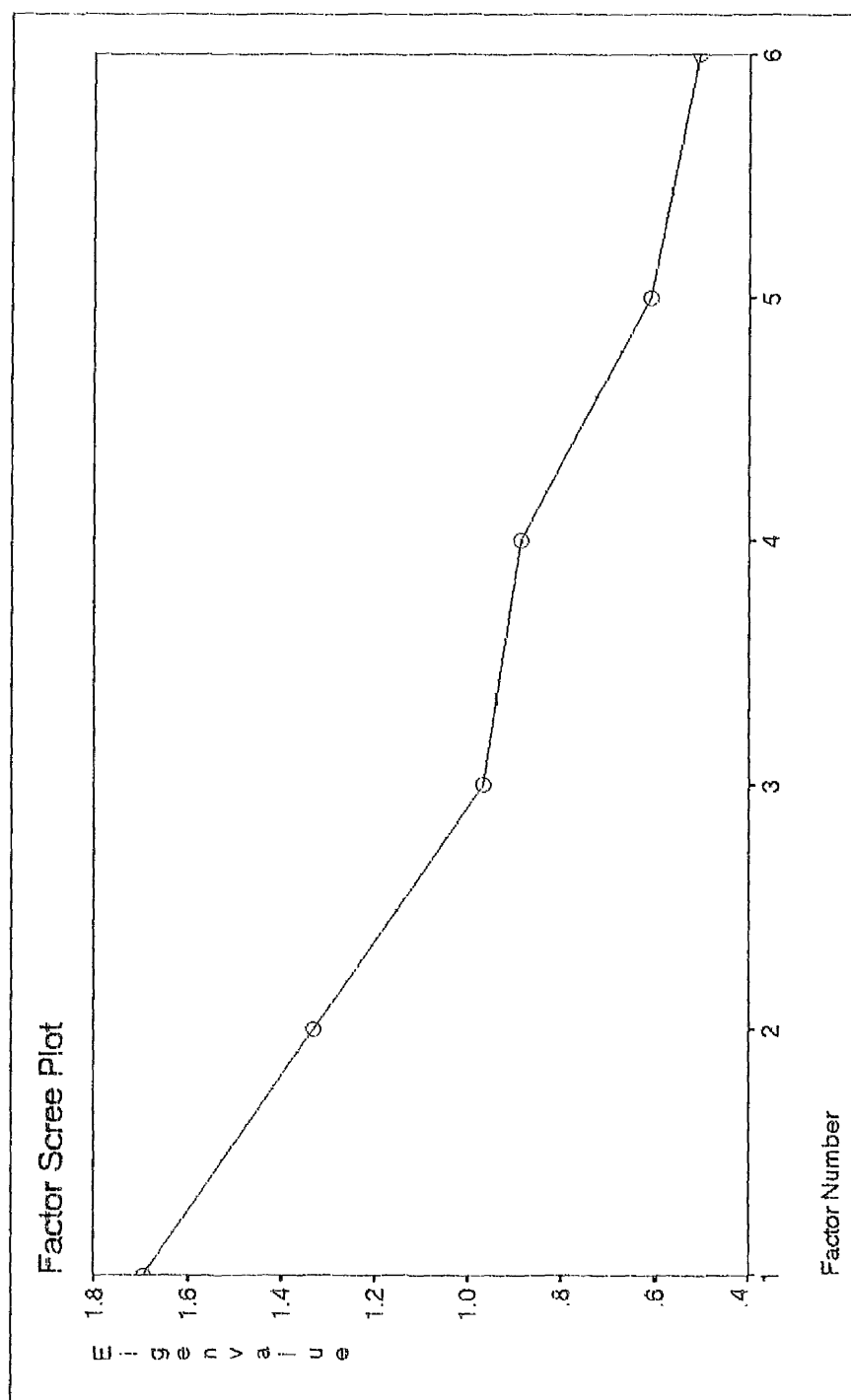
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	
Factor 1	.83069	.31533	.18388	.01304	-.07347	
Factor 2	-.25953	.42852	.47140	.53006	.30241	
Factor 3	-.24939	.54986	-.30708	-.28241	.27677	
Factor 4	.16811	-.56459	.13777	.10649	.60270	
Factor 5	.02695	-.06625	.27047	-.05477	.08755	
Factor 6	-.21241	-.18622	.45454	-.34354	-.17635	
Factor 7	.08227	-.08772	-.40050	-.13045	.23577	
Factor 8	.02566	-.02765	-.08681	.52115	-.20647	
Factor 9	.28404	.20265	.07859	-.22536	.35776	
Factor 10	-.12539	.01539	.05851	-.06536	.43055	
Factor 11	.04971	-.08370	-.41641	.40383	.11385	

	Factor 6	Factor 7	Factor 8	Factor 9	Factor 10	Factor 11
Factor 1	.17158	.10512	.31517	.15162	.08519	-.03285
Factor 2	-.09568	-.20538	.00852	.29702	.03721	.11565
Factor 3	.36136	.30481	.13238	.06802	-.37304	.00116
Factor 4	.23107	-.01765	.12766	.07715	-.42289	-.06804
Factor 5	-.38708	.72029	-.05465	-.10455	-.05530	.47481
Factor 6	.51157	.17118	-.15746	.41393	.27755	-.01725
Factor 7	.02110	-.25570	.05487	.35148	.31626	.67834

Factor 8	.59317	.10609	-.19107	-.38733	-.01020	.35648
Factor 9	.00619	-.13002	-.79733	-.18541	.06303	-.04755
Factor 10	.10815	.09442	.33247	-.47452	.64015	-.15772
Factor 11	-.14318	.45053	-.23064	.40353	.28177	-.37524





## Factor Matrix

	Factor 1	Factor 2	Factor 3	Factor 4
IDQ1	.12402	.02852	.06983	-.12466
IDQ2	.79822	-.03554	-.08068	.07536
IDQ3	.78156	-.11899	-.11125	.04184
IDQ4	.23926	.42575	-.13545	.01554
IDQ5	.10660	.62178	-.23881	.02722
IDQ6	-.20782	.07972	-.27224	-.01731
IDQ7	.68225	-.19057	.09310	.22645
IDQ8	.33018	.45481	.24224	.14718
IDQ9	.05337	.50623	-.07031	.09141
IDQ10	.26688	.53790	-.32471	-.09397
IDQ11	.05526	.49628	-.24775	.04373
IDQ12	.03660	-.39657	.42384	-.19375
IDQ13	.24149	.21756	-.21696	-.42624
IDQ14	.01848	-.15496	.35709	.26062
IDQ15	-.30061	.39303	.20597	.35129
IDQ16	.41386	.31013	.31680	-.37964
IDQ17	.43014	.34366	.39371	-.55085
IDQ18	.26176	.52057	.38320	-.38516
IDQ19	.15738	-.40523	.13001	.19037
IDQ20	.30435	.41692	-.14720	.38138
IDQ21	-.70445	.18487	-.06757	-.15275
IDQ22	-.03120	.27411	.22387	.59564
IDQ23	.45787	.17202	.09560	.00246
IDQ24	.45540	.41132	-.17114	.14002
IDQ25	.72218	-.28711	-.32728	-.04635
IDQ26	.51343	-.07264	.22334	.06644
IDQ27	-.29871	.30432	-.03946	.04841
IDQ28	-.67181	.31750	-.06862	-.06576
IDQ29	.31546	.33869	.43359	.04956
IDQ30	.65658	-.10972	-.17382	.29194
IDQ31	-.20462	.14942	.63274	.26148
IDQ32	.40097	-.56649	-.03863	-.12805

## Final Statistics

Variable	Communality	*	Factor	Eigenvalue	Pct of Var	Cum Pct
IDQ1	.03661	*	1	5.69260	17.8	17.8
IDQ2	.65061	*	2	3.89112	12.2	29.9
IDQ3	.63912	*	3	2.12623	6.6	36.6
IDQ4	.25710	*	4	1.88786	5.9	42.5
IDQ5	.45574					
IDQ6	.12396					
IDQ7	.56173					
IDQ8	.39621					
IDQ9	.27242					
IDQ10	.47483					
IDQ11	.31264					
IDQ12	.37579					
IDQ13	.33441					
IDQ14	.21979					
IDQ15	.41067					
IDQ16	.51194					
IDQ17	.76157					
IDQ18	.63471					
IDQ19	.24212					
IDQ20	.43357					
IDQ21	.55833					
IDQ22	.48101					
IDQ23	.24838					
IDQ24	.42546					
IDQ25	.71323					
IDQ26	.32318					
IDQ27	.18574					
IDQ28	.56116					
IDQ29	.40469					
IDQ30	.55858					
IDQ31	.52393					
IDQ32	.49958					

VARIMAX rotation 1 for extraction 1 in analysis 1 - Kaiser Normalization

VARIMAX converged in 6 iterations

## Rotated Factor Matrix

	Factor 1	Factor 2	Factor 3	Factor 4
IDQ1	.06442	-.01042	.17335	-.04798
IDQ2	.75799	.18777	.18703	-.07627
IDQ3	.76401	.12053	.15070	-.13478
IDQ4	.08853	.47070	.16512	-.02077
IDQ5	-.08570	.65703	.12491	-.03330
IDQ6	-.19885	.14290	-.19492	-.16124
IDQ7	.73217	-.01003	.09444	.12903
IDQ8	.16836	.37343	.35211	.32316
IDQ9	-.09062	.48786	.12036	.10823

IDQ10	.06098	.63082	.17417	-.20698
IDQ11	-.08535	.54905	.04181	-.04642
IDQ12	.08269	-.56005	.22527	.06738
IDQ13	.04870	.23292	.30453	-.43017
IDQ14	.11117	-.22783	-.00169	.39436
IDQ15	-.32380	.25474	-.04924	.48837
IDQ16	.14714	.11595	.68949	-.03802
IDQ17	.09983	.07381	.85749	-.10424
IDQ18	-.06627	.22993	.75791	.05493
IDQ19	.31750	-.32271	-.13900	.13360
IDQ20	.24783	.56515	-.04290	.22564
IDQ21	-.73267	.00593	-.13448	-.05841
IDQ22	.02217	.25790	-.13392	.62934
IDQ23	.34985	.19579	.29037	.05780
IDQ24	.32390	.54741	.14271	.02285
IDQ25	.75857	.04472	-.01024	-.36836
IDQ26	.48887	-.04094	.25173	.13836
IDQ27	-.35496	.22253	-.04385	.09111
IDQ28	-.72415	.14409	-.12407	.02500
IDQ29	.15392	.16460	.47300	.36080
IDQ30	.71884	.18769	-.08000	.01488
IDQ31	-.21101	-.14256	.19629	.65540
IDQ32	.51888	-.40422	-.01836	-.25809

### Factor Transformation Matrix

	Factor 1	Factor 2	Factor 3	Factor 4
Factor 1	.90252	.20553	.36826	-.08722
Factor 2	-.33200	.83837	.38995	.18667
Factor 3	-.07254	-.45077	.58760	.66804
Factor 4	.26454	.22735	-.60585	.71504

**APPENDIX 12 (b)      Attitude and Identity Questionnaire (ATIQ) - Multiple Regression**

**MULTIPLE REGRESSION**

Listwise Deletion of Missing Data

	Mean	Std Dev	Label
HQS	4.784	2.948	
IDENT	21.701	3.985	Identity score

N of Cases = 97

Correlation. 1-tailed Sig:

	HQS	IDENT
HQS	1.000	-.417 .000
IDENT	-.417 .000	1.000

Equation Number    1      Dependent Variable HQS

Descriptive Statistics are printed on Page

Block Number        1      Method: Enter      IDENT

Variables(s) Entered on Step Number

1.      IDENT          Identity Score

Multiple R	.41698
R Square	.17387
Adjusted R Square	.16518
Standard Error	2.69379



# Analysis of Variance

	DF	Sum of Squares	Mean Square
Regression	1	145.08784	145.08784
Residual	95	689.36577	7.25648

F = 19.99424      Signif F - .000

## Variables in the Equation

Variable	B	SE B	95 % Confidence	Intrvl B	Beta
IDENT	-.308515	.068996	-.445489	-.171541	-.416979
(Constant)	11.478595	1.522060	8.456924	14.50065	

in

Variable	T	Sig T
IDENT	-4.471	.0000
(Constant)	7.541	.0000

End Block Number 1      All requested variables entered

## MULTIPLE REGRESSION

Equation Number 1      Dependent Variable HQS

Casewise Plot of Standardized Residual      HQS  
Casewise Plot of Standardized Residual

Outliers = 3      \*: Selected      M: Missing

Case #	-6.	-3.	3.	6.	HQS	*PRED	*RESID
91	0:.....	..*	:.....:0	.	12.00	3.4572	8.5428

1 Outliers found.

## Residuals Statistics

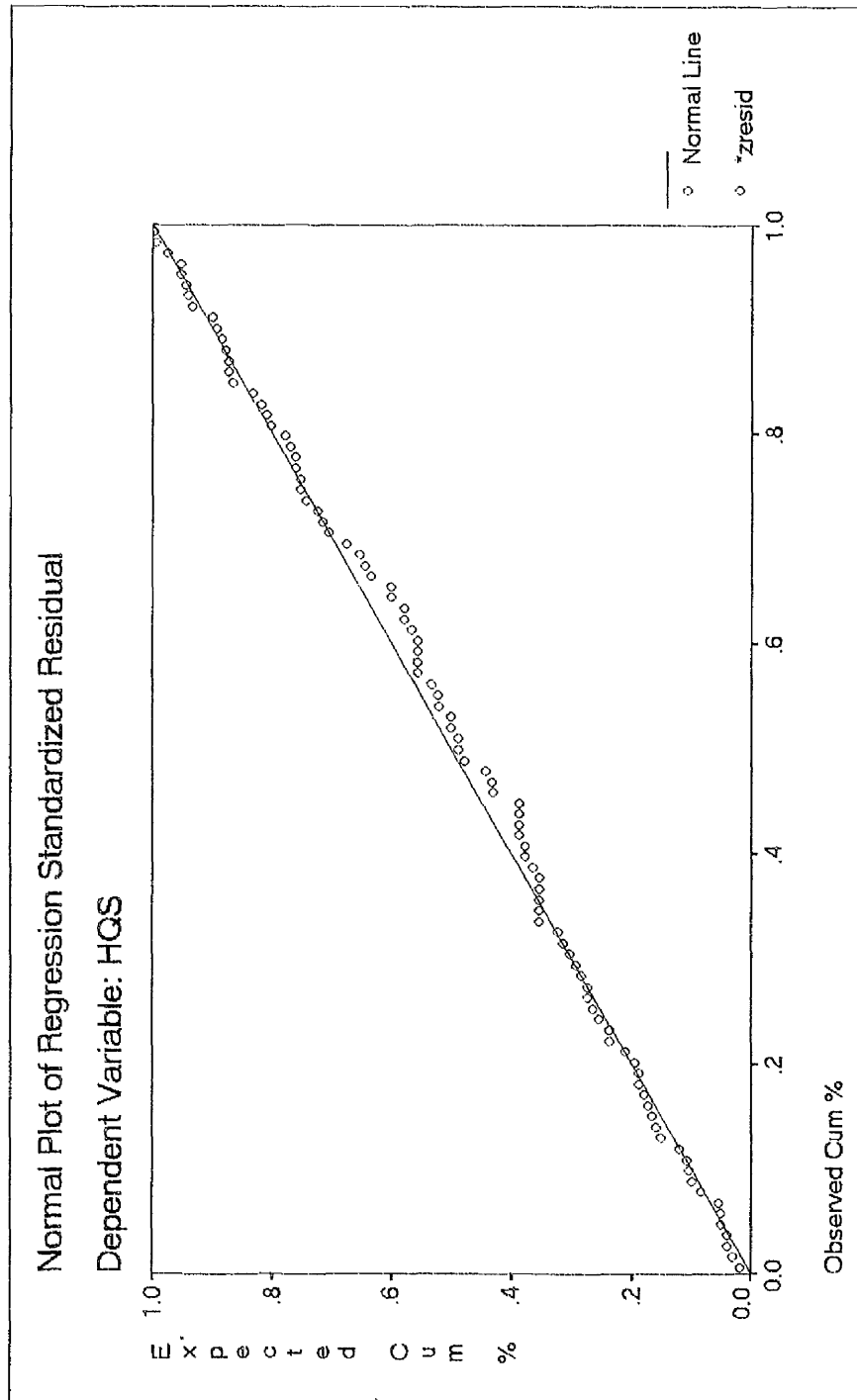
	Min	Max	Mean	Std Dev	N
*PRED	2.5317	8.0849	4.7835	1.2294	97
*RESID	-5.5424	8.5428	.0000	2.6797	97
*ZPRED	-1.8317	2.6855	.0000	1.0000	97
*ZRESID	-2.0575	3.1713	.0000	.9948	97

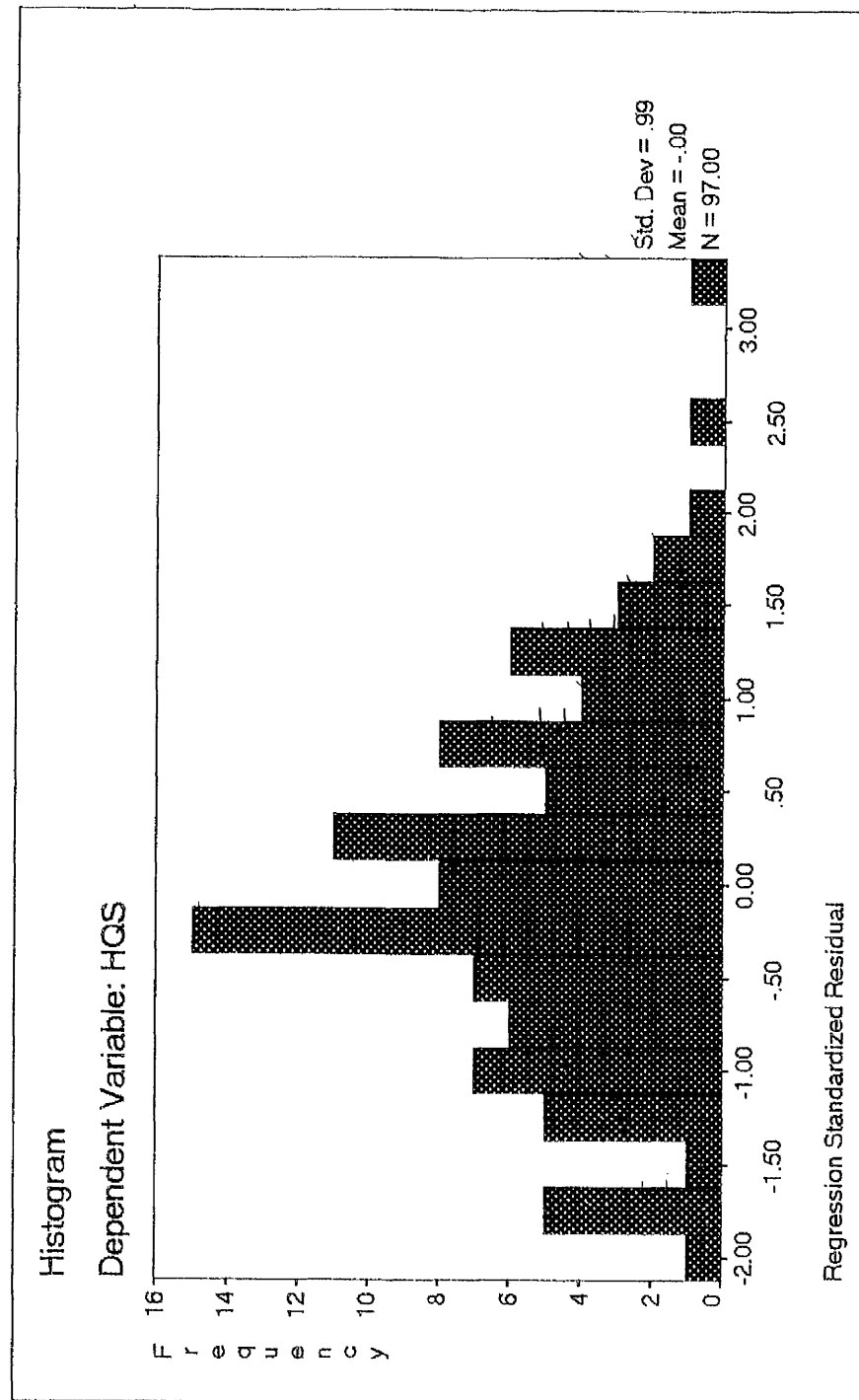
Total Cases = 102

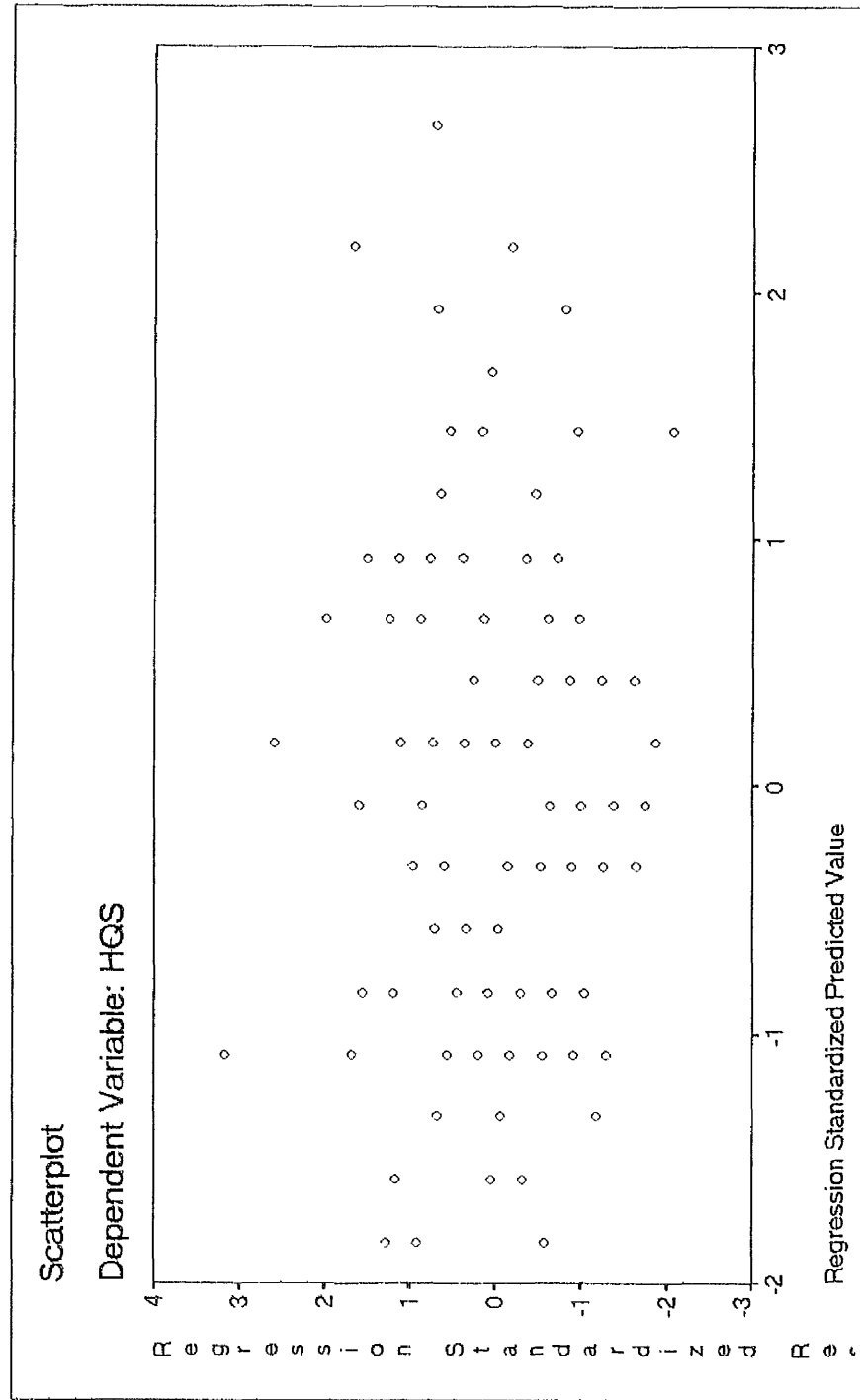
Hi-Res Chart # 4: Histogram of \*zresid

Hi-Res Chart # 6: Normal plot of \*zresid

Hi-Res Chart # 5: Scatterplot of \*zresid with \*zpred







## GLOSSARY

- Typetalk* A telephone relay service devised for deaf people, to enable them to access the telephone network. The service is based in Liverpool, sponsored and supported by British Telecom and managed by RNID. A deaf person dials an 0800 number to connect to the hearing operator who will take details and contact the hearing person the deaf caller wants to reach. The cost of the calls are billed separately by *Typetalk* and sent to the person who made the call. The system works also to provide hearing people, who may not have a textphone, with access to deaf people. The service is also of benefit to those with speech difficulties. All callers are allocated a PIN number, the service is free and callers only pay for the cost of the call from the originator (caller's line) to the person they wish to contact. The service has been in existence over six years now and has 18,687 registered accounts and handles over 40,000 calls per week.
- BDA* British Deaf Association - the sole representative organisation for Deaf people whose first or preferred language is British Sign Language (BSL). The BDA was formed in 1890.
- CACDP* Council for the Advancement of Communication with Deaf People is a national examining board in Sign Language and human aids to communication. Examinations are held and training is provided by CACDP. The numbers of examination candidates increased from 10,000 in 1992 to 23,000 in 1996. *Source: CACDP Directory, 1997/98.*

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