Diversity in Deafness Mental Health: Lessons for Cross-Cultural Clinical Practice

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Educational Objectives
Attendees will be able to identify:

• Cultural, personal identities - Deaf/Hard of Hearing clients
• Culture vs pathology - Deaf/hearing family
• Dyadic systems view of communication
  Child development, treatment settings
• Language attunement with clients
  Deaf, HOH, Limited English Proficiency, literacy challenged
• Cross-language service strategies
  Clinician-Interpreter-Client teamwork
  Multiple modality communication
Lessons from Deaf Mental Health
Language, Communication, Literacy

d/Deaf people who sign-
  fluent – dysfluent – a-lingual

d/Deaf English speakers
  fluent – dyfluent- a-lingual

Hearing people –
  Native language other than English
  Literacy challenged
Hearing Loss Statistics – United States

• 48,000,000 Americans – significant hearing loss
• Over 90% deaf children – born to hearing parents
• Hearing loss - 5 of every 1,000 newborns
• Approximately 3,000,000 children have hearing loss
• 1.3 million under age of 3
• 15% children – ages 6-19-measurable hearing loss in at least one ear
• 14% people – ages 45-64- some type of hearing loss
• Early identification/appropriate services – deaf children can develop communication skills – same hearing peers
• Only 16% of physicians routinely screen- hearing loss
Culture Is:

- Ethnicity, race, class, language, gender, sexual identity/orientation, generational status, religion, migration experience, differing abilities
- Correlated with our worldview
- Primary, essential, integral to developmental/healing processes
Ethnicity is:

- Group’s common ancestry through which shared values, beliefs, customs evolve

- Transmitted over generations thru family

- Provides sense of belonging, historical continuity, shapes identity
Culture and Ethnicity are:

Ongoing, evolving social contexts that pattern

- Thinking, feeling, behavior obvious/subtle ways
- How lives lived – how we eat, work, love, raise families, celebrate, grieve, die
- Cultural identity - impacts sense of well-being, mental, physical, spiritual health
- How cultural identity determined; by whom; how to integrate culture into therapy
Vertical Identities

• Shared cultural norms, values transmitted cross generations
• Children, parents share at least some traits
• Children of color - born to parents of color - skin pigmentation – genetic fact – self-image – person of color - subject to generational flux
• Language usually vertical – Greek speaking parents raise Greek speaking children – inflectional differences, or may speak another language at times

Horizontal Identities

• Horizontal identity – child’s inherent, acquired trait - foreign to parents- must acquire identity from peer group

• Most gay kids born to straight parents -learn gay identity by observation, participation in extra-familial sub-culture

• Physical, intellectual disability, genius, psychopathy, autism, tend to be horizontal

Deaf or Hard of Hearing
Client/Caseload Variables

- Age – 5 to 95 years of age
- Race/ethnicity/personal-self*/cultural identification
- Audiology– mild-moderate hearing loss-profound
- Hard of Hearing, deaf, Deaf
- Hearing loss etiology, age of diagnosis
- Age of onset – congenital, pre/post-lingual, late, traumatically deafened, Deaf-blind
- Language and communication – family choices; functional levels
- Educational programming
- Current grade or educational level achieved
- Employment/vocational
- Psychiatric diagnoses
- Co-morbid conditions/issues
Deaf or Hard of Hearing
Client/Caseload Variables

• Early development
• Functional Strengths/Challenges
• Resilience
• Awareness of self
• Awareness of others – theory of mind
• Personal sense of identity – cultural, pathological
Family Systems
Pathological Versus Cultural

- Major fallacy - family is hearing; deaf child is deviant

- Hearing Parents - d/Deaf children aim to make their 'deviant' child 'normal'

Family Systems
Cultural Adaptation

• When hearing loss is diagnosed, family re-organizes itself

• d/Deafness belongs not just to child, but to entire family

• Family considered hearing and deaf

• All members participate, contribute, draw on family resources equally

Family Systems - Lifespan Development

Family Support – Historical and Current
• Reaction to diagnosis, resilience, coping, acceptance, recovery
• Information sources – pediatricians, otolaryngologists, audiologists, oral educators, Deaf role models?
• Interventions- hearing aids, cochlear implants
• Language, communication choices – degree of family shared fluency; sign; visual; spoken
• American Sign Language, communication skills - fluency – dysfluency-alingual
• English language and communication skills – spoken, read, written
• Education – early intervention, oral school, mainstreamed (with/without DHH resource room), School for Deaf
• Community support – role models, programs, exposure

Empathic and Linguistic Attunement

- Empathic attunement – sensing the inner life of another person – “to put oneself in the shoes of another” – “experience-near”
- Linguistic attunement – importance of (parent) therapist communicating with the client via his/her primary/preferred mode of communication; of understanding facts of deafness and of understanding the impact of special problems that deaf persons often experience (linguistic matching)

Lens on Deaf Identity... Reflect Diversity of the World

- Don’t learn how to be deaf/hard of hearing in isolation
- Perceptions of messages conveyed - different life stages
- Assert identity - acceptance/rejection of messages
- Reframing of self over time; identity differ from era to era, individual to individual
- Interactions - individuality, personalities, ethnicity, religion, skills, limitations, gender, socioeconomic status, sexual orientation, etc., and deaf/hard-of-hearing identities metamorphose as they proceed through time from one environmental contact to another

“A Lens on Deaf Identities”
A broad tapestry...

- Exciting insight into one of most diverse groups of people alive
- Focus – identity, labeling – two basic instincts humans use to classify other humans
- To naïve observer - deaf people think, behave alike, have the same life experience - you meet 1 deaf person, you’ve met them all - 1-size-fits-all approach persists, even today
- Deaf people share common trait - hearing loss severe enough that lives, world views - primarily visually, spatially oriented.
- Retreat from phenomenology of the deaf experience; focus on diverse nature of deaf/hard- of-hearing people, the deaf community

Researchers have identified Indigenous Deaf/hearing signing communities ...

• Deaf/hearing inhabitants - Bedouin community, Israel; Bali, Indonesia; Martha’s Vineyard - multiple generations in living memory
• Deafness - perceived as natural occurrence, part of life
• Deaf/hearing - equally valued, continuously communicate
• No significant boundaries to deaf/hearing social interaction
• Social labeling - differentiate deaf/hearing members - not prominent, no concern about “dealing” w/deaf child
• Deaf identities not prominent, eg situations where differentness more salient; hearing minimal exposure to deaf

Researchers have identified Deaf/hearing signing communities ...

- Israel, Bali, Vineyard experiences support idea - descriptions of deaf people - handicapped/disabled-arbitrary social construct - emerges when deaf people are not perceived as equal
- Accommodating environment, deaf becomes a simple human characteristic - differentiates one from the other, e.g., red hair – not a stigmatizing deficit
- Predominant perspective of genuine equality may work against need to assert any form of deaf identity

The purpose of this position statement is to acknowledge and emphasize the importance and need for direct communication, sensitivity to cultural affiliation, and sensitivity to the psychosocial impact of hearing loss in the delivery of mental health ... services to people who are deaf, hard of hearing, late deafened and deaf-blind...
The NAD recommends that for estimated 28 million individuals with hearing loss in U.S.:

- Mental health services should be provided using culturally, linguistically affirmative approaches
- Should be referred to specially trained providers when/where possible
- Positive therapeutic process includes facilitating the acceptance of hearing loss as integral, potentially valued part of individual; understanding, respecting communication choice, family needs...

https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-services/
Culturally and linguistically competent provider skills include ability to...

- Communicate directly with deaf/hard of hearing individuals, frequently requiring fluency in American Sign Language, signed/visual communication systems
- Appropriately use services, adaptive technology as identified, used by consumer and family members, inc. qualified/certified interpreters, assistive listening devices, captioning services
- Awareness of cultural, linguistic differences, psychosocial impact associated with hearing loss

- https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-services/
Dyadic Systems View of Communication
Parent-Infant Social Interactions Framework

• Primary task – communication- understand messages of other – modify own action - meet needs of other
• “Getting into sync” process -person acts responsively to actions of others in communication
• Parent - greater range, control, behavioral flexibility
• Child’s functional development - first social (between people), then individual (inside child)
• Mutual recognition of entering into each other’s field of perception establishes system of communication

Dyadic System and Self/Other Regulation

• Dyad (parent/infant) - critical unit of organization
• System of joint participation in shared organizational forms
• Shared rhythms, affective displays, eye contact, proxemics, conversational rhythms, games, signalizing
• Emphasis on self/mutual regulation

Foundations for Relating, Communicating, Thinking

- **Shared attention, regulation** - 0-3 months — calm interest in, purposeful responses to sights, sound, touch, movement, other sensory experiences (e.g., looking, turning to sounds)
- **Engagement, relating** – 2-5 months – growing expressions of intimacy, relatedness (e.g., gleam in the eye, joyful smiles initiated, sustained)
- **Purposeful emotional interactions** – 4-10 months - range of back/forth interactions, with emotional expressions, sounds, hand gestures, etc., used to convey intentions

Foundations for Relating, Communicating, Thinking

- Long chains of back/forth emotional signaling, shared problem solving (e.g., joint attention) – 10-18 months – many social, emotional interactions in a row used for problem solving (e.g., showing parent a toy)
- Creating ideas -18-30 months – meaningful use of words or phrases and interactive pretend play w/ caregivers, peers
- Building bridges between ideas: logical thinking/connections between meaningful ideas- 30-42 months (“Want to go outside because I want to play)

American Sign Language - Communication Variables
Fluency, Dysfluency, Alingual

Four major causes of dysfluency:
• Neurology
• Aphasia
• Psychiatric disorder
• Language Deprivation

• Cognition, IQ, reading level
• Psychosocial stressors – family, community, educational, vocational, socioeconomic, immigration, addictions, etc

Cross-Language Mental Health Settings
Language Attunement Strategies

Clinician-Interpreter-Client Teamwork

Multiple Modality Communication
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