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Silence speaks volumes - the deaf  
experience of mental health, culture and  
communication

Otilia Rodrigues  
University of Wollongong

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**SILENCE SPEAKS VOLUMES – THE DEAF  
EXPERIENCE OF MENTAL HEALTH, CULTURE  
AND COMMUNICATION**

A thesis submitted in fulfilment of the  
Requirements for the award of the degree

DOCTOR OF PHILOSOPHY

From

University of Wollongong

By

OTILIA RODRIGUES

BA Psychology & Sociology

MA Psychology (Forensic)

School of Psychology

2007

## CERTIFICATION

I, Otilia Rodrigues, declare that this thesis, submitted in fulfilment of the requirements of the award of Doctor of Philosophy, in other the School of Psychology, University of Wollongong, is in every respect my own work unless otherwise specified by referencing or acknowledgement. This document has not been submitted for qualifications at any other academic institution.

Otilia Rodrigues

July 2007

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*This thesis is dedicated to my dad, Jose Gabriel Fernandes, 1931 – 2001.*

## **PREFACE**

During the write up of this thesis an incident took place which pinpointed the heart of this thesis. A very distressed patient contacted the researcher in her capacity of therapist following a sexual assault. She had been wandering the streets helplessly in an attempt to return to the refuge which was her temporary home. The background of this person was very difficult and included enduring a horrendous child sexual assault, being used as a sex slave, raped multiple times throughout her life with no counselling and finally being referred to the current therapist who is fluent in Auslan. The distress call directly to the therapist came in the early hours of the morning (1-00am) via sms which was the only form of contact the person could manage.

Following the proper procedure the therapist called the police, informing them of the call (during which the client had threatened suicide) and requesting that they go to the premises while the therapist remained in contact with the client. The client messaged that she had taken the overdose and at this stage the police had not yet attended. When the therapist contacted the police again at 2.30 am the response by the constable was “but we can’t communicate with her, isn’t she profoundly deaf? Do you know anyone who can communicate with her”? The officer contacted the refuge and then the client herself contacted the mobile number for the refuge. The worker on call contacted the ambulance and she was taken to the hospital by ambulance without the police ever attending.

The following day the therapist contacted the client again to ascertain what had happened not knowing at this stage that the police had not attended the refuge and had left it to the refuge worker to see that she would be taken to hospital. The therapist then contacted the police department and requested to speak to someone regarding the

incident which took place. Not unexpectedly, there was no events number (a number that is assigned after a call comes in regarding an incident). The officer who took the call during the crisis had not recorded any details of what had occurred. During the conversation the therapist was then transferred to the supervisor on duty who then assigned an officer and also went personally to the hospital to get the facts from the client.

In the afternoon when the therapist had finished her usual clinic hours, she proceeded to visit the client in hospital. Tired and frustrated, the client was still in casualty (emergency) and had not yet been admitted into the psychiatric facility. She was pacing the floor, moving continuously in and out of the rooms. At this stage she informed the therapist that the police had been to take a statement but she had not yet been seen by the psychiatrist on duty.

The therapist consulted with the psychiatrist on duty and relayed the message that she had feared for this client's life should she be allowed to go home. The client was depressed and there were other mitigating circumstances that would have been detrimental to her welfare had she been discharged. She was admitted into the psychiatric facility. The following day one of the nursing staff telephoned the therapist stating "we have a lady in here - would you like to speak to her"? This call did not take into account that the client was deaf and therefore could not speak on the phone, and the nurse referred to the ward name only, and not the patient's name. Furthermore, this client had had a similar experience six weeks prior when she was taken to hospital but was not admitted. The same therapist had been verbally abused by the hospital social worker at that time stating that the patient was not suicidal (even though she had taken an overdose on the weekend and was claiming that she would take her life. She had had nowhere to go after having been evicted from a women's

housing facility. It had also been recognized by other residents that this client had been victimized by some residents). The social worker claimed the client had been assessed by the mental health team twice! This raises the question as to who made this assessment and the qualification of the person, given that we do not have any mental health professionals within the area who could have adequately communicated and evaluated her state of mind.

As this case had not been handled appropriately, the client was once again evicted from another refuge because she had overdosed and no housing was organized before her release from hospital. The end result of this case was that the client ended up in intensive care fighting for her life.

The therapist was requested to go out to the hospital to visit the client as the staff were experiencing difficulty communicating with her and did not know what steps to take. The therapist contacted the hospital to ascertain why the client had been discharged in the first place given that she had a history of suicide attempts, ostracised from the Deaf community and had no social supports within the wider community. The nurse on duty stated (in a defensive tone) that the client knew very well that she was not to go back to the refuge as she had been evicted because of the overdosing behaviour and this had been relayed via a “Braille” interpreter. The therapist questioned this with the nurse and reaffirmed that the client was deaf and not blind. The nurse proceeded to state emphatically that “yes, she had a Braille interpreter”. The therapist stated once again, the client is DEAF! The nurse stated “Well, that’s what it says on the notes!

While the client was in intensive care, the therapist was asked once again to visit the client as the medical staff were having great difficulty communicating and then was greeted by the medical staff with what appeared to be contempt, being asked why she

had come to see the client, given that the client was non-communicative. They had taken the client's glasses from her. Unable to see, no one in intensive care could communicate with her at all and no one had Auslan skills. Frustrated, distressed, exhausted and struggling for air the client appeared relieved when she saw the therapist and signed for her glasses. However, the use of medical equipment made this impossible. The nurse on duty said to the therapist that they were not allowed to administer pain killers to the client directly, that she had to do it herself intravenously via the connected drip. The nurse had instructed the client (in the therapist's hearing) to "listen for the click" (!)

Prior to leaving, the therapist attempted to provide the nurse with some simple signs which may have assisted her to communicate with the client but there was very little response from the nurse, to the point that she did not engage or look at what was being signed, repeated one of the signs (the sign for "bad") but that was all.

This incident highlights all the issues this thesis raises – health, mental, communication, language, education, culture – and the plight of our Deaf population. It is hoped that this research will contribute to the changes that so much need to be made.

# ABSTRACT

This thesis sets out to explore the world of deafness and to identify the major issues that beset deaf people. The experience of deaf people is largely unknown by the hearing world, partly because of the unimaginable nature of the reality of deafness (unlike blindness which, to some extent at least, can be easily simulated, though blindness from birth cannot), partly because deafness is not immediately visible and partly because the communication issues are so complex. The thesis begins with an historical view of deafness to provide a rationale for the way in which deaf people are understood and treated today and then moves on to identify the most serious and far-reaching issues that affect the lives of this population. Health and mental health, language, education, communication and cultural issues are explored in depth and their importance compared. Cultural issues emerge as a special complexity as Deaf\* communities have strong difficulties in being recognised as a culture as opposed to a disabled minority. To overcome this, a paradigm shift is needed whereby Deaf people can be viewed as both a separate culture and a normal population within a wellness model. A theoretical framework, Personal Construct Theory, is proposed as a theoretical approach that will validate Deaf experience and also provide an explanation of the hearing world's interpretation of Deafness. It is proposed that this framework provides both a bridge for more effective communication and useful clinical perspectives, thereby providing the context for the paradigm shift that is needed.

Three studies are presented. Study 1 establishes the extent of the problems associated with diagnosis of health and mental health problems; Study 2 presents an initial strategy to combat diagnostic issues by translating a widely used diagnostic mental

health test into Auslan (Australian Sign Language) using a CD-ROM format and trialling the test with a pilot group; Study 3 presents an exploration of the ways in which Deaf and hearing people interpret themselves and one another using the Personal Construct Theory framework. The thesis concludes with a discussion of the ways in which this research contributes to the paradigm shift that will change the perception of deafness and the social conditions related to this population.

\*"D" Deaf is used to refer to the culture of deaf people; "d" deaf is used to refer to the physiological (audiological) condition of deafness. This usage continues throughout the thesis.

# PART ONE

## History, diagnosis and communication

*“Diversity is a fact of life. People from different cultures live beside one another. We must share our knowledge, thoughts and feelings so that we, as members of the human race, can understand and appreciate one another”  
(Shirley Allen, 1999, p. 77).*

# Introduction

*“Deaf futures hinge not only upon the recognition that stereotyped beliefs, values and attitudes are the scourge of minority communities, but upon an understanding that a restriction of diversity prevents growth and adaptability” (Corker, 1996, p. 202).*

This thesis set out to explore the misdiagnosis of deaf people in relation to mental health, and the position of the Deaf community within an Australian context in relation to a review of what is happening on a global scale in the area of mental health and deafness. In the course of investigating these issues, the importance of communication was highlighted as it became apparent that there were no diagnostic tools available to appropriately assess psychological disorders amongst the Deaf population. Moreover, the results of the first study in the thesis, revealed that the magnitude of the misdiagnosis and multiple diagnoses attached to deaf people was revealed to be even more prevalent than predicted. It was ascertained that deaf people do not have access to appropriate specialised care within the psychiatric domain. It was apparent that there was only one specialist within Australia who was partially equipped to properly assess the mental state of deaf psychiatric patients and he required the assistance of an interpreter. It has been established that in Australia, and in other parts of the world, deaf people do not have the same access to mental health services as their hearing counterparts and the major reasons emerged as lack of diagnostic instruments, poor communication and a lack of knowledge or understanding of Deaf culture. The second study showed how diagnostic instruments can be translated and applied to the deaf population. The third study addressed the communication problems, providing a theoretical framework that allowed for both Deaf and hearing interpretations of deafness. It became apparent that a paradigm shift was needed whereby Deaf people could be viewed and understood on their own terms and that an appropriate adjustment in mental health care be established. This thesis provides the theoretical framework for such a paradigm shift and also the beginnings of providing mental health assessment that reflects the needs of Deaf people.

## **Background**

My personal and professional experience in working with Deaf people over a period of 17 years was the impetus for this thesis. Deafness is a very personal phenomenon and working with Deaf people teaches you to be personal. So, it is a personal story that must begin this thesis. My first experience began in 1988 when I was undertaking casual work as a medical secretary for a local general practitioner. At this time I was planning to study psychology while raising a family. A male patient walked into the surgery. Until then I had never met or had any experience with Deaf people and this encounter proved ground breaking. The patient came up to the counter and attempted to communicate with me. I realized he was Deaf, but I had no sign language skills and no concept of where to start in order to communicate. I offered him pencil and paper to establish some form of communication. He refused and pointed down under the counter. I did not know what he was trying to refer to and looked helplessly for what it was that he was trying to show me. After a few minutes, which seemed like a lifetime, he pointed to the manual alphabet and showed me the sign and using lip patterns said, "LEARN." He then turned away, perhaps never to give this encounter another thought. I, on the other hand, was mystified and transfixed! I sat there in awe of this man, pondered on what it would be like to be deaf and felt that while he could not change who he was and his mode of communication, I could. This was the start of my awakening to the fact that there was a way of communicating without spoken words, a world that was so alien to me. Coming from a European background and thus a different culture, I came to discover that there were a lot of similarities between deaf people and myself. Concurrently, I also came in contact with the relatives of a friend; one of them had been studying in a Masters program at Gallaudet

University, Washington D.C in the United States. It became apparent to me that this experience was outside my range of convenience (as in Kellian terms) and was something completely foreign. I had no concept of what Gallaudet University stood for and the significance of the University. I began a friendship with both these people who subsequently have become colleagues and very good friends. Both work in the area of Deafness. With their enthusiasm and dedication to this field (Deaf education) I took on board some of their inspiration and I enrolled at the local Technical and Further Education (Tafe) College in a signed English course, which led me to undertake further studies in Auslan. I didn't see the patient who began all this until 2003 (many years later) at a Deaf Theatre production. I recognized him in the crowd, went up to him and asked him if he remembered who I was? He replied naturally with a "No!" He had a perplexed look on his face. I said "I met you many years ago and you told me to go and learn how to sign. So I did!" He signed, "I'm so embarrassed, how rude." My response was, "No! Thank you, you had a huge impact on my life and I have never looked back." This began my exposure to a group of people and a world which I have come to appreciate and respect.

So, with my signing skills, I began working at the local high school in the hearing impaired unit where I was employed as a teachers' aid, interpreting for Deaf students from ages 12 to year 18. The majority of these students came from CALD (cultural and linguistic diversity) backgrounds. Not only did they have to learn Auslan and English as second and third language, but the parents of some of the students did not have the language to communicate with them when they were at home. For these parents, deafness

was seen as a disability and they felt chronically guilty and responsible for their child's 'disability'. I worked with these students for a period of eight years. At the time I had completed my degree in psychology/sociology, followed by my masters in forensic psychology and looked for an appropriate supervisor to guide me through my internship. I soon realized this was not going to be an easy task. I contacted two major Australian bodies who informed me that there was not one registered psychologist with such skills. This was quite alarming as it raised lots of questions in my mind as to who were the professionals looking after the welfare of the Australian Deaf population.

Eventually, I came in contact with a psychiatrist (hearing) at an Australian city university and enrolled in a doctoral degree. At the same time I began working in his private practice assisting him with his deaf patients. My role was to gain clinical experience and to act as an interpreter for deaf patients coming into the clinic. I also had the opportunity to work with patients at a hospital psychiatric facility for deaf patients. My involvement with this raised further questions in my mind, given the fact that none of the staff in the unit had Auslan skills. This meant that patients were placed in a psychiatric facility with no one to communicate with them, further isolating and alienating them from their family and friends. They were unable to communicate with other patients or the staff so a lot of their time was spent in their rooms. They seldom ventured out into the main area of the unit. When calling on them, one knew to check their room first as socialization did not appear to be developing with other patients. The patients did not understand them and deaf patients themselves stayed away, perpetuating their isolation and differences. Unfortunately, due to the fact that deaf people are a minority, it was not likely that there

would be another deaf individual admitted into the unit at the same time. The information in the diary which was kept on the patients at the nurses' station was alarming. For example, the daily diary had an entry next to the name of a deaf female patient which read "deaf and dumb." When I inquired about the terminology used to describe this woman, staff appeared perplexed and did not have insight into the connotations of the wording, namely that it was harmful to the identity of Deaf individuals and served only to perpetuate the stereotype that deaf people are disabled in the eyes of the hearing majority. Moreover, as Andrews, Leigh and Weiner, (2004) point out, the hearing community fails to recognize that "disability" is not static and the Deaf community continues to find ways to try to remove the barriers or discrimination which hearing people so strongly maintain, albeit unwittingly. As Andrews, Leigh and Weiner, (2004) point out "it essentially reflects a facet of discrimination that society does not own up to" (p. 225). In relation to the unit, the staff had to be educated to use appropriate terms such as Deaf (with a capital "D" to denote their cultural identity) instead of "deaf and dumb". Andrews, Leigh and Weiner, (2004) have reported such experiences. They state that "...they emanate the typical perceptions by hearing persons that, because deaf persons cannot hear, that suffices to classify them as having a disability, since communication using spoken language is blocked or limited" (p. 224). Having worked with the Deaf population in several contexts by this time, and being aware of Deaf culture, I could not comprehend why the distinction was being made when there were other patients from multicultural backgrounds where spoken English was also a barrier. There was no identifiable message beside their names stating that they were "Greek and dumb" for example. Thus, it was becoming more apparent that Deaf people were being

treated differently to their hearing counterparts because they did not share the same language. As stated by Andrews, Leigh and Weiner, (2004) the “reluctance of hearing society to accommodate to the needs of deaf people, or even in some situation, the tendency to ignore deaf people” (p. 227) has been observed in various domains within our society, confirming for me that this population was greatly under serviced, in particular in relation to their psychosocial and mental health needs.

I began to ponder firstly, how these patients were being assessed before being admitted into a psychiatric facility; secondly, what the criteria were for assessment; thirdly, what assessment tools were being used to assess them, fourthly, who were the professionals doing the assessments and what experience and qualifications did they possess to make such diagnosis, and lastly, how were the professionals coming up with such diagnoses. As these patients had longer stays in hospital than their hearing counterparts, the question was also raised of the medical model and whether this model was appropriate to tackle the issue of Deafness. As Gutman (2002) states “After exposure to such treatments, [deaf psychiatric patients] become extremely concerned with and adept at avoiding and protecting themselves from service providers who show the slightest indication of paternalism (p. 14).” These questions led to the beginning of a thesis that initially aimed to address this major problem of misdiagnosis and communication.

As part of this research I was granted access to the medical records of the first 20 Deaf inpatients at the unit. I was amazed at the number of diagnoses and labels which were attached to these patients. I questioned these diagnoses, especially given that one patient throughout her treatment over a period of many years had multiple diagnoses. Moreover,

the initial diagnoses were different to the discharge diagnoses. This raised ethical and moral questions as to the treatment of these people. It also highlighted the lack of expertise in this field within Australia. Shortly after, I was privileged to be given the opportunity to attend the First International Conference on Mental Health and Deafness at Gallaudet University. This broadened my awareness on the rights of Deaf people and how the Australian Deaf population are disadvantaged in all spheres of life but in particular our (hearing) lack of understanding and recognition of their right to claim their Deafness as a cultural identity as opposed to being viewed as disabled. Deaf people have for many years been scrutinized for being different, denied their human right to their natural language and equal access to services because it is often considered too costly. Their language is not considered by the general population as a language in its own right, but rather is often referred to by “that thing that deaf people do.”

Then, in addition to my research activities, I began work at the Royal Institute for Deaf and Blind Children as a Psychologist and the Coordinator of the Host Family Program. My clientele encompassed the Deaf students at the institute, their families and host families for those children who lived outside of the metropolitan area and interstate, liaising with other services related to deafness and the staff (teachers, volunteers and administrators). I soon discovered that even within this safe and supportive environment there were questions which needed to be answered and not necessarily with psychometric tools. For example, for the first 12 months of my employment I was required to assess all the students at the school with the Snijders Oomen Nonverbal intelligence test (SON-R) Noordhoff (1989). This test is used to assess intellectual capacity of deaf children.

However, it has not been normed on an Australian Deaf population, but on a sample of children from multicultural backgrounds. Also, over protection from staff and the creation of co-dependency was also observed with the isolation that the children appeared to endure when they returned home because their families did not share their language. As stated by Scheetz, (2004) “One of the contexts that impacts significantly on child development is the family unit...central to this core of development is communication” (p. 21). Some of the families at the school had neither English nor Auslan skills. Their desire to connect with their child was obvious, for example, attending an Auslan class with the aid of a verbal interpreter (the identifying language has been withheld in order to preserve anonymity). The interpreter would translate the English word and they would know the meaning of the sign. This provided the family with rudimentary signs in order to communicate with their child.

The Host Family program allowed students to attend the Auslan program and live with a family who were themselves Deaf or hearing families with a deaf child and were fluent in Auslan. The rationale was to move away from boarding school and place children within a family context, whilst exposing them to a full cultural and academic Deaf experience. Some of the students who came to the program had some Auslan skills and had been part of the mainstream system.

All the above experiences confirmed my determination to undertake a doctoral thesis that incorporated the development and trialling of diagnostic tests in a format suitable for Deaf people. As the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) was a

widely used diagnostic tool and there was a lot of support for translating this test, I began with an Auslan interactive CD ROM of the MMPI-2 for this research. I wanted to look at the possibility of developing an instrument that would assist Deaf community and hearing professionals to make better informed decisions about the lives of Deaf people given the evidence found within the medical records to support the method for diagnosis was not comprehensive and certainly not in the best interest of Deaf patients/clients. The aim was to demystify deafness, remove the barriers and allow Deaf individuals to fully integrate into the community by giving them equal access to services which will not alienate them from family structures (especially if they were born into a hearing family which did not share their language) and the community at large. As Taylor and Darby (2003) state, “the formulation of identity is an ongoing process of negotiation between individual perceptions and social structures” (p. viii).

The depth of the alienation and separation which deaf individuals appear to experience in their daily lives whilst attempting to interact with the hearing community became another focal point and formed the second part of this thesis. It became equally relevant to look at the cultural aspects of Deafness. As the research progressed it became evident that Deaf and hearing persons viewed the world from totally different perspectives.

With these aims in mind, the thesis was structured in the following way:

**PART ONE** of the thesis, comprising Chapters One, to Four, explores the historical perspective on Deafness and the current position of Australia within a global context, the effect of the medical model, the problems and consequences of misdiagnosis and the

development and trialling of a widely used mental health diagnostic measure for use with the Deaf population.

**PART TWO** of the thesis, comprising Chapters Five to Seven, explores Deaf culture and cultural issues, puts forward a theoretical framework that could give a valid voice to Deaf culture and identifies the nature of the communication problems that beset Deaf and hearing worlds.

Accordingly, **Chapter One** presents an historical perspective on Deafness, the ways in which it has been perceived, treated and interpreted worldwide, and where and how Australia fits into the picture.

**Chapter Two** explores mental health issues, the problems with mental health testing and diagnosis and the consequences of using a medical model to interpret Deafness.

**Chapter Three** presents Study 1 of the thesis, a descriptive study which presents a series of cases to illustrate the reality and seriousness of the mismanagement of Deaf people with mental health problems and to support the need for the development of adequate diagnostic tools.

**Chapter Four** presents Study 2 of the thesis which describes the development and trialling of the MMPI-2 for use with a Deaf population.

**Chapter Five** explores the complex reality of Deaf culture and the ways in which it has been struggling for recognition.

**Chapter Six** presents a theoretical framework within which Deaf culture can be validated and within which the many communication problems between Deaf and hearing people in a variety of contexts can be addressed.

**Chapter Seven** presents Study 3 of the thesis which illustrates the use of Personal Construct Theory (Kelly, 1955) methodology to identify communication problems and provide common ground for understanding.

**Chapter Eight**, the final chapter of the thesis, discusses what has been achieved with this thesis, limitations and future directions for research.

**Please note:** A capital “D” in the word deaf, refers to cultural identity within the community of deaf people worldwide. This is a term deaf people want recognised to denote their identity as a culturally and linguistically diverse group. Therefore, in this thesis, when the term is spelled “deaf” (with a small “d”), it refers to the medical, audiological aspects of deafness; when the term is spelled “Deaf” (with a capital “D”), it refers to the cultural aspects of deafness such as cultural identity and Deaf perception of deafness.

## CHAPTER ONE

**An historical view of deafness and the problems of definition.**

*“Blindness cuts people off from things; deafness cuts people off from people.” Keller, cited in Walker (1986, p.20)*

## **1.1 Problems associated with deafness**

Countries throughout the world have been faced with the problem of the care of deaf people and over the centuries have developed their own distinct ways of reacting to the issues involved. In the United Kingdom, the National Association of the Deaf was first established in the late 1880s. Prior to this, there was considerable stigma by society with respect to deaf people, in particular those from low socio-economic backgrounds. In general, they were unable to inherit their family's titles and fortunes and they were not permitted to marry (Lane, 1980). It was generally believed that deaf people should not be allowed to marry because they would produce other deaf offspring. Prior to this century, deaf people were not recognised under the law as being capable of making their own decisions.

In the sixteenth and eighteenth centuries it was the general perception by hearing educators that if they made deaf people "hearing", and taught them how to speak, they would 'normalise' deaf individuals. Thus, deaf people were ridiculed and forced to learn to speak, regardless of how crudely or haltingly. Speech was still generally considered proof of intelligence and gentility Allsop, Mason and Milles (eds.) (1988). The Deaf population was treated as lower class citizens, subjected to deprivation and isolation from the rest of society and often institutionalised and forgotten. The general consensus of the time was that the Deaf community had suffered from medical pathology for centuries (Woodward, 1982).

The sixteenth century was a turning point for the Deaf community on a global level, but especially in Europe. People were acknowledging the fact that comprehension did not depend entirely upon hearing words. There were other means of communication and this included the language of Deaf community.

According to Van Cleve and Crouch, (1989) the earliest records of deaf education originated from Spain in the sixteenth century. It was only the wealthy who could educate their deaf children. Parents would hire educators to teach their children individually “and so the literature of deaf education commenced” (Van Cleve and Crouch, (1989, p. 10). One of the early educators of deaf children was Juan Pablo Bonet, who was hired by a wealthy Spanish family. He revamped Melchor de Yebra’s fingerspelling chart from 1620. However, his motives were not to teach deaf children sign language - “his objective was to teach oral language, but he did mention the use of his predecessor’s hand alphabet...means of teaching a deaf child to speak, read, and write Spanish” (Van Cleve and Crouch, 1989, p. 12). During this period it was only deaf males who were given the opportunity to be educated. Deaf boys were expected to learn to speak. The conditions were that the alphabet was used merely as a tool for emphasising the words spoken in the home. “This was predominantly used to socialise deaf boys and integrate them into society. The “deaf person should reply by word of mouth to the questions put to him, even though he may err in pronunciation of his replies” (Bonet, 1890 cited in Cleve et al., 1989, p.12). Moreover, it is not very clear as to how the fingerspelling came about but it is suspected that it was through the Catholic brotherhoods and then developed into the

communication pattern of deaf people. Exactly how this took place is unclear. It is speculated that deaf boys were sent to monasteries and taught by Catholic clergyman.

The Spanish successes in educating deaf children were being discussed in various parts of Europe; naturally such successes were the deaf individuals who had been taught how to 'speak'. This aroused curiosity in noble families who also wanted their deaf children to be taught how to communicate orally. Sir Kenelm Digby, an Englishman, met Don Luis Velasco, a deaf man who was taught the oral way and Digby reported, "accomplishments so remarkable that all oral teachers since must surely have been envious" (Van Cleve, et al., 1987, p.15). During this period, hearing people were beginning to investigate deaf people and their communication skills much more deeply and this was to the insight which Bonet expressed. He believed "that deaf mutes are not really so, as far as speaking and reasoning are concerned, but are simply deaf, and capable of learning any language or science" (Bonet cited in Van Cleve and Crouch, 1989, p. 15). This highlighted great insight into his understanding of deaf individuals.

Anthony Deusing, wrote "*The Deaf and Dumb Man's Discourse*" a case study about a wealthy deaf man in Holland. This was translated into English and according to Van Cleve and Crouch, (1989) is one of the most significant writings of the sixteenth century. Deusing had the insight to see that sign language was more than just gesture, that it was a communication system, a language which allowed deaf people to communicate thoughts and ideas effectively with those who shared and understood their language. However, it was prominent with the wealthy noblemen, who could afford to be educated and

accompanied by others who could understand their language and thus, serve as interpreters for the deaf person. He believed that signs were to the sight as speech was to the ears. “Deusing perceived no limits to the ability of signs to convey thought” (Van Cleve, et al., 1989, p. 16). But Deaf education at the time was only for those who could afford it. It was very much a private enterprise. Those deaf individuals who were not born into wealth did not have the same access to education until the eighteenth century when Abbè Charles Michel de l’Èpée became one of the first pioneers in providing free education in Europe for deaf children who came from poor families. Abbè Charles Michel’s de l’Èpée initiated this when sign language was encouraged. At the time it was the peasants who used rudimentary signs and gestures to communicate. de l’Èpée was first introduced to sign when he observed two deaf girls communicating. He initially thought that the girls were rude because they did not respond when he attempted to communicate with them. This inspired him to formulate a sign language that could be understood by deaf people within the village “and teach these language-less children” (<http://deafness.about.com/cs/education/a/deafeducation.htm>). “He taught them to associate signs with pictures and written words and he taught them to read” (Wiltshire, 1997, p.4).

In 1755 Abbe de l’Èpée opened his school for the deaf, with trained teachers. This was a major breakthrough as they received public support. At the time of his death, there were 21 schools operating for the Deaf in France. Many followed in his footsteps, great hearing educators for the deaf such as Pedro Ponce De Leon in sixteenth-century in Spain, Braidwoods in Britain, Amman in Holland, Pierire and Deschamps in France.

Sicard and Clerc were both Abbe de l'Épée successors, in 1815 Sicard was the head of the Royal Institution for the Deaf in Paris. In 1817 Clerc opened the first school for the Deaf in America, Hartford Asylum (American Asylum for the Deaf) which later became known as the American School for the Deaf (Cleve, et al., 1989).

In 1754 he established the first school for the Deaf in Paris, “Institution Nationale des sourds-muets de Paris” which translate to the “National Deaf-Dumb Institute of Paris” (<http://deafness.about.com/cs/education/a/deafeducation.htm>). This meant that Deaf people in France were able to communicate using a language which was understood by other Deaf people. This exposed the Deaf population to a world of knowledge and enhanced their cultural appreciation. However, this did not extend to America. Until the 1800s America did not have any educational facilities for deaf children and children were sent to Scotland to be educated at the Braidwood Academy.

The Braidwood Academy provided an oral program. The program was not accessible to all deaf children but rather only to those that could afford the fees as it was a private college (Van Cleve, et al. 1989). Moreover, children were sent from their families. Parents in America did not pursue the education of their deaf children but rather accepted the status quo that there were no facilities for their deaf children to be educated in their homeland. It was only until 1812 when Braidwood went to America with grandiose expectations that he would follow in his father's footsteps and set up a school for the deaf in America. However, this did not eventuate until many years later when Braidwood was forced to take on deaf children within the home of the Bolling family who themselves had

deaf children. The school ceased to operate because it did not gain political support and was forced to close down in 1816 when Thomas Jefferson was in power (Van Cleve, et al., 1989). There was a proposal to affiliate the Braidwood School with the University of Virginia but Jefferson refused on the basis that the University was scientific in nature and the school was based on charity. Ironically, Jefferson, the president who had written that “all men are created equal”, did not support the view that deaf children had a human right to be educated. During this period, America’s population was growing and nationalism was alive and well. The notion of sending deaf children abroad to be educated was not viewed as favourable but rather a threat to patriotism. However, deaf children were still being educated in America in residential schools and were still isolated and alienated from the general hearing community. “In effect, the residential schools became surrogate parents; the language and behaviours learned there became more influential to the lives of their residents than were their previous experiences in their biological families” (Van Cleve, et al., 1989, p.30). One of the most significant factors in deaf education within America was deaf students were being educated by Deaf educators, who themselves had graduated from the same discipline. This enriched the education of Deaf students and preserving the cultural values of deaf people. Essentially, there were three prominent men in the history of American Deaf education. They were Mason Fitch Cogswell (parent of Alice, a deaf child), Thomas Hopkins Gallaudet (a Minister), and Laurent Clerc (a Deaf teacher from Paris). Cogswell rallied political support and parents who had deaf children, in particular Sylvester Gilbert (a solicitor) who had five deaf children. “The National Deaf-Mute College (later Gallaudet College, then University), founded in 1864”

(van Drenth, 2003, p.371) and set up by Thomas Hopkins Gallaudet. Initially the College was set up to train deaf individuals to become teachers of the Deaf.

By 1880, America had 55 schools for Deaf children and 30 for those with vision impairment. “At the turn of the century, there were 112 schools for deaf pupils, employing over 1,300 teachers or “instructors” (schools for the Deaf in the United States, 1900)”, van Drenth, (2003, p.371). At the end of the nineteenth century there was a shift in Europe and the United States of America, to teach the deaf the ‘humanitarian’ way, that is, through the use of speech and lip reading.

Alexander Graham Bell was also a teacher of speech and the inventor of the telephone. Bell a prominent figure in the United States, believed that the Deaf community should be oral (Gregory et al., 1994). He believed that by teaching Deaf individuals to speak and lip-read that they would be assimilated into the hearing world (Allsop, Mason & Milles (1988). Bell believed that the use of sign language was bringing Deaf people together and keeping them within their cultural groups. Moreover, Bell used his position and power to promote and enforce oralism. “His ideas very much influenced the tradition of oralism. For Bell, sign language was not the spontaneous result of the interaction among deaf people” (van Drenth, 2003, p.378) contrary to what supporters of sign language wanted the world to believe. He taught deaf students at various places including the Boston School for Deaf Mutes, the Clarke School for the Deaf and the American Asylum for the Deaf (<http://deafness.about.com/of/deafhistory/a/deaftimeline.htm>). Bell opened a school for Deaf children together with hearing children but this was opened for only two years. The irony was that Bell was married to a deaf woman and his mother was also

hearing impaired, even though he opposed intermarriages amongst deaf people. He feared “contamination of the human race by the propagation of deaf people even though most deaf people statistically are born to hearing parents,” (<http://deafness.about.com/of/deafhistory/a/deaftimeline.htm>). Bell orchestrated the push for a bill to be passed through parliament in order to prevent deaf individuals from marrying one other and to ensure that they were sterilised in order to prevent further deaf births. However, he wanted to discourage deaf people from socialising, organising and publicising themselves (to such a degree that he wanted to stop them from marrying altogether). According to Hertan, (1993) “By World War 1 (1914), sixteen American states enforced these sterilisation laws” (p.7).

In 1878, there was an International Congress in Paris, attended by educators and those in favour of oralism. However, the term “International” gives a false impression, as the majority that attended were from Europe, in particular, from different parts of Italy. In 1880, there was a second attempt at having a congress, this time in Milan, Italy. The conference portrayed a very biased view of Deafness, and what form of communication was appropriate and acceptable for deaf people to adopt. “On the final day of resolution that in teaching the deaf ‘the pure oral method ought to be preferred’” (Allsop, Mason & Milles, 1988, p.26). It was the philosophy of the time that signing interfered with the acquisition of knowledge and “the pure oral method, the manual method should be abolished from the school curriculum” (Hertan, 1993, p.6). Thus, Deaf people were educated in the oral method. This approach was adopted and signing was banned in education facilities, it was viewed as taboo and with disdain. “Oralists were convinced

that deaf people were made different by using sign language” (van Drenth, 2003, p.378). It was this mentality which forced hearing values onto deaf people and oralism became the dominant method of educating deaf children.

Children were not permitted to sign even in the playground amongst their signing friends. The oral success stories were those deaf people with a hearing impairment who were able to utilise their residual hearing with the aid of hearing aids. Unfortunately for those who were profoundly deaf and did not have access to oral/aural channels these individuals were considered failures by the hearing communities. The outcome had devastating repercussions for the Deaf community worldwide, to the point that in Nazi Germany deaf people were identified by wearing a collar around their necks in order to distinguish them from the general hearing population.

## **1.2 Effects in Australia**

Australia was not immune to subjecting deaf individuals to discrimination and alienation during this period. Elizabeth Steel was the first Deaf convict to be brought out to Australia in 1790; she was the first deaf person recorded as using sign language to communicate. In 1825, John Carmichael another deaf individual migrated to Australia and had been educated in sign language (<http://www.answers.com/topic/auslan>,).

In 1860, Thomas Pattison, a Deaf Scotsman, established the first school for the Deaf in Sydney, which is today known as the Royal Institute for the Deaf. Consecutively, Frederick J. Rose also set up another school for the Deaf (Victorian College for the Deaf)

in Victoria on the twelve of November 1860. These two men played a significant role in the recognition of sign language in Australia. Initially, the two institutes were set up as boarding schools for Deaf children. Children who did not have access to formal education because of their deafness were now provided with opportunities to become educated using their preferred method of communication, sign language. During this period signing was stigmatized and viewed as inferior and not recognised as a language. By 1879, the oral method was introduced to the Victorian Deaf and Dumb Institute. By 1905, there was yet another shift in educating deaf children. During this time in Victoria, sign language classes were being provided for families and friends of deaf individuals, and as a result interpreters emerged (Hertan, 1993). The education of deaf children became compulsory in 1910 and by 1920 the Department of Education (state) took on the responsibility of sending teachers abroad to be taught the oral method and to bring back to Australia their knowledge in order to teach deaf students.

### **1.3 Issues of understanding and responsibility**

Since the beginning of the twentieth century, responsibility for the care of Deaf people worldwide has been increasingly within the domain of medical, church and educational authorities, but over the years other stakeholders, including Deaf people themselves, have developed various resources. When it comes to understanding deafness, complexities arise because of the very different perspectives used to describe deafness and in particular those who are deaf. The medical profession, for example, is not perceived as a source of assistance to those individuals who identify as capital 'D' deaf, culturally Deaf, people who use sign language as their first language. These individuals see themselves as part

of a cultural group and do not view themselves as having a disability or something that needs fixing; thus they see little value in being part of the hearing world. When they are not accepted for who they are, they have often forced to assimilate into a culture that views their deafness as a disability rather than a different way of being in the world. As Sussman, (1999, p.9) states, “the field of deafness for too long has been preoccupied with what is *wrong* with deaf people rather than with what is *right* ...which pathology leads to a distorted view of deaf people and the deaf community.” This disparity occurs when hearing people and Deaf people see deafness from totally different perspectives. For example, in the following quote, Laurel’s a Deaf person describes her experience of being deaf and having hearing parents.

“I had no idea how much I was missing out on. When I did realize it, I became angry with my parents, because I’d learned from them, and from my teachers, that any involvement in the DEAF-WORLD would isolate me from the world in general and make me a very limited person. Now I know this to be false...because in fact the opposite is true “(cited in Lane, Hoffmeister & Bahan, 1996,p. 22).

Deaf people view deafness as a way of life; it is their heritage, their culture (Lane, 1993). There is no room for the label of disability as this only oppresses members of the Deaf community. McQuigg (2003) refers to the rift that exists between Deaf and hearing culture and quotes Lane (1994) as providing the reason:

“...an extrapolative leap, an egocentric error. To imagine what deafness is like, I imagine my world without sound – a terrifying prospect and one that conforms quite well with the stereotype we project onto members of the deaf community. I would be isolated,

disorientated, uncommunicative and unreceptive to communication.” (Lane, 1994, cited in McQuigg, 2003, p.1). According to Humphries, (1993, 1996 cited in Leigh, 1999) it is hearing individuals who define deafness as a disability. Furthermore, according to Braden “(d)eaftness is a ‘low incidence’ disability” (1994, p. v.). Furth, claims that “deafness is an invisible disability manifesting itself mainly in failure to communicate” (1966, p.7). It is only when one witnesses a different form of communication taking place between two individuals, more specifically when they are signing, that one is able to determine that the individuals may be deaf. Miner (1999) states that, “deafness is the core of their identity, they are almost always culturally Deaf, use American Sign Language (ASL), and feel positive about being Deaf” (Miner, 1999, p.308). Many members of the Deaf community operate within an entirely different perspective and perceive themselves as members of a linguistic minority with a rich cultural identity. Their language is visual, their identity embedded with people who have had similar life experiences and their heritage is as rich and meaningful as that of any hearing group. Decibel loss or loss of discriminative ability is not the only criteria for membership. CODAS (Children of Deaf Adults), interpreters, siblings of deaf individuals also come together to be part of the Deaf community.

### **1.3 Current facilities and services overseas and in Australia**

There are organisations around the world which comprise of both hearing and deaf individuals. One of these is the European Society of Mental Health and Deafness which is made up of professionals from all over the world working in the field. The World Federation of the Deaf (WFD) was first established in 1951 and currently has members in 120 countries. The philosophy of the organisation is to provide “good quality of life for

Deaf people in the areas of communication, education, employment, citizenship, and opportunities to be involved in their communities” (conference proceedings, The First World Conference on Mental Health and Deafness, 1998, p.13). In Australia we also have the Australian Association of the Deaf (AAD), Inc. which provides services to Australian Deaf community at a national level. It was first established in 1986. During the National Deafness Conference in Adelaide. Four years later the National Advocacy Service for Deaf people was set up to provide deaf individuals with specialist advocacy services within Australia. The AAD aims to raise the profile of the Deaf community.

Australia has limited services for Deaf individuals unlike countries such as America, the UK and The Netherlands. For example, America is the only country in the world to house a university, (Gallaudet) specifically for Deaf people. Here in Australia individuals wanting to learn about Auslan and the Deaf community can attend the Technical and Further Education (TAFE) college but the qualifications are only at certificate levels. To obtain qualification at a tertiary level in the area of deafness one has to enrol in a teaching degree specialising in deafness, linguistics or audiology/speech pathology, and this is done through only a few selected universities in Australia. The majority of professionals in the area of deafness are still dominated by teachers of the Deaf or interpreters. In the field of psychology, legal domain, including correctional services and medical arena deafness is still viewed as a disability. Professionals in these fields have very little understanding of deafness as a cultural minority group. Their knowledge base is purely from a theoretical perspective and they generally view deafness as a disability.

In NSW, Australia, there are two main units set up to cater for the needs of deaf psychiatric patients, one specifically for adults and the other for children and adolescents. However, upon inspection this facility was not designed to meet the needs of deaf individuals. The unit has no facilities such as flashing lights, to warn patients that something is happening, for example, in the case of an emergency or a fire. The patients do not have privacy as staff members have to knock on the door which is not conducive to the patient's sensory input. There is no teletypewriter (TTY) for patients to keep in contact with family and friends. But most importantly there are no trained staff with the qualifications to deal with the communication and psychological needs of the deaf inpatient. The consulting psychiatrist had limited rudimentary signs and fingerspelling which meant that he was not able to consult with patients one to one without the aid of an interpreter. This often meant that patients were being administered antipsychotic drugs and other forms of treatment without their informed consent.

The UK and The Netherlands have psychiatrists operating clinics and units specifically designed for deaf individuals (children and adults), employing deaf people as social workers, psychologist and case managers. These professionals are fluent in sign language and thus are able to provide individual care for their clientele. Dr. Brendan Monteiro a forensic psychiatrist working in the UK established a medium and maximum security services for Deaf inmates. In Australia, we have not yet reached this level. Deaf inmates are placed within the hearing population and no provisions are made for their deafness or psychiatric needs. They are isolated and generally end up within the psychiatric facility of the jail which is often not the optimum place for them. They tend to serve longer

sentences. For example, Mr Beamish spent 15 years in jail for a crime that he did not commit.

Gallaudet University has its own counselling centre which was established by a group of three Deaf psychologists, Dr. Allen Sussman, Dr. Larry Stewart and Dr. Barbara Brauer, a Deaf pioneer in the area of Deafness and psychology. The late Dr. Brauer was the first Executive Director of the Mental Health Centre at Gallaudet University. Currently the centre is run by Deaf and hearing professionals all fluent in ASL.

Worcester in South Africa (regarded as a third world country) has a well established Deaf community. The Institute for the Deaf is a place where children go to school and church, adults are employed within the grounds of the institute. They run their own coffee shop and gift store, producing arts and crafts, including sandblasting and glazing. These items are produced by deaf individuals and then sold to the general public. Families reside within the institute. There is a sense of community within this complex.

In Australia, we don't have any facility which resembles the Deaf Institute in Worcester. The closest is the Royal Institute for Deaf and Blind Children in NSW but (the trend has been to move away from institutionalisation and hence the name change to institute) currently there are no boarders within the Institute. On the same grounds is Renwick College which is affiliated with The Newcastle University.

In Australia, services for deaf individuals are restricted to Deaf Societies (in all states and territories), Deaf Sports Australia, and The Australian Chamber of Commerce Inc. where deaf individuals are encouraged to manage and own their own businesses. Deaf Education Network also provides education and resources for deaf individuals. The Australian Deaf/Blind Council and The Association for the Deaf are a political groups who lobby government for the rights of Australian Deaf community. Teachers working in the field of deafness have the Australian Association of Teachers of the Deaf and Australian Sign Language Interpreters Association.

In terms of access to information, deaf people do not have the same access to the media as hearing people. For example there is only one television channel in Melbourne which designed for deaf people. In Australia, only those deaf individuals who have access to teletext are able to access information in English. However, this is problematic as most deaf individuals have not acquired literacy in English and the majority have a reading age of 8 years. Australian Captioning Centre also provides videos with captions for schools. The National Relay Service (NRS) provides access to deaf individuals and the hearing community. This service is allowing deaf individuals to be more independent make the own appointments, contact hearing services who do not have access to a TTY. The NRS provides a telecommunication link between hearing and the Deaf community. The National Auslan Interpreter Service (Nabs) provides interpreters to Deaf individuals who rely on sign language to communicate. This service is specifically for medical appointments. It also provides interpreters for Deaf parents of hearing children who need to see a medical professional.

### **1.3 Difficulties with definitions of deafness**

Physically there are as many ways of defining deafness, as there are ways to experience it. A person may be born deaf, be deafened pre-lingually at a very young age, or be deafened post-lingually during childhood or adulthood. In addition, people may experience mild (20-45dB) to moderate (60-75dB) loss (Australian Hearing) and be classified as hard of hearing. This population usually benefits from use of a hearing aid to assist with their residual hearing and it may also aid in improving their speech discrimination. This is often achieved by “incorporating communication strategies they are able to access the mainstream of the larger hearing society” (Scheetz, 2004, p.17). Individuals in this group are more likely to identify and function as a hearing person within the hearing community and are most likely to have hearing parents and siblings. However, later in life, usually in their teens, these people appear to experience difficulty with their identity and finding a place in the world where they feel they fit in. “They may often state they do not feel as if they belong in either society, or their loyalties may shift without evidence of true solidity” (Leigh & Lewis, 1999, p.51). In many cases these individuals experience displacement because they don’t feel that they are part of the Deaf community and are also often ostracized by the hearing world, perceived as having a disability (Lane, 1994). They are often judged by some Deaf individuals as “hearing wannabe’s.” There is a specific sign that depicts such a phrase; it is the point hand shape (‘d’) tapping and bounces the forehead twice. Deaf individuals see these individuals as the outsiders. That is, they do not share their language. According to Leigh and Lewis,

(1999) these deaf people are culturally marginalised. Moreover, Harris, (1980) further stipulates that deaf people are outsiders because not only can they not hear but they have to reside in a world that is dominated and controlled by sound “they are not fully part of that world...they are outsiders in a hearing world” (p.22). This view is also supported by Alker (2000) who states that “the potential of Deaf people, used as one more weapon by those more interested in maintaining their own positions and control over Deaf than with any advancement for Deaf people” (p.13).

“Hearing impaired” is a term, which is often used to describe people with a hearing loss. Deaf individuals who identify with capital D deaf find this term derogatory and often relate it to “calling a Black person a Negro” (Lane, et al., 1996, p.13). The term “hearing impairment” is not welcomed and is often viewed as offensive by some members of the Deaf community (Gregory et al., 1991). It is usually a term that is used in the school environment to identify the lack of hearing amongst deaf students and thus reinforcing that they are not ‘normal’.

This is illustrated by Padden and Humphries, (1988) in one of their case vignettes where Sam, a Deaf child from an all Deaf family did not know that others around him were different. That is, he did not comprehend the difference between hearing and Deaf people, only that hearing people, in particular his next door neighbour, used unusual and bizarre mouth patterns to communicate with her family. He asked his mother why the neighbour was so different. But it was only when he went to school that the full impact of this phenomenon impacted on Sam. He was then in an environment where he no longer

was the norm. He was now perceived by his teachers and peers as having an affliction, as having something lacking.

In another case vignette, Howard knew the meaning of Deaf but realised the differences in meaning when he started school. “When Howard arrived at school, he found that teachers used the same sign he used for himself at home, DEAF. But it did not take him long to detect a subtle difference in the ways they used the sign... the child uses DEAF to mean ‘us’, but he meets others for whom ‘deaf’ means ‘them, not like us’” (Padden & Humphries, 1988, p.8). Once again, it is the hearing world which isolates deaf people and categorises them into someone with a disability. A hearing child with deaf parents who grew up in a Deaf-World which used sign language as the primary language, found it equally difficult attending school for the first time when she was five and did not realise that the rest of the world used speech to communicate (Lane, et. al., 1996).

Another definition of deafness utilised by Wiltshire, (1997) is that “(D)eaf is described as the audiological condition of lack of hearing, and ‘deafened’ is the term used to describe those who experience major hearing loss after the acquisition of spoken language (often called ‘adventitious deafness’).” Braden, (1994) stipulates that the term deafness implies a complete lack of hearing. However, this definition does not incorporate the different degrees of hearing impairment and the many methods that the Deaf community use to communicate. Alker (2000, p.36), states “because society depends on a sound-based geography, Deaf people are strangers.”

According to the World Health Organisation, impairment is defined as any loss of physiological or psychological structure or function considered normal for human beings.

A disability is any restriction or lack of ability to perform “normally” due to impairment, and a handicap is a disadvantage for a particular individual, resulting from an impairment or disability, that limits or prevents that person’s ability to function in appropriate social and career roles within our society. While this may be perceived as a description of deaf people, the perception applies only from the perspective of a hearing community. Deaf people do not define “normal” as “hearing” and they do not regard deafness as disabling or “not normal”. While this has been hard to grasp for the hearing community, this thesis attempts to clarify the Deaf perspective and present a theoretical framework within which Deaf people can be seen to be justified in their view.

At present, deafness is defined from several different perspectives - medical, educational, linguistic and cultural. These different perspectives and their implications are explored in sections 1.4 to 1.7 below.

#### **1.4 The medical view**

Within the medical domain, which has historically informed education attitudes, hearing loss is defined broadly by sensorineural or conductive deafness. There are three main areas in which sound waves are reconstructed into neural impulses. First is conduction of sound waves through the external and middle ear. The second aspect of hearing hindrance is the transformation of motion to neural impulses. This type of hearing impairment is termed as sensorineural. “Sensorineural deafness occurs when there is a dysfunction in the inner ear or damage to the auditory nerve” Scheetz (2004, p.15). The other codification of deafness is what Braden (1994) termed as “mixed”. This is a mixture of sensorineural and conductive impairments. It is also essential to identify whether the

hearing loss is bilateral, that is, the hearing loss is in both ears, and if there is unilateral hearing loss. It is also necessary to identify whether deafness is mild (20-45) decibel (dB), these people may experience difficulty in hearing the ocean; at moderate (45-60dB), to severe (60-75 dB) one would have great difficulty in hearing conversations and in particular when in groups where more than one conversation is occurring simultaneously. With severe hearing loss (75-90dB) the individual would not hear someone on the other end of the telephone without the assistance of a hearing aid and in some cases even with the assistance of a hearing aid they would not be able to receive sound input. Individuals with profound hearing loss is (greater than 90 dB) are unable to hear sounds from lawnmowers or an aeroplane even if they were standing right next to it (Australian Hearing Pamphlet). However, these individuals would feel the vibrations. Another factor, which is important to consider, is whether the deafness was prelingual, before the individual acquired language or postlingual onset, deafness occurred after language had developed. Physically therefore, deafness is viewed within the medical model, as being a result of physical damage/disability.

Accordingly, Alker, (2000) argues that the medical model sees deafness as something that needs to be fixed. Many disciplines, such as communicative disorders, audiology, or even neuropsychology, often function from a pathological perspective, and it is within this framework that deafness was viewed as a “illness” (Tavormina, Boll, Dunn, Luscomb, & Taylor, 1981) or as a “wrong to be made right” (Gregory, 1976). Alker (2000) also states that “denial of deafness and on rehabilitation might have a very real

role in the lives of the deaf. It (disability) has no relevance in the lives of the Deaf” (p. 38).

The medical model, however, has been very relevant to hearing impaired individuals, that is, individuals who rely on their residual hearing and oral skills to function within society, and are less likely to identify as a member of the Deaf community. Generally this group of people has been raised by a hearing family where sign language was not used, or was not the dominant language used in the home. People who have children identified as hearing impaired are often likely to be advised by the medical profession that deafness is a disorder and that their child’s deafness may be rectified with, for example, the aid of a cochlear implant (Padden & Humphries, 2005). They are often placed in a position where they are making uninformed decisions based on medical bias. Deaton (1996 cited in Gutman, 2002) refers to this as medical paternalism. The dangers with this approach, Gutman points out, is that “these decisions have significant impact upon the child’s development of language and cultural identity, yet neither the young child (lacking legal standing and cognitive maturity) nor the parents (in distress at their child’s deafness and having difficulty getting, understanding, and evaluating information)” (p. 15). Andrews, et al.,(2004) states “critical decisions are made regarding these deaf children by psychologists, teachers, and administrators who have little or no experience with deafness and who cannot communicate with them (p.5). This perspective tends to operate from the “broken ear with a child attached” model (Andrews et al., 2004, p.377). Such decisions affect the lives of their (hearing parents) child in the long term, especially when the outcome is a cochlear implant. Children who are implanted rarely learn sign language. If,

as in some cases, the implant is not successful, these children are left without a language at all. Thus, Padden (2005) poses the crucial question: “Why is it easier for doctors to embrace speech and discourage signing?” (2005, p.178) One Deaf man, describing his personal experience, said: “My parents tried to pound speech into me and dragged me from one clinic to the next” (cited in Lane, et al., 1996, p.20). In this context, medical professionals were most likely to have had very little contact with Deaf adults who had reached tertiary level education, who were bilingual (Auslan and written English) and did not rely solely on speech. “Thus, they (the medical profession) are more susceptible to describing Deaf culture members as lonely and isolated rather than socially unfulfilled through insufficient interactions with deaf peers” (Stewart, 1991 cited in Andrews et al., 2004, p.23).

Deaf individuals using sign language have been seen as a threat to the medical profession as they challenge the professionals’ own value system and their inability to communicate with Deaf people using their language (Lane, 1994). Thus it is easier for hearing professionals, especially in the medical area, to dismiss sign language as a true language rather than reassess their view of deafness. Deaf individuals have been seen as challenging the dominant cultural value, that speech is the preferred method of communication, and therefore not been allowed equal access to professional domains (Lane, 1993). At the same time, the medical profession’s assistance to those individuals who identify as capital ‘D’ deaf, culturally Deaf, people who use sign language as their first language is limited by the disability model. Members of the medical profession need to have a clear understanding of the cultural difference in order to offer appropriate

assistance. Deaf people see no value in being part of the hearing world when they are not accepted for who they are and are forced to assimilate into a culture that views their deafness as a disability rather than a way of life. Alker (2000) reinforced this view with the notion that generally society depends on sound and hearing this excludes Deaf people. “Deaf people are strangers” (Alker, 2000, p.36) within hearing societies.

Historically, psychologists, like many medical professionals, have adopted the view that deaf people should be viewed according to the medical model. That is, the central identification code is their audiological criteria. It is only since the 1980s and more in the 1990s that the rich heritage of Deaf people has begun to be acknowledged by mental health professionals around the world. However, in Australia this has not been the case. The reinforcing of the medical model is preferred when dealing with deaf individuals with mental health issues with most deaf people in that category being referred to psychiatrists rather than psychologists. However, one cannot ignore the fact that Deaf culture and history, especially in Australia, is still in its infancy unlike the wealth of written records of many other cultures.

The change in ideology, from the need to cure to awareness that Deaf people do have their own culture, language, shared values and morals, has instilled a sense of empowerment in the Deaf community. This has been through the media, lobbying for equal rights, through lobby groups such as the Australian Association of the Deaf, written expression and the fact that many Deaf individuals are now more informed and tertiary educated and in positions of power. This is ensuring the breakdown of barriers and Deaf

people are not just being seen but heard. Padden and Humphries (2005) observe that “Without diversity of culture, language, and different ways of seeing the world, we would never have learned what we now know about the different ways that humans live” (p. 180).

The awakening of knowledge and attitudes toward Deaf culture also resulted in psychologists having to reframe deeply entrenched perceptions regarding the personality and intellectual characteristics of the Deaf individuals. In Australia this is still very slow. For example, on one occasion, the author of this thesis was presenting a paper at a tertiary institution and introduced the talk in Auslan to demonstrate the differences and difficulties in communication between hearing professionals and Deaf clients/patients. A member of the audience showed increasing signs of frustration as this introduction was presented. When asked about his experience, he stated “I was about to leave. If you had not started to speak when you did, I was leaving”. His tone was one of resentment and anger. This educator/practising psychiatrist was unable to withstand five minutes of what a Deaf individual experiences is when seeking assistance from hearing professionals. As Jake, cited in Lane et al., 1996,) stated, “That kind of thing - being at a loss because you can’t understand what people are saying, or because you can’t make yourself understood - is the sort of experience Deaf people have every day on the job or when they go shopping or wander into a strange neighbourhood” (p. 11).

Myklebust’s (1966) research into the area of deafness has highlighted the fact that deaf individuals perceive and experience the world from a different perspective, contrary to

earlier perceptions that deaf people were inferior to their hearing counterparts. Neuropsychologists are also questioning the impact of deafness on the psychological developments of deaf children in order to understand such differences (Andrews, et. al., 2004).

## **1.5 The problems of education**

The first school for the Deaf in the UK was established by Thomas Braidwood in 1760. Thomas Braidwood believed in the oral method of educating deaf children. “The Braidwood family, which had a monopoly on the education of the British deaf, was unwilling to disseminate their method” (Lane & Philip, 1984, p.9). Between the period of 1880 and 1967 deaf children around the world were educated using the oral method. Residential schools began in France “in the mid-nineteenth century there were 160 schools for the deaf, and the manual language of the signing community was the language of instruction in all of them” (Lane & Philip, 1984, p. 3), and shortly after in America. Residential schools played a large role in the lives of deaf children and in particular in preserving sign language. On the other hand residential schools deprived deaf children of social competence. They felt confident within their environment but interaction with the general population would have been problematic because of the language barriers between Deaf and hearing people. Whilst in residential schools Deaf children were exposed to an environment that was rich in language, sharing ideas, maintaining long term friendships and providing a sense of community. “By the nineteenth century residential institutions had become the dominant pattern in deaf education” (Van Cleve &

Crouch, 1989, p.10). Most of the children who attend residential school keep in contact with their deaf friends. This allowed sign language to evolve and develop.

There was a shift in philosophy from educating deaf children in boarding schools to mainstreaming and teaching them the hearing way. Lane and Philip (1984) state, that “by the turn of the century, it was not allowed in a single one” (p. 3). In the hearing world, speech and literacy are the main means for effective communication and success. Benderly, (1980) states, “Speech dominates the general culture and hearing people take verbal ability as the measure of intelligence” (p.69).” Historically the assumption has been made that Deaf people lacked normal intelligence because they could not speak (Furth, 1966). Thus, it is not surprising that the Deaf population have been ostracized as most do not acquire proficiency in literacy and in speech. As stated by McCleary (2003) “For deaf people, the only route to full language mastery is through a sign language” (p. 105). The majority of deaf children also struggle with the acquisition of sign language because 90 % of them are born into hearing families and sign language is not their first language. On the other hand, most Deaf people are not fluent in English as this is often their second language. When they attend a school for hearing children (mainstream), they are disadvantaged because they are competing with hearing children in the classroom where the teacher is often hearing and is not familiar with the complexities of teaching Deaf children. For example, they will turn their back as they are writing on the board, simultaneously speaking with the expectation that the deaf child in the classroom will have heard what was said or more often they are not even considered. This is particularly the case if the child wears hearing aids as the teacher may make the assumption that the

child has heard what was said, after all she or he is wearing a hearing aid. Moreover, the teacher providing information, may also come to the conclusion that because the deaf child he or she able to lip-read and thus, their ability to understand 100% as a hearing child.

Lip-reading is a skill which requires many years of experience for a person to achieve some level of competency. This is, of course if the individual has had some exposure to English or any other spoken language and are able to hear normally (Rope, 2005). Rope (2005, p.3) further emphasises that “people who have highly developed lip-reading skills can only read about 30 percent of what is visible on the lips.” It is comprehensible that if one has never heard any sounds or language that it would be much harder to acquire lip-reading accuracy in a language which is foreign to the individual. There is never the expectation that someone from Portugal visiting Russia will comprehend the spoken Russian. But Deaf people as expected to acquire skills, if not become proficient in English, when English is not their first language.

Moreover, there is no consideration or thought given to the fact that our lip patterns when producing certain words are very similar without sound, for example, *Tan* and *Stan* for a deaf child will appear to be exactly the same. Thus, this may result in the child becoming disinterested and withdrawing from class lessons and remain silent and not participate in the classroom activities.

In mainstream education systems, teachers generally do not necessarily receive specialised training. In particular, they do not specialise in special education and are not trained in the area of Deafness, and therefore are unable to cater to the special needs of the deaf child in their class. This has detrimental consequences for the deaf child as she or he will be excluded and will not be exposed to the same educational information provided to their hearing counterparts.

In Australia, Thomas Pattison, a deaf migrant to from Scotland, established the Royal Institute for Deaf and Blind Children in 1860. The Institute moved premises several times but became permanently established at North Rocks, Sydney, in 1961. It has been relevant that from the outset, the major facility in New South Wales, Australia for the care of Deaf people has been inextricably bound with care for blind people and that both populations have been regarded as severely disabled. The Public Education Act in 1880 made no provision for deaf and blind people while providing compulsory, free education for all others. Care for deaf and blind people was still falling within the domain of charity funding. Children attending residential schools were often sent away without knowing where they were going and why they were being sent away. For example, a Deaf woman explained during data interview for this thesis that her mother took her on the train. The Royal Institution for Deaf and Blind Children (there has been a name change from Institution to Institute) and did not explain why they were taking the trip and why she was left at the school and not able to go home with her siblings. Deaf children were often kept in the dark as to what was happening, especially if they were from hearing families and the family had not learnt how to sign and communication was difficult.

In the past few years, Deaf culture has been recognized and supported by the Royal Institute and Auslan has been recognized as the official language of Deaf culture. Even so, public awareness of this shift in perspective has remained very low. In different states within Australia there is, Carronbank School for the Deaf, Ewing House School for Deaf Children in Victoria, Western Australia has Cottesloe School for Deaf and Hearing Impaired Children and Mosman Park School for Deaf Children. The Wollongong High School of the Performing Arts (NSW) houses a hearing impaired unit where deaf children are in the mainstream education system and receive support from the unit. Currently the educational system in Australia provides education for Deaf students in two specific domains. First, in bilingual programs such as the one in Thomas Pattison School (TPS) at the Royal Institute, where the language of instruction is taught in Auslan and English is considered as the Lote (language other than English). School for the Deaf in Tasmania, Claremont also follows a similar path. TPS also provides education to deaf children outside of the Sydney metropolitan area by allowing them to access such programs as the Host Family Program, where children living in remote areas reside with a Deaf family or a family who are fluent in Auslan and attend TPS. This exposes the student to Auslan, immersing them into their natural language. The school employs both hearing and Deaf teachers (specialised in Deaf education), Deaf teacher's aids and other professionals who promote a positive view of Deafness and respect the basic human right of Deaf individuals to use their native language. This environment is rich in language, culture and positive role models. "The question that has motivated so much denial of Sign language might be appropriately reworded, considering that many deaf children around the world

still enter school with very little language of any kind” (Mahsie, 1997, p.20). Unfortunately, even today we are seeing more deaf children in Australia and around the world leaving school with insufficient education. Christensen, (2000) states “Efforts to restructure education, schools, and teaching will help us to rethink our priorities” (p.55). This will undoubtedly benefit the wider community especially those within the Deaf community.

## **1.6 A Linguistic view**

“Sign languages have been defined from a linguistic viewpoint as languages, and those using sign languages have been defined as a linguistic minority” (Kauppienen, WFD). Schembri (1996) refers to research conducted in the 1960’s which supports the view that sign languages consist of the same linguistic properties as that of any other spoken language. He further questions the use of universal gestures within the hearing communities, such as shrugging of one’s shoulders which may indicate uncertainty and thumbs up suggesting that everything is ok. These gestures have given rise to the ideology that sign language is not a ‘true’ language. As Schembri states, “This confusion has led to the widely-held misconception that the sign languages of deaf communities are merely elaborated forms of spontaneous and imitative gesture, or that they are gestural surrogates for spoken language” (1996, p.1). Moreover, “the manual language of the (sic) deaf had to be branded a pathetic pantomime-just what it seemed to the uninitiated-a fallback, even an atavism, in the absence of real language” (Lane & Philip, 1984p.2).

According to Schembri and Adam, (1998, workshop notes) sign language has its own structure. It consists of phonology (sounds/hands faces, body and space), morphology (words and signs), syntax (sentences), discourse (conversations, letters, speeches etc) and semantics (meaning). Sign language has 5 major parameters which consist of handshape, movement, orientation, location and non-manual signals. It also has 68 handshapes with 34 major handshapes used. They further support the view that Auslan has evolved through BSL (British Sign Language), ISL (Irish Sign Language) and American Sign Language (ASL). Auslan has two distinct dialects they are the northern with includes, New South Wales, Australian Capital Territory and Queensland. In the Southern part of the country includes Victoria., South Australia, Tasmania and Western Australia. In fact these vary from city to city. For example, one may use the sign for hungry (the 'good' handshape bouncing twice on the side of the neck) in NSW but in Melbourne this sign is used for sex.

McCleary (2003) raises a question posed by many speaking people who question the notion of why Deaf people don't acquire the language of a particular country given that they are not blind. However, as stated by McCleary "This commonplace idea ignores the complex nature of language acquisition and the relation between orality and literacy" (2003, p.105). A major issue ignored is that by the time hearing children go to school they have almost fully developed their oral language skills which deaf children in particular from hearing families do not have.

The Australian Deaf community's language is Auslan. Auslan is visuo-spatial. The Australian Government has recognised Auslan in policy as the language of the Australia Deaf population.

“It is now increasingly recognised that signing deaf people constitute a group like any other non-English speaking language group in Australia, with a distinct sub-culture recognised by shared history, social life and sense of identity, united and symbolised by fluency in Auslan, the principal means of communication within the Australian Deaf Community” (Dawkins, 1991, p.20).

Auslan has its origins in BSL and ISL. Auslan derived from BSL and New Zealand Sign Language (NZSL) “Auslan was recognised by the Australian Government as a “community language other than English” and the preferred language of the Deaf community in policy statements in 1987 and 1991 (<http://www.ridbc.org.au/aboutus/history.asp>).

There is a difference between spoken languages and sign languages. These differences are in the production of the language itself. Spoken language is produced from the mouth utilizing the vocal cords, whereas with sign languages the key elements used are the arms, hands (handshapes), facial (expression), movement, location of the sign (where on the body or face the sign is produced) are also important factors. Most research in linguistics, especially the phonology of sign language, has been carried out by scholars in the United States. “As for spoken language phonology, sign phonologists have focused on determining the distinctive features of signed languages, and rules that specify an articulatory phonetic plan for the actual production of phonemic lexical representation” (<http://www.bris.c.uk/Depts/DeafStudies>), Stokoe (1991) proposed a theory of semantic phonology. “Semantic phonology argues that signs are not represented in terms of

meaningless and distinctive features; they have a syntactic rather than phonological structure” (<http://www.bris.c.uk/Depts/DeafStudies>,). Armstrong et al. (1995) purport that sign languages have developed the same way as other languages. “Their position is that manual gestures constituted the first forms of linguistic communication, and the manual gestures were necessary prerequisites for the development of spoken language... to communicate in a spoken language, a grasp of syntax is required by the speaker” (<http://www.bris.c.uk/Depts/DeafStudies>,). Auslan, ASL and other sign languages are structured using the basic principles of language which include morphology, phonology, syntax, and grammar. As postulated by Emmorey (2002), there are three basic phonological categories in sign language. She describes these categories in relation to handshape or hand configuration, that is, the orientation of the hand when forming a sign. Is the hand open or closed? The location of where the sign is made, for example, the sign orange and lemon the handshape is the same but the location is different. “To ascertain a linear segmental structure for signs, location, movement, and handshape are likened to consonant, vowel, and tone, respectively” (Emmorey, 2002, p.2 cited in <http://www.linguistlist.org/issues/13/13-1631.htm1>). Time lines are also important factors in sign language as it distinguishes whether something is happening, has happened or is about to happen. For example, ‘last year’ is signed with the ‘d’ handshape behind the ear (showing past) and ending on the opposite hand with the sign ‘year’. Whereas, ‘tomorrow’ same handshape location is on the face, ‘d’ sweeps on the right side of the cheek and ends in front of the face (Emmorey, 2002). Schembri, (1996) stipulates that, “Signs in a natural sign language (like words in a spoken language)...form a lexicon, and these signs can be combined, following standard rules of organization (i.e. grammar), into

hierarchically-structured phrases, clauses and sentences” (p.13). He further emphasizes that sign languages are as much a part of the linguistic system as any other spoken language.

## **1.7 A cultural view**

Capital “D” deafness is representative of cultural identity, and the lowercase “d” as it refers to deafness as determined solely through audiological criteria (Woodward, 1972). Marschark (1997, p.7) states that for “people who understand Deaf culture, hearing loss is a sign of community membership rather than a limiting characteristic.” Walker (1986,) supports this view and states that “deafness is a culture every bit as distinctive as any an anthropologist might study” (p.22). In contrast to the medical view where deafness is seen as something that requires rectification, many members of the Deaf community operate within an entirely different worldview and perceive themselves as members of a linguistic minority with a rich cultural identity. Deaf individual “do not measure themselves against hearing people, but rather take themselves, their identity, and their interpretation of the world as the norm...believe that deafness opens them up to membership in the Deaf community; a community with its own rich history, language and value system” (Hladek, 2002, p.33). These are those individuals who refer to themselves as capital ‘D’ deaf. This group of Deaf people “would regard deafness as a normal human variant or a lifestyle choice and may react defensively to suggestions that they are disabled” (Austen & Crocker, 2004, p.4). The decibel loss or discriminative ability is not a criterion for membership. Deaf individuals see their culture as a way of life, an opportunity to grow and learn. According to Andrews et al. (2004) Deaf individuals see themselves as serving as role models or mentors for the younger

generation of deaf children. Moreover, this is particularly significant if they are from a hearing family. Deaf individuals who have grown up within a hearing family and have had little exposure to the Deaf community are introduced to Deaf culture and Auslan, will make the transition by the time they reach adolescence.

The Australian Deaf community's identity is clearly identified in people with similar life experiences. Their heritage is as rich and meaningful as that of a hearing person from a different minority group. Historically, Deaf people's culture has not been recognised as such because of hearing people's belief. Deaf people have long been associated with disability. Many authors have challenged this view and propose that "cultural and ethnic identity is an important variable for understanding both individual deaf persons and Deaf community" (Gutman, 2002, p.15).

Deafness as a culture first achieved prominence in the world in 1988 when the students at Gallaudet University, Washington, D.C, America abolished the notion that they were disabled. Like hearing communities, the Deaf community has a shared history which is passed down from generation to generation. However, the method by which this information is passed down is somewhat different to that of hearing people. Generally, the dissemination of history is done so through family, but in the case of deaf children, they often don't learn about their Deaf culture until they leave home. They do not acquire the stories, language and customs of the Deaf community through their family. This is often acquired at residential schools or when they leave secondary school and commence university or college. This is often when they have come in contact with Deaf adults.

“The acculturation continues with involvement with Deaf churches, and Deaf civic or social organisations” (Hladek, 2002, p.34). Hearing people perceive deaf individuals as a disabled group but Deaf people are proud of the uniqueness of their visual language. “The Deaf culture views Deafness as another trait in a heterogenous community, different but not deficient” (Hladek, 2002, p.34).

These many perspectives and history all inform the current position of deaf/Deaf people in today’s society and provide a context for the serious problems they face. The next chapter explores the communication and diagnostic problems that arise for this population when accessing the health/mental health system.

## **CHAPTER TWO**

### **Current problems with communication, mental health testing and diagnosis**

*“Voice is not only what we mean and what we say, but it is also how we express what we mean...To be truly heard depends on having a place from which to speak and listener who is willing and able to hear what we have to say” (Phillips, 1996, p. 137).*

## **2.1 Communication and health professionals**

The perception within the hearing community is that there are plenty of psychologists available to provide services to the Deaf community and who are Auslan literate. For example, a current group of 22 undergraduate Wollongong University psychology students was surprised to learn that there was only one registered psychologist with Auslan skills in NSW. These students, many of them psychologists-in-the-making, and many other similar groups in Australia, are likely to make up the next generation of psychologists working in the field with “the likelihood that they will encounter a deaf or hard of hearing client” (Leigh, et al., 1996, p.364). However, while their training course and similar courses at other institutions deal with other cultural issues, they do not equip them to deal with this unique group of people who are a part of the community but may present very differently to their hearing counterparts due to their life experience and their mode of communication.

There is now sufficient evidence to support the view that hearing people, and in particular most hearing professionals, view Deaf people as disabled, incompetent or inferior to their hearing counterparts. Hearing people also want to ‘fix’ Deaf people and make them more like themselves. As Harris(1995) states, “the hearing world, especially those in power such as the medical doctors, were astounded by assertions from Deaf people, particularly those from the BDA, that they did not want to be changed into hearing people” (p. 167). This dichotomy allows hearing people the luxury of formulating hypotheses without any attempt to understand deafness from a different perspective. Deafness is not an area which receives sufficient exposure, especially for those who are in the helping

professions. As pointed out by Denmark (1996), medical students learn all about the anatomy and physiology of deafness but the psychological and sociological aspects of deafness are not part of the curriculum. “Moreover, most text books of psychiatry make no reference to the difficulties which may be encountered in the diagnosis and treatment of some deaf people with mental health problems” (Denmark, 1995, p. 2). As Denmark (1995) points out further, it is difficult, if not impossible, to provide treatment for patients if one has not been able to make a correct diagnosis. He emphasises the necessity of communication in this process, “communication is the cornerstone of diagnosis” (p. 46). On average, preverbal deaf individuals with limited sign language and no English or spoken skills have difficulty in expressing their feelings. This will often manifest itself later in life as a psychological disorder (as observed in some of the researcher’s clients). If health professionals do not have an understanding of Deafness they will misconstrue behaviours and provide incorrect diagnosis which may lead the patient to unnecessary treatment or longer stays in psychiatric facilities (Denmark, 1995). Timmermans (1988 cited in Denmark 1995) also found that deaf people who have been committed to a mental institution stay an average of 17 years, which was 40 times longer than their hearing counterparts. According to Vernon and Rich (1997) “J.S. spent his school-age years with no language system. He did not know sign language, he could not write, he was unable to talk, and could not read. His mother communicated with him by pointing” (p.300). Denmark (1995) stated “in such circumstances it may be difficult, and at times impossible, to detect the presence of abnormal psychic phenomena. As a result, mental illness may remain undiagnosed” (p. 48). Often this is due to the fact that prelingual deaf individuals are not aware that they are experiencing a mental health problem, for

example, depression. Often they do not have the language to describe what they are feeling.

Some of the difficulties which Deaf people experience in everyday life are things that the hearing community takes for granted. For example, not being able to simply go to a convenience store and ask for what you want without having to confront someone who will not understand you. Deaf people are easy to ignore, one can just turn away and pretend they are not there or one can claim that one does not understand what they require. “A deaf person’s greatest problem is not simply that he or she cannot hear but that the lack of hearing is socially isolating” (Groce, 1985, p.3).

Interestingly Groce, (1985) points out that deaf people are able to integrate into society as full functioning members of that society if no barriers exist. That is, if hearing people are bilingual, having spoken and sign language. A study conducted by Groce revealed that Deaf people were treated as equal individual members of the Vineyard Island community. Their deafness was not a distinguishing characteristic. They were not categorized as “the deaf.” One of the interviews conducted by Groce (1985) supports this view that they were members of a community. He elicited information regarding similarities between two men of that community and the respondent stated that they were both good fishermen. When Groce prodded the interviewees about their deafness the response was “Yes, come to think of it, I guess they both were,” she’d replied. “I’d forgotten about that” (Groce, 1985, p. 4).

On the other hand Higgins postulated that deaf people are excluded from the hearing world. “The deaf (sic) are outsiders in a world which is largely controlled by the hearing” (1980, p.17). We live in a world, which is dominated by sounds. It is geared to hearing people. This means that Deaf individuals are not part of that world. Deaf people are not solely isolated in a world that is dominated by others. Oblowitz, Green, and Heyns (1991 cited in Scheetz, 2004) stated “...deafness per se does not determine the emotional and social development of the individual. Rather it is the attitude of hearing people that causes irreparable harm to the personality of the deaf person” (p.130).

## **2.2 The role of language**

Language plays a crucial role in the assessment, treatment and management of mental health patients from culturally and linguistically diverse (CALD) people. The Australian Deaf-signing community is particularly disadvantaged in this respect as they are not currently established as a (CALD) population. However, the Australian Deaf community argues that it does constitute a valid linguistic and culturally distinct group and has suggested specific ways in which communication and mental health services to this population may be improved.

One of the major difficulties is the inability of health professionals to communicate directly with their deaf clients. “It is essential to acknowledge that the majority, if not all professionals, specifically psychologists, psychiatrists, and counsellors, are hearing and thus do not know how to sign. This places a greater gap in communication between Deaf and hearing individuals” (Rodrigues, 2001, p.136). Interpreters, therefore, play the central role in making mental health services accessible to deaf consumers. However,

Brunson and Lawrence, (2000) found that even though sign language interpreters are theoretically “impartial conduits” their moods are likely to affect the communication process between the deaf client and the hearing therapist/clinician. For example, a deaf individual may interpret the mood of the interpreter as rejection because they have picked up on the interpreter’s flat affect and construe this as a rejection of them. “A despondent interpreter induced significant negative mood changes in the deaf recipient despite the presentation of neutral/slightly cheerful stimuli or behavioural cues from the therapist” (p.579). The nature of sign language means that both the interpreter and the client are dependent on eye contact, unlike other spoken language interpreters who do not have such an integral part to play within the relationship of client/therapist. As pointed out by Napier and Barker (2004), “interpretations therefore need to be based on a linguistic and cultural understanding of the participants within... their differing norms and values” (p, 370). It is not simply the interpretation of two languages, but the meaning of the message that is conveyed, which is crucial (Napier et al. 2004). Brunson and Lawrence (2000) found that the interpreter does affect the therapeutic process, but also plays a significant role in facilitating the therapeutic alliance between the psychologist and the deaf client. In order to minimise this conflicting effect, psychologists need to have some prior knowledge personally of the language and culture needed to address the issues with which the client/patient may present. This lack of basic awareness can prevent the health professional from adjusting the therapeutic approach to suit the client. For example, Leigh, et al. (1996) discusses a case vignette where a couple attended marriage counselling where an interpreter needed to be used. The issue of intimacy was raised and the psychologist requested that the couple engage in a visualisation exercise, asking the

clients to close their eyes, which of course made it impossible for them to continue participation.

By contrast, a deaf man was referred to the researcher (of this thesis) for therapy when his mother was unable to tolerate his idiosyncratic behaviours. She perceived him as needing to be “fixed”. During the past few years he had withdrawn from the Deaf community and isolated himself within the confines of his unit. His adult working life had been a negative experience, he had been a victim of bullying and harassment, having been locked in a cool room and ridiculed because of his deafness. He was too afraid to report the abuse and preferred to stay at home. He would not leave the house at night, fearful that he was unable to hear if someone crept up behind him. The majority of the time he spent at his parents’ home, which exacerbated the problem. During one of the sessions the client, who had displayed a gentle nature, was describing an altercation which had occurred between him and his father. As he was describing this, he played the role of his father and became aggressive. Rather than construing the anger as transference to the therapist, the therapist recognised the miming, role playing process, a normal way of describing and explaining for deaf people, recognised also that the client had been caught up in the role, and drew him out of the role. The consequences of the client’s behaviour could have resulted in his being admitted to a psychiatric facility in the absence of a deaf educated psychologist/psychiatrist. As it was, the client understood that he did not have to take on the aggressive persona of his father in order to be understood. The researcher, when in the role of the therapist, could understand the true nature of the problems using the client’s own language and culture.

### **2.3 Problems of mental health diagnosis in a deaf population**

The consequences of deaf people going unrecognised as self-perceived members of a distinctive culture have proven seriously detrimental in the area of mental health. From a medical perspective, deafness is defined in relation to decibel loss and loss of auditory discrimination, focusing on the location of the impairment. Deafness is viewed as a pathology, as a lack in the individual, rather than the presence of an alternative perception (Lane, 1992). The aetiology is based on the results that the individual obtains from the audiogram which is designed to measure the ability to hear and discriminate spoken language. Diagnostically, this is the starting point and the inability to hear is often perceived in itself as an underlying cause of mental health problems. At present deaf individuals are diagnosed using the same process as hearing people. This often results in multiple diagnoses, for example at time of admission, the patient receives a diagnosis of depression and the discharge diagnosis changes to schizophrenia with no real indications as to which factors are related to audiological problems and which are related to genuine emotional or psychological problems. If mental health professionals are not aware of the linguistic and psychosocial aspects of being Deaf as opposed to simply deaf, they will inevitably misinterpret the behaviours and attitudes of Deaf people, even those without mental disorders.

The well-being of Deaf people who have been diagnosed with mental illness is crucially dependant on the accuracy of diagnosis, the relevance of treatment and the attitude of the health professional treating the patient/client. Leigh, Corbett, Gutman and Morere, (1996) have pointed out that there has been a shift within the psychology domain to

incorporate ethnicity and cultural diversity within its discipline. Australia is a multicultural country. As stated by Phillips (1996) “individuals who share common knowledge, beliefs, attitudes, behaviours, language, values, rituals, and styles of discourse may comprise a cultural group” (p. 137). Deaf people are part of that diversity with a mode of communication that is different to the majority, English speaking population and other oral populations. Unfortunately, both the medical profession (which could arguably form a cultural group of its own on the above definition) and the general population do not recognise Deaf people as a distinct cultural group. Instead, Deaf people are regarded as disabled, while regarding themselves as simply a different culture, with a different way of perceiving the world, thus giving rise to all the associated misunderstandings and communication problems. The negative consequences for this population in the area of mental health are profound.

American legislation (The American With Disabilities Act of 1990) safeguards Deaf individuals by ensuring that they have the same access to services and recreational programs as the general population. According to Raifman and Vernon, (1996) this ideology extends to mental health services within many states of America by ensuring that there are inpatient facilities which cater for the needs of Deaf people, including staff who are fluent in sign language and also interpreters. In Australia, there is a gap in the service delivery in mental health to the Australian Deaf community, especially in relation to the lack of health professionals fluent in sign and the availability of appropriate psychometric assessment tests. The experience is that many deaf psychiatric patients have been subjected to inappropriate labelling of psychiatric disorders. A study conducted by

Thacker, (cited in Brauer, et al. 1998), revealed that “non psychotic Deaf people produce several linguistic behaviours analogous to those traditionally identified in hearing schizophrenics...caution must be exercised in assessing communication errors in pre-lingually Deaf people on the basis of the presentation of schizophrenia in the hearing population” (p57). The consequences of such misdiagnosis for deaf people can be catastrophic and add to the already established stereotypical negative attitudes prevalent within the hearing community. As Von Cleve (1987) remarked, “For centuries, deaf persons were perceived by society as dependent, defective, difficult, and limited emotionally and intellectually” (cited in The Gallaudet Encyclopaedia of Deaf, 1987, p.329, vol.2 H-R).

Only since the 1960's in Australia has there been at least a small shift in awareness by psychologists, psychiatrists, and mental health workers who have begun to acknowledge that there does exist the issue of mental illness amongst deaf people which is quite distinct from non-hearing factors. This led to the establishment of some mental health services specifically for Deaf individuals. However, a large part of the problem is that there are no appropriate psychiatric evaluation screening tools for available for use with Deaf individuals, and still an almost complete lack of health professionals with the necessary literacy in Auslan.

Awareness in many parts of the world that Deaf people do have their own culture, language, shared values and morals has recently begun to instil a sense of empowerment in the Deaf communities everywhere. This has been evident through the media, written

expression and conferences. “The awakening of knowledge and attitudes toward Deaf culture also resulted in psychologists’ having to reframe deeply entrenched perceptions regarding the personality and intellectual characteristics of the Deaf individual. Psychological test results obtained from Deaf individuals have begun to be challenged by a handful of clinical psychologists in the field who recognized the dangers inherent in administering English-based verbal tests to a non-speaking population which does not have English as a first language. It is only from a cultural clinical perspective that psychologists will be able to effectively address the needs of this special group” (Woodward 1972, p.378). A brief case study illustrates this point.

#### **2.4 Case study from the researcher’s files, illustrating the far-reaching consequences of misdiagnosis**

A young deaf mother had had her children removed from her care by a government organisation. This case was before the Children’s Court. A psychologist (with no signing abilities or any experience working with Deaf people) was involved with the case and had tested the mother, observing her interaction with her child and assessing the mother’s bonding and attachment with her children with the assistance of an Auslan interpreter. The results indicated that the mother had failed to bond adequately with her children. A second psychologist (who was the current researcher and had experience with the Deaf community) was requested to assess the mother’s level of intelligence. The first psychologist, who had no knowledge of signing, stated that the “mother had answered all the questions with no difficulties.” The second psychologist’s results revealed that the mother had obtained a score indicating borderline intellectual disability on the Snijder

Oomen Nonverbal Intelligence Test revised, 5 ½ - 17 (Son-R – 5 ½ - 17) test. The first psychologist questioned the results obtain from the Son-R. That is, she did not accept that this mother had obtained a score that was consistent with borderline intellectual disability given that she had no difficulties answering the questions on the bonding and attachment assessment. However, what the first psychologist did not consider was the impact of deafness on the individual, the mode of communication and the influences of the interpreter present. With further inspection of how the results in the bonding and attachment questionnaire were obtained, it became apparent that the Auslan interpreter, who was not a health professional, had limited terminology in this area and had been unable to relay the information to the client. This can sometimes be a result of conscious or unconscious omission by the interpreter, where the interpreter does not interpret verbatim what the clinician has said (Napier & Barker, 2004). The interpretation of the deaf person's responses (which is an accepted part of the transliteration process) is then being made by someone who is not trained to recognise responses that need to be queried further from a psychological perspective. Napier and Barker (2004) reinforce the view that there are many interpreters who are interpreting in settings that are not within their expertise, not having the language or terminology to adequately service this minority group. Moreover, Napier and Barker, (2004), term this as “conscious intentional omissions that contribute to loss of meaningful information. The interpreter...makes it intentional due to a lack of understanding of a particular lexical item or concept, or because of an inability to think of an appropriate equivalent in the target language” (p.377). Unfortunately, this young Deaf mother is still enmeshed in the judicial system fighting to get her child back after three years. Her children had been removed from her

care based on the results of the bonding and attachment tests which had been normed on hearing/speaking individuals, and using an interpreter who was not familiar with the terminology. Whether this was a case of poor parenting or a misdiagnosis by a system that does not understand Deaf culture remains unresolved to date. It is possible that this mother does have adequate bonding and would have been able to parent her children with appropriate support.

## **2.5 Deaf patients in Psychiatry and Mental Health settings**

Formal psychiatric assessment of the Deaf is said to pose additional problems for clinicians. A major disadvantage for the Deaf community is that very few professionals can communicate directly in sign language. Traditionally, family members were, and in some cases are, often conscripted as an interpreter which is entirely inappropriate for the assessment and management of psychiatric disorders. Professional interpreters are not always accessible or have adequate training or experience to accommodate the special challenges of psychiatric Deaf people. In addition, Auslan, although a rich language in its own right, does not always have equivalent English words, particularly more abstract concepts, including descriptors of mental state such as anxiety, delusions or hallucinations are difficult to translate.

## **2.6 The problems with current practice**

From the information presented in chapters one and two, it can be argued that the current practices employed when dealing with deaf individuals within the mental health system are largely ineffective. The medical model has been utilised to pathologize deaf people for hundreds of years and consequently deaf people within psychiatric facilities have

received multiple diagnoses and been subjected to misdiagnosis because they utilise a mode of communication which is neither shared nor understood by the majority in society. The Deaf community has never been at the frontline of the political agenda both in Australia and internationally. For example, when in 1959 the Royal National Institute for the Deaf “made representation to the Medical Research Council proposing a study of the special difficulties of deaf people in relation to mental illness, the council replied: ‘It does not seem that there is a case for attempting to set up research such as is envisaged which can only lead to the narrower question of the prevention of deafness’” (M.R.C. 1959, p. 2 cited in Denmark, 1985). The first “deaf Psychiatry” units were developed in the U.K. and the U.S in the early 1960’s. There are now over two hundred individual psychiatric services available to the Deaf throughout North America and Europe. In Australia, a consulting psychiatrist established the first psychiatric service for the Deaf and Hard-of-Hearing in an Australian hospital in August 1994. It was opened officially by the then Minister for Health, who himself is the hearing son (CODA) of Deaf-signing parents. The initial aims of the Psychiatric Unit were to provide an outpatient and inpatient psychiatric service based in a capital city and covering all of NSW. The unit was also set up to allow mental health providers to obtain training and education on aspects of deafness. Also, videoconferencing (Telehealth) facilities were established to provide services to rural and remote areas.

In the next chapter, the study presented explores and illustrates the process deaf people encounter when accessing this unit. De-identified descriptions of deaf people patients in the unit are presented. The first 20 consecutive in-patients were selected to identify the

major problems currently experienced. These cases, while being the first, also reflect the diversity of problems and diagnoses that can occur.

## **CHAPTER THREE**

### **The problems with current practice**

*“Deafness is bad. I am deaf. I need to be fixed. I must be like them, no matter what, because deaf is bad” (Drolsbaugh, 2000, p.15).*

### **3.1 Rationale**

The purpose of this study was to examine retrospectively, the first five years experience of deaf, psychiatric in-patient admissions to a deaf unit established at an Australian hospital. There have been many similar deaf psychiatric units established overseas. This study aimed to broaden the awareness of mental illness, its prevalence and the experiences of the mental health system amongst the Deaf population in Australia, highlighting the complexities of providing health care, having adequate communication, correct diagnosis and appropriate treatment. Information about admission, diagnostic procedures and outcomes was collected from patient records.

### **3.2 Participants**

The participants were the first 20 patients consecutively admitted to the Psychiatric Unit for the Deaf and Hard-of-Hearing at an Australian hospital. The patients were from various cultural backgrounds and different age groups. Patients consisted of 10 females and 10 males with ages ranging from 16 years to 83 years with the mean age of 41 years.

### **3.3 Methodology**

The data collected were medical record number (MRN) of each consecutive deaf inpatient, hearing status, method of communication, date of birth, age, sex, mode of referral, date of admission and discharge, primary, secondary and discharge diagnosis, medication at the time of discharge and the follow-up plan. In compliance with ethical requirements to ensure participant confidentiality, patient names, addresses and other illnesses not related to psychiatry, were omitted. Demographic data were compiled and

tabled. Teleconferencing was also conducted within the hospital setting at RPA. This was to assess the degree of the psychiatric condition in patients from remote areas in Australia and to ascertain whether the patient required hospitalization. Case interviews were conducted, psychiatric review meetings held and medical records examined. The information is presented as brief case studies.

### 3.4 Results

#### 3.4.1 Participant demographics

The hearing status of the patients was found to be 10 males and 9 females who were pre-lingual deaf and 1 female who was hard of hearing. Pre-lingual deafness is deafness that is present before the acquisition of language. Their communication mode was Auslan, 6 males and 6 females; Deaf/Blind Sign (tactile), 1 males, 2 females; speech, 2 males, 2 females; lip-reading, 1 male. The following tables give diagnostic details.

**Table 1: *DSM – IV Criteria at time of discharge***

<i>Diagnosis</i>	<b>Males</b>	<b>Females</b>
Schizophrenia	5	2
Adjustment disorder	0	1
Organic Personality Disorder	1	1
Depression	2	2
Depression (Early Dementia)	2	2
Bipolar (Depression)	0	1
Bipolar (Manic)	0	1
Schizoaffective Disorder	0	1
Adjustment Disorder (Depressed mood)	1	1

**Table 2: Breakdown of information gathered**

Patient	Age	Gender	Communication	<i>Total Length of Stays days</i>	<i>Estimated Delay In Final Diagnosis</i>	<b>Previous Incorrect Diagnosis</b>	<i>Final DSM-IV Psychological Diagnosis</i>
K1	29	F	Auslan	12	1 year	1	Depression
A2	29	M	Auslan	70	8 years	3	Depression
S3	29	M	No sign/lip read	97	3 years	0	Schizophrenia
G4	53	F	Deaf/Blind sign	25	1 year	3	Organic Hallucinations
K5	48	M	Lip read	41	1 year	1	Depression
Y6	23	M	Auslan (oral)	45	3 years	2	Depression
D7	46	F	Auslan	170	7 years	3	Schizophrenia
B8	16	M	Auslan	52	2 years	1	Schizophrenia
J9	33	M	Deaf/Blind sign	57	3 years	5	Depression Schizophrenia
F10	40	F	Deaf/Blind sign	52	8 years	4	Organic Personality Disorder
B11	63	F	Sign Language	52	3 years	3	Depression/ Dementia
A12	50	F	Oral	58	2 years	2	Depression/ Alcoholism
S13	67	F	Sign Language	56	5 years	3	Schizophrenia
C14	41	F	Sign Language	298	2 years	2	Schizophrenia
K15	27	M	Sign Language	5	4 years	3	Schizophrenia
K16	32	M	Auslan	24	1 year	2	Depression/ Adjustment disorder
P17	44	M	Auslan	26	5 years	2	Schizophrenia
A18	27	F	Auslan	15	3 years	3	Schizophrenia
D19	40	M	Auslan	58	5 years	2	Schizophrenia
E20	83	F	Oral	2	2 years	2	Depression

### 3.4.2 Case vignettes – examples of diagnostic complexities and problems

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Case	Diagnosis	Length of stay
K1	Deafness second to Rubella Adjustment Disorder Depressive episode	12 days

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K1 was born into a hearing family and married a hearing man. This woman patient was admitted to the psychiatric Unit following a series of traumatic events in her life. She spent 5 weeks in hospital following a car accident where her child was killed and she fell into a coma for 5 weeks. This patient was first seen by deaf consultant psychiatrist (27/08/98) as an out-patient the because her family were concerned about her depressed state. K1 had appeared to be more and more depressed, showing signs of suicide ideation. She was very secretive about her ideas of suicide. This raised concerns for the treating psychiatrist. Upon admission, K1 was a voluntary patient and her contact with other patients was minimal. This appeared to be a result of the language barrier, more so than her choice to isolate herself. Staff treating her did not have any signing skills. This perpetuated the isolation and segregation experienced by many deaf people, and now she had been placed in a facility which carried stigma. This would have the potential to alienate her further from her husband, family and friends. She was discharged with treatment of Paroxetine 10mg and oral contraceptive pill and follow up as an outpatient was recommended. Final note: No follow-up recorded. Nothing further known at time of writing this thesis.

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Case	Diagnosis	Length of stay
A2	Chronic Schizophrenia	70 days

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A2, a 30 year old male, presented to the Psychiatric Unit for a psychiatric assessment as an outpatient. He felt that he was being punished. He presented with insomnia. Feeling of isolation and loneliness as his wife was overseas. There were no evident signs of suicidal plans. He presented with a history of multiple admissions into the psychiatric wards in other health facilities in the area. He had an eight year history of schizophrenia and presented in this occasion with positive symptoms (paranoia, passivity of thought, ideas of self-reference) and negative symptoms (social withdrawal, reversal of sleep pattern, blunting of affect, poverty of thought). He had an insight into his poor quality of life. He was discharged with Clozapine 150mg. There was a further admission with exacerbation of the schizophrenia. He was brought in by a Crisis Team, presenting with a three to four week history of progressively worsening psychotic symptoms. He

described distressing persecutory delusions of being threatened by Australia and tortured by motor vehicles. Increased thoughts of suicide to escape the persecution were present. He was discharged with community follow-up and was on Clozapine 350mg morning and 550mg at night. Final note: No other follow-up recorded. Nothing more known at time of writing this thesis.

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
S3	Chronic Schizophrenic Congenital Deafness second to Rubella	29 days

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This 29 year old Deaf man had a history of mental illness. He has a twin brother who is hearing. He has had auditory hallucinations. He was recently discharged from another hospital (27/07/95). He was not taught sign language but attended a school for the Deaf until Year 10. He referred himself for voluntary admission to the Psychiatric Unit. He believed that he has a “ghost” inside his head. He was discharged on 22/09/95. On 31/10/95 he was admitted to the Unit again. He presented on admission with four day history of hearing voices of a ghost and suicidality. He was found to be sniffing petrol. He had cut his wrists in an effort to get rid of the ghosts. During his stay he was recommended for a Ziprasidone trial But he was unable to tolerate the washout as he became acutely suicidal. He was then put on clozapine to which he responded well with remission of positive outcome. He was discharged on 26/01/96. Final Note: No other follow-up recorded in the patient’s file at the time of write up.

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
G4	Organic hallucinations, Deaf /blind Usher’s syndrome – schizophrenia-like psychotic illness	25 days

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
K5	Depression – Suicidal Poisoning by Benzodiazepine Based Tranquillizer	

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This 48 year old man was admitted to the Psychiatric Unit for major depression. On both occasions it was believed that the major contributing stressor was the threat of losing his job. He presented depressed and with flat affect. His speech was dysarthric. He had feelings of hopelessness, anxiety, tinnitus and persisting suicidal ideation. He was depressed for the first

week. He received ECT and after the fourth treatment he made significant improvement. His sleep pattern improved and he appeared brighter. He was later discharged on Moclobemide 300 mg mane; 150 mg midi and Thioridazine 100 mg nocte. Final note: No other follow-up recorded in the patient's file at the time of write up.

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
Y6	Major Depression with Melancholia Congenital Deafness	41 days

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This 23 year old man was admitted to the Psychiatric Unit for the first time. He had a history of depression which went back to his school years. He had been very suicidal, despite antidepressant therapy. There was possible treatment non-compliance. He was found carrying a noose around in his school bag. He had shown symptoms of sleep disturbance, decreased appetite, decreased energy, poor concentration, suicidal thoughts and plans, subjective slowing of his thoughts and movements, depressed mood without diurnal mood variations, a sense of self-loathing and helplessness. He felt he had no future and no one cared for him. One major factor was that he had been forced out of the family home by his father. Family dynamics appeared very poor. Whilst on the ward he continued to express suicidal ideation and intent. He had a weekend out but was admitted once again after a suicide attempt. He disappeared again leaving a suicide note and a noose in his locker. He returned accompanied by the police following another suicide attempt by making multiple superficial lacerations to his wrists. He improved and requested leave. He left with the aim that he was going to undertake part-time work and to repeat his final HSC year at TAFE. Final note: No other follow-up recorded in the patient's file at the time of write up

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
D7	Congenital Deafness (second to rubella) Puerperal Psychosis, Hypothyroidism, Chronic Schizophrenia, Alcohol dependence (in remission) and Epilepsy.	45 days

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This 46 year old woman, three days later after giving birth to her daughter, had developed delusional thoughts about her milk being contagious. She thought that she had venereal disease. She had jumped from the first floor verandah of the maternity hospital in response to a hallucinatory experience. Four days later she was free of any hallucinations or delusional thoughts. However, she remained psychotic and fearful and having ideas of reference. She was placed on Melleril 25mgs three times per day. The psychotic tendencies diminished. D6 was admitted into the unit once again because of non-compliance with oral medication. She had a 27 year history of recurrent psychotic episodes following post partum. D6 was brought in to the hospital once again after a history of increasing confusion over a period of several weeks. She was grossly hypothyroidal and also had a respiratory arrest soon after admission. D6 showed signs of psychosis (believing that the television was making references to her) and there was evidence of cognitive impairment. It was believed that she was not compliant with treatment for her thyroid problem and also psychiatric treatment was not adhered to. Community services have found her very difficult to manage. Her affect was blunted, with inappropriate smiling at times. Thought disorder was identified via the use of a sign interpreter. Whilst in the ward staff observed that she experienced difficulty with communication even when using sign language, poor self-care, unpredictable behaviours, and difficulties with cooperation in daily routine and inappropriate sexual behaviours. She is seen as an outpatient. Final note: No other follow-up recorded in the patient's file at the time of write up.

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<b>Case</b>	<b>Diagnosis</b>	<b>Length of stay</b>
B8	Congenital Deafness & Schizophrenia	Not specified

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This 16 year old Deaf youth was admitted to the Psychiatric Unit following deterioration to his mental health. He was displaying psychotic behaviours, pacing aimlessly, uncommunicative, laughing to himself, disorganised in his behaviour, distracted, not sleeping, concerned about "prawns and crabs" under his bed. B7. appeared to be responding to hallucinations. He appeared perplexed and with emotionless expression, affect blunted and his mood inaccessible (according to his file notes). He displayed no speech and no signing when first admitted. B7. did however improve with a change of medication from Olanzapine to Clozapine. Consulting psychiatrist (experience in working with Deaf patients) arranged to have regular teleconferences to keep up to date with B7. progress.

Case	Diagnosis	Length of stay
J9	Parkinson's, NIDDM, schizophrenia,	
1 <sup>st</sup> Admin	blindness and deafness.	2 days
2 <sup>nd</sup> Admin	Atypical psychosis (Hallgren's Syndrome) and malignant neuroleptic syndrome.	52 days
3rd Admin	Partial epilepsy, without impairment of consciousness, without mention of intractable epilepsy. Schizophrenia unspecified type. Hearing loss, blindness both eyes, hypertension, diabetes mellitus without complications, type II (non-insulin dependent - adult onset). Usher's syndrome	1 day
4 <sup>th</sup> Admin	Schizophrenia which is associated with Epilepsy brought on by Clozapine Usher's, Hypertension, Diabetes, Partial epilepsy,	2 days
5 <sup>th</sup> Admin	volume depletion disorder & Minor skin disorder	

This 33 year old man has a history of multiply admissions to the psychiatric ward. This gentleman has been blind from birth. Upon his second admission he was fine until 2 weeks prior to admission. Friends were concerned because he had been mute and withdrawn. Strange behaviours were also noted such as walking around without clothes and "talking to the wardrobe" and had been expressing bizarre, persecutory and religious delusions. Furthermore, auditory hallucinations, of a commentary nature, which he believed to be "God's voice" His mother reported a history of deterioration over a period of 4 years, believed to be acute psychosis. He was discharged after making good recovery. Final note: No other follow-up recorded in the patient's file at the time of write up. Third admission he was due an epileptic seizure. Diagnosis was partial epilepsy, without impairment of consciousness, without mention of intractable epilepsy. Schizophrenia unspecified type. Hearing loss, blindness both eyes, hypertension, diabetes mellitus without complications, type II (non-insulin dependent - adult onset). Fourth admission he has schizophrenia which is perhaps associated with Usher's syndrome. Epilepsy brought on by Clozapine. He does not lose consciousness. He is mobile and responds to simple commands. Does not talk but makes throat clearing/grunting noises. Hypertension, but is well

controlled with medication. His diabetes is also controlled by diet. Partial epilepsy, without impairment of consciousness, without mention of intractable epilepsy. All of the above and volume depletion disorder. Minor skin disorder and all the above. Final note: No other follow-up recorded in the patient's file at the time of write up.

Case	Diagnosis	Length of stay
<b>F10</b>		
1 <sup>st</sup> Admin	Deaf blind, emotional lability & revision of shunt	2 days
2 <sup>nd</sup> Admin	Hydrocephalus	2 days
3 <sup>rd</sup> Admin	?Malfunctioning Shunt	2 day
4 <sup>th</sup> Admin	Malfunctioning Shunt/ Hydrocephalus Aggressive behaviour	7 days
5 <sup>th</sup> Admin	Evaluation of ventriculo-peritoneal shunt function	3 days
6 <sup>th</sup> Admin	Organic Personality Disorder Childhood meningitis with secondary hydrocephalus Ventriculoperitoneal shunt Deaf Blind.	21 days

This 15 year old deaf and blind girl was transferred from an institution. She presented with a history of increasing ataxia, diminished concentration, increased emotional lability and infrequent headache over a period of six months. She presented with ataxia, her concentration and emotional lability increased after revision of her shunt and she was discharged. As a result she was left mildly mentally disabled and almost completely blind. A further assessment was scheduled as there was some behaviour deterioration.. Malfunctioning Shunt -Complicated history following shunting procedure for hydrocephalus complicating meningitis age six months. At the operation the scalp flap over the shunt was elevated, the shunt tubing distal to the pump was disconnected. Following the tests it was concluded that the change in her behaviour was not due to any malfunction in the system. F9. ventricular system was enlarged, but previous isotope flow studies had appeared to indicate a functioning shunting. She was readmitted because of aggressive behaviour. CAT scan showed grossly enlarged ventricles. The right frontal burr hole and ventricular catheter was inserted. This young woman was referred to the Psychiatric Unit. The main reason for her admission was her poor behaviour, her non-compliance with medication and her forgetfulness and muddled thoughts. Her mood has been angry and sad as she refuses to take Clorpromazine because it sedates her. She stated she would rather be dead. This young lady

initially wanted to leave her room, banged on the door and gesticulated dramatically and aggressively. Her mood was euthymic, signing was normal rate, thought form was tangential and disorganised, preoccupation with the past. Often gesticulated to herself. It was difficult for her to socialise. Difficulty in forming rapport through the interpreter. Her problems appeared organic in nature but there was no curative approach. Hospitalisation was virtually respite for her support networks. Final note: No other follow-up recorded in the patient's file at the time of write up.

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Case	Diagnosis	Length of stay
B11		
1 <sup>st</sup> Admin	Paranoia Disorder with anxiety symptoms, Left Bell's Palsy Congenital deafness & Hypochondriasis	17 days
2 <sup>nd</sup> Admin	Early dementia, hypochondriasis, Chronic paranoid disorder with Possible anxiety/depressive syndrome – trial of Fluoxetine, Dependent traits Grade 1 compound fracture, left olecranon, epilepsy & Congenital deafness	35 days

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This 71 old lady was admitted to the Psychiatric Unit because of her labile mood, paranoia and acute anxiety. She was shouting fearfully when in the company of those she did not know. She presented with anxiety symptoms and concerns about sensations in her legs and head, with paranoid ideation, believing that people were laughing at her. She was tremulous, 'frantic' preoccupied with being watched, scrutinised to delusional proportions. However her orientation was good. There were no signs of pervasively depressed mood or nocturnal confusion. There was an improvement in her anxiety but her paranoia still remained. Stressor: isolation – son moved out twelve months ago. B10. presented to the Psychiatric Unit as a voluntary patient, with worsening of anxiety symptoms and somatic sensations. She described 'nerves' and 'electricity' in her stomach, which shifted to her head and legs. When she becomes distressed she would lash out at her husband by hitting and scratching him. She stated that she was upset and worried and she was unable to sleep for quite some time. B10. had also threatened to harm herself with a knife at various times. She was able to communicate via sign language giving appropriate responses to the questions. She did not have any suicide plans. There were no perceptual abnormalities. Final note: No other follow-up recorded in the patient's file at the time of write up.

Case	Diagnosis	Length of stay
A12		
1 <sup>ST</sup> Admin	Chronic dysthymia, Alcohol abuse, Bipolar affective disorder, suicidal (Rozelle Hospital)	3 wk admin
2 <sup>nd</sup> Admin	Suicide attempt (over dose of Aropax)	2 days
3 <sup>rd</sup> Admin	Suicide attempt (cutting/piercing instrument and poisoning) Bipolar disorder, depression & unspecified alcohol dependency	20 days

This 50 year old lady was admitted to a Psychiatric Unit with a history of depression and various episodes of suicidal ideation. Following a suicide attempt with an over dose of Aropax. AT11 had previously been admitted to a psychiatric facility in 1995 for 3 weeks because of depression again after a suicide attempt. During this time she cut both her wrists. She was placed on Lithium and Aropax. This lady showed subjective signs of depression and objectively reactive. As the time approached for her discharge she became increasingly anxious and needed to be reassured. She presented to Missenden Psychiatric Unit giving a one week history of depression. AT11. said she had impulsively taken an overdose of Aropax because her friend was returning home. However she continued to deny that it was a suicide attempt. In summary this lady has an extensive history of chronic anxiety, dysthymia and major depression. In 1995 she was admitted to a psychiatric facility within the hospital for three weeks for depression after cutting both wrists. She has a hearing deterioration. Final note: No other follow-up recorded in the patient's file at the time of write up.

Case	Diagnosis	Length of stay
S13		
1 <sup>st</sup> Admin	Congenital deafness Hypomanic phase with mixed features & Alcohol intake	51 days
2 <sup>nd</sup> Admin	Hysterectomy for cervix 1986, Lithium toxicity, congenital deafness/mute, manic depression, chronic airways limitation, cholecystectomy & Duodemitis – scoped 1991	Not specified

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Argument with sister - This 67 year old deaf lady with a history of alcoholism had become increasingly agitated and unwell prior to her admission, following an argument with her sister. She appeared thin, “staring-eyed” drinking, unable to sit still, anorexic an inability to follow what staff were saying. She presented with low grade paranoid hypochondriacal traits, attention seeking behaviour and heavily nicotine addicted. Poor physical hygiene, blunted and non-reactive during the interview. Her signing was poor. She failed to understand questions and providing tangential or inappropriate replies. Disoriented in day, month and year. During her stay staff observed an affective disturbance, with volatile mood swings, histrionic and disruptive demanding behaviour, nocturnal sleep disturbance and suggestibility. She was put on Clorpromazine which helped her sleeping pattern but caused incontinence during the night. This lady’s presentation was pale. She had poor sleep, tremor, poor appetite, lethargy and drowsiness. Treatment at discharge was Thoridazine 300mg nocte Premarin, Lithium carbonate 250mg mane, 500mg nocte. Premarin 0.625mg nocte and methyl cellulose eye drops 0.5 Follow-up was scheduled with a psychiatrist experienced in working with Deaf patients.

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Case	Diagnosis	Length of stay
C14		
1 <sup>st</sup> Admin	Adjustment disorder with depressed mood Choreoathetosis ?Huntington’s Chorea, Suicidal thoughts. Principal Choreoathetosis, Secondary Tetrabenazine withdrawal Acute stressor disagreement with sister	Not specified
2nd Admin	Behavioural problems	8 days
3 <sup>rd</sup> Admin	Behavioural problems	7 days
4 <sup>th</sup> Admin	Behavioural problems	8 days
5 <sup>th</sup> Admin	Behavioural problems	5 days
6 <sup>th</sup> Admin	Psychotic	3 days

7 <sup>th</sup> Admin	Psychotic	31 days
8 <sup>th</sup> Admin	Overdose	26 days
9 <sup>th</sup> Admin	Involuntary move.	66 days
10 <sup>th</sup> Admin	Psychotic involuntary movements	18 days
11 <sup>th</sup> Admin	Huntington's Chorea	39 days
12 <sup>th</sup> Admin	Mood disorder & Schizophrenia	23 days
13 <sup>th</sup> Admin	Exacerbation of schizophrenia, Congenital deafness Medication prescribed: Thiridazine 50mg, Paroxetine 20mg Tetrabenazine 25mg	19 days Stressor

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This 37 year old, Deaf woman who normally lives alone was brought in by a nun from a Catholic Deaf Club. She feels that her problems began when she experienced problems with her family when she was 18 years old. Another time she was brought in by the police. For 7 years she had been back and forwards in and out of hospitals. She stated that she had been raped at least 5 times. She had felt depressed for about 20 years. Her symptoms included poor sleep, felt nervous and was restless and had suicidal ideations. She stated her thoughts were muddled because she was feeling stressed. This stress was attributed to her sister's children living with her. She felt she was not getting any help from her sister around the house, that is, with cleaning. She said her sister was very disorganised. This lady presented clean, neatly dressed. She has some involuntary movements of her arms, legs and head which were mild. Affect was bland and her mood was depressed. She expressed that she was had suicidal thoughts in the past but not recently. Her communication was through mouthing words (this may have been due to the fact that no staff had Auslan skills). She provided to tangential answers to questions put to her. She was preoccupied by stories of her rapes. She also focused on arguments and fights with her sister and mother in the past. She thought that others were talking about her, particularly her sister and mother. She denied hearing voices. Cognitive testing was limited, she had very small amount of general knowledge, and was unable to say anything about things that were happening around the world.

**Investigations:** Thyroid function, biochemistry and haematology was normal. She settled onto the ward. At times she felt low but other days she was okay. She described feelings of being penetrated vaginally when no one was there. At first this was thought to be psychotic. However, after further questioning it seemed more a flashback of a rape episode. Her movement problem continued to be mild and not distressing. **Referred by:** Consulting psychiatrist. C13. presented with paranoid ideas, thought disorder and hearing voices. Criminal (male) following her she believes he is from the television and newspapers. He wants to kill her. Behaviour disorganised, running into traffic to get away and ringing the police saying that children had been killed. She denied suicidal ideation or nihilistic or guilty ideation. The deterioration occurred in the context of possible poor compliance with medication and the recent illness of sister. She was admitted to the Psychiatric Unit as a voluntary patient. Started on Thioridazine for sedation and Risperidone. Initially she remained disorganized and fearful, believing a man was waiting outside to harm her. Preoccupied and would hit the walls. She settled after day 7 with steady improvement. She was cheerful and joining activities, particularly craft. At discharge there was no evidence of thought disorder or persecutory ideas. Remained concerned about her relationship with staff at the Ephpheta Centre and her desire for intimacy. **Treatment Discharge:** Risperidone 3mg, Thioridazine 50mg and Clonazepan 1mg. Final note: No other follow-up recorded in the patient's file at the time of write up.

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Case	Diagnosis	Length of stay
S15	Profound congenital deafness, schizophrenia-paranoid type, antisocial personality disorder, polysubstance abuse and social isolation partially deafness related	5 days

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**Mode of Referral:** Consulting psychiatrist (deaf specialists) This 26 year old male was taken to hospital following an overdose of benztropine tablets, while intoxicated with alcohol. Whilst in hospital he became aggressive and was scheduled to a psychiatric in Sydney Hospital. He settled very quickly and was transferred to another facility on 07/07/94. Through a sign interpreter he presented as settled, with no apparent thought disorder denied any psychotic or perceptual disturbances and was cognitively intact. However, he did have some fixed delusional ideas, regarding aliens communicating with him. He also believed he had undergone a sex change and Asians were waging war

against Australia. His delusions seem fixed and unchanged. S15. has a history of antisocial traits whilst at school he was involved in fighting vandalism and truancy. From the age of 14 year he had been self abusing for 4 years and diagnosed with schizophrenia at the age of 16 years. Conduct problem, including break and enter, 2 counts of stealing, once with assault and drink driving offences. Borderline traits, self harm behaviours – burning himself with cigarette lighters. He settled in the ward. He was discharged into his own care. Treatment: 150mg Haldol intramuscular (IM). There was no follow-up care as he refused to be referred to consulting psychiatrist (Deaf specialists) or to any rehabilitation alcoholism.

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Case	Diagnosis	Length of stay
S16	Congenital deafness, antisocial traits &	25 days
1 <sup>st</sup> Admin	cerebral palsy	

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**Mode of Referral:** consulting psychiatrist (Deaf specialists)

This 32 year old deaf man was admitted to the Psychiatric Unit under Deaf consulting psychiatrist care. This gentleman was living in shared house for people with disabilities. He had lost his accommodation because he refused to share with another resident. He moved with a friend but this did not work out. He was currently homeless. He had no contact with his parents following an incident with the police. He made false allegation against his father, where he claims his father threatened him with a gun. Upon interview he presented friendly, happy, no psychomotor agitation/retardation. Mood was okay, affect euthymic, reactive appropriate. His thoughts were mainly to find accommodation. He showed little insight as to why his family were upset with him and he was never a management problem. There was no treatment upon discharge. Follow-up to be arranged S15 to see consulting psychiatrist (Deaf specialists).

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Case	Diagnosis	Length of stay
P17		
1 <sup>st</sup> Admin	Hypoxia 2 degrees fume inhalation, Asthma & profound deafness	34 days
2 <sup>nd</sup> Admin	Chronic schizophrenia & congenital deafness	17 days

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3 <sup>rd</sup> Admin	Acute schizophrenic episode Schizo-affective type schizophrenia, Chronic with acute exacerbation, Asthma, unspecified type, without status asthmaticus, Deaf mutism	17 days
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P16 was treated for fume inhalation where he was coughing black sputum, after a suicide attempt and was referred to a psychiatric facility within a hospital in Sydney and seen by consulting psychiatrist (Deaf specialist) for the enrolment of a drug trial. P17. has been monitored by the local Community Health Centre for his antipsychotic medication. He had been more distressed with possible nihilistic ideation concerned about the constant rain. P17. communicates via sign language. He lip-reads and is able to mouth a few words. On admission he had a reactive affect and his mood was euthymic. He showed evidence of passivity phenomena and thought disorder. P17. was placed on an eight week double blind study comparing Ziprasidone with Risperidone in the treatment of patients with acute exacerbation of schizophrenia. Follow-up by consulting psychiatrist (Deaf specialists) due to his involvement in the drug study.

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Case	Diagnosis	Length of stay
A18	Congenital Deafness/schizophrenia	104 days

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**Mode of Referral:** Consulting psychiatrist (Deaf specialist)A18. constantly complained that her family were controlling her. She felt that her parents wanted to send her overseas to marry. However, A18. did not want the restriction and demands that her parents were subjecting her too, which caused A18. to become increasingly frustrated resulting in her arguing with her mother. She also showed positive signs of schizophrenia and felt that her family were persecuting her. A18. showed symptoms of paranoia and delusions. She was non compliant with her antipsychotic medication. Domestic disputes with her family resulting in A. having to find new accommodation in a woman's refuge in May 1998. A18. kept pretty much to herself whilst in the ward but this may have been a result of not having any other whom could communicate with in sign language. A18 would became very demanding and when her requests were not met she became frustrated and tearful. According to her medical file there was no evidence of psychotic illness. A18. was discharged from hospital with 2 mg of Risperidone nocte and Fluoxetine 20mg mane. Follow up to be by consulting psychiatrist (Deaf specialist) and community worker. Consulting psychiatrist has maintained constant contact with A18. at the local medical centre

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Case	Diagnosis	Length of stay
D19		
1 <sup>st</sup> Admin	Acute exacerbation of Chronic schizophrenia/congenital deafness (second to meningitis at age 5)	13 days
2 <sup>nd</sup> Admin	Schizophreniform psychosis	6 days
3 <sup>rd</sup> Admin	Situational stress	5 days
4 <sup>th</sup> Admin	Paranoid schizophrenia	202 days

This 41 year old Deaf man was referred to a psychiatric unit at a Sydney hospital by the consulting psychiatrist because he was showing signs of delusional thinking. He believed that he was being followed by the police and experiencing perceptual abnormalities. He stated that his wife had asked him to leave their home. D19. was on antipsychotic drugs which he discontinued because of itchiness. D19. has a history of psychiatric admissions to a Sydney Hospital. He is married and has three children. He was working in a cleaning/printing business on full-time bases. Upon admission he was talking to himself, gesticulating, communicated in sign language and lip-read. His mood was elevated and irritable at times. He expressed paranoid thoughts and seemed to be responding to internal phenomena. He had poor insight into his illness. During his admission he displayed bizarre mannerisms. At times he was noticed to be sexually disinhibited and requested to be discharged. He was released on Trifluoperazine 5 mg nocte and Benztropine 1 mg daily. This 41 year old man was admitted to a psychiatric facility involuntary from another hospital following an episode where he attempted to jump from a third story window in the city. He had gone to a former place of employment to clarify an incident. D19. admitted that he had been sad for the last 13 years because of a woman he had met and since then has been searching for her and that she was everywhere. He lives with his wife and his three children. D19. had an argument with his wife which resulted in his admission. He is well regarded by his work mates and clients. D19. was able to lip read and communicated by answering written questions. He denied that he did not attempt suicide that he simply leaned over to get some fresh air and fell out the window. He denied hallucinations and passivity phenomena. Furthermore, he was cognitively intact. He was discharged on a small dose of Fluphenazine 5mg but had to be monitored as an outpatient. Follow up by a local community health centre. D19. presented with his father and uncle

requesting admission following an argument with his wife which was happening on a regular basis. D19. had told his wife he no longer loved her and he had been moving from his home to his father's home. The family reported that he had been up and about knocking on neighbours doors in the early hours of the morning. His employer also reported that there was instability with his moods. For the past two weeks he had been mood was labile. He did not display any disturbed behaviour but was unhappy. D19. had decided that he would leave his wife again and was released to his father's care. This Deaf man was scheduled by the local Health Centre. D19. was accompanied by his father and wife following a week of disturbed behaviour, insomnia, hyperactivity, inappropriate laughing. He was involved in a motor vehicle accident, but did not sustain any injuries. His mental state upon examination did not show any signs of auditory hallucinations but was delusional. He laughed inappropriately. During his admission he was reviewed with an interpreter present. He was experiencing delusions about a girl called Maria he believed he was superman, he had laser beam vision and could make people disappear, he was being followed by the police, people tried to kill him and he had the power given by God. D19. settled into the ward with no signs of restlessness, hyperactivity or insomnia. He was prematurely discharged without being fully recovered at his wife's request. He was discharged with Thioridazine 400mg nocte oral and to be followed up by the registrar psychiatrist and no other information was recorded.

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Case	Diagnosis	Length of stay
E20	Prelingual deafness Depression suicide attempt.	7 days

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This 83 year old Deaf lady was referred to the Psychiatric Unit by the consulting psychiatrist because of a suicide attempt. She was discharged without any follow-up or prescribed any medication. There was no other information kept on this patient.

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### 3.4.3 Key issues identified from case vignettes

Inadequate diagnostic tools emerged as a major issue. This was partly responsible for multiple diagnoses. Poor communication between medical service providers, staff and patients added to diagnostic and treatment problems. Deaf patients could be seen to be

increasingly isolated from both staff and other patients. Lack of knowledge of Deaf culture by staff caused further communication and understanding problems. Inadequate follow-up procedures with no resolution of cases could be seen in the majority of these cases.

### **3.5 Discussion**

This series of case studies highlighted that measures of mental health in the Deaf community and their access to mental health services are profoundly affected by inadequate access to services and existing methods of assessments being unreliable. The demographics included in this study were sex, age, primary, secondary, discharge and DSM-IV diagnoses.

The data collected illustrated that deaf psychiatric patients received multiple previous diagnoses and treatment continued in the context of often incorrect previous diagnosis based on communication problems and lack of knowledge of deaf issues. Behaviours of patients were seen to improve when communication skills were improved. Stolk, et al., (1998), states that in a CALD population, “misdiagnosis may lead to ineffective and possibly harmful treatment”. In fact, it was found that these patients from CALD stayed 21 – 46% times longer periods than patients from English speaking backgrounds. The same is clearly the case for the deaf-signing population. Some deaf patients who had been diagnosed with schizophrenia were said to have heard voices. However, careful questioning revealed that only some loud noises such as door banging could be heard, consistent with louder noises they might have heard before their severe hearing losses.

Interestingly, people with acquired post lingual deafness can, and often do, hallucinate about hearing voices, despite their total deafness. This can be likened to the “phantom limb” experience of amputees. In addition, “sign disorder” or a disruption of the hearing flow, grammar, syntax of Auslan, occurs as an equivalent to thought disorder revealed by audible speech in hearing people. In keeping with any CALD patients, deaf patients often somatise their description of depression using several words such as “sick” rather than more subtle affective language available to the hearing population.

There was a clear difficulty in relation to inability to access mainstream psychiatric services without substantial delay in, or incorrectly given, psychiatric diagnoses. Many also had multiple diagnoses. Most had a very simplistic notion of mental illness and were either unaware of, or reluctant to access existing psychiatric services. Psychiatric disorder, although not more prevalent in the Deaf population, can present itself quite differently, with, for example, the existence of sign disorder and auditory hallucinations in Deaf people and the marked somatisation language used by depressed Deaf patients. This poses a particular challenge to psychiatric assessment diagnosis and management. It is clear that the Deaf community and interpreters needed to be more aware of mental health issues through community education but also mental health professionals needed be more aware of Deaf cultural issues. In line with overseas developments, formal psychiatric services to the Deaf population need to be established in each State with a Deaf user-friendly in-patient unit made available including more extensive use of Telehealth facilities for follow-up and consultation. To further address the serious

problem of misdiagnosis that continues to occur when Deaf people attempt to seek assistance in the health system, the question of appropriate assessment tools is vital.

### **3.5.1 The need for appropriate psychometric assessment tools**

In Australia there are no diagnostic tests used to establish Deaf individuals' personality characteristics/traits/behaviours/symptoms which have been specifically normed on the Australian Deaf population. Tests currently used are not culture or language specific and result in data on Deaf patients that is, at best, misleading, and at worst, a source of on-going misconceptions and inappropriate treatment that can last for many years as this chapter has shown. Personality tests in particular, that have been normed on a hearing population are used as one of the main diagnostic instruments with both hearing and deaf patients. One of the most widely used tests is the Minnesota Multiphasic Personality Inventory-2(MMPI-2). The information presented so far provides some indication of the seriousness of the problems that have arisen, and continue to arise daily, when only these diagnostic tests are used in relation to mental health and deafness. These problems reflect the vital need to develop appropriate psychometric assessment tools.

The next chapter discusses the Minnesota Multiphasic Personality Inventory (MMPI-2), which is widely used as a diagnostic tool, and its adaptation for a Deaf population. A study outlining the development and pilot trialling of the Auslan version of the MMPI-2 is presented.

## **CHAPTER FOUR**

### **Development and Trialling of the Minnesota Multiphasic Personality Inventory (MMPI–2) for use with Deaf people**

*“A deaf person’s greatest problem is not simply that he or she cannot hear but that the lack of hearing is socially isolating” (Groce, 1985, p. 3).*

## **4.1 Rationale**

This study addresses the problem of misdiagnosis of Deaf people by developing more accurate, culture specific diagnostic tools to assess psychological dimensions amongst the Australian Deaf population. The discrepancy between Deaf and hearing people and how they respond to the world around them can often be misconstrued by a hearing professional who has had no experience in dealing with Deaf individuals. In chapters two and three the multiple diagnoses which Deaf people in inpatient services received was described. This can be attributed to the presentation of behaviours which, as stated earlier, are often misinterpreted by hearing professionals and labels such as schizophrenia are often attached. As stated by Phillips (1996) and Zazove et al.(1993, cited in Steinberg, Loew, & Sullivan cited in Leigh, 1999), “It is more likely that utilization patterns result primarily from cultural differences and poor communication between clinician and client, leading to misdiagnoses and inappropriate care” (p. 23). The problems of misdiagnosis, multiple diagnosis and inappropriate treatment, outlined in chapters 2 and 3 together with the severe consequences, have been the product of a mental health system which does not allow for the Deaf view of themselves and their experience of the world. In particular, as stated, personality tests provide misleading data on deaf people. The MMPI-2 is the most widely used test currently for diagnostic purposes. Currently, this test in its present form, takes many hours to administer and is used in hospital facilities, private practice and is the preferred test for legal assessment in forensic settings. This study seeks to transform the MMPI-2 into a more accurate, deaf-friendly diagnostic tool.

### **4.1.1 Aims and hypotheses of the study**

The aims of this study were:

- a) To translate the MMPI-2 into Auslan.
- b) To administer both the original English pencil and paper version of the test and the translated Auslan version to a selection of participants from the Deaf community and to compare their reactions and scores for both versions. *It was hypothesised that the participants would prefer the Auslan version, report high satisfaction and produce differing scores in relation to each version.*
- c) To compare their reactions and demographic information.
- d) To scrutinise a number of selected subscales that are closely related to misdiagnosis issues to illustrate how these can be misinterpreted in relation to Deaf people. *It was hypothesised that the difference in scores in the subscales would illustrate how and why misdiagnosis could be occurring.*

## **4.2 Using the Minnesota Multiphasic Personality Inventory (MMPI-2) with Deaf adults**

### **4.2.1 Background to the MMPI-2**

The Minnesota Multiphasic Personality Inventory (MMPI-2), “focuses on persons with more severe problems and attempts to diagnose serious mental disorders” (Thorndike, Cunnigham, Thorndike and Hagen, 1991, p. 409). The original MMPI was developed with the objective that each scale would provide an insight into aspects of psychological disorders. According to Levitt and Gotts (1995) the original MMPI, created 50 years ago, is still the most widely used formal assessment tool in psychology and education. It is

classified as one of the most effective with the deepest potential at analysing human personality, ascertaining change in personal and emotional status. Hathaway and McKinley, first published the MMPI in 1943, at the University of Minnesota Hospitals. During this period the emphasis was on determining psychopathology, individuals being categorized with psycho-diagnostic criteria. Prior to the MMPI, psychologists and psychiatrists were assessing each case based on personal opinion which proved to be a cumbersome method. There was no unified diagnostic test that could be administered to a large number of people using diagnostic categories. It was believed therefore, that a paper-and-pencil personality inventory would be a much more effective and reliable method at labelling individuals (Graham, 1993, p.3). The construction of the MMPI entailed a large selection of personality-styled statements from psychological and psychiatric case vignettes, reports, text books, and previous published scales of personal and social attitudes (Graham, 1993). The scales in the MMPI are associated with the type of disorder. Subgroups included in the norming were hypochondriasis, depression, hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, and hypomania (Graham, 1993, p. 4). This list was expanded to include scales, which identified masculinity-femininity and social introversion.

In 1982 a special committee was set up to revise the MMPI. The authors of the emergent MMPI-2 wanted to establish new national norms in accordance with the changing American population. In particular they developed “a more consistent format for the T scores in the basic test profile...eliminate(d) ambiguity, sexist wording and outmoded content, and... items containing objectionable comment “ (Hathaway & Mckinley (1989,

p. xi). They also extended the scales to include three extra scales which looked at inconsistencies, feminine and masculine roles.

While this assessment tool is now widely and effectively used with the hearing population, it proved fraught with difficulties when applied to a Deaf population. Communication and literacy problems resulted in serious problems with diagnosis, the consequences of which were dire for deaf patients, including considerable problems of administration and lack of comprehension. This study therefore seeks to translate this widely used diagnostic tool and trial it on a Deaf population for comprehension, ease of use and accuracy of scoring and analysis.

#### **4.2.2 Procedure for the development of the Auslan interactive CD-ROM version of the MMPI-2**

This instrument was developed through various stages, beginning with obtaining a license from the University of Minnesota and selecting an appropriate person to translate the test from English to Auslan. Initially, the researcher discussed the development of the MMPI-2 with the supervisor of Audiovisual Department. The initial contact was to establish whether this study was feasible and whether the Department had the facilities to produce the Auslan interactive CDROM version of the MMPI-2. The MMPI-2 was discussed in greater detail, especially the technical aspects and how best to display the MMPI-2 video clips. During the meeting it became evident that the most appropriate method, in keeping up with the current technology, would be to develop an interactive, computerized version using CDROM. The MMPI-2, as stated by Myklebust (1966), only

requires “only minimal level of reading ability” (p. 134) and is one of the most widely used tests within the field of mental health and forensic settings. The American Sign Language (ASL) version of the MMPI-2, which was the catalyst for developing an Auslan version, was translated by Brauer (1993) who translated the original MMPI-2 onto videotapes. The test was administered via a videotape and then the participants recorded their responses on the answer sheets. Brauer (1993) used 28 deaf subjects from the graduate school and professional community at Gallaudet University, USA. While better than the untranslated test, the ASL version still did not have the benefit of computer interaction for more accurate responses, nor had it yet been normed on an American population as Dr Brauer passed away before she could complete this task.

#### **4.2.2.1 Selecting an interpreter**

The researcher sought Auslan interpreters at Level 3 for the translation project. Two interpreters were recorded on videotape to ascertain their signing style and their suitability for the translation of the questions in the MMPI-2. The selection was based on their signing style (which needed to be sufficiently neutral to avoid prompting responses), skills and their knowledge of the Deaf community and culture. Each interpreter was shown a copy of the items from the MMPI-2 and briefed on the procedure of the trial. They were informed that they would be asked the first 10 items on the first page of the MMPI-2 booklet and then two questions from each other page following, completing a total of 31 items. Each interpreter had to listen to the English verbal question voiced by the researcher and then they had to translate this into Auslan. This was completed on the same day. Following the recording onto videotape the interpreters expressed difficulty in

maintaining the Auslan without changing the concept of the items. The other issue raised was how to phrase the item in Auslan form so that Deaf people could extract the meaning of the question.

One of the two interpreters was selected as they were best suited for the study had Auslan as his first language and had been part of the Deaf community all his life. He had a neutral style of signing and thus was able to translate the questions from written English into Auslan. It was essential that the interpreter be neutral in his/her style of signing as the facial expression element of the language had the potential to alter the meaning of the questions. For example, when asking the item 198 (MMPI-2 test booklet), “I hear voices without knowing where they come from”, a change in the facial expressions of the interpreter could prompt the Deaf person taking the test to misinterpret the meaning of the question. For example, if the interpreter had a particular facial expression, the Deaf person could take the question to mean the voices were real and had an actual geographical location, whereas the hearing person would understand from the written question that it meant “voices in the head”. In the case of the Deaf person, “voices in the head” could indicate visions of someone signing to them.

#### **4.2.2.2 Producing the interactive CD-ROM**

The production of the CD-ROM occurred at an audiovisual department of a major Sydney hospital. The researcher, interpreter and audiovisual staff were present for the filming. The interpreter wore a burgundy shirt that proved visually suitable. Generally when interpreters are translating it is recommended that they wear a black shirt as this

accentuates their hands. However, it was agreed by all present that the burgundy shirt was more suitable as it was much more pleasing to the eye. The researcher read the items to the interpreter who then translated them into Auslan. Some of the items posed problems at the outset, as some of the English words and concepts did not translate into Auslan. The example in previous section of “voices in the head” is a case in point as it refers to “hearing”. The items were then posed in an appropriately cultural way. For example, ‘I hear voices without knowing where they come from’ became “I hear voices in my head” when translated into Auslan. Once all the 567 items were translated the recording was complete the next step was to transform the video clips into mpeg files. The audiovisual department completed this process.

The back translation (translating literally from Auslan back to English) also had to be completed in order to ensure that the items were culturally suitable. It was essential that the Auslan version translate back to English without losing its meaning. Butcher et al (1996) also recommends that the translator must be an independent bilingual person. This was completed by Deaf man who has a Master’s degree in linguistics. The Auslan interactive CD-ROM was then complete.

The second stage of the project was to translate the instructions into Auslan. This segment informed participants about the test in Auslan and stated what was required of them. The instructions were designed to be played at anytime throughout the test. Therefore, if a participant is unsure of what was expected, he or she can go back and review the instructions. A Deaf man, employed by the University of Wollongong as a

technical person with the research office, completed this stage of the project in conjunction with audiovisual staff from the University of Wollongong. This participant's parents were both Deaf and his first language was Auslan.

### **4.3 Study 2 - Trialling the MMPI-2 interactive CD-ROM**

A pilot study was carried out at the University of Wollongong. The aim of the study was to test the CD-ROM for technical aspects and any potential problems with communication. An additional aim was to test Deaf participants' reaction to the CD-ROM version compared to the pencil and paper version, thus both versions of the test were administered to each of the participants. The researcher was particularly interested in the differences between ease of use (as the MMPI-2 pencil and paper version as been very difficult to use, taking hours to complete) and the degree of comprehension for each version of the test (as at present, administration of the test to deaf people needs constant monitoring and explanation of the meaning of items). Differences in scores were also perused to see what kind of differences occurred and whether it was evident that one or other version of the test yielded a more realistic diagnostic tool for this population.

#### **4.2.3 Method**

##### **4.2.3.1 Participants**

There was a total of 27 deaf individuals, four with Deaf parents. Demographic data were collected. This included sex, occupation, education type (oral or sign, mainstream or Deaf school), level reached, hearing status and parentage.

#### **4.2.3.2 Materials**

The standard pencil and paper version of the MMPI-2 response sheets, questionnaire booklets were used, together with the Auslan interactive CD ROM version of the MMPI-2.

A satisfaction survey to gauge participant reaction to the CD-ROM and the pencil and paper version of the tests, was compiled by the researcher and administered at the end of all testing. Copies of all materials are available in the Appendices.

##### *Description of the CD-ROM*

The CD ROM begins with a Deaf person explaining the instructions in Auslan which has its own distinctive grammar. The interpreter asks, “how you want to start?” and then goes through the process of explaining the instructions. He also states that there will be a different person signing the items and that person will be asking the participant the questions. The interpreter also states that when he asks the items he will sign “me” but he is referring to you (the participant). This is directional, for example, when he signs “me eat well,” the interpreter uses the sign “swap” to indicate that it is the participant and not the interpreter that “eats well.” He further stipulates that it is “you” being the participant by qualifying the sign. The interpreter signs “me eat well, means you eat well.” The initial window also displays in written English, “Welcome, how would you like to start? Start a new session?” (This would be for first time participants).” Continue from a previous session?” (for those participants who stopped for some reason and did not complete the test). Participants are able to go back at any stage using the cursor. Each participant was assigned a number in order to protect their identity. The CDROM is

designed to allow them to load the previous session data and continue by immediately commencing at the next unanswered questions. For example, if a participant did not complete his or her test; the next time they enter their identification number this automatically takes them to the question they last answered. If the participant decides that they want to peruse the items they are able to do so by scrolling the list on a vertical orientation of the right hand side of the screen. As they do this, the items will be displayed. The screen is text-colour coded. That is, green for all items that have not been answered, orange for all false answers and violet for all items answered with a true response. They are able to go back and forth if they wish to change their response. Every interaction a participant makes is recorded. Data saved includes the time and date they logged onto the program and the length it took participants to complete the test was also recorded. This will assist in the analysing the data. One is able to record how many times the participant went back to a particular question.

#### **4.2.3.3 Rationale for selection of subscales and data analysis**

To gain an indication of whether the differences between the pencil and paper version and the Auslan CD-ROM version of the MMPI-2 being predicted are as pervasive as they have seemed, a sample of 10 participants' scores was sent to (Psychological Assessment Australia (PAA)) for computer-processing of both versions of the test to analyse differences. PAA were provided with both versions for each of the 10 participants' score sheets. The subscales measuring paranoia, schizophrenia and social introversion were chosen as the salient subscales for perusal as the symptoms related to these scales are particularly prone to being misinterpreted in relation to Deaf people (Myklebust, 1966)

and thus being a cause of misdiagnosis. Deaf people are often interpreted as displaying paranoid behaviours, schizophrenic behaviours and social introversion when these behaviours do not in fact reflect actual pathology, but are a reflection of their different ways of reacting to the world in their situation Myklebust (1966).

The *Paranoia Subscale* is made up of 40 items which is specifically designed to “acknowledge the existence of delusions and paranoid thought processes” (Green, 2000, p. 155). According to Hathaway et al. (1989), this subscale “reflects both marked interpersonal sensitivities and a tendency to misinterpret the motives and intentions of others” (p. 30). Some of the items included in this scale are representative of self-centeredness and insecurity. T scores above 60 on this scale are indicative of someone who maybe over responsive to rejection. New social situation are often problematic. They can also be very trusting of others until someone betrays them and are also moralistic. However, T scores of 76 and above are suggestive of thought disorder, mistaken beliefs, ideas of reference, vengeful and brooding and may act on delusions (p. 39). In addition, Greene (2000) stated that “an egocentric self-righteousness seems to permeate their behaviour” (p. 157). They do not necessarily display psychotic thought disorder, but there is sufficient evidence to support the paranoid character (Greene, 2000).

According to Greene (2000), the *Schizophrenia Subscale* is designed to assess “bizarre thought processes and peculiar perceptions, social alienation, poor familial relationships, difficulties in concentration and impulse control, lack of deep interests, disturbing questions of self-worth and self-identity, and sexual difficulties” (p.163). This subscale

was selected from other subscales because there is the perception that deaf people display behaviours which are analogous to someone with schizophrenia. As stated by Myklebust (1966) “the adjustment pattern...was similar to the profile found in psychosis...the pattern was one of lack of apprehension, worry and concern with oneself, and the manifestation of obliviousness in regard to the true circumstances” (p. 157). Moreover, his results showed that “the most pronounced feature of this profile was the way in which it was peaked on the Schizophrenia Scale” (Myklebust, 1966, p. 157).

The *Social Introversion Subscale* consists of 69 items. High T scores (65 and above) are an indication of social introversion. This scale was selected because of the language barrier between Deaf and hearing. Moreover, as stated by Leigh and Lewis, (1999, cited in Leigh, 1999) “One’s connection or non-connection to others directly influences social integration and identity” (p. 48). Juxtaposed low T scores (less than 45) on this scale indicates extroverted characteristics. Moreover, T scores below 35 “are described as flighty, superficial in their relationships with others, and lacking any real intimacy” (Greene, 2000, p.173). A person with high scores will find social situations difficult and uncomfortable and feel the need to withdraw from such interactions. The individual is likely to have poor social skills or may choose to be in the company of a few friends Greene (2000). The individual who may prefer the company of friends will obtain a T score of 58-64, which is classified as moderate. Item content on this scale “reflects personal discomfort in social situations, isolation, general maladjustment, and self-deprecation” (Greene, 2000, p. 171). Deaf people have often been perceived to have these characteristics.

#### **4.2.3.4 Procedure**

##### *Recruitment*

Advertisements were placed in the Australian Association for the Deaf newsletter, Deaf Society and fliers were posted at the University of Wollongong and local Technical and Further Education (TAFE) College and handed out to leaders of the Deaf community. The Royal Institute for Deaf and Blind (RIDB) were also sought to disseminate information regarding the research..

##### *Venue and process*

The computer laboratories at the University of Wollongong were utilised. Each person was allocated a number which they had to place on the top of the personal computer screen which coincided with their number on the pencil and paper test in order to record their results. This also meant that they were able to come back to the test and continue from a previous session. Each participant was provided with the original MMPI-2 question booklet and a response sheet to record their answers (MICROTEST Q). Also provided (in English) were an information sheet outlining the aim of the study and introducing the researcher involved, a screening questionnaire and a participant satisfaction survey (which was completed when both versions of the tests had been administered). The information sheet was then interpreted from written English into Auslan by the researcher for each group. They were instructed to complete the pencil and paper test. If there was a question they did not understand the meaning of, they were to leave it and move onto the next one. Once participants completed both tests, the Auslan version output was placed on Excel and then manually recorded on an MMPI-2 record sheet as the program is not set up to score the Auslan version. Half the participants were

given the pencil and paper test first and half were given the interactive CDROM test first to avoid response bias. Participants were also observed for their reactions to the testing procedure and their personal response to each version of the test. Finally, participants were asked if they wanted to be contacted for further research to leave an email address, or mobile telephone numbers on a sheet of paper.

## **4.3 Results**

### **4.3.1 Demographic data**

Demographic data provided a breakdown of age, parentage, onset, degree and cause of deafness, education and occupation of participants. These details are summarised in the tables below.

**Table 3: Demographic data** Note: ♯ Deaf parentage

Participant No:	Current Age	Gender	Age of deafness	What caused deafness	Degree deafness dB	Education level/type of school	Occupation
01	50	Male	0-3yrs	Meningitis	Profound 96+	Yr10/deaf unit	Accountant
♯ 02	46	Female	Birth	Family	Severe 71-95	Uni/Tertiary/Hearing/ Oral program	Teacher Deaf
♯ 03	49	Male	0-3yrs	Accident	Profound 96+	Tafe/Deaf school	Carpenter
04	21	Male	0-3yrs	Not known	Profound 96+	Tafe/hearing and Deaf school	Unemployed
05	33	Male	Birth	Not known	Profound 96+	Tafe/hearing and Deaf school	Cabinet maker
06	22	Female	Birth	Rubella	Moderate 41-70	Tafe/hearing and Deaf school	Kitchen Hand
♯ 07	22	Male	Birth	Naturalness	Profound 96+	Tafe/hearing and Deaf school	Fencing
♯ 08	22	Male	Birth	Genetic	Profound 96+	Tafe/hearing and Deaf school	Web support Deaf Youth worker
09	51	Female	Birth	Accident	Mild 25-40	Tafe/deaf school	Machinist
10	34	Female	Birth	Rubella	Moderate 25-40	Tafe/deaf school	Kitchen hand
11	33	Female	0-3 yrs	Meningitis	Profound 96+	Hearing/ University	Teacher Deaf
12	28	Female	Birth	Rubella	Moderate 41-70	Deaf/ Tafe	Data entry
13	47	Female	Birth	Parentage	Profound 96+	Deaf/ NS	Teacher's aid
14	51	Female	Birth	Rubella	Profound 96+	Deaf/University	Employment Consultant
15	48	Male	Birth	unknown	Profound 96+	Deaf/ university	Tafe Teacher
16	48	Male	Birth	Rubella	Profound 96+	Deaf/ Tafe	Australia Post Driver
17	63	Female	Birth	Rubella	Profound 96+	Deaf/oral/Tafe	Typist/store
18	63	Male	Birth	Rubella	Profound 96+	Deaf/oral/Tafe	Fitter & Turner
19	46	Female	Birth	Rubella	Profound 96+	Deaf/oral/Tafe	Data entry & kitchen hand
20	47	Female	Birth	Rubella	Severe 71-95	Deaf/oral/Tafe	Unemployed
21	44	Male	Birth	Rubella	Profound 96+	Deaf/hearing/Tafe	Grave Digger & Tafe teacher
22	44	Male	Birth	Rubella	Profound	Deaf/oral/Tafe	Tax Office –Data entry
23	66	Female	Birth	Rubella	Profound 96+	Deaf/Not Stated	Machinist
24	62	Male	Birth	Rubella	Profound 96+	Hearing/Not stated	Vehicle spray painter
25	32	Female	Birth	Over due	Profound 96+	Deaf/hearing/Tafe	Assistant nursing/cook
26	61	Female	Birth	Rubella	Severe 96+	Deaf/Tafe	Machinist
27	39	Male	Birth	Not known	Profound 96+	Deaf/hearing/Tafe	Carpenter

#### 4.3.2 Satisfaction survey responses for all participants

Participants responses to the satisfaction survey were very consistent. They all expressed a preference for the Auslan version of the test, even those who did not complete the entire test in either format. Participants' comments also reflected difficulty experienced with English as Table 9 below demonstrates.

**Table 4: Participant Satisfaction Survey Responses**

Participant ID No:	How did you find the experience?	Which version did you find easier?	Other comments
01	Easy	Auslan	"for Deaf would find much easier to use Auslan...frustrating English"
02	Pleasant	Auslan	"easier by having Auslan...than reading the English language on the test"
05	Difficult	Auslan	No comment
08	Easy	Auslan	Not enough time
10	Frustrating/difficult	Auslan	"Make challenge what mean understand limit but good for knowledge help improve technology system for the deaf..."
15	Easy	Auslan	Good experience but English version first would have been difficult
16	Pleasant	Auslan	First experience, enjoyed
17	Pleasant	Auslan	Good, research for Deaf culture, health more awareness for government
18	Pleasant/Difficult	Auslan excellent	Auslan better for Deaf, English difficult
19	Did not complete either		
20	Frustrating	Auslan	None
21	Frustrating	Auslan	English sometimes hard to understand, in word couldn't get picture in my head – unusual words don't understand
22	Pleasant/difficult	Auslan	Auslan better for Deaf
23	Pleasant	Auslan	Auslan better Deaf- frustration hearing talking. Sometimes feel talk about me
24	Pleasant	Auslan	Grew up hearing parents - oral/fingerspelling
25	Not complete	Auslan/Not complete	Not complete
26	Pleasant	Auslan	No comments
27	Pleasant	Depend/ both	No comments

#### 4.3.3 Comparison of overall response rates for Pencil and Paper and Auslan interactive CD-ROM MMPI-2 versions

Participants uniformly reflected low response rates for the pencil and paper version of the test and either high response rates for the Auslan version or non-completion due to non-attendance for the second (Auslan) session.

**Table 5: Response rates for all participants**

Participant No:	P & P	Auslan
+01	567/563	DNC
02	567/527	567/527
03	567/566	567/566
04	567/561	567/559
05	567/220	567/567
+06	567/567	DNC
07	567/562	567/559
08	567/513	567/567
09	567/438	DNC
10	567/563	DNC
11	567/567	DNC
12	567/567	567/567
13	567/520	567/567
14	567/500	567/567
15	567/530	567/566
+16	567/558	DNC
17	567/187	567/567
18	567/277	567/567
19	567/314	DNC
20	567/491	567/567
+21	567/114	DNC
22	567/130	567/567
23	567/84	567/567
24	567/168	567/567
25	567/549	DNC
26	567/445	567/567
+27	567/443	DNC

\* These participants misunderstood the instructions. They took the instructions of “YOU” to mean someone other than them.

+ DNC- did not complete

All participants who completed both versions of the MMPI-2 expressed (via sign language) difficulty with the language in the pencil and paper version except for participants who had tertiary education. Participant 2 did not complete 40 questions in both versions and these proved to be the same in both versions of the test. As this participant had tertiary education in English, this could not be regarded as a language problem.

Inconsistencies were found with the responses between each version. For example, participant 18 responded to question 13 as true on the pencil and paper test and false on the Auslan version. In total this participant had 75 inconsistencies, that is, on one version they responded true on the other it was false. The participants who had higher education also experienced similar difficulties. This may suggest that even Deaf people with higher education may require more effort in the pencil and paper test. Cultural difference and the language component may be affecting the results.

Some of the participants who did not complete the Auslan version of the test did not return. It is believed that the distance to the university may have been a factor as most of the participants were from outside the metropolitan area. For example, some of the participants had to travel 200kms to and from their home to the university. The other factor is that these participants were administered the pencil and paper test version first and this may have had an adverse effect on them. It is hypothesised that if they were administered the Auslan version this could have provided sufficient incentive for them to return.

#### 4.3.4 Comparison of scores and response rates between the MMPI-2 pencil and paper subscales and Auslan interactive CD ROM versions.

**Table 6: Paranoia Subscales (6) – Males**

Pa1 - Persecutory Ideas; Pa2 – Poignancy; Pa3 – Naiveté

Participant ID No:	MMPI -T scores – Aus & Response %			MMPI -T scores –P/P & Response %		
	Pa1	Pa2	Pa3	Pa1	Pa2	Pa3
04	100/94	75/100	41/100	82/94	68/100	41/100
22	120/100	82/100	32/100	70/35	48/33	30/11
15	70/100	41/100	56/100	52/76	41/78	51/89
03	94/100	62/100	32/89	88/100	55/100	30/89
07	58/94	48/100	51/100	58/94	48/100	46/100

**Table 7: Paranoia (Subscale 6) – 5 Females**

Participant ID No:	T scores – Aus Response %			T scores –P/P Response %		
	Pa1	Pa2	Pa3	Pa1	Pa2	Pa3
26	93/100	53/100	50/100	81/71	53/89	41/78
14	93/100	53/100	45/100	93/76	40/89	45/10
20	57/94	53/100	55/100	117/100	46/100	36/100
02	99/82	53/89	31/78	99/82	53/89	31/78
17	93/100	53/100	36/100	45/06	40/33	30/11

Participants showed a marked difference between the P&P and Auslan response rates and T-scores. With this scale, Deaf people can be perceived as having paranoid behaviours on both versions. Response rates however varied markedly in favour of high response rates with the Auslan version. Participant 04 had very good English in comparison to the average Deaf person.

**Table 8: Schizophrenia (Subscale 8) – 5 Females**

Sc1 - Social Alienation, Sc2 – Emotional Alienation, Sc3 – Lack of Ego Mastery, cognitive, Sc4 – Lake of Ego Mastery, Conative, Sc5 – Lack of Ego Mastery, Defective Inhibition, Sc 6 - Bizarre Sensory Experiences

All females had elevated T scores (65 or above ) in the Auslan version except for 02 who had mastery of English as well as Auslan and 26 who scored less than 65 on SC2. Marked differences appeared between scores on the two versions.

ID No:	T scores /Auslan Response %						T scores /P/P Response %					
	Sc1	Sc2	Sc3	Sc4	Sc5	Sc6	Sc1	Sc2	Sc3	Sc4	Sc5	Sc6
26	73/100	58/100	86/100	80/100	78/100	95/100	77/90	49/73	67/60	59/79	85/91	81/80
14	69/100	86/100	86/100	85/100	72/100	81/100	73/90	95/91	98/100	85/93	91/91	95/90
20	88/100	67/100	98/100	80/100	78/100	81/100	57/90	58/100	55/90	54/100	59/100	72/90
02	61/95	67/91	67/90	65/93	59/91	63/75	61/95	67/91	67/90	65/93	59/91	63/75
17	77/100	86/100	80/100	85/100	85/100	81/100	46/33	49/36	43/10	44/29	59/27	59/20

**Table 9: Schizophrenia (Subscale 8) – 5 Males**

ID No:	T scores – Auslan Response %						T scores –P/P Response %					
	Sc1	Sc2	Sc3	Sc4	Sc5	Sc6	Sc1	Sc2	Sc3	Sc4	Sc5	Sc6
04	80/95	78/100	66/100	60/100	96/100	90/95	76/95	59/100	60/100	65/100	68/100	75/100
22	101/100	98/100	96/100	98/100	117/100	104/100	55/48	69/27	60/30	55/21	47/9	65/25
15	55/100	50/100	48/100	49/100	75/100	60/100	47/95	40/82	42/90	39/86	68/91	75/90
03	80/100	88/100	72/100	87/100	75/100	85/100	76/100	88/100	72/100	87/100	75/100	90/100
07	68/100	59/100	60/100	65/100	54/91	65/95	76/100	59/100	60/100	65/100	54/100	65/100

All participants had a higher response rate for the Auslan version. T-scores also showed differences between the two versions that would affect the profile of the participant. Participant 02 is fluent in Auslan and English (BA. in Education). Her scores are identical for both Auslan and English.

**Table 10: Social Introversion Subscales (0) – Females**

Si1–Shyness/Self-consciousness, Si2–Social Avoidance, Si3– Alienation—Self and Others

Participant ID No:	T scores – Aus Response %			T scores –P/P Response %		
	Si1	Si2	Si3	Si1	Si2	Si3
26	63/100	47/100	72/100	55/93	47/100	58/65
19	49/100	56/100	63/100	49/100	51/88	69/82
20	60/94	47/100	66/100	53/100	60/88	41/88
02	46/93	47/100	66/94	46/93	47/100	66/94
17	63/100	65/100	66/100	57/71	65/75	44/18

**Table 11: Social Introversion Subscales- Males**

Participant ID No:	T scores – Aus Response %			T scores –P/P Response %		
	Si1	Si2	Si3	Si1	Si2	Si3
04	54/100	49/100	59/100	51/100	49/100	68/100
*22	59/100	45/100	86/100	39/21	37/25	44/18
15	51/100	45/100	50/100	48/100	49/100	41/88
03	62/100	45/100	68/100	62/100	45/100	68/100
07	56/100	67/100	59/100	54/100	67/100	62/100

Response rates were again much higher for the Auslan version but fewer differences were present in the T-scores obtained for each version. Participant 22 showed a marked difference for Si1.

#### 4.4 Discussion

The overall aim of this study was to translate and then trial the MMPI-2 using both the original English pencil and paper form and the translated Auslan interactive CD-ROM version with a sample of the Australian Deaf community. Related aims were to scrutinise demographic information and the administration procedure; to ascertain whether the Auslan version was preferred by members of the Deaf community as opposed to the

written English pencil and paper test; to compare response rates and satisfaction levels in relation both versions; and to compare results on selected subscales. It was hypothesised that participants would show marked differences in response rates; would prefer the Auslan version and report high satisfaction levels; that meaningful differences between scores from both versions would be demonstrated and that differences in scores on the selected subscales would illustrate how misdiagnoses could occur. Overall, the hypotheses were supported. However, the difficulties of administration of tests to this population were well demonstrated and these difficulties caused further complexities in relation to interpretation of data.

#### **4.4.1 Demographic and observation of administration factors**

Difficulty was experienced in accessing even a small sample of Deaf population even though there were prominent members of the Deaf community who participated in the early stages of the project. Although the researcher also had a long standing relationship with the Deaf community both socially and professionally, it was difficult to get Deaf people who were in professional jobs to participate in the research. Given the nature of the research and previous indications in the literature (as discussed in Chapters 1, 3 and 5) it is possible that this population has remained sensitive to mental health issues and aware of the stigma attached, hence their unwillingness to participate.

Another contributing factor is the dispersion and size of the Deaf community. At the location where the research was conducted (at the University of Wollongong), the distance from Sydney is approximately 100kms. Thus participants would need to travel

for one and a half hours, a prospect Deaf people would not be enthusiastic about having to rely on public transport and its associated problems for them.

Also, this group of people has experienced a lifetime of having to deal with labels and hearing professional people who do not share the same language and culture, and indeed do not acknowledge the existence of Deaf language and culture. It was clear that this group of people was not keen to participate in any research which did not directly benefit them. For example, Participant 20 asked, “how will this help me?” She further stated that she was born into a hearing family and had had to use gesture and pointing to items. Her first language was English which she never mastered. She stated that she was forced to learn English and her attempts were ridiculed. She attended a hearing school where the method of communication was spoken English. She stated that she felt frustrated because she would ask the teacher what the meaning of a word was and they would dismiss her by saying “you should know the meaning” and would turn their back to her whilst in the classroom. She further stated, “I hate English and I refuse to use it.” Sign language was also forbidden at home; it was only when she went to a Deaf school that she was allowed to use sign. The authors of the MMPI -2 clearly state that “The item content must be meaningful to the subject, given his or her range of experience (a more difficult challenge for the very young, the intellectually limited, the learning disabled, the severely culturally deprived, or the recent immigrant to this country for whom the meaning of many English idioms may be obscure),” (Hathaway, et al.,1989, p. 14). Participant 20 clearly reflects a form of cultural deprivation, and it could be argued that most Deaf people are in this category, belonging, as they do, to a largely unrecognised minority.

An omitted response generally suggests some level of incomprehension, defensiveness, confusion, carelessness or indecision. In this case some of the responses omitted in the pencil and paper test may reflect an inability to comprehend the written English language or the item. Only three participants were able to complete all items in the pencil and paper test. It is worth noting that participant 22 answered 130 out of the 567 questions in the pencil and paper test (the complete MMPI-2) but on the Auslan version (also the complete MMPI-2) had a response rate of 100%. This may indicate that they had no difficulty with the language in the Auslan version.

Four of the participants completed items 1 to 185 but they misunderstood the instructions on the Auslan version. When they answered the questions they responded in relation to the person who was signing on the CD-ROM. That is, the interpreter was asking the items and they answered for him even though the first signer who stated very clearly in the instructions that when the next person signing the questions when he referred to 'me' he meant 'you' as the person taking the test. They misunderstood the entire process and took the exercise as an analysis of the language contained in the CD-ROM. All participants experienced difficulty with the meaning of the word "brood." This is not a word that is generally used within the Deaf community. Participant 27 questioned why the Auslan version was not in spoken English and in Auslan. He stated that in the past he has found it difficult to mix with the Deaf community because he is very oral and reliant on spoken English. He stated that "Auslan users have not accepted him, prefer to have 50/50 meaning Auslan and speech...other Deaf don't like him to use his voice. One of the older

participants had no difficulty in using the Auslan version. This was surprising given that she was raised with fingerspelling as opposed to direct Auslan.

During the testing Participant 9 missed 129 questions in the pencil and paper test due to the language barrier. She continuously asked for assistance in deciphering what the question was asking, at times requesting the meaning of words and concepts even though she had been instructed to leave any questions which she did not understand. After five and a half hours Participant 5 completed only 220 questions out of 567. Of the 220 he did not respond to 9 questions because he did not understand the questions. His level of stress was observed during the test. He did not want to leave any questions out for fear of being judged as unintelligent. Participants 23 and 24 were originally from Perth and their dialect is different from State to State. Thus, the potential for miscommunication was quite likely.

The relevance of certain questions to the Deaf population was highlighted. For example in question 392 in the pencil and paper it states “lightning is one of my fears” (Hathaway & McKinley, 1989, p. 11). The participants stated that this question did not apply to them as they did not hear the preceding noise of thunder. They stated, “We enjoy watching the lightning.” However, Myklebust (1966), in his research using the MMPI in relation to psychology of deafness highlights that “the fact that approximately 50 per cent of the deaf stated they were easily awakened by noise...the deaf person is dependent on tactual-kinaesthetic-vibratory sensations” (p. 138). Myklebust further stipulates that deaf individuals are aware of noise through feelings, “and he has learned to rely on vibratory

sensations to alert him concerning the stability of his environment” (p, 138). This was supported in the current study where it was found that participants recorded ‘true’ on the MMPI-2 the Auslan version to the same question 5, “I am easily awakened by noise” (Hathaway & McKinley, 1989, p. 2). However, on the pencil and paper test they responded ‘false’. Moreover, the participants in Myklebust’s research also questioned why they were startled by sudden noises (feeling) when hearing people did not react in the same way. According to Myklebust (1966) “deaf person must monitor his world differently. He must be alert to signals which the hearing person has learned it is safe to ignore” (p. 139). This problem is pertinent when interpreting results obtained from pencil and paper tests which have not been normed on the Australian Deaf population. As previously mentioned, the participants in this study constitute a cultural minority. The results are used to evaluate and ‘confirm’ (in the eyes of the hearing world) psychological states of deaf people within the courts and mental health settings. This is often carried out by professionals who have had little or no experience in working with Deaf people and thus are not aware of the nuances within the Deaf culture.

The participants’ language ranged from Auslan as their first language to others who had Auslan as a third language. For example, one participant was born to an Italian speaking family, English was her second language, Auslan her third and it was only later in life that she acquired Auslan.. She experienced great difficulty with comprehension in the pencil and paper test and did not return to do the Auslan version.

Participants returned for a second session because they were unable to complete both the Auslan version and the pencil and paper test in one session. Attempting to do this proved

time consuming and frustrating for the majority of the participants. For example, Participant 5 managed to complete the paper and pencil version up to item 220. He commenced the test at 10-30am and finished at 3-00pm with two breaks in between. Participant 9 experienced difficulty with each question. She required clarification on meaning of words, sentences and concepts. She did not complete the pencil and paper version of the test after 5.5 hours. This was frustrating for both the researcher and the participant. The participant did not want to leave any questions unanswered even though they had been instructed to leave any questions that they did not comprehend. This was to be expected as the written form of the test is in English and not in Auslan. She was disappointed that she did not get to complete the Auslan version.

#### **4.4.2 Preference and satisfaction factors**

The majority of the sample of deaf people in this study preferred the Auslan version (see satisfaction tables for all four groups); one participant stated that it “depends” and indicated that both versions were suitable. . This participant is an oral deaf person and does not rely solely on Auslan as his preferred mode of communication. He moves in and out of both worlds quite comfortably. The researcher had anticipated that two of the older participants in the group may have encountered some difficulty or felt threatened by the way in which the test was presented, given that they grew up using finger spelling and not Auslan grammar. However, both asked for minimal clarification only during the process.

#### **4.4.3 Subscale factors**

The scores of 10 participants on both paper and pencil and Auslan version of the test were sent for analysis of subscales. These 10 participants all fully completed both versions of the test.

*Paranoia subscale* – For the Auslan version of this subscale, the majority of males obtained high T scores on Pa1 (anything above 65 being considered high according to the hearing test norms). In one case the participant's T score was 120 on Persecutory Ideas (Pa1) and Poignancy (Pa2) 82. These indicate that he would see the world as threatening, and feel persecuted and ill- treated. Given the reality of this participant working and living in an environment where he is the minority and no one shares his language, it is feasible that he may experience high levels of what appears to be paranoia given the fact that he is unable to hear what is said around him. All he observes are his colleagues talking, laughing and at times perhaps even looking his way. Greene (2000) suggests that “high-scoring normals are described as being interpersonally sensitive, emotional, rational and clear thinking” (p.158). Furthermore, sensitivity is often translated into empathy, which can “reflect some of the same underlying dynamics as suspiciousness and projection” (Green, 2000, p. 158). The females in this study also obtained T scores above 65. One female had a T score of 117 on Pa1. This female is unemployed and thus, is not spending much time with hearing people. However, she does have a hearing child and was born into a hearing family where signing was forbidden. It is understandable that she too may feel a sense of paranoia having to grow up in an environment where she was constantly second guessing what people around her were saying, laughing or talking

about. As stated by Scheetz, (2004), “while some form close friendships with their hearing peers, others remain withdrawn and aloof from those around them” (p. 152).

*Schizophrenia subscale* - The T scores obtained in the Auslan version and the pencil and paper tests were markedly different and illustrates the way in which misdiagnosis could occur if the test were not normed on a Deaf population. For example, Participant 22 had elevated scores in this subscale in the Auslan version. He had T scores (in the Auslan version) above 96 (see Table 23). If one were to compare this with a hearing population it could indicate that this participant is suffering with some form of psychosis, but as Myklebust (1966) points out, the “question was whether the results indicate true mental illness or whether they might be more adequately explained on other bases” (p.157). In the case of Participant 22 it may be a question of his social isolation. He works in a hearing-dominated environment. He is also experiencing major life changes with interpersonal relationships. Myklebust (1966) also states that “from this frame of reference the high mean score on Schizophrenia might be due to the inherent isolation resulting from deafness rather than from true mental disease” (p.158). He further stipulates that this high score on this subscale indicates “feelings of detachment, lack of empathy, and inability to understand reality” (p.158). In this case, Participant 22, the individual is isolated and, due to his deafness and working in a dominant hearing environment, is detached from interpersonal relationships with his colleagues. This is not necessarily an indication that he is suffering with a mental illness. Furthermore, Myklebust states that “the Schizophrenic Scale seems to be an effective means for measuring the isolation which ensues from deafness” (p.158). Myklebust’s research

supports the view that Deaf individuals experience a physical barrier of not being able to hear and living in a world which is dominated by sounds. In clinical settings, a hearing person with such elevations on this scale it is likely to be in a psychiatric facility receiving treatment. For example, Participant 22 on this subscale (Table 23) for the pencil and paper test obtained a T score of 55 for social alienation (Sc1) within the schizophrenia subscale (which indicates no pathology) but in the Auslan version obtained a T score on the Sc1 of 101 (which indicates high pathology).

*Social Introversion subscale* - Two of the female participants' T scores on this subscale were between 46 and 66 which fall within the normal to moderate ranges. That is, they balance between introversion and extroversion and at times prefer to socialise with a small group of friends. In light of the fact that the Deaf community are only a minority group it is expected that Deaf individuals are likely to socialise in smaller groups. They also do not have the confidence, share the language of the majority group (hearing) and thus are in many ways forced to socialise in smaller groups. None of the females in this group recorded a T score above 72. Both women who scored above 65 were seniors (61 and 62 years), which may also isolate them further for various reasons. For example, some of their peers may have passed on and limiting their social contacts. Four out of five male participants in this research obtained a T score above 65 with the exception of participant 23 who scored T scores for shyness/Self-Consciousness (Si1) 51 for Social Avoidance (Si2) T score 45 and Alienation--Self and others (Si3) 50 (see table 22). Given these scores this man is likely to be classified as falling into the "normal" range and according to Greene, (2000), "report a balance between socially extroverted and introverted attitudes and behaviors" (p. 174). This participant is considered to be a leader

within the Deaf community and holds a position within the workforce to which deaf people would aspire. Participant 17 on the English pencil and paper test received a T score on the Si1, Si2 and the Si3 all below 44 which once again would indicate that he maybe described as an extrovert. However, on the Auslan version the T scores were Si1 (59), Si2 (45) and Si3 (86) which is perhaps much more in line with his personality traits.

#### **4.4.4 Concluding remarks**

This study highlights the many difficulties and ambiguities that the pencil and paper version of the MMPI-2 when applied to the Australian Deaf community. Firstly, as argued above, the pencil and paper test is written in English and Deaf people struggle with the English language as it is not their primary language. Secondly, as Myklebust also found in his study, the scores on the schizophrenia scales are elevated as Deaf people have the tendency to show higher scores because of their isolation from the majority of society who are reliant on hearing. These results are often interpreted by hearing professionals who have had little or no experience in working with Deaf people and so rely solely on the results obtained or on observable behaviour. Thirdly, as hypothesised, all participants preferred the Auslan version of the MMPI-2.

## PART TWO

### Culture, identity and communication

*“Having ears is not just hearing. With eyes, seeing is believing!” (Barbara G. Goldman, 1999, p. 76)*

## **CHAPTER FIVE**

### **The language and culture of Deafness**

*“...deafness per se does not determine the emotional and social development of the individual. Rather it is the attitude of hearing people that causes irreparable harm to the personality of the deaf person” (Oblowitz, Green and Heyns 1991)*

## 5.1 A sign of the times

Language is a complex phenomenon and is regarded as one of the greatest differentiators of culture. For centuries, the average person, clergymen and the medical profession believed that deaf people have been without language. In 1966 Hans Furth titled his treatise on the thinking-language relation *Thinking without Language: Psychological Implications of Deafness* (Stokoe, 2000, p. 52). But the language of Deaf people is as complex and culture-bound as any other national group. Their language is very different from English or any other spoken language. “Signed languages use attention-attracting visible symbols...it has taken a long time for scientists and the public to acknowledge that they are actually languages” (Stokoe, 2002, p. 52). Significantly, “...hearing people resort to gesturing when it becomes necessary to communicate across language barriers” and this is considered a valid part of language communication (Stokoe, 2002, p. 53-54). Typically in a situation where the current language is not understood, people will attempt to communicate by using gesture to get their message across (Schein & Stewart 2002). They resort to nonverbal means as a way of communicating with others who do not share the same spoken language and this is regarded as valid language, but at the same time, as stated by Stokoe, (2000) “speech and language have usually been equated” (p. 52).

Sign language has only emerged during the past 300 years, unlike oral languages that have had thousands years to develop. To allow sign languages to evolve and develop, communities of deaf people are required, but historically deaf people have been dispersed across large geographical areas both in Australia and internationally. Thus, signing development within Deaf communities varies (Lucas, 2004). Sign language as we know

it today, has progressed because of the establishment of Deaf schools in Europe in the late eighteenth century (Lucas, 2004). By contrast, “spoken languages have always been in contact with one other and there have always been linguistic and sociolinguistic consequences of this phenomenon (Lucas, 2004, p. 33).” As stated by Myklebust, (1966, p. 224) “Language is the instrument, the tool, the means whereby experience is symbolized and communicated.” Bolton (1976) illustrates these phenomena by utilising the Russian language and its use of double negative constructions. That is, when translating literally a negative Russian sentence would look something like this: “He no when no thing not saw” (On *nekogda, nechevo, nevidil*) or “He never saw anything” Bolton (1976, p. 20). Schein and Stewart state: “Translations of any language always risk some loss of meaning or even misunderstanding” (2002, p. 90). When one attempts to give a literal translation in English the outcome is often incomprehensible to the listener. “Each language has its own complexities and intricacies...language use varies on the basis of such social factors as age, sex, social class, race, ethnic origin, and many other” (Bolton 1976, p. 20). Interestingly, the Chinese language is constructed by “hundreds of dialects, grouped into eight “macro-dialects” which are to some extent mutually unintelligible” (Lucas, 2004, p. 13). However, Chinese people consider their language (and its dialects) to be one language. In the case of deaf people, “...sign languages are visuospatial languages, which use a combination of hand shape and movement, facial expression, eye gaze and body movement to convey semantic and syntactic information” (Hindley & Kitson, 2001, p. 272). Sign language is visuospatial, with its own structure, syntax and very specific grammatical rules. Adjectives follow nouns, as in Romance languages. In sign, one says “house blue”, establishing a picture of

what is being described, and then elaborate on that. Many sign language “sentences” begin with a time element or phrase and then proceed with what happened, thereby conjugating the verbs (Walker, 1986, p. 47). For example, if one wants to ask a friend *if they want to go to the movies tomorrow* in sign language, the order of the language would be “*movies, tomorrow*” with the use of facial expression and direction. That is, looking at the person being addressed would be sufficient to communicate to that particular person that the question was directed to them. Whereas, in spoken language, such as English one would ask the question, “*Do you want to go to the movies tomorrow?*” In the case of the deaf recipient, the person asking the question is providing “*when*”, “*what*” and “*where*” rather than in spoken terms the “*what*”, “*when*” and “*where*” of the hearing version.

Researchers in the US have reported that signs are identified as language by the brain. According to Schein and Stewart (2002) the right side of the brain is responsible for processing pictorial material. The area of the brain responsible for language includes both auditory and visual capacities (Andrews, Leigh & Weiner, 2004) and that verbal language is processed in the left hemisphere. The left side of the brain is more susceptible to auditory input. It is suggested that deaf people, whose language is sign, will process Auslan or other sign languages on the right side of the brain whereas, a hearing person who uses spoken language will process the signs on the left side of the brain. “Prior to this it was predicted that signs would be treated as pictorial, spatial codes and would be more likely to be processed in the right hemisphere...sign language appears to be processed just like spoken language in the left hemisphere” (Schembri and Adam, 1997 verbal communication). It would seem that if the right hemisphere is responsible for visual stimuli, it is safe to predict that damage to the right hemisphere will affect one’s

signing ability. However, as stated by Schein and Stewart (1995), this is not the case. Signers with damage to the right hemisphere showed “severe spatial disorganization, were unable to indicate perspective, and neglected the left side of space, reflecting the classic visuospatial impairments seen in hearing patients with right hemisphere-damage” (p. 6), but they did not show any impairment to language. However, patients with damage to the left side hemisphere were noted to have no impairment to visuospatial tasks but their language was impaired. So far researchers have not been able to establish how one acquires sign language from a neurological perspective. But they provide support that sign language is a true language in every sense, whereas, in the past it was considered that “sign languages were kept well outside the language preserve, and professional educators termed them substitutes or surrogates for “real,” that is, spoken, languages” (Stokoe, 2002, p. 54). It is notable that sign language is not restricted to deaf people; divers, for example, use signs in order to communicate whilst under water, various professions also utilise signs and gestures to communicate; in the building industry riggers use signs to communicate to the crane driver where they want the load to be placed. Stokoe, (2002) stated “for centuries members of religious communities used manual signs as codes for spoken language when their orders imposed silence” (p.54).

The language used by the Deaf community in Australia, Auslan, has all the complexity of a true language, as does each national sign language. Research into Auslan began in 1980 when Trevor Johnston set out to “preserve and revive the language when the development of the Auslan dictionary was developed” (Johnston & Schembri, 2007) Johnston (2004), states that Australian English is a variant of English and thus Auslan is also a variant of BSL. He argues that Auslan can be traced back to the early 19<sup>th</sup> century

forms of signed language as used by the Deaf community in Britain. “The first schools for the deaf in Australia were established relatively early (in the 1860) compared to those in most other countries” (Johnston, 2004, p. 20). In Auslan the use of space, facial expression, location, orientation, hand-shape and movement are utilised. According to Johnston (1989) there are 34 major hand-shapes with 32 variations. Auslan is made up of three different sign modes, one-handed, two-handed and double-handed. For example, the sign for ‘egg’ is formed by using two different hand-shapes, ‘A’s fist hand-shape with a ‘H’ hand-shape bouncing off the fist hand-shape in front of the body (orientation). The sign, ‘which’ is formed with one-handed sign where one ‘y’ hand-shape is used in a moving motion side to side, once again the use of facial expression is fundamental in creating this sign. Double-handed signs are also a two handed sign but they differ because the hand-shapes are both the same. For example, the sign ‘where’ is signed with both palms facing up (orientation) in front of the body moves from side to side (movement) simultaneously and utilising facial expression to indicate that it is a question comes together to construct the sign ‘where’ Johnston, (1989).

The misconception within the general hearing community that if one can fingerspell then one is a proficient user of Auslan is widespread and uninformed. Marschark (1999) reports that he is often taken aback when he meets people who introduce themselves as knowing someone who is Deaf and say they can use some fingerspelling. However, this does not constitute effective communication or proficiency in sign language any more than putting letters of the alphabet into a few words constitutes proficiency in English. Sign English is often confused with Auslan. Sign English is the use of single signs in

English spoken in a certain order. For example, asking someone if they want to go to the shop would be signed in this order, “*Do you want to go to the shop?*” The sign for ‘do’ the index finger comes down onto the thumb followed by pointing to the person whom you are asking the question and so forth. This becomes a laborious task, taking far too much time to communicate a simple question. Whereas, in Auslan there would be no need for signing the word ‘you’ for example because you are asking the question to that particular person, it is assumed that it is them therefore no need to use the sign ‘you’. One would know that you are signing to that particular person so all that would be necessary to sign would be, What you want to do, in this case *SHOP* with the use of your facial expression using your eye brows in a raised manner. As in American Sign Language, Auslan questions “also end with the eye gaze focused on the person being questioned and with the hands held momentarily where they were as the final sign ended...tell or state something conclude with a dropped-eye gaze, and the hands return quickly to their resting or relaxed position. Commands or demands keep the gaze and hands up and may add a forward push of hand, head, or trunk” (Stokoe, 2002, p. 61). This would indicate that a question is being asked. The person, to whom you are signing, already knows that the question is directed to them. Therefore, there is no need to sign “*do you want to go?*” Knowledge of Auslan therefore, or any other sign language, requires knowledge of the complex elements and logic of the way the language is structured and used and not merely a few representative signs.

In America and Australia, the onus is placed on hearing parents by health and education professionals (for example, psychologists; paediatricians; ear, nose and throat specialists;

audiologist; speech pathologist and educators to decide on what modality their Deaf child will utilise as their mode of communication. “Parents who are emotionally vulnerable when they meet someone with an axe to grind or a philosophy to sell can be swayed from making their own well-informed choices-and the results can be tragic” (Ogden, 1996, p. 23). Whereas, in Sweden and Denmark “childhood is a relaxed, play-oriented time that by nature includes spoken language, and - by design - includes signed language...the child will be the guide regarding his or her predisposition toward a more oral or more visual language” (Mahshie 1997, p. 2). This is what Mahshie terms as a win-win situation. Naturally, as pointed out by Graney (1998), this also depends on various factors such as the amount of residual hearing the child has, whether they will benefit from hearing aids and how much they use them, language competency, family support, their intellectual level and their attitude in acquiring a spoken language. “Traditionally, if parents wanted their child to develop speech skills, they were told not to use sign language with their child” (Graney, 1998, p. 5). Today this philosophy still operates in Australia within organisations that promote speech for deaf people. It is notable that the majority of deaf children born into hearing families are not exposed to sign language as their first language (Johnston & Schembri, 2007).

Australian Aborigines have their own sign language (Miller, 2005). Before British settlers occupied Australia in 1788 Aborigines were using sign language. In fact, the Warlpiri community’s Sign Language still exists today (Kendon, 1988). Miller discussed the use of sign language amongst different tribes and pointed out that, interestingly, pregnant women are not permitted to use spoken language during their pregnancy and utilise sign language to communicate. Even though Aborigines have their own sign language there is

“no evidence to suggest that any existing or extinct Aboriginal signed languages were adopted or adapted by deaf communities in Australia” (Johnston & Schembri, 2007, p.53). Furthermore, “it has been reported some deaf indigenous individuals from regional areas (such as far north Queensland) includes signs that differ from Auslan signs (Karin Fayd’herbe, personal communication, 2005 cited in Johnston & Schembri, 2007, p.53).

ASL is quite distinct from Auslan. ASL alphabet is formulated by one hand. The origins of ASL stems from French Sign Language, with Charles Michel de l’Èpée playing a significant role in its development. “l’Èpée conceived the idea of using the visible signs of deaf Parisians, modified by him to accord with the grammar of spoken French, to teach them French language an culture” (Stokoe, 2002, p.52). The signs are different from Auslan. For example, the sign for ‘try’ in Auslan is ‘X’ hand shape, index finger rests on the right side of the cheek just below the eye, palm towards the cheek and sliding it down. The same sign in ASL is ‘cry’. This can complicate matters when one is communicating with a Deaf person from America because of the lip patterns. Moreover, when the sign comes from under the eye it is easy to understand why American people would confuse the signs. The sign for ‘try’ in ASL is the ‘T’ hand shape (ASL), double-handed sign in front of the body (in a neutral space) and in a circular motion moving back toward the body and away from the body to end with the palms of both hands facing down and meeting together.

There is no international sign language. Hindley and Kitson, (2001) support this view and state “each national sign language will have its own dialects and regional variations” (p.

272). At mental health and Deafness conferences and at the XIII World Federation Congress of the Deaf, which was held in Brisbane, Australia in 1999, it was noted that the official languages presented at the congress were Auslan and spoken English. For special interest groups, International sign (“Gestuno”) was utilised. “A form of signed language using a special lexicon devised to assist communication between deaf people who had no language in common (either signed or written” (Johnston & Schembri, 2007, p.73). However, there is no documentation to support that International sign language is an official sign language. The use of gesture, some signs from America and Australia combined with mime are utilised and form the basis of what is termed “international” sign language. If it is deemed that international language is not a true language, perhaps a better term would be to regard the communication mode utilised by deaf people around the world when coming together at conferences as a ‘contact language’ (Hall, 2006, personal communication). However, in social situations deaf people from different countries seem to be able to understand one another, even though they use different signs for the same object/word. This was evident when attending a conference in Austria where German Sign Language (GSL) was utilised. The researcher experienced minimal difficulty when conversing with Deaf Austrian persons. A similar experience occurred in Madeira, Portugal, where Deaf people are using sign language to communicate. This is in its infancy. The preferred method is oralism and Deaf individuals are viewed as disabled by the majority of the population, especially in professional arenas. Teachers are only currently beginning to make the transition from oral/aural to sign language. In fact the researcher noted during a visit to an organisation for the Deaf in Madeira in September, 2006, there had been some significant changes since 2003. There are now three Deaf

teachers employed at the Institute and sign language is being recognised as a viable language of instruction. This would not be possible if it were a spoken language - one would require two interpreters to allow communication to occur. With the establishment and acceptance of sign language as a proper language, it becomes possible to argue for a distinctive culture for deaf people.

## **5.2 Deaf Culture, Identity and Community**

A major distinctive factor of identification for the Deaf community is the visibility of their language. Their identity is entrenched with other people with similar life orientations, and their heritage is as rich and meaningful as that of any hearing person from a culturally and linguistically diverse group. The difficulty for deaf people as a minority group is that, unlike other hearing minorities, they are not able to learn the spoken language of the majority cultural group (Harris, 1995 & Austen & Crocker 2004). In addition, the ideology of Deaf people as a minority group is often problematic for hearing individuals to conceptualise. “Within the Hearing construction of Deafness, Deafness is an individual problem or disability, within the Deaf construction of Deafness, Deafness is a socio-political phenomena, with a cultural meaning based upon the commonality of BSL” (Harris, 1995, p, 168). In Australia, Deaf individuals share the same positive notion and see their language as a dynamic, common feature within their culture. “The point to be made is that the hearing population, including professionals, need to focus on and recognize the assets and positive aspects of deaf people...the focus placed on their abilities, not limitations” (Andrews, Leigh & Weiner, 2004, p, 12).

The decibel loss or discriminative ability is not a criterion for membership. Daplin (2001) stated that membership was judged by the capacity to communicate without sound, not the inability to hear. For example, an interpreter cited in Daplin with the Deaf Society is considered to be culturally Deaf. He was born a hearing child into a Deaf family and thus his first mode of communication was sign language. A Deaf man, for whom the interpreter interprets, is one of a few Deaf people born into Deaf families. He is the fourth generation of Deaf and this is often referred to Deaf of Deaf. “The culturo-linguistic discourse has been led by Deaf children of Deaf parents, for whom the degree of deafness is very much secondary to their hereditary cultural influences” (Ladd, 2004, p. 35). This is becoming rarer because of medical research and technological (such as, brainstem cell to identify the ‘defective’ deaf gene or as Ladd 2004, terms it, “genetic manipulation” p. 35). More and more children are recipients of cochlear implants. As stated by Breivik (2005), “the seductive power of medical/scientific arguments contributed to alternatives to “cure” a flavour of backwardness” (p. 152).

According to Paul and Jackson (1993 cited in Leigh, 1999), Deaf culture “is the view of life manifested by the mores, beliefs, artistic expression, understandings, and language particular to Deaf people” ( p. 50). Also, “Deaf culture has its own folklore – including ABC story - poems, ASL stories, stories and narratives, literature, puns, riddles, jokes, theatre, and visual arts” (Andrews, Leigh & Weiner, 2004, p.26). “The *deaf community* is a term that represents a very diverse entity with demographic, audiological, linguistic, political, and social dimensions” (Andrews, Leigh & Weiner, 2004, p. 16). Deafness is a means by which those who are denied the social interactions of the general community,

experience life. “Attitude rather than specific practice forms the acid test of membership in the Deaf community” (Benderly, 1980, p. 224). To be a member of the Deaf community one must identify with the ‘Deaf world’, have a common shared experience and be immersed into the cultural norms of the Deaf world (Higgins, 1980).

Identity is a concept which is constantly changing throughout one’s life. According to Taylor and Darby (2003) “identity is an ongoing process of negotiation between individual perceptions and social structures, and deaf people have available to them the possibility of acquiring and changing multiple identities” (p. viii). Deaf identity is important to constructing their subjective reality and one’s identities are formed in relation to society (Taylor & Darby, 2003). Deaf people’s identity has been subjected to different schools of thought. For example, the medical model has for many years attempted to portray Deaf individuals as deficient, with an emphasis has been on impairment (Knight, 1998 cited in Taylor & Darby, 2003). “Playing on those parents’ fears of ‘abnormality’ and their desire to achieve ‘normality’, medical professionals then present their medical model which claims that normality can only be achieved by denying the realities of deafness and keeping their children away from Deaf communities lest they be ‘contaminated’ by them” (Ladd, 2004, p. 35). From a cultural perspective Deaf identities are those which are affiliated with the Deaf community, those who use sign language as their primary communication mode. This view is welcomed by the Deaf community as it promotes psychological wellbeing. There are individuals who do not fit easily into either hearing or Deaf cultural definitions; however these individuals, with additional disabilities such as Usher’s syndrome, are still included within Deaf culture.

Retinitis Pigmentosa combined with congenital deafness, is “a genetic disorder involving the loss of both sight and hearing...a progressive loss of vision” (Raistrick & Sims, 1995. p. 3). Also, Leigh (1999) reports that there are those individuals who are “culturally marginal”, those who do not fit into either hearing or Deaf societies as demonstrated through their behaviours. Their identities emerge as confused, without clear notions of hearingness or deafness. They may often state they do not feel as if they belong in either society, or their loyalties may shift without evidence of true solidity” (p, 51).

“Identity marks the ways in which we are the same as others who share that position, and in the ways in which we are different from those who do not. Often, identity is most clearly defined by difference that is by what it is not” (Woodward, 1997, p. 2 cited in Taylor & Darby, 2003, p. 16). According to Leigh (1999), “core identity changes can occur in any direction, depending on life circumstances and opportunities for acculturation. For example, there are individuals who emerge from immersion within Deaf culture and move toward a culturally hearing orientation” (p. 51). Equally, we often witness these shifts in adolescents with hearing families. Often, when deaf adolescents are exposed to Deaf culture for the first time later in their teens, they may reject their hearing parental culture and take on their Deaf identity - that is, they will use only sign to communicate and will not utilize their oral skills. An example from this researcher’s files is a Deaf woman was brought up with an oral orientation and was introduced to Auslan only in her late teens. She had very good verbal skills but refused to use them in the company of hearing people who did not know how to sign. However, some individuals move in and out of both cultures quite comfortably. “Although deaf children in most

communities occupy a complicated linguistic and cultural niche, deaf children of Mexican heritage potentially move among several worlds” (Christensen, 2000, p. 123). According to Leigh (1999), “One’s connection or non-connection to others directly influences social integration and identity” (p. 48).

When Deafness is viewed by the general population as a disability, Deaf people become too inhibited to socialise within the general community of which they would otherwise be a part of because of their place of residence and their work (Lawson, 1981 cited in Gregory & Hartley, 1991). According to Furth, (1966) “society in general traditionally considered the deaf to be on a subhuman level, incapable of education or culture, bereft of human intelligence” (p, 7). Deafness per se therefore, does not exclude deaf people from society, but rather hearing people who feel there is no point in attempting to interact with deaf people. “Furthermore, what exposure hearing people have to the deaf has not always been pleasant, sometimes creating the impression that there is something wrong, certainly inconvenient, and maybe even dangerous in a person who does not hear” (Stokoe 2002, p. 54). The opposing view is that some deaf individuals also resist interacting with hearing people. This is often observed within the workforce where deaf people may alienate themselves from fear of being rejected. As Alker (2000), states, “Being Deaf means confronting social prejudices” (p. 36), a difficult task in any context. As Lane (1993b: cited in Ladd, 2004) states “it is not hard to see how a disinterested observer...might arrive at the stereotypes with which we stigmatise deaf people, and the conclusion that their plight is therefore desperate” (p.36). Deaf individuals,

understandably, prefer to seek other deaf people to provide them with a sense of belonging and a connectedness with those who are similar to themselves.

Deaf social clubs are a vital connection for deaf individuals. This was particularly before mobile phones, internet and SMS text were introduced. People who attend these social clubs are Deaf people and their children, CODAS. Often some hearing people attend as either interpreters, CODAS, hearing spouse or students who are learning to sign. “Deaf clubs were places where Deaf people could leave behind the drudgery of the factory and the anonymity of their neighbourhoods and find respite with Deaf friends” (Padden & Humphries, 2005, p, 78). Deaf individuals would gather around chatting and catching up on what was happening within their community. Social clubs for the Deaf community are very different to hearing venues. Lighting is very bright to facilitate communication. One other distinctive feature about these social clubs is that there is no music unlike hearing clubs where one expects there to be music.

CODAS grow up with sign language as their first language. Lane, Hoffmeister and Bahan, (1996), report an interview which took place in America between a reporter and some members of the Deaf community at the Metro Silent Deaf club. “Everyone in her family is Deaf- her grandparents, aunts, uncles, cousins-everybody. She grew up with them on a farm, where everyone signed. She just grew up signing to everyone, not knowing until she first attended school, at the age of five, that the rest of the world used speech to communicate. At school she had to go to speech therapy and learn how to talk” (p, 16). Padden and Humphries (1988), demonstrate a CODAS’ perception of being born into a Deaf family, “I never knew I was hearing until I was six. I never suspected in any

way that I was different from my parents and siblings” (p. 11). This isn’t an isolated case; one of the participants involved in this research said to the researcher (personal communication, 2004) that he too did not perceive anything odd about his family, since he had extended family members who were also Deaf. It was only when his hearing friends came home and his parents asked him to play outside and not in the house because they did not want the visiting children to speak when the parents could not understand what was being said. He also noticed that when he went to his friend’s home he would be offered cake and drink after school, but he was not able to reciprocate because his parents could not speak to his friends and his friends could not sign so the cultural practice of offering hospitality did not occur in that context. He also pointed out that when he first started school he noticed that the teachers would react in an odd manner. Teachers wanted to know what time mum was arriving, whereas, they did not appear to do this with other students. “Everyone acting really quite strangely, saying, ‘Oh dear how do we talk to your mother, how do we do this’ and I was thinking what’s funny about my mother...she doesn’t understand anybody else” (personal communication, 2004). To both these children sound was something that just happened, it was incidental, just as one takes for granted that we have hands and feet. CODAS learn a spoken language (their country’s spoken language) as a second language. According to Pettito, (2000 cited in Andrews, Leigh & Weiner, 2004) “they acquire both languages on the same timetable as other bilingual children do” (p. 27).

In the Deaf community, when meeting a Deaf person for the first time, the initial questions asked include “Who are you?” “You deaf?”, “What school you attended?” This

is considered to be culturally acceptable. Being direct is something that deaf people do as part of their culture. For example, if a Deaf person has not seen someone for a lengthy period of time and the person had put on weight the Deaf person will say directly “wow, you fat.” This type of directness would not be taken kindly in the hearing community, but is acceptable as part of Deaf cultural norms. According to Leigh (1999), “Deaf culture rules allowed for people to ask and receive an immediate answer regarding others’ hearing status” (p. 53). Also characteristic of Deaf culture is that most Deaf individuals who have attended residential school will often remain friends for life. Three of the participants who were part of the current research had attended school together and were still friends after 40 years.

In some hearing cultures, for example Japanese culture, it is considered disrespectful to look at the speaker but for Deaf individuals eye contact is mandatory. Within Deaf culture it is an important and essential feature, as it forms part of the grammatical structure of the language and allows the conversation to flow. Deaf people need to look at the person signing in order to show respect and illustrate attentiveness (Schein & Stewart, 1995). Another cultural aspect of Deafness is cutting across people who are signing. Deaf people don’t stop and excuse themselves, they simply cross between them. This is not considered rude but simply a way of allowing conversation to continue.

An integral part of Deaf culture are things like vibrating alarms and attention to lighting. When fax machines, doorbells and TTY’s ring, a flashing light will alert the individual (photographs of these devices from the Kellogg Conference Centre, Gallaudet University

are available in the Appendices). Baby monitors also operate on a flashing light system. Deaf people are reliant on their vision in the absence of hearing. Hearing aids play a part in the lives of deaf individuals with residual hearing. These assist deaf people to interact within their hearing environments. In the current technological society, advances have also meant that deaf people over a wide area are able to communicate via the mobile phone using the text facility (SMS). Further to this advancement is the new electronic device which is known as the “i711 wireless relay” which includes models such as the sidekick 1, 2 and 3 (in Australia the closest device is the Blackberry). Some of the features include live TTY and pager-to-pager, that is, deaf people are able to make calls from their wireless relay directly to a TTY or vice versa. Sending and receiving messages are much quicker with the wireless relay from anywhere within America. It also has the convenience of voice-to-text messaging, similar to that which we currently have as the Relay Service. During the researcher’s visit to Gallaudet in 2006 it was obvious that the students were busy accessing their i711 wireless. It is a common sight in the cafeteria area. One student stated that it gave her mother peace of mind knowing that she was able to keep in contact and that she had quick access to emergency services using her wireless relay. It was interesting to observe the university students at Gallaudet busily sending and receiving messages, accessing the internet, receiving emails etc. all from the convenience of their wireless relay device. According to Mark Stern, vice president of product management for GoAmerica “the T-Mobile Sidekick is an extremely popular communication tool for many in the Deaf community,” (Stern, 2006).

### **5.3 Family and Deaf identity**

Given that 90 to 95% of deaf children are born into hearing families, the majority have never met other deaf children or in particular another Deaf adult. They often believe that when they grow up they will become hearing because the majority of adults in their family and around them are hearing. When deaf children reach adolescence they often move away from their hearing family and will seek other Deaf people - this is when they learn about Deaf culture. For example, one man, Ian, spoke about his experience in growing up in a hearing family with four older hearing brothers. He described his oral education, (which he never “mastered”) and the isolation he experienced when he was at home before attending a Sydney based school for the Deaf. “Significantly, the majority of deaf children of hearing parents achieve only a minimum of articulated communication with others during their earliest years” (Furth, 1966, p. 12). Ian stated that when he came home during the school holidays he could not wait to go back to school - a very different attitude from his hearing brothers who couldn’t wait for the holidays to be at home. Ian felt a strong connection with his Deaf classmates, which he did not with his biological family. Whilst he was at home he was isolated, with no one to communicate with except for a few notes from his father from time to time. Often when the conversation was too complex, his family would give up, with phrases like “it doesn’t matter, not important.” When he left school and started working within a hearing environment, he met two other deaf men, one of whom was a signer, the other wanting nothing to do with signing. Ian stated that his work colleagues would gesture and include him and his other colleague. Ian felt that this was because his identity as a Deaf man was well defined and he was accepted by his hearing peers. But the other deaf man who was “culturally marginalised”,

not communicating orally or by sign, was very isolated. “Where the attitude of hearing people is negative...Deaf workers suffer the disadvantage of linguistic isolation (Harris, 1995 p, 105).” Harris (1995) has also identified that the pressure is on Deaf people to interact and behave as hearing folk within the work force, “that is, to use speech, lipread and ‘fit in’” (p.105). She argues “that Deaf identity becomes ‘submerged’, since there are so few opportunities for the expression of Deafness as a *positive* difference and concurrently so many reminders that to be linguistically different is to be disadvantaged” (p. 105). Ian also described bringing home hearing friends and his parents taking over the conversation, which perpetuated his isolation and exclusion remembered from when he was a child. He felt disempowered and again alienated. Ian stated that with his Deaf friends it was very different; he was able to socialise, communicate and feel a sense of belonging, it was his world.

During his early adulthood Ian was told by his parents that he “should marry a hearing woman, so that she could look after him” (e.g. answer the telephone, pay bills). They were concerned that he would not be able to function within society independently as a Deaf man. This attitude appeared to impact on his self esteem as his parents did not appear to have an understanding of his culture and language. Ian described his experience when he first met his wife (a Deaf woman of Deaf parents). He stated that he found himself gravitating towards her family and wanting to spend more time with them. One of the distinctive factors was the difference when he was at his parents place at dinner time. There he would have a hot meal because but there was no one to talk to or interact with, so he felt alienated. However, when he was at his in-law’s home this was very different;

meal times were generally a time for all to sit around the table and chat about the day's activities. He stated that he soon got use to eating cold meals, lots of banging on the table and stamping feet in order to get someone's attention. This would not be considered table etiquette at a hearing dinner table. Ian also stated that one of the aspects of family life that he recalls is the fact that he did not know any of his extended family. When he first met his wife's extended family he was introduced to her aunt and uncle. He asked, what is "*aunt*" and "*uncle*"? She was astounded at his lack of knowledge and asked him "where had he been?" Ian stated, "I fit into the community, the Deaf community that's my culture, my family" ( Video Society, 1994, p. 81). As stated by Furth, (1966), "it is therefore, in the deaf (sic) community that the deaf person finds opportunity for social, emotional, and intellectual development and fulfilment" (p. 16). As in Ian's case, Drolsbaugh (2000), was born into a Deaf family with hearing grandparents but experienced similar alienation. He too describes his grandparents' attempt at "fixing" his deafness. "Unbeknownst to them, the mixed message I received was "we love you, but...deafness is a horrible condition, and we have to fix you". He further says that "To me, it meant I had to deny who I really was, and had to pretend I was hearing" (p. 15). This man experienced life growing up in a hearing family as a period of isolation and segregation. He felt a sense of belonging when he discovered the Deaf community and Deaf culture. "The vast majority will, of necessity, spend their working lives in primarily hearing environments, but will choose to spend their social lives with other deaf people. The worlds of deaf and hearing people intersect but are separate" (Hindley & Kitson, cited in Graham & Martin, 2001, p, 272).

Ian also stated that when his daughter was born and three months later they found out that she was deaf, they were “delighted”. His parents, on the other hand, were devastated. The difference was that Ian perceived his daughter as being fortunate to be deaf and have Deaf parents because they shared the same culture, language and values. Communication was not going to be a barrier and she would have the opportunity to develop psychologically, cognitively and have a positive identity as a Deaf woman. Ian’s parents saw deafness as a disability and expressed their grief. The majority of Deaf parents who have children feel pleased at the news that their child is Deaf. They know that their child will be part of their culture, their world and their Deaf heritage.

From the time that Deaf parents bring home their Deaf child this child is exposed to visual communication, into an environment which is visually stimulated which promotes learning and development. This child’s first language will be sign language which will allow effective communication to occur and thus the child will progress through each milestone (Lane, Hoffmeister & Bahan, 1996). This type of environment is conducive to the child’s social, emotional, psychological, cognitive, and linguistic development. As stated by Lane, Hoffmeister and Bahan, (1996), “social development is assured through exposure to adults who function normally as models for the child” (p. 26). The family’s positive attitude towards their deafness will ensure positive emotional development. Psychologically, Deaf parents have well developed identities; this is promoted in their child. Cognitively, there are no limitations as to what their child can achieve (Lane, Hoffmeister & Bahan, 1996). “Deaf people do not register regret (as hearing parents may

well do) when their children are deaf...there appears to be less problem in having a deaf child than a hearing one” (Harris, 1995, p. 167).

However, not all Deaf parents are pleased with the fact that their child is Deaf. Unfortunately, their view has been coloured by their own history of prejudice and stigma which they endured. They are all too familiar with the “arduous trials on the way to adulthood in a world dominated by hearing people...professional people offer such alien advice, viewing the Deaf baby not as a godsend but as a problem” (Lane, Hoffmeister & Bahan, 1996, pp. 29-30). “Hearing parents and their deaf child commonly act out roles that are socially prescribed and extremely painful” (Lane, Hoffmeister & Bahan, 1996, p. 24). Hearing parents’ sense of loss is often equated to grief, especially when the diagnosis of deafness is delayed. As stated by Moses (cited in Ogden, 1996), “losses are...occurrences or events that shatter dreams that are core to a person’s existence...The initial diagnosis oftentimes marks the point when a cherished and significant dream has been shattered for the parent...The parent and therefore he (sic) is frequently confused by the grief process that follows” (p. 13). This typically results in confusion for the parents, distress because their child is not responding to their voices and the parent’s feelings of guilt, anxiety, fear and anger will manifest themselves and become a barrier, inhibiting their ability to perceive and resolve the problem, “a problem they clearly perceive but cannot identify” (Vernon & Andrews, 1990 cited in Chovaz, McKinnon, Moran & Pederson, 2004, p. 7). The parents will go from professional to professional in order to gain some insight into what is “wrong” with their child, why s/he is not responding according to their expectations. They continue to deny the possibility that their child may

be deaf and persist with auditory input in order to establish some form of connection with their child and continue to operate as a hearing family. Unfortunately, the consequences are great as the child struggles to make sense of the world and thus his/her psychological, emotional, cognitive development is at risk. “In this frenzied quest for normal hearing, doctors and so-called experts bombarded us with the old “it’s a hearing world” routine” (Drolsbaugh, 2000, p. 16). For example, Luterman (1987) illustrates a father’s grief of a 15-year-old son: “At first you hurt like hell, and then it becomes a terrible dull ache that never goes away (p. 41). Relatives (and professionals) may contribute to this feeling by insisting that the parents must work very hard to mitigate the child’s impairment” (Lane, Hoffmeister & Bahan, 1996, p. 30). Hindley and Kitson, (2001) also state that “most of these families have no prior experience of deafness” (p. 273). A distressed hearing baby will be assured by the mother’s voice but when the child is deaf “her lullaby to her infant is meaningless...hearing infants can effectively use audition as a bridge to security provided by the mother” (Chovaz, McKinnon, Moran & Pederson, 2004, p. 6).

Hearing parents’ choice of what mode of communication to use with their child will often depend on the professionals’ philosophical view as to whether the child will be exposed to sign language, attend a school for the deaf, oral/aural or be the recipient of a cochlear implant. As Hindley and Kitson (2001), point out, “Their child’s experience of being deaf and their beliefs and attitudes will be shaped by these experiences...contact with deaf culture will be through deaf peers and deaf adults from outside the family” (p. 273).

Drolsbaugh (2000) described his experience, stating that “the doctors told my hearing grandparents to make sure my Deaf parents didn’t use sign language with me, because

they felt it would cause me to lose my speech, a supposedly crucial element of my development. The experts had spoken, and that was that” (p.16). These decisions are often made during overwhelming times where parents are given one perspective and that is nearly always the medical view as the medical track is the one first used to diagnose deafness. These parents often feel disempowered to make such vital decisions regarding the education and mode of communication for their child. The imbalance could be addressed by hearing parents being exposed to other Deaf professionals who may serve as role models and provide other avenues which may empower hearing parents to make educated choices for their children (Austen & Coleman, 2004 cited in Austen & Crocker, 2004).

In contrast to the medical view of deafness, many members of the Deaf community operate within an entirely different perspective and perceive themselves as members of a culturally linguistic and diverse group. Socially political controversy has been associated with the Deaf community, created largely by the conflicting views of the medical and cultural perspectives. Deaf people have historically fought against oppression and for the right to be acknowledged as a cultural, linguistic minority (Austen & Coleman, cited in Austen & Crocker, 2004). Harris (1995) has found ‘oppression’ has (at least) three forms; identity replacement, symbolic language oppression and oppressive attitude” (p. 117). Deaf individuals regard themselves as individuals who “regard deafness as a normal human variant or a lifestyle choice...(and) may react defensively to suggestions that they are disabled” (Harris, 1995, p.4). Deaf individuals do not see themselves as having a deficiency but rather see the cultural majority, hearing people, as not knowing how to

sign and thus unable to communicate with them (Austen & Coleman, cited in Austen & Crocker, 2004).

Currently, the State-Wide Infant Screening-Hearing (SWISH) program in Australia, screens newborn babies for deafness prior to them leaving the hospital. Brainstem cell research, reduction in children being born with meningitis and rubella due to advances in medicine, and children being fitted with cochlear implants at a very young age are also part of current practice. This is changing the demographics of the Deaf community and poses a potential threat to the culture and the language. Johnston (2004) alludes to the fact that Auslan is potentially an endangered language because of such interventions. However, there appears to be a slight shift in perception by the Deaf community in regards to those who choose to have cochlear implants. There appears to be less tension and separateness between the members of the Deaf community. Professionals within educational organisations involved in this area are also encouraging parents to teach children some rudimentary signs for safety reasons, particularly when they are at the beach or in the water. However, as Ladd (2004) points out:

“It is a central position in modern Deaf discourses that community members do not wish to ‘become hearing’ and that to give birth to and raise Deaf children is a positive, even desirable goal. For those who have made liberal ethnocentric projections, the idea seems scandalous. “How dare you wish more Deaf children into the world?”, they cry. To which the response is ‘if by “deaf” you mean people who were born hearing but whose daily reality is now one of forever being condemned to live on the margins of existence, where, to adapt an old

advertisement, “*the edge of a conversation is the loneliest place in the world*”, ; who have to cling to the coat-tails of the hearing world and numbly accept being reduced to imbecilic status in the eyes of the media, by cartoonists and comedians’, yes indeed, who would wish that isolated and unhappy existence on anyone?” (Ladd, 2004, p. 37).

However, Deaf communities around the world believe that they have an authentic, beautiful language, and great Deaf organisations, such as AAD (Australian Association of the Deaf), history, theatre etc. “You will understand our pride in what we have created, our desire to pass this on to future generations of Deaf children” (Ladd, 2004, p. 37). This epitomises the feelings of Deaf people around the world in relation to having Deaf offspring. “Deaf believe that if societies learn [their] language and become able to participate in what we have created, barriers can come down, and all may benefit from the unique skills of Deaf existence” (Ladd, 2004, p.37).

The next chapter explores a theoretical framework that is able to validate Deaf people’s perception of their distinctive culture and also make it accessible to the hearing community.

## CHAPTER SIX

### **Giving a theoretical voice to Deafness**

*“What is it like to ‘hear’ a hand?  
You have to be deaf to understand. (Madsen W. in Taylor & Bishop, 1991, p.  
xii cited in Harris, 1995, p. 170)*

## **6.1 Finding a theoretical framework for Deafness**

### **6.1.1. Limitations of traditional approaches**

As demonstrated in the earlier chapters of this thesis, Deaf people are traditionally perceived as physically disabled, locked into a medical model that takes into account only the aetiology of deafness. That is, whether the hearing loss is conductive or sensorineural, the focus is on whether the individual will benefit from hearing aids or a cochlear implant, something that will make them 'hearing like' or 'normal'. "This construction is underpinned by an assumption that Deaf people are not *whole* - they are people with a sense missing." (Harris, 1995, p. 166). Within this theoretical framework, deafness is something that requires 'fixing'. To date, there has been no theoretical framework - wellness model - within which Deaf people's view of themselves as a separate culture, having an alternative experience of the world, can be validated or even understood by the hearing world. The major theoretical perspectives on human personality – the psychodynamic, behavioural view and existentialist views – do not address Deafness, except in the cases where it is perceived to be related to personality disorder. The psychodynamic view does not address deafness and the personality structure put forward is not relevant to consideration of deafness. A deaf person would be deemed as having the same personality components and be subject to the same developmental processes as hearing people. The behaviourist view would hold that deaf people experience a different environment and would therefore behave differently. However, this does not go anywhere near the complexity of Deaf culture and self-perception, nor does it allow for an essential normalisation of the Deaf experience. At best, this view presents behaviourist principles to describe and perhaps justify, the differences in behaviour between Deaf and

hearing people. Or the view presents behaviourist principles to indicate behavioural problems which would be treated with behavioural therapy. The existentialist view would be that Deaf people are subject to the same existentialist burdens as hearing people – to suffer existential anxiety and to seek an authentic existence. While the existentialist view would not need, theoretically, to view Deafness as a disability and could describe the Deaf experience in terms of the world around (Umwelt), the social world of interaction (Mitwelt) and the private, personal world (Eigenwelt), (Heidegger, 1927, cited in Kaufmann, 1975), there is no direct theoretical pathway that would validate the way Deaf people perceive themselves, or provide an argument for the acceptance of such a perception by the hearing world. Each could only continue to have their own phenomenological experience of their worlds.

### **6.1.2 What kind of theory would work?**

In a clinical setting where the therapist is hearing and the client Deaf, “awareness of these differences is critical to understanding and responding to clients who identify with Deaf culture” (Leigh, et al. 1996, p. 366). A therapist with no prior experience with Deaf clients/patients (who may have some English literacy skills) may formulate an incorrect diagnosis on the basis of what the client/patient has written as it can be misinterpreted as aphasic or psychotic. This can “result in incorrect conclusions about the deaf person’s cognitive and psychological functioning” (Leigh, et al., 1996, p. 367). The following case study is presented to illustrate the problems with a lack of understanding of Deaf perceptions and experience of the world, and to provide a context for outlining the theoretical features necessary for a framework that is directly relevant for this population.

### *Case Vignette - 33 year old Deaf man*

A. was born into a hearing family with three hearing siblings and parents of European descent with no signing skills. He attended mainstream school until he was 16 years old but never acquired English speech. He has limited Auslan skills and is linguistically (receptive and expressive) deprived in both languages. At 33 years, A. leads a very isolated existence. He has extremely limited connection with members of the Deaf community and no friends or acquaintances in the hearing community with whom he socialises. One of his few deaf friends has recently moved away, adding to his isolation. His social life consists of visits to a local gambling establishment and occasionally the local pub. He does not venture outside his unit or parents home in the evening for fear of being attacked. In his previous employment, he was a victim of bullying behaviours by his hearing colleagues who locked him in a cool room and at times ridiculed him because of his deafness. He is currently unemployed due to an injury which he sustained at his last employment. He spends the majority of his time at his place of residence and at his parents' home next door.

Even though he is able to maintain independent living he is still very dependent on his mother for support and assistance. This dependency is also perpetuated by his mother who constantly sets up double standards, wanting him to be independent but when an opportunity arises for him to take initiative, holding him back stating that he can't do it on his own. His mother has raised concerns that she has witnessed him talking to himself and suspects that there is some psychotic behaviour, questioning whether he is suffering

with schizophrenia. Myklebust (1966) has argued that “schizophrenia (associated with Deafness) might be due to the inherent isolation resulting from deafness rather than from true mental disease” (p. 158). It can also be argued that it is not deafness per se that results in perception of apparent psychosis, but the ignorance of hearing people who fail to comprehend the way in which Deaf individuals view their world. When the situation was raised with A., he felt embarrassed that his mother had told the therapist that he often talks to himself, and learning that his mother could actually hear him, he was surprised and embarrassed even more. A. stated that at times he does talk to himself but he was not aware that he was actually vocalising, as naturally, he couldn’t hear himself. He also stated that his brother had been diagnosed with drug induced schizophrenia. Neither side of the family had a history of mental illness. A. stated that he had read some of his brother’s writings and described them as “words weird, he writes ‘star’, ‘kill’. Yes, talk myself my head, think.” He also stated, “Other people same?” questioning whether others also self talk.

The therapist consulted was experienced in working with deaf clients and the way they used language, and so was able to conduct an assessment and ascertain the accurate level of mental functioning of A. If A. had been seen by a therapist who was not experienced in working with deaf people and who had relied on his mother’s description of events, he may have been assessed as having lower mental functioning and subjected to unnecessary, inappropriate assessments. The consequences of this possibility, would have been that A. may have been scheduled into a psychiatric ward which would have detrimental effects on his psychological well being and further isolating and alienating

him from the general community. In relation to his mother, she required some education on communication, isolation, mental health and deafness. She did not have any knowledge regarding the world of Deaf people and the fact that they construe the world in different ways to hearing people. She had not considered the fact that he spends a lot of his day on his own; there was no one with whom he could communicate when he was at either his or his parent's home. His mother was able to gain some insight into his construction of his world and come to the realisation that A. does indeed perceive the world from a different perspective to her own. This allowed the therapeutic process to continue without his mother projecting her anxiety onto A. His mother's insight into these issues alleviated some of the stress from their strained relationship. She was much more receptive to recommendations in relation to allowing members of the Deaf society to intervene where necessary to provide more support for A. to live an independent life. A.'s mother had, as many other hearing people perceived deafness as a negative phenomenon. This perception can be attributed to the fact that from the moment the deaf child is born, professionals become a central dominating factor in the lives of hearing parents. They are told what to do and what not to do with signing often discouraged or banned.

A case such as A.'s illustrates the ways in which hearing and deaf people differ in their interpretations of the same events and the theoretical features necessary to allow a true, clear understanding of deafness (as opposed to opaque tolerance). A crucial factor in any attempt to enter and understand the world of another is the suspension of our own beliefs and value systems - "...acceptance that other ways of seeing the world are real and valid

to the people within those systems” (Harris, 1995 p. 165). According to Leigh, Corbett, Gutman and Morere, (1996) “the way these [deaf] people perceive and interpret their experiences differs according to their cultural expectations and values” (p. 366). To appreciate and enter the world of deaf people, these differences must be acknowledged and affirmed as something that is positive rather reflecting a deficit. Equally, for Deaf people to be able to enter the world of hearing people, they need a framework for gaining understanding of how hearing people interpret the world. Without such a two-way bridge, their worlds have already been demonstrated as being damagingly separate.

### **6.1.3 Personal Construct Theory as a framework with necessary theoretical features for understanding Deafness**

Harris (1995), stated that “Deaf people are actively engaging in the construction of their own reality” (p. 164) so a theory that allows alternative constructions of reality is necessary theoretical feature for understanding Deafness; a theory that recognises and validates each individual’s personal experience and meaning is a second necessary feature; a theory that allows for genuine understanding and meaningful communication between people is the third necessary feature. As deafness provides an experience of the world that is so radically different, a theory that encourages constant adjustment to understanding is also useful. Kelly’s Personal Construct Theory has all the features necessary to provide a framework within which Deafness can be understood as a- specific culture and Deaf people’s perception and construing of the world can be validated.

#### **6.1.3.1 The basis of Kelly's Personal Construct Theory**

Kelly, (1955) bases his Personal Construct Theory on a philosophical position that argues for the validity of each person's construction of reality and for the validity of multiple possible perceptions of reality. In other words, people are able to construe and reconstrue events and situations in as many ways as their perceptions and imagination allows. Kelly claims that there is no limit to the number of ways and times a person may re-construe (or make sense of) their experience – hence the term “constructive alternativism” which he uses to describe his philosophical position. (Kelly, 1955). (Kelly 1955). As Kelly claims that we live in a real universe that exists independently of our constructions of it, his position is not a relativist one (Kelly, 1955). He is saying that while there exists a real universe, each person has their own, necessarily subjective way of seeing and interpreting their sense data. Landfield and Leitner (1980) comment that Kelly believed that the universe is real but the difference is in the way each person construes it and his/her place within the universe. Kelly uses the metaphor of “man the scientist” to argue that people interpret (construe) the world around them then use that interpretation as a means of prediction. If the predictions based on a particular interpretation are sound, then the interpretation (or construct) becomes a part of that person's framework of understanding. In this way, a system of interpretations (or constructs) builds up that reflects an individual's unique way of understanding and operating within the world. Each person's construct system is a reflection of their way of understanding and being in the world and, as such, each person's interpretations are valid and real in themselves.

An example of how construing applies to the current hearing view of deafness is useful to illustrate further. As discussed in Chapters 1 and 2, hearing people construe deaf people as disabled. “Disabled” (as opposed to “normal”) is the construct applied to deaf people as a predictor. On the basis of this construct, hearing people expect (predict that) deaf people will have difficulty living a “normal” life, that they cannot speak and communicate effectively, that they will have difficulty in the workplace and that they are deprived of the benefits of the hearing sense, deprived therefore of the cultural advantages of music, conversation and speech. In their experience, deaf people are perceived to speak oddly, if at all, to have odd facial expressions, to be unable to understand, to be simplistic and to be difficult to communicate with. Without further knowledge of how deaf people perceive the world, hearing people see their construct of disability validated each time they have contact with deaf people, and the construct gains strength. However, if the predictions do not work for any given interpretation, the person begins to revise his/her interpretation in an attempt to better re-construe the reality they are perceiving. This is the process of constructive alternativism. Thus, in construing, people are continuously attempting to actively provide meaning to their world and envisage what will happen next (Winter, 1992). To continue with the example, if hearing people gain more knowledge and begin to experience deaf people differently, they can re-construe their interpretation of disability. But something has to happen to enable that different experience; hence the essential role of education of the hearing. Education of Deaf people is also crucial so they may understand that hearing people’s constructs are simply based on their interpretations and are open to change.

### **6.1.3.2 The usefulness of Personal Construct Theory**

The usefulness of Kelly's Personal Construct Theory for greater flexibility and understanding of diverse explanations and views of the world, can be illustrated by Landfield and Leitner's use of the example of physics. In relation to the differences between Einstein and Newton's theory, Landfield and Leitner posit that physicists will opt for Einstein's laws of physics as opposed to Newton's because Einstein's is able to anticipate events. According to Landfield and Leitner (1980) "In Kelly's terminology, it (Einstein's theory) has a broader range of convenience (application)...the broader the range of application, the more useful the theory" (p. 4). In contrast, other theories have, and still rely on, piecing together information, referred to as "accumulative fragmentalism" (Landfield & Leitner, 1980, p. 4). This is restrictive however, and suggests that people are unchanging in their perception and interpretation of sense data. The medical model approach to deafness has relied on this view of piecing the puzzle together in order to formulate a diagnosis because it appears to be scientific and can be supported by empirical data. On the basis of this philosophy the Diagnostic and Statistical Manual (DSM) is generally referred to when clinicians require a diagnosis for a patient who is mentally ill. Phillips (1996) claims clinicians, using a base of knowledge which is not shared by the general culture, tend to work from a superiority perspective. Phillips (1996) points out "As a result, the patient's view of reality and interpretation of his or her world is often subjugated to that of the practitioner, who has made assumptions about what has been seen and heard," (p. 138). Such a view is often based on the diagnosis which has been formulated using DSM criteria which are outside the patient's range of understanding. In the DSM there is no room for alternate perceptions of reality.

As stated by Phillips (1996), the DSM is used by clinicians to “rewrite their [patient/client] realities in the language of our own texts” (p. 138). According to Winter and Viney (2005), Kelly did not share the same ideology as the medical model. Personal Construct Psychology (PCP) was contradictory to the medical model because it allows people to construe their world according to their experiences. As Kelly has stated “man is always free to reconstrue that which he cannot deny” (cited in Landfield & Leitner, 1980, p. 5). When Deaf people construe their world differently from hearing people, their world view is based on their own experience of the world, which they cannot deny, or allow to be denied, if they are to preserve any personal identity.

### **6.1.3.3 The usefulness of constructs**

According to Epting and Landfield (1985), Kelly argued that constructs are an essential part of describing one’s behaviour and experiences. Kelly (1955) described constructs as bipolar. When describing someone’s behaviour for example, one must have something or someone to which a comparison can be made. For example, if a person describes deaf individuals as also ‘dumb’ then that person would give a meaning to “dumb” that incorporates some interpretation of “not dumb”. This opposite to ‘dumb’ may be “intelligent”, or it may be “wise”, or it may simply be “speaking” etc. The meaning given to “dumb” therefore, informs the opposite. For example, “dumb” may mean “not speaking” to one person, but it may also mean “stupid” or “not intelligent” to another. However, when a Deaf child is born into a Deaf family, deafness is not initially viewed as anything but normal by the family. Later, it is found to be a difference, but a difference only in comparison to the rest of the world and to be embraced. As stated by Scheetz,

(2004) “their deafness is just another way of being human...early acceptance is natural phenomenon as parents view their children as extensions of themselves” (p. 156). The Deaf person comes to the realisation that he/she is different only when the difference is brought to their attention in the hearing world. “Only later, when they encounter and attempt to communicate with hearing individuals who cannot sign, do they realize they are different,” (Scheetz, 2004, p. 156). Hence, they may construe themselves as different because of the hearing person’s inability to communicate in their own language. Thus, it can be seen that Deaf people have a very different view of the world; they experience the world from a different perspective. According to Kelly (1955) “experience is what we know up to now. It is not necessarily valid” (p. 171). Hearing people find it difficult to comprehend deafness or what it would be like to be deaf because it is outside their range of convenience, outside their experience. Deafness is not a part of their construct system except as an interpretation of how some people are and behave. It is a construct based on superficial observation only rather than on varied experience and understanding.

#### **6.1.3.4 Identifying the problems using the PCT framework**

Hearing people, especially those in authority over deaf people (as demonstrated in Chapters 1 and 2), have difficulty in shifting their perceptions of deaf people. They choose to see and label deaf people as disabled as this fits into their construction of deafness as a disability. As stated by Harris (1995), it also assists in ensuring that the status quo is maintained and “the disability framework for the purpose of social policy and legislation” (p. 168). Unfortunately, Deaf individuals perpetuate this ideology by falling into the trap accepting such labels because if they don’t they are often forced into

a position which is detrimental to their own living standards. Harris, (1995) found that Deaf individuals will adopt the disabled label for financial support. This does not aid their political stance as they encourage the double standard - on the one hand they are willing to accept the disability pension but on the other, they do not want to be stigmatised or perceived as disabled. As Harris (1995) has eloquently stated, Deaf people are “at the mercy of hearing labellers,” (p. 168). Deaf people are not able to acquire the language of the hearing majority, nor are they able to be a part of an independent, totally Deaf society. Thus, they are unable to express their needs/wants and their point of view. This perception encourages hearing people to continue to construe the majority of Deaf people as indeed ‘disabled’. Deaf people who are considered ‘intelligent’, the ones who are able to lipread and have very good English literacy, are considered the successful Deaf, but successful only according to hearing constructs. As Harris (1995) has pointed out “this practice has the effect of ‘invisibilising’ deafness and may be acting to support the hearing construction of deafness as an individual problem and ultimately as a ‘disability’” (p. 170).

#### **6.1.3.5 Resolving the conflicting perspectives**

Within the Personal Construct Theory framework of the recognition of the reality of deaf people’s construing can occur, as well as the reality of hearing people’s construing. Identifying the constructs deaf people use to understand and describe themselves provides the means for hearing people to extend their understanding. Similarly, identifying the constructs hearing people use to describe and understand deaf people, provides the means for deaf people to understand the difficulties hearing people experience when faced with

deafness. Deaf people for many years have not been able to trust hearing people and, in particular, professionals within the medical domain. Hearing professionals are often viewed as outsiders. As Dolnick (1993) states, “they [hearing people] will take advantage of you. You don’t know what they’re going to do behind your back,” (cited in Phillips, 1996, p.140). This distrust has stemmed from the medical framework which deaf people have been subjected to; the idea that they are in need of ‘fixing’. Just as the medical model perpetuates the disabled view of deaf people and so deaf people’s guardedness and reservations towards hearing professionals are validated (Phillips, 1996), the PCT model can open a new understanding of deafness that counters the dominant medical view and validates deaf perceptions and experience. Kelly explains that people choose the ways in which they organise their constructs, those choices being made with the aim of extending and defining the construct system, making it more useful for interpreting experience and making accurate predictions (p. 45). According to Winter (2005), this is achieved by broadening the range of convenience of the construct system, that is, being able to apply a greater range of experiences to the system. For example, Deaf individuals, for whom deafness is a way of being, choose to see their deafness as a distinguishing characteristic which gives them a unique experience of the world and allows them to be part of a cultural linguistic minority group. Hearing people, on the other hand, for whom deafness is not a large part of their experience, can choose to see deaf people as disabled. They have no real need to seek a more elaborate view until, and unless, their experiences of deafness become more central. The constructs they have developed to explain their experiences of deafness are enough and have a limited range unless their experiences become more complex and demand elaboration of their

constructs to make sense of them. For Deaf people, Kelly's (1955) explanation of how people can retain contradictory views of their experience is especially relevant. Explained in terms of his *Fragmentation Corollary*, Kelly states that people may "successively employ a variety of construction sub-systems which are inferentially incompatible with each other" (Kelly, 2001, p. 58). This can occur when a sub-system applies to a particular context only. For example, Deaf people may have a strong construct of themselves as being normal and healthy, (just different, in the same way as any other culturally linguistic minority group). However, in the context of the social security system, they may accept the construct of being disabled, partly as imposed by the dominant society they live in and partly because it is the way they gain support. Historically, this ability to accommodate contradictory views has been a means of survival for Deaf culture. Equally, it may be a means of allowing hearing people to understand the "normal and healthy" construct held by Deaf people while they wear the disability label.

### **6.1.3.7 Conclusion**

This chapter aimed to introduce a theoretical framework that can re-define the historical view of deafness, that is, deafness as a disability, and bring it more in line with the views held by deaf people themselves. It is argued that the use of Personal Construct Theory can change the perspective of deaf and hearing people and can lead to communication doorways that have hitherto been closed to the detriment of both cultures. With a means to identify the ways in which deaf people construe themselves and hearing people, and the ways in which hearing people construe deaf people, Personal Construct Theory allows

for the possibility of a resolution of the contradictory views that have resulted in serious consequences for deaf health and quality of life. In the next chapter, the usefulness of Personal Construct Theory is demonstrated with a study that elicits constructs from both Deaf and hearing cultures and identifies the major ways in which each construes the other.

## **CHAPTER SEVEN**

### **Exploring Deaf and hearing constructs using methodology from Personal Construct Theory**

*“It is difficult for those with normal capacities to understand the implications of a sensory deprivation” (as opposed to simply living in a silent world). Myklebust (1966, p. 45)*

## **7.1 Study 3 - Using Personal Construct Theory Methodology**

This chapter demonstrates the use of methodology based on Personal Construct Theory to establish empirically that deaf and hearing people have different and mostly incompatible, views about deafness. Quality of life issues related to deafness, the impact of deafness on the individual and the cultural/social implications from the perspective of both deaf and hearing people are identified and explored. In this chapter, the cultural rules of capital 'D' deaf will be utilised to denote a cultural identity and small 'd' to refer to deafness from an audiological perspective. The Personal Construct Theory framework will be utilised both in relation to data collection and in relation to understanding cultural differences.

### **7.1.1. Identifying attitudes to deafness**

Benderly (1980) states, "speech dominates the general culture and hearing people take verbal ability as the measure of intelligence," (p. 69). He claims that there is an assumption that hearing society is where deaf people should seek their personal identity and most important relationships. (1986, p.144). Oblowitz, Green, and Heyns (1991, cited in Scheetz, 2004) stated "...deafness per se does not determine the emotional and social development of the individual. Rather it is the attitude of hearing people that causes irreparable harm to the personality of the deaf person" (p.130). For example, Myklebust (1966, p. 45) states that "it is difficult for those with normal capacities to understand the implications of a sensory deprivation" (as opposed to simply living in a silent world). Furth (1966) also supports this view that hearing people are unable to comprehend the effects of not being able to hear, because non-hearing is perceived as a

handicap. Deaf individuals feel part of a community because they are amongst people who understand them, accept them for who they are without fear of being judged or stigmatised because they do not share the same language as the majority of the population. “Those who are Deaf embrace the group because they sense a feeling of acceptance and belonging” (Scheetz, 2004, p.19). For this reason a lot of deaf (from hearing families, where exposure to the Deaf community has been limited or in some cases nonexistent) teenagers discover the Deaf community.

The Deaf communities in Australia have their own language, values, and norms, rules of behaviour, traditions and morals. For example, when two deaf individuals are communicating and one needs to get through, (unlike hearing people that would interrupt the flow of the conversation) it is not considered rude to walk through the conversation even though the language is visual. In the hearing world this would be considered rude and unacceptable. Also, communication can be difficult when misunderstanding related to meaning occurs, especially when information is presented in written form and is open to literal interpretation. Such problems of understanding and communication among deaf people have long been unknown and unrecognised by hearing people. As a result, the quality of life of deaf people has been seriously affected, including misdiagnoses of mental health, levels of education, legal situations and prospects of employment. In America, attempts have been made to tackle this problem by training deaf individuals in psychology and related fields. However, as Pollard (1996) found, deaf interns were confronted with barriers and obstacles from the onset. Pollard takes as an example a deaf psychology student receiving the following response to her application to do an

internship: “Don’t all deaf people read lips? It’s not practical to have a hearing-impaired intern; Patients are very disturbed already and having a hearing-impaired therapist would make them more so; I can’t say on a stack of bibles that we would consider a deaf intern” (Pollard, 1996, p. 389). Leigh and Gutman (2000) also found that deaf students were not given the same access to doctoral programs.

Generally hearing people who have not had exposure to deaf individuals will have preconceived ideas of how to communicate with deaf people. “The average hearing person has difficulty communicating with those who are deaf...frequently become disturbed, irritated, frustrated, or embarrassed and will frequently end the conversation” Scheetz, (2004, p.131) when communication does not flow smoothly. This is in no part the deaf person’s inadequacy or lack of language (as often construed by hearing people) but more from a hearing perspective that challenges our own capabilities which in this case are incompetent. Thus, it is not the deaf individual who cannot communicate.

## **7.2 Rationale for the current study**

This study is an attempt to address this problem of communication by exploring and disseminating information on how deaf individuals construe themselves and the hearing world, and how hearing individuals construe deafness and the Deaf culture. As Scheetz (2004) asks: “Firstly, how do outsiders view deafness and the Deaf community? Second, how do those from within the community view their deafness, their language, and their culture? And third, what impact does deafness have on the emerging self as one forms an individual sense of self-identity?” (2004, p. 15) This study addresses these questions.

## **7.3 Method**

### **7.3.1 Participants**

A sample of 10 hearing people, 11 deaf people and 10 hearing professionals who were likely to experience deaf clients in the course of their work were selected for interview. A group of deaf people was also selected from the sample for a focus group to give them the opportunity to present more fully their cultural perspective and give an individual account of what it's like to be deaf in a hearing world. The ages of participants overall ranged from 21 to 64 years.

The samples consisted of a total of 11 deaf participants – five completed questions online, 1 interview was conducted face to face and the focus group sample consisted of 5 females and 1 male (one participated in both interview and focus group). Ages ranged from 33 – 64 years. For the participants in the deaf sample who had the questionnaires (5) no identifiable data was requested to preserve anonymity.

A total of 10 hearing professionals (5 females and 5 males, age range 22 - 50), psychologists, educators of deaf people, researcher and a solicitor, a total of 10 hearing participants (6 females and 4 males in the hearing group drawn from psychology students from the University of Wollongong and people in the general community, age range, 21-34).

### **7.3.2 Procedure**

In accordance with the PCT approach of identifying differing interpretations of events/situations, semi-structured interviews were conducted to elicit participants' interpretations of deafness. Given the geographical dispersion of the Deaf community and also the need for privacy in some cases, written questionnaires containing the interview questions used in the face-to-face interviews were requested by five deaf participants. In the semi-structured interviews nine specific questions were asked which generated other questions based on the interviewee's response. For the deaf participants who were unable to attend in person, opportunity to elaborate on these questions was not possible but all responses have been included. All interviews, based on the nine initial questions (see Appendices A to C) with the hearing participants were recorded on audiotape and the deaf interview and deaf focus group were recorded on video tape, which were later transcribed. Due to their residential and work locations it was not feasible for the interviews to be conducted in person. Participants from the hearing professional group who were interviewed individually were also asked the 9 questions. An additional question, added to the methodology was asked of all the participants - "If you were offered a cochlear implant what would be your reaction and why?" Both hearing samples were also asked to imagine and describe what they thought it would be like to be deaf. Thematic analysis was carried out on the data to identify the major themes that emerged from each group. Individual instances reflecting these themes were indicators of the constructs participants were utilising.

### 7.3.4 Results

Frequently occurring themes emerged from all participants. These included the problems related to communication, use of language, alienation, lack of education/knowledge/wrong knowledge, perception of culture, lack of understanding, difficulty with health issues/diagnosis, perception of disability. Examples of participants comments are presented in tables 1 – 3.

**Table 12. General themes that emerged from the deaf interviews**

Themes	Examples
Communication with Family	“If my parents who were hearing if they had learnt sign...would have been really close.” “It’s very difficult to communicate with my family.”
Alienation from family	“I was isolated because I was the only deaf the rest of the family would talk.” I didn’t know because they never told me there were things I learnt many years later.”
Pointing, gesture, pencil and paper	“Difficult telling the hearing person what I want often I have to point to something.” “I would either write notes on paper or as a last resort, speak/lipread.”
Concerned with confidentiality	“I would feel uncomfortable and worried about confidentiality.” “I am not sure whether interpreters as a group adhere sufficiently to the Code of Ethics, particularly confidentiality.”
Meaningfulness	“I wish I could hear so that I could actually get the full language...it would give me more deeper understanding in what was actually said.”
Cultural minority	“Hearing people don’t respect Deaf people’s culture.” “Deaf people are very proud of their culture.” “I think most mental health professionals are not aware of the culture of the Deaf community.”
Interpreter issues	“Interpreter is giving out information they don’t always realise that they need to show the different tone of voice.” “Some deaf people want excellent service from interpreter. I remember some deaf saying you should fix that up you should polish your signing you should improve.”
Incongruence, confusion with interpreters	Interpreter’s expression and language isn’t matching the speaker.” “Maybe the signer is smiling and looking really happy and the speaker’s face looking

	really grumpy, I get confused because I'm not sure which the correct expression is."
Wrong information about Deaf	"Often hearing people are so patronising and equate signing with stupidity! They need to be educated about the Deaf community." "I believe some people see deaf people as exclusivist and that they are choosing not to communicate with hearing people to prove a point. I believe that some deaf people persist in extending this belief by being rude and rejecting hearing people who do make an attempt to communicate with them.
Hearing perceive deafness as a disability	"Being patronising, sympathetic, and assuming that I am so different (being disabled in their eyes) it must be why I have problems being deaf" 'Deaf people are dumb and I think that perhaps that stigma sort of growing up with hearing people."
More awareness and recognition	"The government have become a little more aware and they have arranged funding for various things and established various things for the deaf but it is still very slow." "Deaf people are still not equal in society. A large proportion of deaf people do not leave school with the same level of education... ramifications in employment and social development."
Mental health professionals	"I cannot communicate with my doctor and his reluctance to write notes on paper creates significant problems." "Deaf people have a very negative view of mental health workers/ professionals due to the professional's ignorance of deaf being okay."
Fitting into society, not treated as equals	"I believe people view deaf people as deprived and usually not as intelligent." "Most hearing people want to make deaf people better by making them hearing or able to function like hearing people so that they are not different or deprived." "They are not treated as equal or with enough respect."
Cochlear implants, not being accepted	"My internal reaction is usually one of surprise and disgust, because I tend to think, "Am I not good enough for you as I am?" "I'm happy with my life the way it is without a cochlear implant. A cochlear implant will not make me HEAR so therefore its not necessary." "It would be a unequivocal 'no thank you' because I am bilingual, university educated and not reliant on hearing.

**Table 13. General themes that emerged from the hearing professionals interviews were:**

Themes	Examples
Deafness as a disability	<p>“See it as a disability because “I don’t know much about it”</p> <p>“Saw deafness as a disability. Believes there is a high level of intolerance of deaf with other disabilities.” “They are like any other person with a disability, “it’s an invisible disability.”</p>
Language	<p>“Auslan as a communication tool not necessarily a language. They can’t communicate with hearing people, thus, language only in their group.”</p> <p>“I was surprised at how animated Auslan is in comparison to speech; it (speech) can be quite “monotone and flat”</p>
Communication	<p>“There is always more chance of error in the accuracy of communication.” “Listening &amp; looking, intense concentration, rely on lip- reading and conscious of mouth patterns.” “Hearing people who misunderstand sign language irritate me.” “Will also use visual cues such as hand gestures, pamphlets and literature.” “I would feel frustrated if I can’t get the message across and they too would feel frustrated.” “It’s just not working, helplessness.” “I think it’s the hearing people who are disadvantaged...they have their language”</p>
Assessment	<p>“Takes a lot longer with deaf people, crucial because of the life changing decisions.” “That would be difficult in this service because the assessment is done over the phone and we don’t have a TTY not sure about the relay service.” “You will not get, I think, an accurate assessment of anything.”</p>
Concerned with confidentiality/ Interpreters	<p>“Would definitely use an interpreter but would always wonder how much the client is getting.” “Use of an interpreter has huge ramifications because they often filter what the client has said, e.g. swear words are often omitted.” “Always use an interpreter or family member but it would not be the preferred option concerned about information being filtered.”</p>
Cultural minority	<p>“Deafness part of multiculturalism. I don’t know if they want to be assimilated I see them as a very strong culture.” “Deaf people a diverse group. Do not see deafness as an ethnicity.” “I see it as having cultural</p>

	<p>norms and cultural identity.” “It’s just a different way of perceiving the world and perceiving how to be in the world.”</p> <p>“She doesn’t understand anybody else. It came as a kind of revelation to me...so used to so many adults actually signing.”</p>
Fitting into society	<p>“For them to reach such heights they would have to be “exceptional” “I think some people were threatened.” Others in the office were not as tolerant. He also had to get up if he wanted to be part of the office discussion.” “They are easy to ignore...it is not necessary society but the individual person’s reaction on anything different.” “No, can’t do that because they are hearing and they create too much mess and you might be saying bad things about us.” Believed that “Deaf people were ignorant of the world in terms of politically or socially or how does society actually works.” “Have to adapt to mainstream...so I think it’s how they fit into our society rather than how society accommodates.”</p>
Wrong information about Deaf	<p>“They maybe an intelligent person but be worldly ignorant and people behave towards them as they are stupid.” “I used to be embarrassed by my father going ‘yes, yes’, then soon as the person walks away saying ‘What did he say?’”</p>
Confidence	<p>“Significant, the degree to which a hearing professional would feel confident in providing the service.” “Would be terrible to be caught up in a system like DOCS/legal. It would be disempowering, frustrating and scary experience.”</p>
Imagine being deaf	<p>“If I was deaf in an office it would be like sitting in a silent prison cell.”</p> <p>“Only slightly, not properly...there are so many little sounds creeping in, it’s very hard to go to an environment where there is no sound.” “I couldn’t move myself into a position of someone who was born deaf because that is something that is so foreign.” “Have to be more careful about the way you interact with society. Safety issues, like crossing the road. Would always be guarded, more vulnerable.”</p>

Cochlear implants	<p>“If it would make my life easier, easier for me to fit into this box.” “I wouldn’t hesitate to do it.” But it’s about choices; government should provide it for free.” “if it works why not be able to enjoy what ever they maybe missing out.”</p> <p>“I wonder if the cochlear implant is something that mainstream services say that we need to introduce you into this culture because this will allow you, it’s the passport to this life style which is the preferred lifestyle.” “Some people would relish the opportunity.”</p> <p>“Deaf people who refuse cochlear implants are “Choosing to miss out on something to help them hear, make them “normal” as a hearing person. If I had a deaf child I would opt firstly for whatever surgery there was to make them hear.”</p>
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**Table 14. General themes that emerged from the hearing interviews were:**

Themes	Examples
Deafness as a disability	<p>“I view deafness as a disability.” “Of course see it as a disability.” “I guess but depend on how you define disability, but yes it’s a disability. It could be a learning difficulty.” “Yeah, for sure if I had deafness that would mean a disability not being able to hear and interact yeah, I would see it as a disability.” “See deafness as a disability. Believe that deaf people see themselves as challenged.” “It’s taken something away that you need that is a part of you.” As a society one relies on hearing.”</p>
Communication	<p>“I am going to feel totally inadequate.” “Gestures and hand movement to support what she is saying verbally.” “I have no idea how to communicate except use of body language, not mumble, clear mouth patterns, not cover my mouth. Would rely on the Deaf person to know what they wanted.” “No communication difficulties- Fluent in Auslan, experiences difficulties with finger spelling.” “I know the alphabet, lip-read, pointing to things (kind of like charades).”</p>
Concerned with confidentiality/ Interpreters	<p>“Would be concerned about using an interpreter, “it’s a third party, confidentiality would be an issue.” “I wish deaf people would just say hi I’m Deaf and this is my interpreter just talk to me.” Yes, interpreter, but</p>

Assessment	<p>“How to interpret the nuances of a person’s emotions?”</p> <p>“Don’t know how I could assess if the person was guiding their responses. Not sure how reliable or valid the results would be. Tests are not designed for deaf individuals in mind.” Communication would be a barrier, use of body language, verbal conversation, written and that might be misinterpreted without expression. Would still administer the test but can see the potential dangers and barriers because of the communication difficulty.” They should be exposed to the same tests.”</p>
Cultural minority	<p>“Noticed with a lot of deaf they don’t take the initiative to do things they tend to hold back.” “Auslan is vibrant and rich it does not include things like irony and sarcasm, they say what they mean they don’t imply.”</p>
Fitting into society	<p>“Out of sight out of mind, they are on the periphery of society.”</p> <p>“Hearing people get agitated and feel very uncomfortable with deaf people around.” Deaf people are not treated how they would want to be treated, they get pushed aside.”</p>
Wrong information about Deaf	<p>“There is still the perception that Deaf people are dumb and Auslan is just simple English.” “The view that Deaf people are mentally behind.”</p> <p>“Makes them sound retarded, like they don’t belong, stupid.” “It’s condescending.”</p> <p>“Not having the language to speak “I would be extremely lonely, wouldn’t be able to do, learn and know about so many things that are happening in the world.”</p>
Imagine being deaf	<p>“I really couldn’t think how, I’ve never...” It would be difficult, extremely hard and just work opportunities.” “At home would be frustrating, the danger aspect.” “I don’t think I would” engage with hearing people. Safety issues and simply trying to catch a train.” “I think it would be awful. I would feel frustrated that not everybody knows sign language.” “I would definitely feel different and that would be difficult to deal with.” “Socially is would be difficult, how would you start a conversation?” “I could not imagine, really effect me in a very negative way.” Recalls doing an experiment putting cotton wool in his ears and finding it quite “disorienting.”</p>

Cochlear implants	<p>“I would jump at the chance, love to hear for the first time, I am sure it would be a dream come true for any deaf person.” Open up a whole new world.” ““I am pretty sure that most people would have it.” “It’s most probably 1 because everybody would have one if they could have it for free.” “And have the chance to hear? YEAP!” “I would definitely take it because I think it would open more or different opportunities later on.”</p>
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## 7.5 Discussion

As can be seen from the table 1 the sample of deaf individuals identified alienation and lack of communication as a major theme, including alienation from family when family members did not know how to sign, or when the deaf person was the only one who could not hear. Other forms of alienation included concern about privacy and confidentiality, discrimination where the deaf person was aware of being perceived as disabled or intellectually inferior, superficiality of conversations, being aware of a lack of respect from hearing people in various environments and being aware that hearing people did not perceived the Deaf community as having an identity and culture of its own. As well, deaf people perceived hearing people as being very often slow to understand the deaf perspective and “thick” (meaning unintelligent) in relation to communication. The communication problem is well illustrated by Benderly’s comment (2002) “...Deafness is the handicap that allows a child to see the hustle-bustle of life without permitting him access to its meaning” (p.48). This was the case with one of the deaf participants who did not find out that his uncle had died until four years later, when he asked his mother why Uncle Fred wasn’t around any more.

Other themes included problems with interpreters where information from interpreters did not reflect the perceived expressions of the speakers, and, in a confidential setting, the deaf person felt vulnerable and unable to ascertain whether the interpreter was aware of the legal and ethical requirements of confidentiality. Lack of communication with health professionals, a lack of professionals with Auslan skills and lack of knowledge about Deaf culture were identified as the main problem in relation to health issues and diagnosis of mental illness. Deaf people's awareness of the attitudes of hearing people (that deafness was related to disability and intellectual inferiority) was also a source of frustration, and also feelings of being unable to integrate into society on an equal basis. The assumption of hearing people that deaf people would jump at the chance to become hearing is another source of frustration and is reflected in the deaf people's attitude to cochlear implants which was primarily one of complete rejection of that procedure (see Table 1). The deaf participants all agreed that the government needed to become more aware of their concerns and arrange for dissemination of information and a better communication environment.

With the sample of professionals who came in contact with deaf people, only two (the CODA's and the teacher for the deaf) had daily contact with deaf people. The psychologists, the social worker, aged care worker, manager and lawyer, had limited contact with deaf people and said they had no skills related to working with deaf people. As the data shows, they did not feel confident in their ability to provide a comprehensive service to deaf people in mental health settings. They felt that the only way they would attempt to engage with a deaf client would be if they had an interpreter present but they

would always be sceptical as to what information was being filtered through to the client. As one professional stated in his interview “how accurate the information which is being conveyed by the client is actually translated by the interpreter...I’m always a bit nervous when it looks like a client has made a fairly long statement and then an interpreter may make a few comments and summarise.” His other concern was “whether I have had the assessment right.”

The sample of professionals perceived deaf people as disabled and did not recognise the Deaf community as a cultural identity, thus supporting the deaf people’s perceptions (see Table 2). They perceived deaf people as part of the general society but believed that they would experience levels of marginalisation, isolation and discrimination. However, there was no acknowledgement from any hearing participant in the study that hearing people, both professionals and in the general population, could also contribute to the isolation and exclusion. They also identified communication problems in relation to Auslan, perceiving it as a means of possible but limited communication with the aid of an interpreter, but not perceiving it as a genuine language. Therefore, there was no perceived incentive to learn Auslan as a language, and also the use of an interpreter was not considered satisfactory as there were confidentiality concerns and there was no guarantee that genuine communication was taking place. While the participants who worked with deaf people, acknowledged their separate culture and language, others had no perception of the world of deaf people. In relation to medical care and health problems there was a perception that assessment took much longer and was vulnerable to communication error.

Professional people also said they had difficulty with imagining what it would be like to be deaf both from a conceptual and actual perspective. For example, participants indicated that they could not imagine what it would be like not to be able hear any sound at all, especially from birth. Not being able to hear music was especially identified as being unimaginable. There was an expectation, if they were deaf, that people around them would learn sign language and make efforts to communicate, but also an expectation that they would need to withdraw from society. Late on-set deafness was easier to conceptualise as there would be memory of hearing.

The hearing sample also viewed deaf people as being disabled and had difficulty in imagining a world without sound (see Table 3). Confidentiality issues were also raised alienation from society, marginalisation, and lack of awareness of the reality of the Deaf population and culture. A lack of accurate information about deaf people and culture was perceived as a major problem. Inaccurate information was specifically identified with hearing people saying there was a general perception of deaf people as being disabled, intellectually behind, sounding retarded and being dumb, with Auslan being viewed as “just simple English”. When imagining being deaf, hearing people had an assumption that people around them would learn Auslan, especially families, that their physical safety would be a major concern, that they would have fewer or no opportunities for advanced education and career development, and that they would probably withdraw from social activities. All expected that they would “jump at the chance” for a cochlear implant and believed that the only reason deaf people did not all have them were financial concerns.

Communication problems were also identified with hearing people saying they felt completely inadequate when interacting with deaf people. Auslan was not perceived or understood as a genuine language but more the “thing that deaf people do”. They felt their own means of communication with deaf people could only take the form of facial expressions and use of gesture or mime. This was perceived as inadequate and it was expressed that there was an expectation that deaf people would somehow make the accommodation. The only hearing person who was fluent in Auslan (and knew anything at all about the language) was married to a deaf man.

From these major themes it is also possible to identify the kinds of bi-polar constructs each group was using in their interpretations of deafness. For example, in relation to the theme of communication, one construct would be “isolated V. others being able to sign”. (Table 1). Another would be “getting the message across V. hearing people who are disadvantaged because they don’t have the language”. In relation to each theme, the constructs are remarkably visible and reflect clearly the different ways of perceiving deafness which in turn, reflect the difficulties in understanding and communication that have long plagued both deaf and hearing people.

## **7.6 Conclusion**

Overall, the deaf sample’s perception of how they were viewed by the hearing world was supported by the data from the hearing samples. However, hearing people were unaware of how they were perceived by deaf people and indeed were not aware that deaf people had opinions about them at all. Being viewed as disabled was recognised by the deaf people, and hearing people confirmed that deaf people were indeed viewed as disabled.

The attitudes to cochlear implants were markedly different between deaf and hearing people. Dealing with health issues was identified by all groups as an area of concern, involving problems of access, assessment and communication. The responsibility for communication was perceived by hearing people to lay squarely with the Deaf population. Communication and education emerged as the major issues identified by all participants but only the deaf people stated that they believed the government had a responsibility to assist with the education of the hearing population as well as recognising and assisting Deaf culture. Overall, this study validated the ways in which Deaf people thought hearing people construed them and validated the often negative experiences Deaf people had in their interactions with hearing people both personally and when they needed to consult hearing professionals.

## CHAPTER EIGHT

### Conclusion

*“Things are seldom what they seem,  
Skim milk masquerades as cream.  
Externals don’t portray insides,  
Jekylls may be making Hydes” (Jourard, 1971, p. 4).*

As chapter 1 of this thesis established, the history of deaf people around the world, has been skewed unfavourably against the Deaf community. As Alker (2000) points out, “we are treated in condescending manner, a dismissive manner or as ‘village idiots’” (p.35). Deaf individuals have been placed in psychiatric institutions and locked away for years beyond the need of treatment. In some cases they have been locked up simply because they do not share the dominant society’s language. As stated by Alker (2000) states that “While we live in society, we are not a *part* of society. We are people who live on isolated islands floating in the sea of society” (p. 35). Deaf people have been ridiculed, ostracised and alienated from the general public and further damaging their own position within their own family structures. In turn the family have to deal with the notion that their child is ‘subhuman’ and are often kept out of sight from the rest of the world. As stated by Furth, (1966) “in fact society in general (have this perception) that deaf to be on a subhuman level, incapable of education or culture, bereft of human intelligence (p.7).” Moreover, society has unrealistic expectations of deaf people as illustrated in this thesis. Deaf people must learn how to speak and hear in order to integrate into society placing mammoth barriers which are too difficult to break through. Alker (2000) points out that the same society would never impose expectations on children who are not able to walk or those who are not able to see. That is, he states “a blind child is not expected to look up into the sky and count the number of birds...that’s cruel and distasteful!” (p.35) He further postulates that with other sense deprivation, individuals are encouraged to maximise their existing sense, “Whereas, with a Deaf child, the focus is on maximising the use of the deficient sense! Ridiculous!” (Alker, 2000, p. 35).

### **8.1. Early attitudes set the scene**

The difficulties of deaf people being acknowledged as “normal” human beings have been highlighted. Deaf people were ostracised and ridiculed because they were unable to hear. Only the wealthy were able to obtain education for their deaf children so that they could inherit the family estate. At the turn of the century (19<sup>th</sup> to 20<sup>th</sup>) the push from natural sign languages to oralism became more and more prominent. Articulation (speech) was demanded if deaf people were to be recognised as having any intellectual status. Thus the Milan conference made an enormous impact on Deaf culture and the way in which deaf people were educated and perceived. The modality of oralism was introduced. Deaf people were often kept in asylums for many years under the attitude “out of sight out of mind”. Families have had to deal with the social attitude that their child is ‘subhuman’ and better kept out of sight of the rest of the world. The view that sign language was taboo and not considered a language in its own right has also added to the discrimination, isolation and disempowerment of deaf individuals.

Deaf people have endured inappropriate testing procedures, subjected to tests which have been normed on the hearing population only and then administered to the Deaf community.

The judicial system is often provided with results from psychometric test (such as the MMPI-2) where life changing decisions are made for and on behalf of the deaf person based on misleading results. In some cases they don’t obtain justification for their actions and deaf people are left in institutions or prisons for extended periods of time. As

illustrated by the Beamish case in Perth, Australia, Mr Beamish was found guilty of murdering an heiress in 1959 when he was only 18 years of age (no sign language interpreters were used). “He was convicted and sentenced to death...” (Sydney, Morning Herald, April 23 2005). This was changed to life imprisonment even though there was no evidence to put him at the scene of the crime. However, this fact was dismissed and he was incarcerated for 15 years even though someone else had claimed that they were responsible for the murder. He was eventually deemed to be innocent and released but to the time of writing, no compensation has been offered or sought. Only in April this year was his name finally cleared after a 45 year battle with the judicial system of Australia.

## **8.2 Beginning a better path to diagnosis and treatment**

Evidence of the problem with misdiagnosis was provided in study 1 of this thesis where admission and diagnostic patterns were explored. The translation of a widely accepted psychometric tool, the Minnesota Multiphasic Personality Inventory -2 (MMPI-2) into Auslan was undertaken in the second study. The second study provided the diagnostic tool and trialled it to establish the greater suitability and preference for the Auslan version of the MMPI-2 for deaf people by contrast with the original English pencil and paper test which is currently administered to deaf people, especially those who become involved with the judicial system. The findings of this study established that prior uses of this test had not given accurate results, that the questions had been not understood or misunderstood, that deaf people found the experience of the original test gruelling, lengthy and difficult, as did the person administering the test. The study also established that the translated version of the test was comprehensible to deaf people, more easily able

to be completed and provided diagnostic information that could be easily gained and constructively used. The significance of study 2 is that it established the feasibility of translating diagnostic tests on a wider scale for use with this population. In the translated form, the test could be widely used in medical facilities that did not have specialised conditions for deaf people. The task of norming the translated version of the MMPI-2 on an Australian Deaf population and translating other tests is the focus of a current funding application. This subsequent research will include trialling all the translated tests at medical facilities throughout Australia.

### **8.3 Understanding the reality of the Deaf world**

As the depth of the communication problems became more evident when the position of deaf people in society was explored, it became apparent that the self-perceptions of deaf people, their status within the prevailing hearing culture and the perceptions of hearing people about deafness were of critical importance to the understanding of the serious communication problems that had emerged. Study 3 of this thesis, accordingly, established insight into the perceptions of deaf people, hearing people and hearing professionals about the Deaf population and themselves. Both themes in this thesis emerged as being strongly embedded in an overall history of deafness which has provided the context for establishing the major prevailing difficulties.

This thesis aimed to challenge the prevailing views from both Deaf and hearing people by offering a theoretical framework that would allow both Deaf and hearing people to construe deafness and one another more accurately and more realistically. This research

has drawn compelling attention to the differences between the way Deaf and hearing communities construe one another. Findings have made it very apparent that hearing people do not have an insight into the world of deaf people. The majority of hearing people interviewed during study 3 considered deafness as a disability and did not recognise deaf individuals as being part of a distinctive cultural group. The hearing group had no idea how they would communicate with deaf individuals. For example, one of the participants stated that they would rely on the deaf person to know what they wanted and their expectation was that the deaf person would automatically know how to lip-read, read and write English. They also identified that they felt frustrated that they did not understand the deaf person. They also reported that they could not imagine what it would be like to be deaf and unable to hear music in particular. The general consensus was that cochlear implants would make deaf individuals “hearing”. They also believed that the reason that deaf people would not have cochlear implant would be because of the financial burden. One of the participants stated, “I would jump at the chance, love to hear for the first time, I am sure it would be a dream come true for any deaf person.”

From such views there emerged a picture of deaf people that had little to do with the reality of being deaf and highlighted the depth of the misconceptions held by hearing people. On the positive side, the elicitation of such themes and constructs from hearing people has given a clear focus for addressing miscommunication. The Personal Construct framework allows for the reality of the hearing world’s perception of deaf people, while at the same time acknowledging the reality of deaf people’s constructs about themselves and hearing people. It can be acknowledged and taken into account that deaf individuals

viewed hearing people as “somewhat thick.” Participants in the study expressed their views regarding hearing people and how hearing people perceived deaf individuals. They stated “I believe people view Deaf people as deprived and usually not as intelligent.” “Most hearing people want to make deaf people better by making them hearing or able to function like hearing people so that they are not different or deprived.” “They are not treated as equal or with enough respect.” Treated separately, these views of deafness become an insurmountable barrier between hearing and deaf individuals. Treated as equally valid perceptions of reality, as allowed by the Personal Construct framework, they provide a way to the perception of a more accurate reality by both parties. Both parties are enabled to reconstrue until an acceptable reality emerges.

#### **8.4 Limitations and difficulties**

In Study 2, several problems associated with the translation and norming process of the MMPI-2 interactive CDROM were encountered. Obtaining the license took some time, as application had to be made to the University of Minnesota. The license was granted only for the purpose of use in this thesis, so the progression and wider validation of the psychometric measure created could not be pursued. In addition, the Deaf population in Australia is geographically scattered, so gaining the large numbers of participants needed for further validation of the measure will be a lengthy process. However, it will be pursued in further research with funding being currently sought.

Some of the difficulties during this project were accessing participants for the study. Deaf people have been tested and retested throughout their childhood. Hence, they were

reluctant to participate in the research, but when they were informed of what the study aimed to achieve, participants became more enthusiastic. This was achieved through leaders of the local Deaf community and colleagues of the researcher. Even so, gathering of data was slow and painstaking. The location of the university posed difficulties as Sydney, where there is a large population of deaf people, is 100kms away. Participants who were willing to participate in the research had to travel long distances.

Also, given the length of the MMPI-2 (567 questions) and the fact that the test was being administered twice (once for each version), participants had to come back to do either the pencil and paper test or the Auslan version depending on which group they were in. It was evident also, that some of the participants lacked confidence when engaging in the pencil and paper test. For example, during completion of the MMPI -2 pencil and paper test, one of the participants continuously asked for clarification regarding the structure of the questions. He was told to leave any questions which contained language which was unfamiliar to him. However, he persisted and was observed appearing anxious during the process. By contrast, during the administration of the Auslan interactive CDROM version he was observed as becoming much more animated and interactive with the task at hand. It later emerged that he wanted to complete all the questions, as he felt that omitting any may have indicated that he did not comprehend the English language and may have been vulnerable to ridicule. Even with enthusiasm, one of the frustrating aspects of this research was still the lack of attendance at times by Deaf participants. For example, a group of 10 participants one weekend did not show up and no one advised the researcher that they would not attend.

Study Three was developed as a result of the MMPI-2 study. During the testing in Study Two, it became obvious that to uncover what deaf people thought, a different approach to understanding the world of Deaf population was needed, an approach that allowed and validated the reality of deaf people's perceptions.

Given the limited availability of participants, we used the Personal Construct framework in a qualitative approach. The 10 participants interviewed are only a small sample of the Deaf community. But this research will also be pursued on a larger scale to obtain a much broader view of deaf people and their perceptions. Questions we asked were very specific and need to be expanded in future studies. One of the personal limitations working with deaf people was their reservation when answering questions. Paradoxically, if deaf people are out socially they are happy to discuss the most personal issues which hearing people would not necessarily discuss in public. On the other hand hearing professionals appeared to be guarded when answering questions as they did not want to appear politically incorrect. The majority of the other hearing participant group were university students so their views could have been affected by being of a younger age with less experience of the world.

## **8.5 Future directions**

This thesis highlighted the importance for future development of additional psychometric instruments and the norming the MMPI-2 Auslan version to be used with the Australian Deaf population. Tests such as the Depression, Anxiety and Stress Scale (DASS) will be

one of the tests to be translated and normed on the Australian Deaf population. Permission has been sought and granted to conduct this translation. Given that this test consists of only 21 questions (or 42 questions in the long version) it is not a lengthy test and does not require too much time to administer. As a clinical tool it will allow both hearing and deaf practitioners to administer it to deaf clients irrespective of their signing abilities.

As a theoretical model, Personal Construct Theory emerged as a strong foundation for allowing a better understanding of how both deaf and hearing people construe their worlds and one another. The theory also provides related therapeutic techniques which should be equally beneficial for use the deaf people. The benefit of PCT to deaf individuals is that it provides them with equal power and freedom to construe their world from their own perspective with the “psychologist to examine the client’s performance as a projection of the client’s outlook” (Kelly, 1955, p. 207). Some of these techniques are currently being utilised by the researcher and are being presented at world conferences. One that is proving especially useful is a psychophotography technique that allows deaf people to present impressions of themselves using self-selected photographs taken of their significant environments. The exploration of these photographs using a construct approach gives both insight into the psychological issues being dealt with and insights to the client about their own way of perceiving themselves. Other techniques are predicted to be equally useful and have a wide range of applications.

Currently we are limited in Australia with professionals working in mental health and deafness, so it is of particular importance that we provide both psychometric tools that

give hearing professionals a more accurate way of diagnosing deaf people and therapeutic techniques that give a better insight into the mental state of deaf individuals if we are to provide quality of care to the Deaf community of Australia.

## **8.6 Future Practical Recommendations arising from the experience of completing this thesis**

- 👂 Increased awareness by mental health professionals of Deaf cultural and linguistic diversity through professional development.
- 👂 Increased awareness by the Deaf Community of mental health issues through improved community psychosocial education.
- 👂 Formal psychiatric services to be established in each Australian state to integrate with existing mainstream services, while also meeting the special needs of the deaf people. (Each state should have “coordinator”, to liaise and to mediate these developments).
- 👂 Formal training programs for sign language interpreters to be established to increase familiarity with psychiatric terminology and the issues involved in psychiatric assessment and management
- 👂 A Deaf “user-friendly” (employing Deaf staff or at the very least hearing professionals with Auslan skills) at psychiatric facilities in hospitals.

- 👂 Telepsychiatry methods should be further developed as a unique contribution in bridging the gap between the distributed Deaf population of Australia and limited mental health resources and/or expertise.
- 👂 The use of telemedicine within hospitals, Courts and community centres has given deaf people in isolated country areas access to mental health professionals.
- 👂 Promote and encourage future psychology students to go into the field of mental health and deafness
- 👂 Most importantly provide university placements for deaf students to have the same access to information and courses which will equip them in the future with the necessary skills to become service providers for their community.

## REFERENCES

- Americans With Disabilities Act of 1990, 12101 et seq (West 1993).
- Al-Issa, I. T., M Eds. (1997). *Ethnicity immigration and psychopathology: The Psychology of Prejudice and Discrimination*. New York: Plenum.
- Anastasi, A. U., S. (1997). *Psychological Testing*. United States of America:: Prentice Hall.
- Andrew, J., Fitzgerald, S., Johnston, B., Santleben, D., & Walsh, A. (Eds.). (1999). *Open Minds Open Hearts: Stories of the Australian Catholic Deaf Community: Good Impressions*.
- Andrews, J., Leigh, I. W. & Weiner, M. T. (2004). *Deaf People: Evolving Perspectives from Psychology, Education, and Sociology*. Sydney: Pearson.
- Anthony, S. (1992). The influence of personal characteristics on rumor knowledge and transmission among the deaf. *American Annals of the Deaf*, 1(137), 44-47.
- Applegate, J. (1983). *Construct System Development, Strategic complexity, and Impression Formation in Persuasive Communication*. Canada: Academic Press.
- Auden, W. H. (1946). *The Age of anxiety*. New York: Random House.
- Australian Health Ministers. (April 1992). *National Mental Health Policy*. Canberra: Australian Government Publishing Services.
- Baillie-Grohman, R. (1975). *The use of a modified form of repertory grid technique to investigate the extent to which deaf school leavers tend to use stereotypes* (MSc Thesis). London: University of London.
- Basilier, T. (1996). Horseltap og egentlig dovhett I social psykiatrisk perspektiv. In *Deaf Transitions: Images and Origins of Deaf Families, Deaf Communities and Deaf Identities*. London: Jessica Kingsley Publishers.
- Beinfeld, H. K., E. (1991). Between heaven and earth: A guide to Chinese medicine. In *Deaf Transitions: Images and Origins of Deaf Families, Deaf Communities and Deaf identities*. London: Jessica Kingsley.
- Bell, R. Q. & Harper, L. V. (1977). *Child Effects on Adults*. Hillsdale. Lawrence Erlbaum Associates

- Bench, R. (1992). *Communication Skills In Hearing-Impaired Children*. London:: Whurr Publishers.
- Benderly, B. L. (1980). *Dancing Without Music: Deafness in America*. Washington, D.C: Gallaudet University Press.
- Berry, J. W., Poortinga, Y. H, Segall, M. H, Dasen, P.R (1992). *Cross-cultural Psychology: Research and Applications*. New York: Cambridge University Press.
- Bolton, B. (1976). *Psychology of Deafness for Rehabilitation Counselors*: University Park Press.
- Bonser, P., & Burns, L. (1998). Hands up NSW: A profile of the Deaf community of NSW. 50.
- Braden, J. P. (1994). *Deafness, Deprivation, and IQ*. New York: Plenum Press.
- Brauer, B. A. (1993). Adequacy of a Translation of the MMPI into American Sign Language for Use with Deaf Individuals: Linguistic Equivalence Issues. *Rehabilitation Psychology of American Psychological Association*, Vol. 38( 4).
- Brunson, J. G. L., P.S. (2002). Impact of Sign Language Interpreter and Therapist Moods on Deaf Recipient Mood. *Professional Psychology: Research and Practise*, 33(6), 576-580.
- Butcher, J. N. (1996). *International Adaptations of the MMPI-2: Research and Clinical Applications*. London: University of Minnesota Press.
- Cambra, C. (2000). A comparative study of personality descriptors attributed to the deaf, the blind, and individuals with no sensory disability. In *Psychosocial Aspects of Deafness*. United States of America: Pearson Education Inc.
- Chovaz, C. (1998). Cultural Aspects of Deafness. In e. S. S. Kazarian & D. R. Evans (Ed.), *Cultural, Clinical Psychology: Theory, Research, and Practice*. New York: Oxford University Press.
- Christiansen, J. B., & Barnartt, S. M. (1995). *Deaf President Now!: The 1988 Revolution at Gallaudet University*. Washinton, D.C: Gallaudet University Press.
- Christiansen, K. (2000). *Deaf Plus: A Multicultural Perspective*. San Diego, CA: Dawn Sign Press.
- Clark, G. (2000). *Sounds from Silence: Graeme Clark and the Bionic Ear Story*. Australia: Allen & Unwin.

- Cooper, A., Rose, J., & Mason, O. (2004). Measuring the Attitudes of Human Service Professionals Toward Deafness. *American Annals of the Deaf*, 148.5(148.5), 385-389.
- Corker, M. (1994). *Counselling- The Deaf Challenge*. London: Jessica Kingsley Publishers.
- Corker, M. (1996). Deaf Transitions: Images and Origins of Deaf Families, Deaf Communities and Deaf Identities.
- Corrigan, P. W. (2005). *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*. Washington, DC: American Psychological Association.
- Dapin, M. (2004, August 21). Deaf, and proud. *Good Weekend*, 31-34.
- Dawkins, J. (1991). *Australia's Language: The Australian Language and Literacy Policy*. Canberra: Australian Government Printing Service.
- Denmark, J. (1994). *Deafness and Mental Health*. Great Britain:: Biddles Ltd., Guildford and King's Lynn.
- Denmark, J. C. (1966). Mental Illness and early profound deafness. *British Journal of Medical Psychology*, 39, 117-124.
- Denmark, J. C. (1994). *Deafness and Mental Health*. London: Jessica Kingsley Publishers.
- Dolnick, E. (1993). *Deafness as culture*.
- Einstein, A. (1954). *Ideas & Opinions*. NY: Bonanza Books.
- Elliott, H., Glass, L., & Evans, J. W. (1987). *Mental Health Assessment of Deaf Clients: A Practical Manual*.
- Emmorey, K. (1993). Processing a Dynamic Visual-Spatial Language: Psycholinguistic Studies of American Sign Language. *Journal of Psycholinguistic Research*, 22(2), 153-187.
- Emmorey, K. (2002). *Language, Cognition, and the Brain: Insights from Sign Language Research*: Lawrence Erlbaum Associates.
- Epting, F. L., A. W., (1985). *Anticipating Personal Construct Psychology*. Lincoln: University of Nebraska Press.
- Fiske, J. (1987). *British cultural studies and television. In Channels of discourse* Chapel

- Hill: University of North Carolina Press.
- Fransella, F., Bell, R., & Bannister, D.,. (2004). *A Manual for Repertory Grid Technique*. (2nd ed.). England: John Wiley & Sons, Ltd.
- Freud, S. (1971). *The Complete introductory lectures on psychoanalysis*. London: Allen & Unwin.
- Furth, H. G. (1973). *Deafness & Learning A Psychosocial Approach*: Wadsworth Publishing Company, Inc., Belmont, California.
- Gordon, A. (1977). Thinking with restricted language. A personal construct investigation of pre-lingually profoundly deaf apprentices. *British Journal of Psychology*, 68, 253-255.
- Graney, S. (1998). *Where Does Speech Fit In? Spoken English in a Bilingual Context*. Washington, D.C: Pre-College National Mission Programs Gallaudet University.
- Greene, R. L. (2000). *The MMPI-2 An Interpretive Manual* (Second ed.). Boston: Allyn and Bacon.
- Gregory, R. J. (1987). The Measurement of Adult Intelligence. In R. J. Gregory (Ed.), *Psychological Testing: Testing Principles and Applications* (2nd ed.) (Vol. William & Wilkins). Sydney: Allyn and Bacon.
- Gregory, R. J. (1996). *Psychological Testing: Testing Principles and Applications* (2nd edition ). Sydney: Allyn and Bacon.
- Gregory, S. (1976). *The Deaf Child and his Family*. New York:: Cambridge University Press.
- Gregory, S., & Hartley, G. M. (1992). *Constructing Deafness*. London: Pinter Publishers Limited.
- Groce, N. E. (1985). *Everyone Here Spoke Sign Language*: Harvard University Press.
- Gutman, V. (2002). *Ethics in Mental Health and Deafness*. Washington, D.C: Gallaudet University Press.
- Harris, J. (1995). *The Cultural Meaning of Deafness*. Sydney: Avebury.
- Hartlan, J. (1993). Teacher's Guide To Module ABJ558 : Appendix A Timeline.
- Hathaway, S. R. M., J.C. (1989). *Manual for Administration and Scoring MMPI-2*. Minnesota: University of Minnesota Press.
- Hearing, A. (Not specified ). Frequency and Intensity of Familiar Sounds Sydney

- Australian Hearing.
- Hearing, A. (Not specified ). Frequency and Intensity of Familiar Sounds. In A. T. A. N. Ltd (Ed.) (pp. Frequency in ertz). Sydney: Australian Hearing.
- Higgins, P. C. (1980). *Outsiders in a Hearing World A Sociology of Deafness*. London: Sage Publications.
- Hindley, P., Kitson, N., & Leach. V. (2000). Forensic Psychiatry and Deaf People. In P. Hindley, Kitson, N., & Leach. V. (Ed.), *Mental Health and Deafness*. London: Whurr Publishers.
- Hjortso, T., von der Lieth, L., & Carlsen, C. (2001). *Mental Health Services for Deaf People: A Worldwide Perspective ii*. Paper presented at the Mental Health Services for Deaf People: A Worldwide Perspective i, Copenhagen.
- Hobson, R. E. (1989). *Forms of Feeling - The Heart of Psychotherapy*. London: Tavistock Publications Ltd.
- <http://www.bris.ac.uk/Depts/DeafStudiesTeaching/psy/Lecture%204%Psycholinguistic>. (2004). Psycholinguistics of Signed Languages. Retrieved 5th January, 2004
- Jankowski, K. A. (1998). *Deaf Empowerment emergence, struggle, & rhetoric*. Washington, D.C: Gallaudet University Press.
- Johnston, T. (2004) *W(h)ither the Deaf Community? Population, Genetics, and the Future of Australian sign Language*. American Annals of the Deaf. 148.5,358-375
- Johnston, T & Schembri, A. (2007) *Australian Sign Language: An introduction to sign language linguistics*. Cambridge University Press. Cambridge.
- Jourade, S. M. (1971). *The Transparent Self*. Litton Educational Publishing Inc.
- Jung, C. (1964). *Man & His Symbols*. London: Aldus Books.
- Kaplan, R. M. S., D.P. (1993). *Psychological Testing: Principles, Applications and Issues* (3 ed.). California: Brooks/Cole Publishing Company.
- Kazarian, S. S. E., D.R. (1988). *Cultural, Clinical Psychology : Theory, Research and Practice*. New York: Oxford University Press.
- Kelly, G. (1955). *The Psychology of Personal Constructs* (Vol. 1). New York: W.W. Norton & Company.
- Kelly, G. (1955). *The Psychology of PERSONAL CONSTRUCTS: A Theory of Personality* (Vol. One). New York: W.W. Norton & Company. Inc. .

- Kelly, G. (1969). *Clinical Psychology and Personality: The Selected Papers of George Kelly*. New York: John Wiley & Sons, Inc.
- Kelly, G. A. (1955). *The Psychology of Personal Construct: (Vol. 2)*. New York: W.W. Norton & Company.
- Kelly, G. A. (1970). A Brief Introduction to Person Construct Theory. In D. Bannister (Ed.), *Perspectives in Person Construct Theory* (pp. 1-30). London: Academic Press.
- Kitson, N. (1998). *First International Conference for Mental Health and Deafness*. Paper presented at the First International Conference for Mental Health and Deafness, Gallaudet University, Washington DC.
- Koester, L. S., & Meadow-Orlans, K.P. (Eds.). (1990). Parenting a deaf child: Stress, strength, and support. In D. F. M.-O. Moores, K.P. (Ed.), *Educational and developmental aspects of deafness* (pp. 229-320). Washington, D.C.: Gallaudet University Press.
- Landfield, A. W. L., L.M. (1980). *Personal Construct Psychology: Psychotherapy and Personality*. New York: John Wiley & Sons.
- Lane, H. (1992). The Mask of Benevolence. In *Deaf Transitions: Images and Origins of Deaf Families, Deaf Communities and Deaf Identities*. London: Kingsley Publishers.
- Lane, H., Hoffmeister, R. & Bahan, B. (1996). *A Journey into the Deaf-World*. San Diego, California: Dawn Sign Press.
- Lane, H. P., F. (1984). *The Deaf Experience: Classics in Language and Education*. London: Harvard University Press.
- Leigh, I. W., Corbett, C.A., Gutman, V. & Morere, D.A. (1996). Providing Psychological Services to Deaf Individuals: A Response to New Perceptions of Diversity. *Professional Psychology: Research and Practise*, 27(4), 364-371.
- Leigh, I. W., & Lewis, J. (1999). Deaf Therapists and the Deaf Community: How the Twain Meet. In I. W. Leigh (Ed.), *Psychotherapy with Deaf Clients from Diverse Groups* (pp. 45-65). Washington, D.C.: Gallaudet University.
- Leigh, I. W. (1999). *Psychotherapy with Deaf Clients from Diverse Groups*. Washington, D.C: Gallaudet University.
- Levin, E. S. (1967). *The Psychology of Deafness: Techniques of appraisal for Rehabilitation*. New York: Colombia University Press.

- Lucas, C. (2004). *Language and the Law in Deaf communities* (Vol. 9). United Kingdom: Oxford University Press.
- Luckner, J. L., & Stewart, J. (2003). Self-assessments and other perceptions of successful adults who are Deaf: An initial investigation. *American Annals of the Deaf*, 148(3), 243-250.
- Luterman, D. (1979). *Counseling parents of hearing-impaired children*. Boston: Little, Brown.
- MacDonald, P. J. (1980). Is Personal Construct Theory Useful in Studying the Hearing-Impaired? *Brit..Assn. Teachers of the Deaf*, 4(5), 161-167.
- Mahshie, S. (1997). *A First Language: Whose Choice Is it?* : Pre-College National Mission Programs, Gallaudet University.
- Marschark, M. (1993). *Psychological Development of Deaf Children*. New York: University Press.
- Marschark, M. W., J. (1982). *Language and the Maintenance of Ethnic Boundaries in the Deaf Community: Conference and Communication*. Philadelphia.
- Mitchell, R. E., & Karchmer, A. A. (2004). Chasing the mythical ten percent: parental hearing status of Deaf and hard of hearing students in the United states. *American Annals of the Deaf*, 4(2), 138.
- Monte, C. F. S., R. N. (2003). *Beneath The Mask: An Introduction to Theories of Personality. Seventh Edition*. United States of America: John Wiley & Sons, Inc.
- Moore, D. F. M., P.A. (1996). Gender Differences in "Wechsler Performance Scores of School - Age Children Who Are Deaf or Hard of Hearing". *American Annual of The Deaf*, 141.(1), 19-43.
- Munro-Ludders, B., T., S., & Zvetina, D. (2004). Making public mental-health services accessible to Deaf consumers: Illinois Deaf Services 2000. *American Annals of the Deaf*, 148.5(148.5), 396-403.
- Mutton, P. (2006). SWISH. In O. Rodrigues (Ed.) (pp. discussion regarding cochlear implants and the Deafness Centre). Sydney: Rodrigues, O.
- Myklebust, H. R. (1966). *The Psychology of Deafness: Sensory Devprivation, Learning, and Adjustment* (Second Edition ed.). New York: Grune & Stratton.
- Napier, J. B., R. (2004). *Sign Language Interpreting: The Relationship Between*

- Metalinguistic Awareness and the Production of Interpreting Omissions. *Sign Language Studies*, 4(4), 369-393.
- News, B. D. (Writer) (1994). British Deaf News. Britain.
- Noordhoff, W. (1989). *Snijders-Oomen Non-Verbal Intelligence Test (SON-R 5 ½ 17*. Holland.
- Oblowitz, N., Green, L., & Heyns, I. (1991). *A Self-Concept Scale for the Hearing Impaired*. *Volta Review*, 93(1), 19-29.
- Ozolins, U. B., M. (1999). *Sign Language Interpreting in Australia*. Melbourne: Languages Australia.
- P.E., V. (1982). The Ability and Achievements of Orientals in North America (1994). In J. P. Braden (Ed.), *Deafness, Deprivation, and IQ*. New York: Plenum Press.
- Padden, C. H., T. (1988). *Deaf in America Voices from a Culture*. United States of America: Harvard University Press, Cambridge, London.
- Padden, C. H., T. (1988). Learning to be Deaf. In S. H. Gregory, G.M. (Ed.), *Constructing Deafness* (pp. 7-22). Great Britain: Pinter Publishers Limited.
- Padden, C. H., T. (2005). *Inside Deaf Culture*. London, England: Harvard University Press.
- Patterson, J. (1997). Renwick College - Thomas Patterson School for Deaf and Blind Children. (pp. Personal communication). Sydney.
- Paul, P. V., & Jackson, D.W. (1993). *Toward a psychology of deafness*. Boston:: Allyn and Bacon.
- Phillips, B. A. (1996). Bringing Culture to the Forefront: Formulating Diagnostic Impressions of Deaf and Hard-of-Hearing People at Times of Medical Crisis. *Professional Psychology: Research and Practise*, 27(2), 137-144.
- Phillips, B. A. (1996). Bringing culture to the forefront: Formulating diagnostic impressions of deaf and hard of hearing people at times of medical crisis. In I. W. Leigh (Ed.), *Psychotherapy with Deaf Clients from Diverse Groups* (pp. 23-43). Washington, D.C.: Gallaudet University.
- Pinter, R. P., D.G. (1915a). The Binet Scale and the deaf child. *Journal of Educational Psychology*.
- Pollard, R.Q., Jr.,(1996) *Professional Psychology and Deaf People: The Emergence of a*

*Discipline*. Vol. 51, No. 4, 389-396

- Power, D. (22nd April 1997). *Auslan Proficiency Rating Scale*. Queensland: Faculty of Education Griffith University, Centre for Deafness and Communication Studies.
- Raifman, L. J. V., M. (1996). Important Implications for Psychologists of the Americans With Disabilities Act: Case in Point, the Patient Who Is Deaf. *Professional Psychology: Research and Practise*, 27(4), 372-377.
- Raskin, J. D., Weihs, K. D. & Morano, L. A. (2005). Personal construct psychotherapy meets constructivism: convergence, divergence, possibility. In D. A. V. Winter, L. L (Ed.), *Personal Construct Psychotherapy: Advances in Theory, Practice and Research* (pp. 3-20). London: Whurr Publishers Ltd.
- Rodrigues, O. (2000). CD ROM Auslan version MMPI-2. In R. Barber (Ed.) (pp. Development of instrument). Sydney: Rodrigues, O.
- Rodrigues, O. (2001, 18-21 of October 2000). *Personal Development Program for Primary Deaf Children: Promoting a Positive Regard for their Mental Health*. Paper presented at the Mental Health Services for Deaf People, A Worldwide Perspective., Copenhagen, Denmark.
- Rodrigues, O. (2006). Interpretations of MMPI-2 Auslan CD ROM version. In W. Howe (Ed.) (pp. How to compare both versions of the MMPI-2 tests). Wollongong.
- Sainsbury, S. (1986). *Deaf Worlds: A Study of Integration, Segregation and Disability*. London: Hutchinson & Co. (Publishers) Ltd.
- Sattler, J. M. (1986). *Assessment of Children: Revised and Update*. San Diego: Jerome M. Sattler Publisher Inc.
- Scheetz, N. A. (2004). *Psychosocial Aspects of Deafness*. Boston: Pearson.
- Schein, J. D. S., D. A. (2002). *Language in Motion: Exploring the Nature of Sign*. Washington D.C: Gallaudet University Press.
- Schembri, A. (1996). *The Structure and Formation of Signs in Auslan (Australian Sign Language)* (Vol. 2). North Rocks: North Rocks Press.
- Slade, M., Thornicroft, G., & Glover, G. (1999). *the feasibility of routine outcome measures in mental health*. London: Section of community psychiatry (PRiSM) institute of Psychiatry.
- Society, T. D. (1994). "The Deaf Community Family" Conference [Video]. Sydney:

Supervision Deaf Communication Video Production.

- Stern, M. (2006). <http://www.i711.com/wireless/index>. Go America. Retrieved November 2006
- Stolk, Y., Ziguras, S., Saunders, T., Garlick, R., Stuart, G., and Coffey, G. (1998). Lowering the language barrier in an acute psychiatric setting. *Australian and New Zealand Journal of Psychiatry: Psychiatry at the Interface.*, 32.
- Sullivan, P. M., & Vernon, M. (1979). Psychological Assessment of Hearing-Impaired Children. School Psychological Digest. In J. P. Braden (Ed.), *Deafness, Deprivation, and IQ* (Vol. 8, pp. 271-290). New York: Plenum Press.
- Sussman, A. E. (1999). *Psychotherapy with Deaf Clients from Diverse Groups*. Washington, D.C.: Gallaudet University.
- Tavormina, J. B., Boll, T. J., Dunn, N. J., Luscomb, R. L., & Taylor, J.R. (1981). Psychosocial effects on parents raising a physically handicapped child. In *Journal of Abnormal Child Psychology*. (Eds. ed., Vol. 9, pp. 121-131).
- Taylor G. & Darby, A. (2003). *Deaf Identities*. England: Cromwell Press.
- Taylor G. & Darby, A. (2003). *Deaf identities*. England: Cromwell Press.
- Timmermans, L. (1988). *Research Project*. Paper presented at the First European Congress on Mental Health and Deafness, Rotterdam, Holland.
- Van Cleve, J. V. C., B.A. (1989). *A Place of Their Own: Creating the Deaf Community in America*. Washington, D.C: Gallaudet University Press.
- Van Drenth, A. (2003). "Tender Sympathy and Scrupulous Fidelity" : gender and professionalism in the history of deaf education in the United States. *International Journal of Disability*, 50(4), 367-383.
- Vernon, M., & Andrews, J. (1990). *The Psychology of deafness*. New York: Longman.
- Vernon, M. B., D.W. (1994). A Guide to Psychological Tests and Testing Procedures in the Evaluation of Deaf and Hard-of-Hearing Children. In J. P. Braden (Ed.), *J.P. Braden (1994) Deafness, Deprivation, and IQ*. (Vol. 29, pp. 414-423). New York: Plenum Press.
- Vernon, M. D.-K., B. (1999). Historical overview of inpatient care of mental patients who are deaf. *American Annals of the Deaf*, Washington(vol. 144), 51 - 61.
- Vernon, M. R., S. (1997). Paedophilia and Deafness. *American Annals of the Deaf*,

142(4), 300-311.

- Von Cleve, J. V. (1987). The Gallaudet Encyclopaedia of Deaf People and Deafness. In (Vol. Vol.2. H-R.). Washington, D.C: Gallaudet University Press.
- Walker, L. A. (1987). *A Loss For Words: The Story of Deafness in a Family*: Harper & Row Publishers Inc.
- Wechsler, D. (1939). *The Measurement of Adult Intelligence*. Baltimore, M.D: William & Wilkins.
- Whiltshire, C. (1997). *A Critical Review of Psychiatry and Deafness*.
- Willis, R. G. V., M. (2002). Residential psychiatric treatment of emotionally disturbed deaf youth. *American Annals of the Deaf*, 147, 31- 34.
- Winter, D. A. (1992). *Personal Construct Psychology in Clinical Practice: Theory, research and applications*. London: Routledge.
- Woodward, J. (1972). Implications for sociolinguistic research among the deaf. Sign language Studies. In S. S. E. Kazarian, D. R. (Ed.), *Cultural, Clinical Psychology: Theory, Research, and Practice*. New York: Oxford University Press.
- Woodward, J. (1982). *How you Gonna Get to Heaven if You Can't Talk With Jesus: The Educational Establishment Vs. The Deaf Community*. Washington, D.C: Gallaudet Press.
- Woodward, J. M., H. (1975, January 1975). *Some Handy New Ideas on Pidgins and Creoles: Pidgin Sign Languages*. Paper presented at the International Conference on Pidgin and Creole Languages, Honolulu.
- Wright, D. (1969). *Deafness*. New York: Stein and Day Publishers.
- Zazove, P., Neimann, L.C., Gorenflo, D.W., Carmack, C., Mehr, D., Coyne, J.C., & Antonucci, T. (1993). The Health status and health care utilization of deaf and hard-of-hearing persons. In I. W. Leigh (Ed.), *Psychotherapy with Deaf Clients from Diverse Groups*. Washington, D.C.: Gallaudet University.
- Zazove, P. M., H.E.; Derry, H. A.; Gorenflo, D.W.; Burdick, S.W. ; Saunders, E.W. (2004). Deaf persons and computer use. *American Annals of the Deaf*, 148.5, 376-384.
- Zieziula, F. R. (1982). *Assessment of hearing-Impaired People: A Guide for Selecting Psychological Education, and Vocational Tests*. Washington D.C: Gallaudet Press.

# APPENDICES

## **APPENDIX A**

### **MINNESOTA MULTIPHASIC INVENTORY -2 (MMPI-2)**

#### **BACK TRANSLATION**

## **Back Translation – completed by Robert Adam – Deaf Linguist**

1. I like read mechanic magazines
2. I usually eat well
3. I feel good every morning when I wake up
4. I think I would like working in a library
5. I wake up easily
6. My father is a good man but if your father is dead your father was a good man
7. I like to read crime stories in the newspapers
8. Usually my hands and feet are warm enough
9. I have enough interesting things in my life to keep me busy
10. I am as fit as I use to be and I can continue to work
11. Often I have a lump in my throat
12. I'm satisfied with my sex life
13. People should try understand their dreams and take them seriously
14. I like reading detective sand magic stories
15. I feel a lot of tension at work
16. Sometimes I think of things so bad I can't talk about them
17. I know life gives me bad things, shits
18. I Often get sick and vomit
19. Every time I get a new job I like to find out who I have to be nice to
20. I rarely have trouble with my bowel movement and am regular
21. Sometimes I want to leave home
22. No one understands me
23. Sometimes I start laughing or crying and I can't control myself
24. Sometimes I am possessed by evil spirits
25. I like to fantasize about being a singer
26. I know it is best to keep my mouth shut than get into trouble
27. I believe when people do bad things to me I should get revenge
28. Several times per week I feel physically sick in the tummy and I want to vomit

29. I feel like swearing
30. Often I have bad dreams everyday
31. I find it very difficult to focus on things
32. Often I have strange experiences
33. I'm not worried about my health
34. I don't have a problem with my sexual behaviour
35. When I was young I use to steal things sometimes
36. Most of the times I have a cough
37. I have destructive tendencies
38. Sometimes for days or weeks on end I can't do anything.
39. Often I wake up a lot through the night
40. Often my head hurts all over
41. I don't always tell the truth
42. If people did not hold grudges against me I would succeed more
43. My sense of judgement is the best it has ever been
44. Sometimes once a week I feel hot all over, I don't know why?
45. My physical wellbeing is the same as my friends
46. When I see people I have not seen for a long time, I would prefer not to speak to them unless spoken to.
47. I almost never feel any sort of pain in my heart or chest
48. Most of the time I like to sit and fantasise. I would rather do this than doing other things.
49. I like to meet with people and talk to them.
50. I often get told what to do but people don't know I know more than they do
51. I don't read the editorials in the papers every day
52. I haven't lived the right life
53. I often feel a burning sensation, or crawling insects or numbness on my body
54. My choice of career was not approved of by my family
55. Sometimes I want to talk about something but other people get fed up with it
56. I am not as happy as other people seem
57. I never feel pain in my neck

58. I think when people describe their misfortune they make it sound worse to elicit sympathy
59. I have a feeling of discomfort in my stomach for a few days on end
60. When I am with other people I often feel anxious when I hear strange things
61. I am an important person
62. I often wish I was a girl. I am sure I would be happy if I were a girl
63. My feelings are not easily hurt.
64. I enjoy reading love stories
65. Most of the time I feel depressed
66. I am sure it would be best to have all laws abolished.
67. I love reading poetry
68. Sometimes I torment animals
69. I think the job of a forest ranger would be something I'd like to do.
70. I am easily defeated in an argument
71. I find it hard to feel I can succeed; I give up easily
72. Sometimes my soul leaves my body
73. It is true that I don't have much self-confidence
74. I like the work of a florist, I like arranging flowers
75. I feel life is worth living
76. Most people need a lot of convincing to be persuaded of the truth
77. Sometimes I should do things today and not procrastinate until tomorrow.
78. Most people who know me like me
79. I don't care if people who know me make fun of me
80. I'd like to work as a nurse
81. I think most people tell lies for personal gain and self advancement
82. I often do things that I later regret, and I feel that this happens to me more than other people
83. My family don't argue much with me
84. When I was at school I was suspended a few times for bad behaviour
85. Sometimes I feel I want to hurt or shock people
86. I like parties and social events where there is loud fun

87. Sometimes when I have a problem I find it hard to make a choice when there are many possibilities
88. I think women should be free to have sex as men do
89. I have the most struggle with myself.
90. I love my father. If your father recently died, you must have loved him too.
91. My muscles don't bulge, twitch, jump or hurt at all.
92. I don't care what happens to me at all.
93. Sometimes I don't feel well and it makes me irritable
94. Sometimes I feel evil and do something wrong.
95. Most of the times I feel happy
96. I have seen animals, people and things which other people can't see
97. I feel full in my head and nose most of the time
98. Sometimes people are too bossy and I feel I want to rebel and not do what I am told
99. I know someone has a grudge against me
100. I never do exciting or dangerous things for the thrill
101. Often I feel my head is tightly constricted
102. Sometimes I feel angry
103. I enjoy competitions and playing games where I can have a bet.
104. Most people are honest because they are frightened of being caught.
105. At school I was sometimes sent to the principal because I was naughty
106. My speech or my signing is always the same, never faster or slower
107. My table manners are better with company than at home
108. People who can work hard will be successful in the future
109. I feel I can be as clever as other people
110. Most people use dishonesty to achieve a target or make a profit.
111. I have a lot of problems with my stomach
112. I enjoy dramatics and theatre
113. I know who causes a lot of trouble for me
114. Sometimes I am attracted to peoples shoes or gloves and want to steal them for myself but I will never use them

- 115. I have seen blood and it does not frighten me or make me sick
- 116. I often don't understand why I am cranky or irritable
- 117. I never vomit or cough up blood
- 118. I am not worried about catching diseases
- 119. I like collecting flowers and growing house plants
- 120. I often feel I must stand up for what I think is right
- 121. I never get involved in bizarre sex
- 122. Sometimes my thoughts work faster than my speech/signing
- 123. If I could get in to see a movie for free and no one caught me, I would do it.
- 124. Sometimes people are nice to me but I am suspicious of their motives
- 125. I think my home life is nice and the same as other peoples
- 126. I believe laws and police should be obeyed
- 127. When I am criticised or told off I feel hurt
- 128. I like cooking
- 129. My behaviour is the same as that of other people
- 130. Sometimes I feel hopeless and can't do anything
- 131. When I was a young child my friends all stuck together, we tried to be loyal no matter what happened, even through trouble.
- 132. I believe in an afterlife after death
- 133. I want to become a soldier
- 134. Sometimes I feel like fighting with someone
- 135. I often miss out on things because of hesitation
- 136. When I am doing something important I am always interrupted by people asking for my advice and I get fed up and lose my patience with them.
- 137. I have kept a diary in the past.
- 138. I think people plot against me.
- 139. When I play games, I would rather win and not lose
- 140. Most nights I sleep well without worrying over other things which interfere with sleep.
- 141. In the past few years I have been in good health most of the times
- 142. I have never had a fit in my life

143. My weight is constant.
144. I feel sometimes someone is following me.
145. I often feel punished for nothing.
146. I cry easily
147. I used to be able to read better but now I don't understand what I read.
148. I feel the best I have ever felt.
149. Sometimes I feel tender on the top of my head.
150. Sometimes I feel the urge to hurt other people or myself.
151. I hate people who trick me and make me believe things that are not true.
152. I don't tire easily
153. I like to knowing important people, they make me feel important
154. I have a fear of heights
155. It does not frighten me when members of my family get into trouble with the police.
156. I love travelling and sightseeing. IT makes me happy. When I am not travelling I am not happy.
157. I don't care what other people think of me.
158. I don't like showing off at parties where there are other people showing off.
159. I have never fainted in my life.
160. I liked school.
161. I often try to hide my blush when I am embarrassed.
162. Someone has tried to poison me.
163. I don't have a fear of snakes.
164. I almost never feel dizziness.
165. My memory is good.
166. I am worried about sex.
167. I find it hard to make conversation when I meet new people.
168. Sometimes I do things which at other times I can't remember doing.
169. When I am bored I try to make life interesting.
170. I am frightened of losing my mind.
171. I don't believe in giving money to beggars.

172. I notice that when I try to do things my hands tremble.
173. I can read for long periods of time and my eyes do not feel tired.
174. I like studying about the things that I do for a job.
175. Most of the time I feel weak all over my body
176. I rarely get headaches
177. My hands don't fumble and I can do things with them.
178. Sometimes when I feel embarrassed, I sweat and it is a problem.
179. When I walk my sense of balance is good.
180. There is something wrong with my mind.
181. I never get asthma or hay fever.
182. I often find I can't control my movements, speech or signing but my mind knows what is going on around me.
183. All the people I know I don't like.
184. I rarely dream or fantasise.
185. I wish I was not so shy.
186. Financial transactions do not frighten me.
187. If I were a reporter I would be most interested in the performing arts.
188. I enjoy different recreational activities.
189. I like flirting with people.
190. People who I know see me as a child and not as an adult.
191. I would like to work as a journalist.
192. My mother was a good woman. If your mother died, my mother was a good woman.
193. When I walk I always try not to step on cracks in the footpath.
194. My skin never gives me cause for concern.
195. My family don't give me as much love or affection as other people get.
196. I often worry about something.
197. I think I would like to work as a building contractor.
198. I often hear voices in my head.
199. I am interested in science.
200. I am not worried about asking for help as I know I can't return the favour.

201. I am interested in hunting animals.
202. My parents always criticised me and were never happy with my friends.
203. Sometimes I gossip a little.
204. My hearing is good and the same as that of other people.
205. Some of my family members have habits that annoy me.
206. Sometimes I feel I can make a decision easily.
207. I like joining different clubs.
208. I never have heart palpitations or feel short of breath.
209. I like talking about sex.
210. I enjoy visiting places where I have never been.
211. I feel a responsibility to follow my life as it has been planned.
212. Sometimes people try to do things that I don't agree with and I try to stop them because of my different opinion.
213. I lose my temper and then forget about it quickly.
214. I have always been independent and free and I am not obliged to do as I am told by my family.
215. I dwell on things that happen to me.
216. Someone has tried to steal from me.
217. My family and relatives feel sympathy for me.
218. Sometimes I can't sit still for long periods and feel restless.
219. I feel disappointed with my love life.
220. I am not worried about my looks.
221. I often dream about things that I don't tell other people about.
222. Children should be taught the important things about sex.
223. I think people are nervous about the same things that I am nervous about.
224. I feel few or no pain.
225. My way of doing things, other people don't understand.
226. Sometimes there is no reason why things go wrong, I still feel on top of the world.
227. I can't blame other people for taking what they can in this world.
228. Some people try to steal my thoughts and ideas.

- 229. Sometimes I black out and can't remember what I am doing and I don't know what is happening around me.
- 230. When other people do things wrong, I can still be friends with them.
- 231. I like being with groups of people who make jokes and tease each other.
- 232. Sometimes when I vote, I vote for people I don't know about.
- 233. I find it difficult to start work.
- 234. I believe I am a failure and a blameworthy person.
- 235. I was a slow learner at school.
- 236. If I were an artist, I would like to draw flowers.
- 237. I am not worried about not being good looking.
- 238. I sweat easily even on cool days.
- 239. I am confident with myself.
- 240. Sometimes I can't stop stealing from the shop.
- 241. I think it is safest not to trust anyone.
- 242. Once a week or more, I become very excited.
- 243. When I am in a group of people I have found it difficult to think what to talk about.
- 244. I have felt depressed but when something exciting happens, I feel better.
- 245. I usually leave home and don't worry about whether the doors or windows are shut or locked.
- 246. I believe my sins can not be forgiven.
- 247. I have felt dead or numb in certain parts of my body.
- 248. I can't blame people who take advantage of other people.
- 249. My eyesight has always been good.
- 250. Sometimes I think criminals are clever and I am fascinated by their stories and I hope they don't get caught.
- 251. I often feel strange people are watching me and criticising me
- 252. My sense of taste has always been the same.
- 253. I drink a lot of water.
- 254. Most people make friends with each other because it can be mutually helpful.
- 255. When my ears buzz I don't notice it.

- 256. I usually love my family but sometimes I hate them
- 257. If I were a reporter I would love to work on the sports news.
- 258. I can sleep well during the day but not at night.
- 259. I am sure people talk about me behind my back.
- 260. Sometimes I laugh at dirty jokes.
- 261. I rarely am frightened of things – my friends are more scared of things than I am.
- 262. In groups of people when I am expected to initiate conversation or give an opinion over something I know well, I don't have a problem.
- 263. I think lawyers should be ashamed of themselves for twisting the truth so criminals can get away with things.
- 264. I have drunk too much alcohol in the past.
- 265. I usually wait for the other person to initiate a conversation.
- 266. I have never been in trouble with the police.
- 267. Sometimes I feel happy and cheerful for no reason.
- 268. I wish I was not so worried about sex.
- 269. When there is trouble, groups of people should agree on a story and stick to it.
- 270. When I see animals in pain I am not worried by it.
- 271. I think I feel more intensely than other people do.
- 272. I have never liked playing with dolls.
- 273. Life gives me a lot of stress.
- 274. I am sensitive about a lot of things and get so upset I cannot talk.
- 275. At school I could not get up to talk in front of my class.
- 276. I love my mother. Maybe your mother has died, I love my mother.
- 277. When I am with people I still feel lonely sometimes.
- 278. I feel right when people give me sympathy; I deserve it.
- 279. I refuse to participate in some games because I am not good at them.
- 280. I can make friends quickly like other people.
- 281. I don't like having people around me.
- 282. People tell me I sleepwalk whilst asleep.
- 283. If people are careless with valuables, it serves them right if they get stolen, they are to blame.

284. I think most people will lie when they are in trouble.
285. I am more sensitive than other people are.
286. I know most people can't be bothered with helping other people.
287. I dream often about sex.
288. My parents and family always find fault with me.
289. I am easily embarrassed.
290. I am always worried about money and my financial affairs.
291. I have never fallen in love with anyone.
292. My family does things that frighten me.
293. I rarely dream, in fact I almost never dream.
294. My neck is often red.
295. I have never been paralysed on one side or had or weakness in the muscles.
296. Sometimes I lose my voice or it changes and I don't even have a cold.
297. My parents used to make me obey them even when sometimes I thought it was not fair, and I still obeyed them.
298. Sometimes I can smell strange smells.
299. I find it hard to focus my mind on one thing.
300. I have a good reason to be jealous of members of my family.
301. I feel anxious about someone almost all the time.
302. I lose my patience with people easily.
303. Most of the time I wish I was dead.
304. Sometimes I feel so excited I can't sleep.
305. I think I have had my share of worries in my life.
306. No one is worried about or cares about what happens to you.
307. Sometimes my hearing is so acute it worries me.
308. I forget what people tell me almost straight away.
309. I think twice before I do things, no matter how small.
310. I often cross the road to avoid seeing people I know.
311. I often feel things are not real.
312. I am only interested in the comics in the newspaper.
313. I have a habit of counting things, including bolts on signs.

- 314. I don't have any enemies – no one wants to hurt me.
- 315. Sometimes when I meet people who are friendly, I am often careful with them.
- 316. I have strange thoughts often.
- 317. When I must leave my home for a short time I often worry and get upset.
- 318. Most of the things I do, I think I will succeed.
- 319. When I am alone, I often hear strange things.
- 320. I am still scared of things and people I see and know won't hurt me.
- 321. When I walk into a group of people in a room, I am not nervous.
- 322. I don't like sharp knives or knives that have pointed ends.
- 323. Sometimes I hurt people I love for fun
- 324. I can make people frightened of me for fun.
- 325. I have a problem concentrating on the one thing, most people can.
- 326. Most of the time when I do something I give up because I don't have any confidence and think I can't do it.
- 327. Often bad words come into my mind and I can't make them go away.
- 328. Sometimes unimportant thoughts occur to me and bother me for days.
- 329. Things happen almost every day which frighten me.
- 330. Sometimes I am full of energy
- 331. I am inclined to take things hard.
- 332. Sometimes I enjoy being hurt by someone I love.
- 333. People say rude and offensive things about me.
- 334. I don't feel comfortable in houses.
- 335. I don't usually think about myself.
- 336. Someone else has control over my mind.
- 337. When I go to parties, I usually sit by myself and talk to people individually and not to groups.
- 338. People often disappoint me.
- 339. Sometimes I feel difficult situations build up on me and I cannot overcome them.
- 340. I love going dancing.
- 341. Sometimes my mind works slower than usual.
- 342. When I catch the bus or train I often talk to strangers.

- 343. I enjoy the company of children.
- 344. I enjoy gambling small amounts of money.
- 345. If I had a chance I could do anything to improve the world.
- 346. I often meet people who are very knowledgeable and find they are no better than me.
- 347. When I hear about someone I know who has done well, I usually feel like a failure.
- 348. I often wish I was a child again.
- 349. I am happiest when I am alone.
- 350. If I am given a chance I would be a good community leader.
- 351. When people tell dirty stories I am embarrassed.
- 352. People will stand for their rights more than other people do for others.
- 353. At special gatherings I always enjoy myself as I like being with people.
- 354. When I hear good stories, I always try to remember them so I can tell other people about them.
- 355. I feel in my life sometimes someone has made me do things without my control. I can see a presence in front of my eyes.
- 356. When I start an activity, I find it hard to stop and put it aside, even for a short period of time.
- 357. I often don't hear gossip from my group of friends.
- 358. I have good ideas which other people are jealous of because they didn't think of these first.
- 359. I enjoy being with crowds of people.
- 360. I like meeting new people, strangers.
- 361. Someone has tried to influence my mind.
- 362. I have pretended to be sick to avoid doing things I have planned.
- 363. When I am with friends I am cheerful and forget my worries.
- 364. Things have gone wrong and made me give up easily
- 365. I think I would like to express my ideas or beliefs so other people know what I think.
- 366. I have felt energetic before and gone for days without needing sleep.

- 367. I often avoid crowds whenever possible.
- 368. When situations are difficult I avoid them.
- 369. I get tired of things that are not considered worthwhile by other people.
- 370. I like parties and social events.
- 371. I often wish I was of the opposite sex.
- 372. I am not easily irritated and am very placid.
- 373. In the past I have done bad things which I never tell other people about.
- 374. Most people can use unfair ways to achieve what they want in life and get ahead.
- 375. When people ask me personal questions, I feel nervous.
- 376. I feel I cannot plan my future.
- 377. I am not happy with myself at the moment.
- 378. My family and friends always give me advice about my life and it makes me angry.
- 379. As a child I was beaten many times for being naughty.
- 380. I am not comfortable with people saying nice things about me.
- 381. I don't like hearing other people's ideas about life.
- 382. People I am close to can have terrible disagreements with me.
- 383. When terrible things happen to me I know my family will support me.
- 384. I used to like playing houses as a child
- 385. I have no fear of fire.
- 386. I often avoid a particular person so as not to say things I will later regret.
- 387. When I drink alcohol I can express my true feelings.
- 388. I am rarely depressed.
- 389. When people talk about me they know I have a bad temper.
- 390. I often say things that I know I will hurt people which worries me, and I wish I wasn't worried about this.
- 391. I can't tell other people about myself.
- 392. I am frightened of lightning
- 393. I like making people wonder what I will do next.
- 394. Often my plans become too difficult and I give up on them.
- 395. When it is dark and I am on my own, I am frightened.

396. I feel bad sometimes when I try to help people in difficulty and they misunderstand me.
397. Wind and storms frighten me.
398. I often ask people for advice.
399. We don't know what the future holds for us and so don't need to make serious plans.
400. Often things go well for me but sometimes I feel I don't care about anything.
401. I am not frightened of water.
402. When something comes up, I need to sleep and think on it first.
403. People sometimes misunderstand I was trying to help and put them right, they don't understand me.
404. I have no trouble swallowing.
405. I am always calm and don't get upset easily.
406. I know for sure I will enjoy defeating the criminals.
407. I should be punished for my sins.
408. When I am disappointed, I find it hard to forget.
409. I have problems with people watching what I am doing at work – I know what I am doing.
410. I get angry with people who jump queues and I challenge them.
411. Sometimes I think I am no good.
412. When I was young I often used to miss school, even though I knew I should have gone.
413. There are nervous people in my family.
414. Sometimes I have to be rough with people who are rude to me or interfere with me.
415. I often worry about things going wrong.
416. I have a strong belief in politics.
417. I would like to be a car racer.
418. I think it's alright to find a way around the law and twist the truth if you don't break the law.
419. I don't like some people and when things go wrong for them, I am delighted.

- 420. When I have to wait for something it makes me nervous.
- 421. I can give up doing something if people think I am doing it wrongly.
- 422. When I was young I loved being excited.
- 423. When my ideas were challenged I would persist in winning the argument.
- 424. People on the street or in the shops often look at me and it bothers me.
- 425. My father or step-father was very strict with me as a child.
- 426. As a child I loved playing hopscotch or with a skipping rope.
- 427. I have never had a vision
- 428. I have worked through life and changed my mind a few times.
- 429. I have never taken drugs or sleeping tablets unless ordered by my doctor.
- 430. I often feel terrible because I am always in a bad mood.
- 431. I always received bad marks for my behaviour in school.
- 432. I am fascinated with fire.
- 433. When I feel trapped, I have to tell a white lie to avoid getting into trouble.
- 434. When I am in trouble, even if my friends are equally at fault, I would rather take the blame.
- 435. At night I often feel frightened.
- 436. When a man is with a woman he often thinks about sex.
- 437. When I try to encourage or advise people, I am always very direct.
- 438. I am frightened of earthquakes.
- 439. I am not always convinced of people's ideas.
- 440. I always try to work things out by myself and I don't like to ask to be shown how.
- 441. I am scared of enclosed spaces and being locked in a cupboard.
- 442. I have to admit sometimes I worry about trifling and unimportant things.
- 443. I never hide my thoughts or pity for people and stop them from seeing how I feel.
- 444. I am a very highly strung person.
- 445. At work my boss always gets the praise when things go well and I always get the blame, and he doesn't.
- 446. I am very reserved and find it hard to stand up for my rights.
- 447. I am scared and revolted by dirt.

- 448. I have a dream life I never tell people about.
- 449. Some members of my family have bad tempers.
- 450. I can't do anything well.
- 451. I feel guilty sometimes because I pretended to show concern for someone.
- 452. I always stand by my opinion.
- 453. I am not frightened of spiders.
- 454. I think there is no hope in the future.
- 455. My family and close relatives all get on with each other.
- 456. I like expensive clothes.
- 457. I often make a decision and then am influenced by other people.
- 458. Some animals make me nervous.
- 459. I can tolerate pain like other people.
- 460. I have done something and have been the last person to give up.
- 461. I get angry when people try to hurry me up.
- 462. I don't have a fear of mice.
- 463. Several times a week I fear something terrible will happen to me.
- 464. Most of the time I feel tired.
- 465. I like fixing door locks.
- 466. I feel sometimes I know people are watching me and know what I am thinking.
- 467. I like reading about science.
- 468. I am frightened when I am alone in a big open space.
- 469. I sometimes feel I will collapse.
- 470. Many people have bad sexual behaviour.
- 471. Often in the middle of the night I feel frightened.
- 472. I am always concerned because I forget where I put things.
- 473. As a child I was close to a woman I liked very much, who was a mother, aunt, sister or other woman.
- 474. I like adventure stories better than romantic stories.
- 475. I am often confused and forget what I want to say.
- 476. I am clumsy.
- 477. I love rough sports like football or soccer.

- 478. I hate my whole family.
- 479. Some people think they find me hard to get to know.
- 480. I spend most of my free time alone.
- 481. When people do things that make me angry I make sure they know it.
- 482. I always find it hard to decide what to do.
- 483. People don't think I am attractive
- 484. People don't treat me very kindly.
- 485. I often feel I am not seen as equal as other people.
- 486. I am always very stubborn.
- 487. I used to enjoy smoking marijuana.
- 488. Mental illness shows a weakness in a person.
- 489. I have a problem with drugs and alcohol.
- 490. Ghosts can have good or bad influence on people.
- 491. If I have to make an important decision I feel helpless.
- 492. I always try to be nice to people no matter whether other people are upset or critical of me.
- 493. If I have a problem it helps me to talk to someone else.
- 494. My life's aims I feel I can achieve.
- 495. I think people should keep their personal problems to themselves.
- 496. I don't feel as pressured or depressed as I used to.
- 497. If I have to make changes to my life, I usually feel anxiety.
- 498. Most of my problems are caused by someone close to me.
- 499. I don't like going to the doctor; when I am sick I don't go.
- 500. I am not happy with my life, and it is too late – I can't do anything.
- 501. When I have a problem I can usually talk to someone and it is better than taking medication.
- 502. I have bad and harmful habits.
- 503. When other people have a problem and need help, I usually leave it to other people to take care of it.
- 504. I can see myself having a number of faults, but I can't change them.
- 505. I am fed up with the things I have to do every day and I wish I could escape.

- 506. I have recently been considering suicide.
- 507. When I am at work people interrupt me and make me irritated.
- 508. I often feel I can read peoples minds.
- 509. When I must make an important decision I feel nervous.
- 510. People tell me I eat too fast.
- 511. Once a week I am high or drunk.
- 512. My life has had great losses which I will never get over.
- 513. Sometimes I am angry and upset and I don't know what made me feel like that.
- 514. People always ask me to do things and I find it hard to say no.
- 515. I love being by myself and am at my happiest.
- 516. My life is empty and has no meaning.
- 517. I find it hard to remain in one job for a long time.
- 518. My life has had a lot of failures and mistakes.
- 519. I am a little annoyed with myself for trying to please too many people.
- 520. I think a lot that I should kill myself.
- 521. I like to make decisions at work and delegating work.
- 522. I know in the future I won't have my family and that some one will help me.
- 523. When I go to movies or sport events or restaurants I hate queueing.
- 524. People don't know I have tried to kill myself.
- 525. Everything happens too fast for me.
- 526. I know I am a burden on other people.
- 527. When I have a bad day I usually have a few drinks to help me relax.
- 528. When problems occur, they occur just out of bad luck.
- 529. Sometimes I can't stop talking.
- 530. Sometimes I cut or hurt myself knowingly but don't know why.
- 531. I work long hours, even though I don't have to.
- 532. When I cry I usually feel better afterwards.
- 533. I usually forget where I put things.
- 534. If I could start my life over, I would not change much.
- 535. I get irritated at work when people who give me work and they get their work done.

- 536. When I am upset I always get a headache.
- 537. I like to bargain over prices.
- 538. Most men have affairs and are unfaithful to their wives.
- 539. Recently I lost interest in solving my problems.
- 540. I have recently broken furniture while drunk.
- 541. I work best with a deadline.
- 542. Sometimes people make me feel so angry with them I want to explode.
- 543. Terrible thoughts come to me about my family sometimes.
- 544. People tell me I have problems with alcohol, and I don't agree with them.
- 545. I never have time to finish everything.
- 546. I think more and more about death and the afterlife.
- 547. I often keep things which I will never use in the future.
- 548. I have been so angry I have hurt or had physical fights with people.
- 549. Lately I feel that people are testing me on everything I do.
- 550. I don't have much contact with my family or relatives.
- 551. Sometimes I feel my thoughts become spoken words and people can understand them.
- 552. When I am sad, I visit friends who make me feel better.
- 553. Things happen to me now that I feel have happened to me before.
- 554. When my life becomes difficult I feel I want to give up.
- 555. I can't enter dark rooms alone even in my own home.
- 556. I worry a lot about money.
- 557. Men should be head of the family.
- 558. The only place I feel relaxed is in my home.
- 559. My work colleagues don't understand my problems.
- 560. I am satisfied with my salary.
- 561. I usually have enough energy to do my job.
- 562. When people praise me I find it hard to accept.
- 563. Most marriages are characterised by one or both people being unhappy.
- 564. I can always remain in control and never lose control.
- 565. I find it hard to remember what people tell me.

566. When I am sad or depressed, my work usually suffers.
567. Married couples often don't show much affection for each other.

## **APPENDIX B**

### **QUESTIONNAIRES FOR – DEAF (FOCUS), HEARING AND PROFESSIONAL PARTICIPANTS**



**Participants from the Deaf focus group and an individual interview were all asked the following questions:**

1. What contact do you have with hearing people in our community?
2. How did you communicate with them?
3. Have you experienced difficulty in communicating with hearing people?
4. If you have to get help from a psychologist or a mental health worker is there anything that would stop you?
5. Is language a problem for you?
6. How do you see yourselves in the community in general? Do you feel part of the community? Do you see yourselves as different? Or the same?
7. What do you see as difficult in assessing Deaf people in physical and mental health settings?
8. What do you think are the problems for assessing Deaf people?
9. What is your view on how Deaf people are treated in our society?

These questions have been formulated with the thinking processes of Deaf people in mind. Although the question may seem very direct, they are aimed at eliciting elaborate views from Deaf people. Deaf people communicate in very direct ways, hence the specific format of the questions. The questions will lead to an elaborated interview.



## QUESTIONS FOR PARTICIPANTS

### DEAF SEMI-STRUCTURED INTERVIEWS

- Q1. What contact do you have with hearing people in our community?
- Q2. How did you communicate with them?
- Q3. Have you experienced difficulty in communicating with hearing People?
- Q4. If you have to get help from a psychologist or a mental health worker is there anything that would stop you from seeking help?
- Q5. Is language a problem for you?
- Q6. How do you see yourself and other Deaf people in the community in general?
- Q7. What do you see as difficult in assessing Deaf people in psychiatric and mental health settings?
- Q8. What do you think are the problems for assessing Deaf people?
- Q9. What is your view on how Deaf people are treated in our society?
- Q10. If you were asked to get a cochlear implant what would be your reaction and why?



**Participants from the sample of professional were all asked the following questions:**

1. Do you see Deaf people in your professional capacity? Do you know much about Deaf people?
2. If you have Deaf clients, how do you communicate with them?
3. Have you experienced difficulty in communicating with Deaf people?
4. How do you see Deaf people? How do you think they fit into the community?
5. What would you do if you had a Deaf person come to see you and you were not previously aware the client was Deaf? How would you react?
6. What do you see the difficulties in assessing Deaf people?
7. What do you see as the important issues related to Deaf clients and hearing professionals?
8. What are the implications for assessing Deaf people?
9. What is your view on how Deaf people are treated in our society?

These questions have been formulated with the thinking processes of Deaf people in mind. Although the question may seem very direct, they are aimed at eliciting elaborate views from Deaf people. Deaf people communicate in very direct ways, hence the specific format of the questions. The questions will lead to an elaborated interview.



**Participants from the hearing group were all asked the following questions:**

1. Do you know anything about Deaf people? Do you have any contact with Deaf people?
2. If yes, how do you communicate with them?
3. Have you experienced difficulty in communicating with Deaf people?
4. What would you do if a Deaf person approached you?
5. How do you see Deafness? How do you think Deaf people fit into the community? Do you see them as different? The same?
6. What do you see as difficult in assessing Deaf people in mental health settings?
7. What do you see as the difficulties of assessing Deaf people in terms of physical and mental health issues?
8. What is your view on how Deaf people are treated in our society?
9. What is your view on how Deaf people are treated in our society?

These questions have been formulated with the thinking processes of Deaf people in mind. Although the question may seem very direct, they are aimed at eliciting elaborate views from Deaf people. Deaf people communicate in very direct ways, hence the specific format of the questions. The questions will lead to an elaborated interview.

## **APPENDIX C**

### **CONSENT FORM FOR DEAF, HEARING AND HEARING PROFESSIONAL PARTICIPANTS**



CONSENT FORM – FOR PARTICIPANTS

DEAF SEMI-STRUCTURED INTERVIEW

I.....

[name]

I have read and understood the information for participants on the above named research study and have discussed it with Otilia Rodrigues (Contact: SMS: 0403068683 email: [omr58@uow.edu.au](mailto:omr58@uow.edu.au) or [uniqueps@tpg.com.au](mailto:uniqueps@tpg.com.au))

I freely choose to participate in this study and understand that I can withdraw at any time without penalty or adverse effect. I understand that the interview will be **videotaped** for more accurate transcription and I agree to this.

I am willing to be contacted for future research in relation to this project, if I am not included in this project.

I also understand that the research study is strictly confidential. I am willing for information collected to be published or presented at a conference in de-identified form.

I hereby agree to participate in this research study.

**Signature of**  
**Participant:.....**  
...

**Name of Participant:.....**

**Date:.....**

<p>Any person with concerns or complaints about the conduct of this research study can contact the Manager for Ethics, Ms. Eve Steinke, email <a href="mailto:eves@uow.edu.au">eves@uow.edu.au</a> or Fax: University of Wollongong</p>
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**CONSENT FORM – FOR PARTICIPANTS**  
**HEARING SEMI-STRUCTURED INTERVIEW**

**I.....**

**[name]**

I have read and understood the information for participants on the above named research study and have discussed it with Otilia Rodrigues (Contact: SMS: 0403068683 email: [omr58@uow.edu.au](mailto:omr58@uow.edu.au) or [uniqueps@tpg.com.au](mailto:uniqueps@tpg.com.au))

I freely choose to participate in this study and understand that I can withdraw at any time without penalty or adverse effect. I understand that the interview will be **audio taped** for more accurate transcription and I agree to this.

I am willing to be contacted for future research in relation to this project, if I am not included in this project.

I also understand that the research study is strictly confidential. I am willing for information collected to be published or presented at a conference in de-identified form.

I hereby agree to participate in this research study.

**Signature of**  
**Participant:.....**  
...

**Name of Participant:.....**

**Date:.....**

<p>Any person with concerns or complaints about the conduct of this research study can contact the Manager for Ethics, Ms. Eve Steinke, email <a href="mailto:eves@uow.edu.au">eves@uow.edu.au</a> or 4221 4457 University of Wollongong</p>
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**CONSENT FORM – FOR PARTICIPANTS**

**HEARING PROFESSIONALS SEMI-STRUCTURED INTERVIEW**

**I.....**

**[name]**

I have read and understood the information for participants on the above named research study and have discussed it with Otilia Rodrigues (Contact: SMS: 0403068683 email: [omr58@uow.edu.au](mailto:omr58@uow.edu.au) or [uniqueps@tpg.com.au](mailto:uniqueps@tpg.com.au))

I freely choose to participate in this study and understand that I can withdraw at any time without penalty or adverse effect. I understand that the interview will be **audio taped** for more accurate transcription and I agree to this.

I am willing to be contacted for future research in relation to this project, if I am not included in this project.

I also understand that the research study is strictly confidential. I am willing for information collected to be published or presented at a conference in de-identified form.

I hereby agree to participate in this research study.

**Signature of**

**Participant:.....**

...

**Name of Participant:.....**

**Date:.....**

<p>Any person with concerns or complaints about the conduct of this research study can contact the Manager for Ethics, Ms. Eve Steinke, email <a href="mailto:eves@uow.edu.au">eves@uow.edu.au</a> or 4221 4457 University of Wollongong</p>
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## **APPENDIX D**

### **INFORMATION SHEET – FOR PARTICIPANTS**

#### **DEAF, HEARING AND HEARING PROFESSIONALS SEMI-STRUCTURED INTERVIEW**

#### **MMPI-2 Auslan CD-ROM Version**



## INFORMATION SHEET – FOR PARTICIPANTS

### DEAF SEMI-STRUCTURED INTERVIEW

#### MMPI-2 Auslan CD-ROM Version

You are invited to take part in a research study into the translation of the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2). The aim of this study is to assess the usefulness of the Auslan version of the MMPI-2. The original version of the MMPI-2 is in English and we believe that the Auslan version will be much easier for Deaf people to understand. This will give professionals working in the field of psychology/psychiatry a tool that will allow them to assess Deaf individuals accurately regardless of the professionals being hearing or Deaf. Moreover, whether they are able to sign.

In order to provide proper health services to the Deaf community, we need to understand how Deaf people construe their world. How hearing people construe Deaf individuals and how professionals construe Deaf people. This will provide us with some insight into their understanding of Deaf people.

The aim is to make future recommendations based on our understanding and findings that will allow mental health professionals to deliver a service that is accessible to Deaf individual and caters for their psychological and emotional needs.

If you agree to participate in the focus group you will be asked a series of questions that will help identify how you see Deaf individuals and the Deaf community. The interview will be recorded on **videotape** so that we are able to extract your answers for analysis. Otilia Rodrigues will be conducting the interviews. The interviews will take place either at the University of Wollongong or at a location specified by you. All up the interview will take approximately 45 minutes.

We do not believe that there will be any adverse effect on you. However, should you feel that you need to discuss any concerns, which may arise; Otilia Rodrigues is a registered psychologist, fluent in Auslan and will be available at the end of the interview.

All aspects of this study, including results, will be strictly confidential and only the researcher Otilia Rodrigues, Dr. Nadia Crittenden (supervisor) and Peter Caputi (co supervisor) will have access to the audiotape and information relation to this research. A report of the study may be submitted for publication, but information about you specifically will not be identifiable in such a report.

While we intend that this research study will help professionals working with Deaf individuals, we note that you may not benefit directly from it.

Participation in this study is entirely voluntary, you are not obliged to participate and if you do participate you can withdraw at anytime. Whatever your decision it will not affect your relationship with the researcher or the University of Wollongong.

When you have read this information, Otilia Rodrigues will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please contact Otilia Rodrigues, on 42214513 or 0403068683, [omr58@uow.edu.au](mailto:omr58@uow.edu.au) or [uniqueps@tpg.com.au](mailto:uniqueps@tpg.com.au), Dr. Nadia Crittenden on 42214515 and Peter Caputi on 42213717 via the National Relay Service on 1800 555 6777 or 133 677.

This information sheet is for you to keep.

<p><b>Any person with concerns or complaints about the conduct of this research study can contact the Manager for Ethics, Ms. Eve Steinke, email <a href="mailto:eves@uow.edu.au">eves@uow.edu.au</a> or 42 21 4457, University of Wollongong, via the National Relay Service on 1800 555 6777 or 133 677.</b></p>
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## INFORMATION SHEET – FOR PARTICIPANTS

### HEARING SEMI-STRUCTURED INTERVIEW

#### MMPI-2 Auslan CD-ROM Version

You are invited to take part in a research study into the translation of the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2). The aim of this study is to assess the usefulness of the Auslan version of the MMPI-2. The original version of the MMPI-2 is in English and we believe that the Auslan version will be much easier for Deaf people to understand. This will give professionals working in the field of psychology/psychiatry a tool that will allow them to assess Deaf individuals accurately regardless of the professionals being hearing or Deaf. Moreover, whether they are able to sign.

In order to provide proper health services to the Deaf community, we need to understand how Deaf people construe their world. How hearing people construe Deaf individuals and how professionals construe Deaf people. This will provide us with some insight into their understanding of Deaf people.

The aim is to make future recommendations based on our understanding and findings that will allow mental health professionals to deliver a service that is accessible to Deaf individual and caters for their psychological and emotional needs.

If you agree to participate in the focus group you will be asked a series of questions that will help identify how you see Deaf individuals and the Deaf community. The interview will be recorded on **audiotape** so that we are able to extract your answers for analysis. Otilia Rodrigues will be conducting the interviews. The interviews will take place either at the University of Wollongong or at a location specified by you. All up the interview will take approximately 45 minutes.

We do not believe that there will be any adverse effect on you. However, should you feel that you need to discuss any concerns, which may arise; Otilia Rodrigues is a registered psychologist and will be available at the end of the interview.

All aspects of this study, including results, will be strictly confidential and only the researcher Otilia Rodrigues, Dr. Nadia Crittenden (supervisor) and Peter Caputi (co supervisor) will have access to the audiotape and information relation to this research. A report of the study may be submitted for publication, but information about you specifically will not be identifiable in such a report.

While we intend that this research study will help professionals working with Deaf individuals, we note that you may not benefit directly from it.

Participation in this study is entirely voluntary, you are not obliged to participate and if you do participate you can withdraw at anytime. Whatever your decision it will not affect your relationship with the researcher or the University of Wollongong.

When you have read this information, Otilia Rodrigues will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please contact Otilia Rodrigues, on 42214513 or 0403068683, [omr58@uow.edu.au](mailto:omr58@uow.edu.au) or [uniqueps@tpg.com.au](mailto:uniqueps@tpg.com.au), Dr. Nadia Crittenden on 42214515 and Peter Caputi on 42213717.

This information sheet is for you to keep.

<p><b>Any person with concerns or complaints about the conduct of this research study can contact the Manager for Ethics, Ms. Eve Steinke, email <a href="mailto:eves@uow.edu.au">eves@uow.edu.au</a> or 42214457, University of Wollongong</b></p>
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## INFORMATION SHEET – FOR PARTICIPANTS

### HEARING PROFESSIONALS SEMI-STRUCTURED INTERVIEW

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## **APPENDIX E**

### **PARTICIPANT SATISFACTION SURVEY**



## PARTICIPATNT SATISFACTION SURVEY

**Q1 How did you find the experience?**

Pleasant ☐ Easy ☐ Frustrating ☐ Difficult ☐

**Q2 Which version did you find easier?**

Auslan ☐ English ☐

**Do you have any other comments?**

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**Thank you for your time and participation**

## **APPENDIX F**

### **PHOTOGRAPHS FROM GALLAUDET UNIVERSITY – STUDENT PROTEST OCTOBER 2006 AND TECHNOLOGIES AT CONFERENCE CENTRE.**