Providing Psychological Services to Deaf Individuals: A Response to New Perceptions of Diversity

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The Americans With Disabilities Act of 1990 mandates that psychologists provide equal access to services for persons with disabilities. Disabled individuals, including deaf and hard of hearing persons, form an important part of the diversity spectrum. Deafness and hearing loss significantly affect life experiences, development, and the ability to obtain and use services. Psychologists must develop awareness of the implications thereof in order to provide appropriate services in an ethical manner to such clients. This article presents core knowledge about deafness and hearing loss in an effort to enhance this necessary awareness for practitioners not specializing in this area.

Issues of human diversity within the context of psychological service provision and psychology training have gained prominence in recent years. As a result, there have been increased attempts to incorporate a better understanding of ethnic and cultural minorities into psychology training and practice, although the effectiveness of these efforts continues to be questioned (Goodchilds, 1991; Strieker et al., 1990; Sue & Sue, 1990; Tomes, 1994; Yutzenka, 1995).

Disabilities are also part of human diversity. The Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) includes disabilities as one of the areas psychologists need to be aware of. As hearing loss is the most prevalent physical disability in the United States—almost 23 million are affected (Adams & Benson, 1991, as cited in Bess & Humes, 1995, p. 4), and close to one million of this group are classified as deaf (Commission on Education of the Deaf, 1988, p. 9)—psychologists need to be prepared for the likelihood that they will encounter a deaf or hard of hearing client.

There are also new legal issues based on the Americans With Disabilities Act of 1990 (ADA), which is widely regarded as the major civil rights act covering people with disabilities. The twin special issues of Rehabilitation Psychology (Bruyere, 1993) and Consulting Psychology Journal: Practice and Research (O'Keefe, 1993) discussed the responsibilities of psychologists in view of the ADA. The ADA includes private businesses and both for-profit and nonprofit services in its requirement of access to "public accommodations" and has an "affirmative" requirement for providing access. Anyone operating a business of any size or providing services, including psychological services, in any setting (such as hospitals, clinics, and private or home offices) must anticipate providing accommodations for clients with disabilities, including those whose disability affects communication accessibility.

Under the ADA, unlike under previous legislation, any individual with a disability can sue for damages if services are not accessible. Therefore, psychologists need some basic knowledge about the lives of people who are deaf in order to meet their mental health, educational, developmental, and vocational needs. When a client is deaf, the necessary accommodations for accessibility are in the area of communication (e.g., sign language interpreters or note takers; National Center for Law and Deafness, 1994). Psychologists will be required to ensure that training and testing procedures are appropriately used or modified when the consumer is deaf. (Similar ADA requirements related to other disabilities may include making training or testing sites physically accessible for those with mobility im-

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1 The term deaf is used throughout this article to denote individuals whose hearing is disabled to an extent that precludes the understanding of speech through the ear alone, with or without the use of a hearing aid.
Serving Deaf and Hard of Hearing Individuals

Just as the rich intricacies of various cultures must be studied for a student to become culturally literate, deafness must be understood as a multifaceted phenomenon, rich with cultural as well as sensorial implications. Because culturally competent therapists are rated by clients as significantly more credible, caring, and effective than therapists who are perceived by clients as culturally unresponsive (Atkinson, Casas, & Abreu, 1992), the implications for service delivery to deaf clients are profound. Unfortunately, the number of psychologists proficient in American Sign Language (ASL) or knowledgeable about hearing loss is slight. Furthermore, the lack of specialized services in many parts of the United States often results in diagnostic, assessment, and treatment errors by psychologists who lack even rudimentary information (Cantor & Spragins, 1977; Donoghue, 1968; S. T. Freeman, 1989; Heller, 1987; Levine, 1977; Pollard, 1994; Weaver & Bradley-Johnson, 1993; Willigan & King, 1992). Psychologists in general practice, however, can become sensitized to some of the issues involved in providing services to deaf and hard of hearing individuals (Pollard, 1994).

The following vignettes, which are composites of actual cases, illustrate critical errors psychologists can easily fall prey to as a result of ignorance of deaf people's special needs.

A 33-year-old hard of hearing client has problems at work. Her employer claims she does not follow orders and inquires about attention or memory problems. The psychologist administers the Wechsler Adult Intelligence Scale—Revised (WAIS–R), the Wechsler Memory Scale—Revised, and the Minnesota Multiphasic Personality Inventory (MMPI) and finds no evidence of memory or attentional deficits. The MMPI results suggest mild paranoid and depressive tendencies. The clinician concludes that the problems at work are either secondary to depression or represent resistance to authority as based on paranoid tendencies. Therapy is recommended. The psychological report comments neither on the implications of the hearing loss for the assessment nor on the possible impact of the client’s hearing loss on her adaptation to the work environment.

A deaf 9-year-old boy needs an evaluation to rule out learning disability, emotional disturbance, or mental impairment. He is the only deaf child in the school district, reads below the first-grade level, and is not progressing in school. Teachers do not sign and access to qualified interpreters is inadequate. Signing at home is limited. The psychologist uses a volunteer interpreter for the evaluation because the child has no oral language. She administers the Wechsler Intelligence Scale for Children III (WISC III), the Bender, and Human Figure Drawings. Often during the assessment, the child asks the interpreter questions. The interpreter replies without keeping the psychologist informed. When the psychologist asks what is being discussed, the interpreter says that the child is asking for clarification. The child often responds with “Don’t know” or minimal phrases. The results indicate a performance IQ of 95, verbal IQ of 60, and full-scale IQ of 75. The data are interpreted to indicate that the child is either unmotivated on the verbal portions of the test or is mildly mentally retarded with specific strengths in some performance skills. A verbal learning disability diagnosis is ruled out because of the below-average full-scale IQ. The psychologist qualifies her results by acknowledging limited benefit from classroom experiences because of communication problems. She recommends placement in a special education class for developmentally delayed students, preferably with access to an interpreter, without taking into account the influence of deafness on the test administration and interpretation or the fact that the performance IQ tends to be the more appropriate measure of a deaf child’s intellectual functioning.

An elderly woman is referred for possible depression or dementia. The family sees her withdrawing, quitting most of her social activities, and refusing to talk on the telephone. When interacting with family members, she constantly asks the same questions and often does not appear to understand the answers. The neuropsychologist administers intellectual, memory, language, and visuospatial tests as well as measures of depression and personality functioning. Results indicate problems with attention, verbal memory, comprehension, and repetition. Personality assessment reveals feelings of isolation and some depressive symptoms. Surprisingly, all visuospatial functions, including memory and performance on expressive language and written materials, are appropriate for her age and vocational history. The psychologist notes that the client peers intently at her during the assessment and appears to make a valid effort on the tasks. The recommendation focuses on treatment of depression with a need for further evaluation to determine if residual symptoms might represent an early degenerative dementia. The possibility of a late-onset progressive hearing loss is not considered.

A deaf couple enters marital therapy with a psychologist who does not sign. An interpreter is included in the treatment process. An issue related to fear of intimacy comes up. The psychologist asks the couple to close their eyes and engage in a guided imagery exploration of the triggering situation. This proves impossible because the couple cannot receive instructions with their eyes closed. Time has to be spent in educating the therapist.

These vignettes contain examples of common errors resulting from ignorance of the typical effects of hearing loss. Familiarity with the implications of hearing loss, whether diagnosed or undiagnosed, can help psychologists recognize the meaning of symptoms or problems and select intervention or assessment methods appropriate for the client’s communication skills. The judicious use of both interpreters and assistive devices will minimize unintentional errors. The following section outlines information for the general psychologist practitioner who occasionally encounters deaf or hard of hearing clients.
Classification Issues

Hearing loss in and of itself, and particularly profound bilateral deafness (which is a low-incidence condition), significantly affects communication, socioemotional development, education, and vocational considerations. To appreciate the complexity of this impact, psychologists need to be aware of three major perspectives on deafness, each revealing a different aspect of the client’s situation.

The medical perspective focuses on the lesion’s physical site, specifically the middle ear (conductive), inner ear (sensorineural), or mixed (Bess & Humes, 1995). Deaf individuals typically have sensorineural or mixed hearing losses that are irreversible. Conductive losses involving only the middle ear are more easily treatable. Furthermore, the medical approach notes etiological aspects grouped under genetic causes, nongenetic causes, and syndromes in which the cause is unclear (Arnos, Israel, & Cunningham, 1991; Arnos, Israel, Devlin, & Wilson, 1992; Bess & Humes, 1995). This information may be crucial because some, but not all, causes of deafness either are accompanied by additional handicapping conditions or place the individual at risk for other physical, psychological, or neurological anomalies. Some examples are cardiac, visual, or craniofacial abnormalities as well as a range of possible cognitive deficits.

The second approach, which is audiological, classifies the individual on the basis of the level of hearing sensitivity and the impact on communication (Bess & Humes, 1995). Individuals with mild or moderate hearing losses function as hearing or use of their residual hearing, whereas others have essentially no usable perception of speech sounds and require visual communication through sign language, speech reading, or writing.

The third and most recent approach applies to a significant portion of the deaf population who identify themselves as members of a distinct cultural group rather than as handicapped (e.g., Padden & Humphries, 1988; Paul & Jackson, 1993; Sacks, 1989; Tyler, 1993). They contend that Deaf (using the capital letter D) culture has its own values and its own language, ASL, which takes precedence over English in face-to-face communication because it is completely visually accessible. The way these people perceive and interpret their experiences differs according to their cultural expectations and values. Awareness of these differences is critical to understanding and responding to clients who identify with Deaf culture in an affirmative manner rather than with a compensatory and pathological perspective that implies there is something missing in a deaf person. This population, in other words, does not focus on what is lacking but, instead, cherishes the richness of ASL and Deaf culture. According to Padden (1980), Deaf culture is one part of a greater deaf community that also includes deaf people who do not necessarily rely on sign language.

There is great heterogeneity within this greater deaf community (Brauer, 1993), a heterogeneity that also exists within every cultural and minority group as well (Sue & Sue, 1990). For the deaf and hard of hearing populations, this heterogeneity is evident in many dimensions, including intelligence, personality, lifestyle, cultural and ethnic background, communication mode, etiology, age at onset of hearing loss, age of diagnosis and intervention, presence of additional disabilities, and so on (e.g., Paul & Jackson, 1993). These variables dictate against using a stereotypical approach to assessment and intervention. When accommodations to any degree of hearing loss do not meet the needs of individual children and adults, exacerbation of emotional maladjustment is likely (e.g., R. Freeman, Malkin, & Hastings, 1975; Jensema & Trybus, 1975; Marschark, 1993; Meadow & Trybus, 1979; Meadow-Orlans & Orlans, 1990; Paul & Jackson, 1993; Reivich & Rothrock, 1972; Vernon & Andrews, 1990). Thus, appropriate and sensitive service delivery is of urgent importance.

Furthermore, 36% of the children currently enrolled in educational programs for the deaf are persons of color (Cohen, Fischgrund, & Redding, 1990). For this population to receive quality services, psychologists must have cultural competence and sensitivity to dual minority status (Pape & Tarvydas, 1993). They must understand the multifaceted nature of the client’s experience (e.g., Akamatsu, 1993-1994; Anderson & Grace, 1991; Cohen, 1991; Dunn, 1992; Rodriguez & Santibáñez, 1991). Minority deaf persons are members of at least three communities: the deaf community, their ethnic minority hear community, and their ethnic minority deaf community. Although the minority deaf experience is, for each person, a unique blending of deaf and minority cultures, it is not unusual for minority deaf clients to report that they feel forced to choose between these communities in order to ensure that important needs are met (Higgins, 1987; Younklin, 1990). However, this process is often unsatisfactory (Corbett, 1991). Within the deaf community, clients may obtain support on issues related to deafness but not necessarily on issues related to race. Research on African American deaf persons indicates that they view their racial heritage as extremely important (Aramburo, 1987; Corbett, 1991). However, African American and other ethnic minority communities have difficulties confronting issues of deafness (Christensen & Delgado, 1993). Despite bodies of psychological literature related to mental health treatment of minorities (e.g., Sue & Sue, 1990) or deaf persons (e.g., Vernon & Andrews, 1990), there is a paucity of information on psychological issues related to culture within minority deaf communities, with the exception of articles such as that by Eldredge (1993) on counseling with Deaf American Indians.

Diagnostic and Assessment Factors

In working with deaf and hard of hearing persons, a critical variable to consider is the age of onset of hearing loss. Deafness influences cognitive and emotional development; its impact is modulated by age of onset. Age of onset is particularly significant when deafness occurs in the early years when diagnosis and intervention may be delayed, which is typically the case (Vernon & Andrews, 1990). Those whose hearing loss occurred after the development of oral language generally continue to process information using linguistic and cognitive structures similar to
those of hearing individuals, unless there is cognitive dysfunction secondary to the cause of deafness. Nevertheless, some degree of communication difficulty and educational implications subsequent to the onset of deafness should be anticipated if the hearing loss occurred at any time during childhood. Hence, obtaining etiological, audiological, and educational histories is critical in the evaluation process.

With onset in adulthood, the client may identify as hard of hearing, even when the hearing loss is severe or profound, because of the person’s life-long orientation as a hearing person. Furthermore, there is often a period of grief and denial in adjusting to the hearing loss (Meadow-Orlans & Orlans, 1990; Vernon & Andrews, 1990). In older adults, age-related hearing loss is common. The resultant withdrawal from social situations and difficulty in understanding conversations may be misidentified as depression or dementia if the hearing loss is undiagnosed.

When hearing loss occurs before 3 years of age, the acquisition of English through hearing is impeded. Depending largely on the degree of hearing loss, this obstacle to speech perception has a significant effect on the development of academic and social skills and knowledge in general to the extent that these are presented through speech alone. In this situation, interventions include amplification and the introduction of commonly used alternative methods of communication, such as sign language or some visible system for communicating in English.

The value of amplification (hearing aids) varies according to residual hearing and one’s ability to make sense of what is heard (Bess & Humes, 1995). Amplification is not a substitute for normal hearing, but it can sometimes enable the user to recognize environmental sound or speech, depending on the level of hearing loss and amount of training the user receives (Bess & Humes, 1995). If psychologists obtain audiograms that describe unaided and aided functional hearing, they can ask audiologists to clarify the potential benefit likely to be gained from amplification. However, audiograms do not always predict the extent of language problems, which can also be caused by such complications as central processing dysfunction (Maxon & Brackett, 1992).

The two most commonly used methods of communication in the deaf community are sign language, including ASL and a range of English-based sign systems, and oral communication, which is based on speech and speech-reading aided by amplification (Maxon & Brackett, 1992; Vernon & Andrews, 1990). Other communication methods include Cued Speech, a form of visible spoken English that uses hand cues to indicate specific sounds (Beck, 1991), and Total Communication, a philosophy implemented through a combination of speech and signs (Vernon & Andrews, 1990). Often, deaf individuals are exposed to more than one mode of communication during their education. Communication choices in adulthood reflect individual skills and preferences as well as cultural identity (culturally Deaf or culturally hearing).

The mode of communication used in the client’s family of origin can also have effects relevant to assessment results. Over 90% of deaf children have hearing parents (Marschark, 1993). Often, the deaf individual who requires signs for adequate communication has parents who do not sign fluently. Even with exceptional oral skills, the child may discern only a general idea of the topic under discussion in family dialogue, unless a concerted effort is made to include the child. This inadvertent exclusion of deaf children contributes to difficulties in acquiring the wealth of information children typically absorb passively at home. Unusual naivety and odd gaps in general knowledge that may appear as a result are not always rectified at school, regardless of setting.

Clearly, knowledge of the client’s personal and family communication background and educational placements can aid psychologists in interpretation of test results, with the goal of understanding the client’s behaviors. Determining and finding a way to use the client’s primary communication mode is also critical in enhancing the client’s comfort during diagnostic or psychotherapy procedures. Assessment responses are also more valid in the client’s best language. However, for early-onset deaf individuals, including those who prefer spoken English, English-based tests of intellectual functioning, language, and linguistic memory are generally inappropriate unless there is written evidence of adequate English proficiency as indicated by tests in reading and writing (S. T. Freeman, 1989; Orr, DeMatteo, Heller, Lee, & Nguyen, 1987). The average reading level of these individuals tends to be well below that of hearing peers, though the range of English skills may be broad (Marschark, 1993). Preference for spoken English does not necessarily correlate with understanding of English. For this reason, performance scales or nonverbal tests of intelligence, such as the WAIS-R Performance Scale (Wechsler, 1981) or the Raven’s Progressive Matrices (Raven, 1960), more accurately predict intellectual functioning in deaf individuals and should be used for this purpose. For more information, see Braden (1994) and Elliott, Glass, and Evans (1987).

Use of written communication to interact with deaf clients is tedious and frustrating. It can also lead to errors in communication that may, in turn, influence diagnostic errors. Because ASL grammatical structures differ from English, written communications by deaf signers who are weak in English may appear aphasic or psychotic to the unsophisticated practitioner, which can result in incorrect conclusions about the deaf person’s cognitive and psychological functioning. Hence, written communication should not be relied on to judge intellectual or emotional functioning; rather, it should be used to judge only the level of English comprehension. This stipulation is particularly critical in emergency situations when interpreters have not been called. Because mental status examinations incorporate complex English concepts, failure to provide an interpreter often results in inappropriate diagnostic impressions and disposition of cases.

Appropriate Use of Interpreters

The use of professional interpreters certified by the Registry of Interpreters for the Deaf can assist with some of the problems just noted. Knowledge of sign language, which is not always easy to learn, is necessary but not sufficient for appropriate interpreting. Certified interpreters are also skilled in assessing the client’s communication needs, adjusting communication to suit client preferences, providing translations back and forth be-
tween ASL and English, and maintaining confidentiality and professional boundaries. When interviewing a deaf person, it is important that a psychologist have an interpreter who uses sign language unless the psychologist is a fluent signer. Poor communication can result in serious misunderstandings that are frustrating for both parties and may have significant negative consequences for treatment compliance and outcome. To avoid potential communication problems, when the client is identified as deaf or as having a hearing loss, the psychologist can ask the client or referring agency about communication needs before setting up the appointment; then the psychologist can make the arrangements for whatever may be requested, whether it is use of interpreter services, availability of a word-processing computer for reciprocal communication based on typing, or some other arrangement. Information about certified interpreters can be obtained by calling the Registry of Interpreters for the Deaf at (301) 608-0050 or by checking the annual National Directory of TTY Numbers, which has both interpreter and mental health service listings. This directory is available through Telecommunications for the Deaf, Inc., at (301) 589-3786.

It is equally important to consider an interpreter for individuals who function orally and therefore may not typically request interpreting services, especially in situations when they have difficulty speech reading the psychologist or the psychologist has difficulty understanding the speech of the clients. However, oral clients may have mixed feelings about using interpreters because of sensitivity regarding implications of communication incompetence on the part of the oral client, which of course greatly affects self-esteem. Hence, psychologists must be empathic in their approach when inquiring about the acceptability of interpreter services to facilitate difficult communication situations, and they must accede to the wishes of the clients.

Sensitivity to interpreter dynamics is critical because interpreters represent additional parties in situations privy to confidentiality and emotions (S. T. Freeman, 1989; Harvey, 1989; Stansfield & Veltri, 1987; Taff-Watson, 1983). If not incorporated correctly, they may be seen as intrusive. If the psychologist cedes control of the communication to the interpreter, which is what happened in the school vignette, crucial diagnostic information may be lost or go misrepresented. To minimize this risk, it is best to use professional interpreters who are experienced with mental health paradigms and can assist with even complex communication dilemmas. It is good practice to set aside time before and after sessions to discuss prior expectations and actual results. Such discussions will sensitize psychologists to the nature of the communication process and therefore enable them to modify what they want to say in ways that the clients can better comprehend. The use of family members as interpreters can obscure the clinical picture and is not recommended.

Many signing clients will prefer a practitioner who signs to a nonsigning practitioner who relies on an interpreter, but they may accept the latter because of the paucity of signing psychologists in the area. This issue should be discussed with clients, who will then recognize the psychologist’s attempt to be sensitive to their wishes. Psychologists wishing to explore the possibility of referral to a signing psychologist in the client’s geographic area may wish to make inquiries at nearby associations or schools serving deaf individuals.

In testing situations, administering standard instruments with an interpreter does carry some risk and should be done only if the examiner understands the implications of such an approach. The situation is comparable to giving a Spanish-speaking client an English-based instrument through an interpreter. As illustrated by the school vignette, standard procedures can be inadvertently sacrificed and interpretation compromised. Written tests of personality and psychological functioning, such as the MMPI, that require high levels of English skills are problematic (S. T. Freeman, 1989; Levine, 1981). Even when language is changed with care taken to ensure comprehension, a deaf client may respond in an atypical manner because of previous experiences rather than as a result of current psychological functioning.

Instruments that do not require significant English skills or are designed to assess areas unaffected by language functioning can be administered. For this reason, the Draw-a-Person Projective Technique (Machover, 1948) is one of the most frequently used personality measures for deaf individuals as is the House–Tree–Person Projective Technique (Buck, 1948). However, if questions related to the drawings are part of the assessment, competent interpreters are critical to ensure that both the questions and related answers are accurately interpreted. The Thematic Apperception Test (Murray, 1938) and the Rorschach (Rorschach, 1921/1942) rely much more on interpersonal communication. Using interpreters in this process must be approached with caution pending results of a study that is in the process of investigating the validity of using competent ASL interpreters for Rorschach administration (S. Gibbins, personal communication, September 25, 1995).

The Context of Psychotherapy

All of the variables pertaining to deafness and hearing loss that we have discussed in this article are also crucial within the context of psychotherapy. Communication issues are paramount and must be addressed before any other considerations so that clients will feel a sense of relatedness and validation. Many clients may be suspicious or anxious, particularly when they have limited access to information about psychotherapy because of reading or hearing difficulties or because of misperceptions about the context of psychotherapy itself. They may also feel stigmatization and shame as deaf individuals with emotional difficulties (Anderson, 1992; Galloway, 1968). Such feelings can be alleviated by providing information about how treatment can help, clarifying the psychologist’s and client’s roles, defining expectations about self-disclosure and feedback, and exploring issues related to confidentiality, all of which are often critical for client comfort. Networking with local deaf and hard of hearing organizations, with the goal of sensitizing oneself to issues that may be significant for clients, while always respecting the parameters of confidentiality, will enhance the credibility of the psychologist.

The basic principles of therapy in general apply also to the deaf and hard of hearing population; it is the implementation that differs because of the need to understand how the client with hearing loss receives and conceptualizes information (Anderson & Watson, 1985; Patterson & Stewart, 1971). Cre-
ative approaches may be required to convey therapeutic concepts to deaf or hard of hearing clients involved in treatment of any kind, whether treatment is grounded in psychoanalysis, cognitive-behaviorism, Eriksonian techniques, or any other treatment modality (e.g., Collins, 1991; Morrison, 1991; Ray-
sen, 1985; Virsida, 1985). Psychotherapists with expertise in deafness should be consulted as needed. For those who wish to explore further the area of psychotherapy with deaf and hard of hearing individuals, Harvey (1989) presents a systemic model, within the context of deaf clients' families and environments, that incorporates approaches to clinical interventions as well as communication logistics. Stein, Mindel, and Jabaley (1981) also offer different perspectives on clinical interventions. A re-
laxation training model for hard of hearing individuals is offered by Trychin (1987). In essence, however, it is critical for those attempting psychotherapy with this population to be sensitive to the issues that emerge within the context of deafness or hearing loss.

Conclusion

Changes in the law have profound implications for service delivery to populations falling under the mandate of the ADA. The limited awareness of psychologists in general about deafness and hearing loss as well as the lack of trained personnel have been serious impediments to effective service delivery for deaf and hard of hearing persons, particularly in low-incidence areas. Psychologists can improve their ability to serve such clients by acquiring basic information as outlined in this article and by consulting with specialist colleagues when particular client concerns arise.

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In K. Z. Altshuler & J. D. Rainer (Eds.), Mental health and the deaf.


Received July 25, 1994
Revision received October 30, 1995
Accepted November 20, 1996