



Mental Health issues in the profoundly and severely deaf population:  
Psychological and Physiological interaction

Vanessa Nelson

Supervised by Dr David Holmes  
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## ABSTRACT

The study qualitatively explores insight into everyday life, access to help and coping mechanisms of profoundly and severely deaf individuals also encompassing a psychological disorder from a professional or direct stance. As such individuals are somewhat excluded from qualitative methodology, with most psychological investigations favouring numerical data, the research allows subjective interpretation into the target areas from an individualistic perspective. Utilising a phenomenological approach, in the form of Interpretative Phenomenological analysis, lived experiences could be analysed through the semi-structured interviewing of five participants with substantial knowledge into mental health and deafness. Themes derived from the data reflected reoccurrences in lifestyle presented as; Everyday life, Therapeutic interventions and Education incorporated with the subthemes; Language, coping mechanisms, social relationships and emotional implications. The findings suggest language is a primordial factor influencing all aspects of everyday life, impinging on social relationships, educational achievement and access to services. It is concluded that vital changes are needed in the education system and mental health services to promote mental wellbeing along with the overarching need for additional services to be available for the pre-lingual population.

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| <b>KEY WORDS:</b> | DEAFNESS | SERVICES | EMOTIONS | RELATIONSHIPS | LANGUAGE |
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## Introduction

It is proposed there are nine million deaf or hard-of-hearing people in the United Kingdom (Royal National Institute for Deaf People, 2003,) with around seven per ten thousand people in the general population having severe or profound deafness (NHS England, 2013) before language acquisition had evolved. Although recent and reliable estimates of the number of deaf people with psychiatric problems are unavailable (Landberger & Diaz, 2010) it is estimated around 50% of these individuals experience psychological difficulty (NHS England, 2013), ranging between mild depression and psychosis, at some point in their lifetime. It is widely theorised '40% of deaf children' have some form of mental health issue in comparison with '25% of hearing' (DOH, 2005, p3) counterparts highlighting increased prevalence amongst deaf communities.

Through a wide body of literature, it has been acknowledged there is a higher incidence of mental health problems amongst deaf people compared to the hearing population (DOH, 2005) making such individuals part of a venerable unique minority group (Briffa, 2001). With the notion deaf people are thought to have a three to five times higher chance than hearing people to face psychological problems (Graaf et al, 1998) and a strong relationship between hearing loss and the neurosis (Thomas, 1984) has been established, significantly hearing impaired individuals as a group experience a greater number of mental health problems than the general population (Ganzalo et al, 2008) thus should be highly documented in psychological research.

It has been disputed some issues related to deafness may have direct implications to mental health such as isolation (Briffa, 2001) as individuals face exclusion in such aspects as communication. Hearing impaired children deaf before age 3 fall behind in their language (Veentjer & Govers, 1998) due to a lack of auditory contact hampering social and emotional development (Greenberg, 1983) leading to poor mental health increasing isolation (Eastwood, 1985). Additionally, accepting deafness itself could mean individuals being left with anger and denial (De Feu & Fergusson, 2003) along with suppressed antagonism surrounding deprivation of normal patterns of interaction (McDaniel, 1986) thus a need for early multi-disciplinary intervention (De Feu & Fergusson, 2003) is indispensable.

The effect of hearing loss is strongly dependent on the degree of loss and the age and speed of onset (De Feu & Fergusson, 2003) with early onset having a profound effect on childhood development, with adverse consequences for mental health. Regardless that prevalence has shown to be considerably higher, evidently the nature and level of mental health problems are similar to those in the general population (De Feu & Fergusson, 2003). For example in the case of schizophrenia, research surrounding auditory hallucinations proposes deaf patients also experience this phenomenon- with voices often being negative (Sign Health, 2006) alienating with hearing patients.

For many deaf individuals deafness is associated with social exclusion (HMSO, 2004) such as a lack of participation in leisure and social activities most take for granted (DOH, 2005). Researchers have proposed difficulties are often as much to do with society's attitudes as the direct effect of sensory impairment (De Feu & Fergusson, 2003). Deaf individuals therefore can benefit from the more-positive attitudes arising from deaf awareness training (De Feu & Fergusson, 2003). Most

people think of deafness as a disability (DOH, 2005) irrespectively many congenitally deaf individuals regard themselves as members of a cultural and linguistic minority, not as a disabled group (De Feu & Fergusson, 2003) having constructive psychological implications. Consequently, examining the positives and negatives of everyday life from the individual perspective has proven to be a practical and interesting objective.

Gaining insight into access to help has also shown to be advantageous with various sources claiming mental health care for deaf people is often poor (Denmark, 1985) being limited to access by patients geographical location (Roberts, 1990). Specialised inpatient mental health programmes for the deaf are rare (Vernon et al, 1999), presently providing only one specialist mental health service for deaf children and adolescents (De Feu & Fergusson, 2003) based in London and only three deaf mental health service units across the whole of the United Kingdom (Baines, 2010). Controversially, the Department of Health (2005) contend there are five secondary care providers, however the additional two (St George's Healthcare and Nottingham Healthcare) have proven to be medium and high-security units, therefore not accessible to the general deaf community.

In contrast, subsequent to the NHS undertaking a review, 'A sign of the times' (2002), of mental health service provision (Mishcon et al, 2002) it's contended an expansion of deaf community services (Appleford, 2003) arose. With the £2.5 million (DOH, 2005) investment there are presently multidisciplinary teams of inpatient and outpatient care along with a national network of clubs and associations (De Feu & Fergusson, 2003). Nevertheless there is still a pressing need for wider available psychotherapeutic interventions (De Feu & Fergusson, 2003) combined with a need to establish the true extent of need (DOH, 2005). Using the Birmingham facility as an example, having 12 inpatient beds for the estimated population of 20 million within the geographical area covered, illustrates the extent of concern along with diagnostic difficulties (Denmark, 1996) where misinterpretation (Steinberg, 1991) can occur through the national shortage of BSL interpreters compelling relatives to attend appointments often not being competent signers (De Feu & Fergusson, 2003).

In correspondence with early research, recent work suggests a greater prevalence of personality disorders in the deaf population (Vernon et al, 1999) opposed to hearing individuals. Much psychological research focuses on the negative aspects of deafness using quantitative measures allowing little scope for subjective documentation. A minority of books have been established such as Corker's (1994) book into counselling and Harvey's' (2003) Psychotherapy book including direct accounts of patients. In spite of this Few autobiographical accounts (Thomas, 1981) exist suggesting more qualitative research needs to be conducted into such aspects as coping mechanisms, otherwise ignored in research.

Thus the study at hand aspires to gain in-depth insight into the unique minority group (Briffa, 2001) of profound (95+db) and severe (70-95db) pre-lingual deafness in individuals using British Sign Language as their first language. Encompassing both psychological issues and physiological deafness, a reliable and valid depiction of psychological and physiological interaction can be generated through interpersonal transcripts. In contrast to the vast majority of previous research around this paradigm, the investigation undertakes an interpretative phenomenological

stance facilitating to the lack of understanding of deaf culture (Steinberg, 1991), allowing open participant reflection without being subjected to closed measures.

## **Methodology**

### **Approach and rationale**

The current study explores insight into everyday life, availability of help and coping mechanisms of individuals who have both psychological issues and physiological pre-lingual deafness. With the notion little is still known about the disorder or about the effect on lives (Thomas, 1984) with existing psychological investigations favouring numerical data, a qualitative approach has shown to be necessary in obtaining subjective insights into the target areas to explore how individuals with first-hand knowledge perceive living with deafness, obtaining clinical help, dealing with stressors and the psychological implications on mental health.

Previous qualitative insight into mental and health and deafness has shown to be somewhat non-existent retaining little research around factors influencing mental health (Lawler, 1986), dominantly stating negative aspects and limiting subjective lived experience. Along with being knowledgeable qualitative research should strive to achieve understanding represented in a way that achieves coherence and integration while preserving nuances (Elliott, Fischer & Rennie, 1999), the present study has obtained insight into the lived experience of mental health and deafness along with the wider psychological implications. An Interpretative Phenomenological stance therefore has been implicated allowing direct subjective accounts into the target areas appropriately exerted.

### **Design and Sampling procedure**

A semi-structured interview design had been deemed appropriate consisting of five separate interviews endeavouring vigorous transcription shown to be affective in developing a keen understanding of the topic of interest (Cohen, 2006) for analysis. The consistent use of the semi-structured procedure permitted in-depth accounts of participant experiences allowing the evaluator to collect detailed data (World Bank, 2011) whilst encompassing a basic structure of target questions complying with research aims.

The study obtained five participants covering a wide spectrum of insights into mental health and deafness; A consultant psychiatrist/medical director at All Saints hospital for the deaf, A forensic psychologist at All Saints, A speech pathologist working with deaf adolescents, a post lingual/congenitally severely deaf individual (70-95db) and a family member of a deaf participant used, exceeding initial expectations of professional roles. Interviews were set at target minimum of six however a final participant had to be rejected, clarified in the reflection, due to timing matters.

With the notion five or six has sometimes been recommended as a reasonable sample size (Smith & Osborn, 2007) validity had proven not to be impinged upon. As an idiographic method (Brocki & Wearden, 2006) a consensus towards utilising smaller sample sizes seems to be emerging (Smith, 2004) noting the analysis of large scale transcriptions may fashion the loss of potentially subtle inflections of meaning (Collins & Nicolson, 2002) evident in Tuner et al's (2002) study of twelve participants were at this point data saturation had been achieved (Brocki & Wearden, 2006) suggesting smaller samples sizes are paramount in performing effective IPA.

All participants are intended to meet the homogenous sampling (Reid et al, 2005) criteria, sharing relevant knowledge and experience into mental health and deafness from a professional or direct perspective. Suitable potential participants were contacted via the snowball sampling method, typically used with unknown or rare populations (Spren, 1992), via e-mail and social networking being directed to appropriate individuals focusing on organisations caring for pre-lingual deaf individuals also having a mental health issue. Both specialists and deaf participants had to be carefully selected meeting the study criteria keeping ethics at the forefront of all recruitments.

### **Data collection**

Aligning with qualitative phenomena, the study at hand employed the semi-structured interview method across all participants with proven effectiveness in gaining insight and understanding (Gillham, 2000). Typically an interview of this kind will last from 30 to 60 minutes (Fox, 2009), to which all interviews met this criteria, thus a target length of 60 minutes per interviewee was aspired having little deviation as possible. A set of semi-structured questions, attempting to uncover positive and negative aspects, in a facilitative manner rather than interrogative, were used amended slightly for relevance in accordance with professional orientation or status as a deaf individual (APPX5).

The remaining segments were improvised depending on participant response and course allowing flexibility as well as structure, all of which conducted prior to briefing and obtaining informed consent (APPX2/3) complying with ethical considerations. It was thought deaf individuals may be interviewed over e-mail, however after focus narrowing to pre-lingual deafness using the written word to obtain reliable and accurate information from congenitally deaf individuals using BSL as a first language would not be sufficient due to capability. Thus the research made use of a BSL interpreter for the severely deaf individual in order to vocally record the interview.

### **Data Analysis method**

The research makes use of the bottom up (Flowers et al, 1997) psychological measure of Interpretative Phenomenological Analysis (IPA) originated by Jonathan Smith (1996). IPA has shown to be the most sufficient mode of analysis with the notion people are self- interpreting beings (Taylor, 1985) allowing an idiographic mode of inquiry opposed to the nomothetic approach (Smith et al, 1995) predominating in Psychology. Using Conrad's (1987) 'insider's perspective' it was conceivable to fully analyse individual cases before attempting to analyse the group (Weed, 2005) generating rich detail from a personal perspective. Thus the primordial aim of gaining in-depth insight into everyday life, availability of help and coping mechanisms of such individuals has been made possible to be explored from a phenomenological stance producing five objective statements (APPX12) (Smith, 2007) for analysis.

Each interview endured transcription with meticulous accuracy (Smith & Osborn, 2007) forming the concluding five transcriptions making it plausible to undergo analysis emphasising meanings, experiences and descriptions (Coolican, 1990). Such principles as Jefferson's (2004) Glossary of transcript symbols were incorporated in the form of a transcript key emphasizing such aspects as tone to be captured throughout the texts. Each transcript had been read though vigorously on

several occasions, being the initial stage (Smith & Osborn, 2003) of analysis, allowing direct immersion and interpretation (Landridge, 2007) of the text whilst being coded in considerable detail (Larkin et al, 2006).

Themes therefore were identified in the first case (Smith & Osborn, 2007) involving the preliminary coding and noting of initial comments in the left margin of each transcript annotating any significant quotes, connections or contradictions with the intent of obtaining emerging themes (APPX6/7). The focus involved shifting back and forth from the key claims of the participant (Larkin et al, 2006) to pragmatic interpretation capturing the core essence of analysis. With the close re-reading of the text (Smith et al, 1999) theme clusters evolved (APPX7). These were formulated from the individual correspondences between the initial themes in the coding procedure presented in tables and numbered 1-5 dependant on emergence in the transcripts (APPX7), clustered down producing a set of provisional themes having emergence scores of 4-5 in-keeping with relevance.

Themes clusters began to merge into seven subordinate themes (APPX7) in the subsequent stage suggesting an inter-correlational hierarchical relationship (Biggerstaff & Thompson, 2008). A table of master themes could then be constructed (APPX9) ensuring each was connected to the primary source material (Smith & Osborn, 2007), excluding material encountered seeming not to fit the emerging picture (Smith et al, 1995). Aligning with the nature of the research, the target areas were incorporated into the prompt sheet providing main themes for discussion with the participants (Biggerstaff & Thompson, 2008). However aligning with IPA conventions, these themes are merely the basis for a conversation (Biggerstaff & Thompson, 2008) not intended to limit the participant, thus kept broad allowing individualised interpretation forming the master themes; everyday life, therapeutic interventions and education (APPX7/8).

Each of these three themes provide the overall structure to the analysis imbedding the four dominant subthemes; language, coping mechanisms, emotional implications and social relationships proven to be primary subthemes in each section. Due to the nature of significant overlap throughout the subthemes, impinging on each other in accordance with the master themes, the subthemes are incorporated into the analysis under each master theme as a collaborative narrative account opposed to independent entities compensating for the extensive nature of correspondence.

As data collection does not set out to test a hypothesis (Larkin et al, 2006), the research reflects upon preconceptions with the notion of bracketing (Husserl, 1999), involving critical judgment and temporary refusal of critical engagement (Spinelli, 2002), allowing researchers subjective assumptions to be incorporated. Thus a narrative account, being the final analysis phase, has been produced being selective with master theme use anchoring participant's accounts through symbolic interactionism (Denzin, 1995) adjacent to a colour coding procedure allowing the construction of provisional themes (APPX9/10) assuring judicious data selection.

### **Ethical considerations**

The research employed the principles of the British psychological societies' (2006) ethical guidelines following procedures such as the construction of a research proposal to be inspected prior to obtaining ethical approval granted from Manchester

Metropolitan University (APPX1). Distinctive ethical procedures had been considered for hearing and deaf individuals, who may have psychological problems, due to the proposed vulnerability of the potential research participants (Fox, 2009). The standard ethical principles had been enforced for hearing participants with consent being obtained through the selection process accompanied by a brief (AAPX2/3) assuring the nature of the study is fully understood.

During the brief, participants had been made aware of their right to withdraw and offered the opportunity to state whether a pseudo-name was desired for confidentiality purposes, all stated in the consent form given prior to interviewing, thoroughly enforced throughout all data. Participants were kept protected from psychological harm, physiological is non-applicable, briefed with the knowledge they are not obliged to discuss matters which they would feel uncomfortable disclosing. Although health researchers have an ethical to implement innovative research techniques (Murray & sixsmith, 2002), the study aspired to be positive for all participants keeping the questions as minimally invasive as possible being sensitive to participants needs. No deception was necessary as all participants were fully aware of the research aims given in the participant informant sheet prior to consent, finally all being debriefed (APPX4) with the knowledge any data can be withdrawn promptly via the construction of anomalous personal codes.

In terms of hearing impaired individuals, it is proven minority deaf populations pose additional ethical aspects (Gutman, 2002) therefore following the correct ethical procedures is indispensable. Ethical procedures for deaf participants have shown to follow the same procedures, however extra consideration was needed ensuring understanding in obtaining conformed consent, slightly adjusting lexical arrangements and via the use of an interpreter also establishing participation ability. Correspondingly being emphatic to the fact deaf people need to know what subject matter will be discussed (RIT, 2011) interview draft was sent prior to interviewing both the interpreter and the deaf participant. All other procedures such as; briefing, the right to withdraw and protection from harm were equal to hearing participants with slight lexical deviations as deemed appropriate in written material, read using an interpreter.

Environmental factors correspondingly were taken into consideration, making the research process accessible (Young & Hunt, 2011) such as for those who may favour lip-reading. 'Paying attention to light' (Young & Hunt, 2011, p7) in that case would be of prime importance thus the interview setting was scrutinised prior to interviewing ensuring needs were met. Due to the pressing requirement for BSL, the avoidance of distractions and the use of non-verbal communication, said to convey the feeling of direct communication (Scha, 2014), were paramount. Accordingly a sound proof room was hired accompanied with a NRCP registered BSL interpreter ensuring the quality of signing was exceptional, certifying understanding and ensuring validity of the research.

### **Analysis and Discussion**

In exploring personalised accounts of mental health and deafness, the master themes; everyday life, therapeutic interventions and education arose from the data incorporated with the primary significant sub-themes; language, coping mechanisms and emotional influences. Each participant can be seen as sharing in-depth insight



into mental health and deafness from a divergent individualistic perspective thus participant profiles were constructed demonstrating a unique stance upon on a shared experience (APPX11).

### **Everyday life**

Everyday life proved to be a prominent feature amongst transcriptions. With the implication of research suggesting a higher incidence of psychiatric problems among deaf communities (DOH, 2005) proposing elevated feelings of isolation, insecurity and depression (Denmark, 1976) everyday life can be thought as being impinged upon from an emotional stance as demonstrated below:

*“Deaf population will be prone to: frustration...communication difficulties:- ...disempowerment disenfranchisement...it’s harder for them to make adjustments but they don’t necessary have psychiatric mental health problems.”*

*(Psychiatrist, 24-28)*

As stated above, not all deaf individuals are prone to psychiatric problems which must be emphasised throughout analysis however the research indicates higher prevalence:

*“The research indicates that mental health is higher in deaf population.”*  
*(Forensic psychologist, 9-10)*

Language and communication have shown to be prominent features influencing everyday life:

*“I wa:nt to be able: to...speak: and use- speech it wo:uld be good to be able to...have...a (.) voice so I could vocalise...concerns.”*

*“People...recognise a problem in communication and are reluctant to talk to me-...hearing people have mo:re choice and more ability to talk to anybo:dy...I don’t have that...access.”*

*(Deaf participant, 23-25, 2-36)*

Complying with above quotations, language has proven to exert undeviating effects on emotional implications feeling marginalised in society with the lack of ability to vocally communicate and express emotions. Social relationships proved encroached upon with the notion being born into deaf families is speculated to have direct implications to mental health (Austin & Klien, 1996).

*“If their family didn’t sign as well as them...the frustration:- the isolation...even with consoling you and validating you have a ri:ght...to be fed up:-...if you don’t ha:ve other competent communicators at ho:me...your emotional needs- are invisible”*

*(Speech Pathologist, 66-74)*

Aligning with the above quotation, competent communicators have shown to be paramount in maintaining psychological wellbeing, enabling expression of emotional concerns along with impacting on development (DOH, 2005) in obtaining educational preparation such as the norms and values (Haralambos & Holborn, 2000) acquired in primary socialisation (Parsons, 1959). However it has

deemed evident few families acquire sign language to an adequate level, if at all, to pass these skills on effectively, especially if English is a second language:

*“Very few families that I have come across in my experience since two thousand and five have actually learnt to sign.”*

(Forensic Psychologist, 57-58)

*“If English is a second language those families may not learn to sign:- because of the language barrier...those children don't get: the same type of communication- with their parents-.”*

(Speech Pathologist, 82-85)

*“You get a lot of if you like idiosyncratic sign language what's used at home as opposed to formalised BSL which is ok: between them...but it's not a formalised language in terms of the wider:...deaf population.”*

(Psychiatrist, 187-191)

In accordance, idiosyncrasies used in the home can be described as inadequate on a societal and educational level creating disadvantages in development. The level of communication between family members evidently impinges upon trust exerted in the quotation below showing reluctance to seek emotional support from parents in correspondence with a recent clinical example highlighting the impact on communication:

*“Sometimes I like have to say ca:rm down and well get it next time...I have to make her understand...but with my da:d-...she won't listen to him no...neither my mu:m- “.*

(Family member, 171-174)

*“I saw a deaf lady...in my clinic knocked down in a road traffic accident...has post-traumatic stress disorder and is subject to a compensation claim...I asked who's name will you put the money in she told me the interpreter (.) and another interpreter who works with them...and I said why:...she said because...I can communicate with them and I know and I trust them...defiantly not her sister-...defiantly not her mo:ther- her interpreters and possibly her partner...now that shows the impact of what communication is.”*

(Psychiatrist, 224-239)

Evidently, social influences arguably can give rise to isolation and exclusion, important influences in developing poor mental health (DOH, 2005). In a practical example of a reoccurring scenario entitled the 'dinner table syndrome' exclusion can be seen as impacting on home life:

*“Dinner table syndrome...your deaf child sitting there in a hearing family where everyone is talking about something while they e:at...the deaf child will be like...what have you just said...doesn't matter (1) doesn't matter (.) well just tell you later so you have hu:ge problems with identity.”*

(Forensic Psychologist, 65-70)

As palpable from the above quotation, many deaf individuals have shown to endure some level of exclusion when born to hearing parents, bearing in mind:

*“With pre-lingually profoundly deaf people...eighty-five to ninety percent are born to hearing parents-...so they are disadvantaged from a very early stage”*

(Psychiatrist, 134-136)

Thus having direct implications on self-actualization (Maslow, 1954). Evidently language restrictions, not exclusively from lacking primary socialisation but pre-lingual deafness itself, have proven to pose additional exclusion in society in terms of deviations from the perceived 'average' everyday life:

*“Needs: someone:- because...if she goes out for shopping:-...if somebody like behind her and saying excuse me she won't- hear:...if she crossing the ro:ad she differently needs somebody...subways:- were they is no- signals...she really stresses and struggles...so that's the restriction I think.”*

(Family member, 99-106)

The communication mode of British Sign Language unmistakeably is an effective communication style being sufficient in expressing emotions however subjectively limited to signing populations:

*“So while it's an ad-vantage: for communication as it allows them to express their emotions-...they can o:nly do it with a certain population they cannot do it with the hearing world...so:- on a day to day basis:- they're extremely disadvantaged.”*

(Psychiatrist, 75-79)

However, with most parents acquiring sign language to a basic level, arguably difficulties in communication are overcome with emotions being expressed through sign. It must also be highlighted deaf individuals born to deaf parents will have minimal communication difficulties therefore cannot be seen as being partially excluded in the family environment. Children from deaf families may also be emotionally stable having secondary relational bonds in the form of peers or external ties exerting their stressors, overcoming emotional barriers:

*“What you might find is th:ose young people are communicating mo:re with their peers- around emotional issues-...I don't kno:w- if they would*

*have long term mental health issues...it would depend on if they have a deaf peer group:"*

(Speech Pathologist, 91-96)

With previous quotations imbedding themes of interdependence and reliability on social reinforces, the use of other compensatory functions such as visual aids have proven to overcome restraint in everyday situations exerted below:

*"Where- they might need to ask a question to somebody who doesn't sign:-...with the mobile phones: and I pads:- you can ask those questions-."*

(Speech Pathologist, 173-175)

### **Therapeutic Interventions**

Therapeutic interventions/services, procedures and coping mechanisms revealed prominent themes throughout transcriptions. Aligning with literature stating mental health care for deaf people is often poor (De Feu & Fergusson, 2003) with specialised inpatient mental health programmes being rare (Daigle-King, 1999) there is a pressing need for wider availability of therapeutic interventions (Roberts, 1990) possessing a three to five times higher chance (Graff, 1998) of developing psychiatric problems.

*"In total...there's about forty six...Inpatient beds for the whole country."*

*"In the community:- there's very little."*

(Psychiatrist, 395-398, 372)

*"There are very few...it needs to improve massively"*

*"Actual inpatient hospitals...there's five...three of which aren't forensic."*

(Forensic Psychologist, 157, 148-149)

As specified above, psychological services for the deaf are extremely limited impinging on access and obtaining treatment dependent on geographical location (Roberts, 1990). Below shows the extent of service limitability for deaf individuals being placed on the same ward in despite of the diagnosed condition:

*"If you look at hearing services...each service is subsumed under a different specialism...with deaf services:...the only communality is the deafness- within the same environment you get people who are mentally ill:...people who are learning disabled...in treatment terms- it's extremely difficult: to get a consistent mili:ar of people."*

(Psychiatrist, 416-423)

Communication has shown to impeded on access to health promotion and care (DOH, 2005) with language proving an overarching contributor to obtaining the correct service:

*"They are hard to find...it's about information and understanding what words are and what services they are- that makes it very difficult to...acc:ess-."*

(Deaf participant, 102-104)

From a first-hand perspective it's demonstrated a large inequality of access to information and services (Briffa, 2001) exists for pre-lingual deaf populations.

With the majority treating on a referral basis only, the procedures involved have proven to be a lengthy process, in itself worsening psychological distress:

*"I don't there are any walk in services for deaf people...to- highly specialised services its very complex...the:y have to be assessed by...a gate-keeping: psychiatrist...who doesn't necessarily work with deaf people:...even though: their disadvantaged will say yah- he needs specialist services...it's quite a combined process...combined processes take time:...the condition is deteriorating all the time:-...this patient is wa:iting."*

(Psychiatrist, 440- 456)

Medical jargon provides serious issues in relation to patient understanding in general GP services with a proposed lack of understanding of deaf culture (Denmark, 1996) evident in the lack of BSL literate doctors using interpreters uncomfortable with medical terminology producing diagnostic dilemmas. This lack of communication between professionals and deaf clients (Austin, 1996) enforces misinterpretation (Denmark, 1996) and difficulties building therapeutic relationships (Steinberg, 1991) evident below:

*"Parents leave frustrated...they don't fee:l-...people have understood- the con:cerns:-...the professions think...that went pretty we:ll...there's a real-mi:ss-match: in understand:ing-."*

(Speech Pathologist, 111-114)

*"One in five: miss at least five appointments a year main:ly because communication- has broken do:wn."*

(Psychiatrist, 341-345)

*"Doctors...do:n't sign and...can be very fast speaking...I would need an interpreter with me."*

(Deaf Participant, 78-79)

Accordingly, interpreters are heavily relied upon by deaf individuals forming a substantial bond through effective communication, demonstrated previously impinging on trust. In terms of psychological services, confusion has proven to also arise in terms of abstract concepts due to the nature of psychological health:

*"When you're talking about concepts like depression...anxiety...hear:ing voices-...these:- are: far- mo:re- complex and abstract: terms...so you ha:ve to expand- tha:t concept-...you're not a hundred percent su:re of the deaf person's concepts...that's why...I usually bring in a deaf person."*

(Psychiatrist, 351-366)

Evidently, with the increased awareness of deaf needs, compensatory functions are used overcoming issues of patient understanding, expanding concepts and using deaf staff members as well as interpreters. As anticipated, a more significant therapeutic relationship emerges in these settings thus enhancing communication. As inpatient hospitals claim to not fully subscribe to interpreter

use in therapy sessions, interpersonal bonds can be made directly with the therapist shown below:

*"We don't support interpreter use in an actual therapy group...it's about...working together with the deaf colleagues."*

*"Sometimes you don't nee:d an extra person in your sessions...you need that therapeutic relationship-."*

(Forensic psychologist, 216-218, 191-192)

These therapeutic relationships have shown to increase treatment facilitation in terms of communicating problems, which sometimes patients do not wish to disclose proven upon interviewing:

*"Not +] really experienced anything like that."*

(Deaf Participant, 224)

It's also stated coping strategies are rare:

*"When they come in...patients- rarely ha:ve coping strategies."*

(Forensic Psychologist, 265)

Therefore, derived from the transcripts, the content of therapy sessions also prove to be empathic to deaf patients' needs understanding the emotional implications involved and appropriate procedures facilitating treatment progress:

*"You have to gi:ve quite pract-ical examples of things...their world is without wo:rds their world is in visual terms- so you paint a picture of: what your...trying to find o:ut...opposed to ask a wordy question."*

*"De:af- staff: are vital: because they bring in:...knowledge and experience...they: understand the frustrations."*

(Psychiatrist, 311-334, 509-511)

*"Very rarely do we find very many...understand...their medication if we want to commence new medication so we have to get a second opinion doctor."*

(Forensic Psychologist 134-137)

In accordance to treatment facilitators, Visual aids have been a reoccurring feature throughout transcriptions unanimously finding patients prefer this compensatory method, shown to be used in psychiatric settings:

*"If staff are speaking...and I'm singing whilst being able to loo:k at visual materials- then the interpreter is...able to translate more easier what we're talking about"*

(Deaf Participant, 198-201)

*“The majority of our patients find CBT very difficult...you have to find other strategies to support them...it might be using cognitive neural rehab model where you are providing them with pictures of maybe deep breathing or cognitive distraction- or maybe- challenging ones thought with pictures.”*

(Forensic Psychologist, 270-274)

In summary Psychological care has proven to be adapted well for treatment needs however there is a vast need for more services as well as enforcing vitality for specialised medical interpreters and signing specialists.

*“I very much worry- weather people who:- are deaf:...are getting the quality of information:...they need to make informed decisions...what you need...is have medical interpreters-...who are specially trained.”*

(Speech pathologist, 219-222)

### **Education**

Throughout the transcripts it has become apparent pre-lingual deaf children are at an educational disadvantage with early influences making it difficult to access education and employment (DOH, 2005), aligning with the quote below:

*“Majority of our patients...come from hearing families they’ve suffered huge deprivation in psychological knowledge- emotional knowledge- educa:tion.”*

(Forensic Psychologist, 108-110)

With the interference in pre-lingual deafness on the acquisition of speech and language (Stevens, 1980) it has been stated children leaving schools for the hearing impaired at the age of 16 are on average 8 years behind hearing peers (Conrad, 1997) mirrored throughout transcripts:

*“The average deaf school leaver...has a reading age of about eight to nine-...not only can they not communicate effectively with others...the conventional:- source of information gathering...the hearing population use...newspapers...magazines:-...the internet-...any sort of source of information you need to have to develop verbal language in this culture...access to...written material in the English written format is seriously limited”.*

(Psychiatrist, 88-98)

As a result many deaf school children have shown to develop emotional difficulties out of this frustration as demonstrated in the interviewing process:

*“She’s: going through a lot of psychological stress...it’s mainly- because she wants to get into higher education-...she’s really stressing and finding it really hard.”*

(Family member, 11-14)

With difficulty in conceptual understanding and language, the curriculum itself has proven to pose additional frustration in pre-lingual deaf individuals especially in the translation of mathematics and literacy impinging on progression:

*“the maths...some of it is just so:- advanced...the interpreter with me sometimes even struggles in terms of being to translate it which makes it very difficult for me to progress.”*

*“Interpreters...there no:t always specialised in a particular subject that yo:u might want to lea:rn- so A if you can you can get an interpreter and B is that interpreter going to be able to help yo:u access that course...to a high standard.”*

(Deaf participant, 315-318, 305-308)

*“Kids that have left at sixteen- say with some qualifications- but much mo:re vocational...literacy impacts their education.”*

(Speech Pathologist, 190-192)

As a result deaf children are taken out of specific subjects along with various other procedures complying with their needs as shown below lessening the emotional implications, however the essential units such as English and maths are still needed to access higher education.

*“What people do is acknowledge...certain subjects can be really difficult-...so they take them o:ut- in a one to one...people pre:-view:- to:pics:...before ha:nd...but some topics:...the rate of learning is just too qu:ick.”*

*“Lo:ads- of people use: i-pa:ds:-...they’ve- videoed part of the teach:ing-session: and go over it again:-.”*

(Speech Pathologist, 318-312, 340-342)

In addition to these factors, the educational environment can have altered implications on social relationships shown below in an example from a mainstream environment being stated to facilitate feelings of isolation:

*“I ha:ve also: worked with...deaf adolescents who are sig;n language users...the educational environment they were in:- didn’t have that many sign language users:- so their peer group became very very sm:all-...I th:ink- there’s emotional and psychological ramifications of having- having the sa:me peer group form the age of th-ree:- to sixteen.”*

(Speech pathologist, 23-28)

Contradictory, relationships with teachers have shown to be enhanced at mainstream schools in contrast to specialised deaf schools where ‘able’ children are shown to become emotionally excluded:



*“The population of children who get lost- are those children who are doing really well:-...but actually their needs are invisible:-...socially they may be very isolated-.”*

(Speech Pathologist, 287-292)

A stable relationship with a teacher for a deaf pupil has shown to be an important feature allowing expression of difficulties in understanding and emotional implications shown below:

*“They get a very close relationship with their teacher when they’re hearing impaired.”*

(Speech Pathologist, 354-355)

Therefore it can be documented teacher/interpreter-pupil relationships along with compensatory strategies are positive in terms of assisting educational and emotional needs for profoundly and severely deaf individuals. In contrast there is a high demand for BSL literate teachers and specialised subject interpreters that may impinge on academic achievement and thus psychological wellbeing in this population.

*“I think if more deaf tutors were available...that might be helpful.”*

(Deaf Participant, 327)

*“It’s a shame: there aren’t more schools:- for sign language users.”*

(Speech Pathologist, 194-195)

### **Reflexivity**

As a female final year undergraduate student, it was initially thought such a broad scale of professional participants may not be obtained not yet having a degree or professional occupation, accompanied by being the age of twenty, assuming the research would not be taken seriously. However, once obtaining psychical access to appropriate institutions, respectable professional participants were quickly obtained. As an aspired psychologist and an increased passion into researching deafness a respectable researcher-participant relationship emerged, conceivably from enthusiasm, creating a pleasurable, relaxed environment enhancing participant response.

In spite, access to participants was obtained though e-mailing various deaf organisations, only one of which agreed to participate, allowing the use of professionals and patients at All Saints hospital for the deaf. In accordance, time was spent at the hospital weekly attending ward rounds, CPA meetings and therapeutic interventions with the patients consent, furthering insights and building confidence in the potential participants through familiarity. However it was uncovered late in the research process the hospitals and patients approval was not sufficient enough to allow NHS patient participation along with the hospital director assisting in this process not being permitted to directly ask colleague’s to participate.

Thus separate e-mails were sent to professionals with the aspiration of three consenting, two were obtained from that source and another external professional. As profoundly and severely deaf individuals with a psychological disorder are a restricted group, only one severely deaf individual was interviewed along with a close

family member which was also aspired. A week before the finished product a profoundly deaf clinical psychologist, exceeding the final participants aspired requirements, agreed to participate however due to the lengthy transcription process, timing limitations could not allow this thus resulting in the total of five participants in contrast to the aspired six, however there is confidence that this has not affected validity.

A further struggle arose in the interviewing process of the severely deaf participant, being exclusively BSL reliant having limited lexical ability, participant responses were not as detailed as anticipated. As the questions intended to be open-ended the phrasing appeared awkward in terms of translation therefore the interpreter re-phrased various questions allowing the opportunity for limited responses. Nevertheless the responses obtained from the severely deaf participant have proven sufficient in providing captivating subjective insights

### Conclusion

The study has qualitatively explored the experiences of professionals and first-hand individuals into mental health and deafness. An interpretative Phenomenological analysis revealed the master themes; Everyday life, Therapeutic interventions and Education considered to represent underlying reoccurrences in the target populations experiences to be scrutinised by the various subthemes. The present findings build upon existing literature allowing direct qualitative insights into mental health and deafness from a personal perspective. Positive and negative aspects were also recorded in the form of compensatory functions/coping mechanisms adding weight to existing research. It is evident pre-lingual deafness and encompassing mental health disorders is a unique yet shared experience, thus a vast amount of commonality exists between the transcripts however exerting idiosyncrasies, displaying subjective insight into a shared experience.

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